RULE

Department of Health
Bureau of Health Services Financing
and
Office for Citizens with Developmental Disabilities

Act 421 Children's Medicaid Option
(LAC 50:I.3103, III.2331, and XXII.Chapters 81-85)

The Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities have amended LAC 50:I.3103, adopted III.2331, and repealed XXII.Chapters 81-85 in the Medical Assistance Program as authorized by R.S. 36:254, 46:977.21-977.25 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3103. Recipient Participation

A. The following Medicaid recipients shall be mandatory participants in managed care:

1. mandatory enrollees:

a. - i. ...

j. individuals and families who have more income than is allowed for Medicaid eligibility, but who meet the standards for the Regular Medically Needy Program;

k. individuals from age 19 to 65 years old at or below 133 percent of the federal poverty level with a 5 percent income disregard as provided in 42 CFR 435.119, hereafter referred to as the new adult group; or

l. individuals eligible through the Act 421 Children's Medicaid Option (421-CMO) program.

B. ...

1. Participation in a managed care organization (MCO) for the following participants is mandatory for specialized behavioral health, applied behavior analysis (ABA)-based therapy and non-emergency medical transportation (NEMT) services (ambulance and non-ambulance) only, and is voluntary for physical health services:

a. – a.vi. ...

b. individuals under the age of 21 who are otherwise eligible for Medicaid, and who are listed on the DHH Office for Citizens with Developmental Disabilities' request for services registry and not enrolled in the 421-CMO. These children are identified as Chisholm class members:

B.1.b.i. – I. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:1573 (June 2011), amended LR 40:310 (February 2014), LR 40:1096 (June 2014), LR 40:2258 (November 2014), LR 41:929 (May 2015), LR 41:2363 (November 2015), LR 42:754 (May 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:663 (April 2017), LR 43:1553 (August 2017), LR 44:1253 (July 2018), LR 47:

Part III. Eligibility
Subpart 3. Eligibility Groups and Factors

Chapter 23. Eligibility Groups and Medicaid Programs

§2331. Act 421 Children's Medicaid Option (TEFRA/Katie Beckett)

A. General Provisions

1. Pursuant to section 1902(e)(3) of the Social Security Act the state may extend Medicaid eligibility to certain children living in the community, who require the level of care provided in an institution, and who would be eligible for Medicaid if living in an institution.

2. Effective January 1, 2022, the department implements the Act 421 Children's Medicaid Option (421-CMO) program to provide Medicaid State Plan services to children with

disabilities who meet the eligibility criteria set forth in this Section, despite parental or household income and resources that would otherwise exclude them from Medicaid eligibility.

B. Eligibility Requirements. In order to qualify for the 421-CMO program, an individual must meet both programmatic and clinical eligibility requirements set forth herein.

`1. Programmatic Eligibility Requirements. In order to be eligible for the 421-CMO program, an individual must meet all of the following criteria:

a. is 18 years of age or younger (under 19 years of age);

b. is a U.S. citizen or qualified non-citizen;

c. is a Louisiana resident;

d. has or has applied for a Social Security Number;

e. has countable resources that are equal to or less than the resource limits for the Supplemental Security Income (SSI) program;

i. only the applicant/421-CMO enrollee’s resources shall be considered in determining eligibility for the 421-CMO program;

f. has countable income equal to or less than the special income level for long-term care services (nursing facility, ICF/IID, and home and community-based services);

i. only the applicant/421-CMO enrollee's income shall be considered in determining eligibility for the 421-CMO program;

g. has care needs that can be safely met at home at a lower cost than the cost of services provided in an institutional setting; and

h. is not otherwise eligible for Medicaid or CHIP.

2. Clinical Eligibility Requirements. In order to be eligible for the 421-CMO program, an individual must meet all of the following criteria:

a. qualifies as a disabled individual under section 1614(a) of the Social Security Act;

b. requires a level of care, assessed on an annual basis, provided in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a nursing facility, or a hospital;

i. an individual meets ICF/IID level of care when he/she:

(a). has obtained a statement of approval from the Office for Citizens with Developmental Disabilities or its designee, confirming that he/she has a developmental disability as defined in R.S. 28:451.2; and

(b). meets the requirements for active treatment of a developmental disability under the supervision of a qualified developmental disability professional, as prescribed on Form 90-L;

ii. an individual meets nursing facility level of care when he/she demonstrates one of the following two standards, assessed in accordance with the Act 421 children's Medicaid option assessment tool:

(a). Standard I

(i). the need for skilled nursing and/or therapeutic interventions on a regular and sustained basis; and

(ii). substantial functional limitations as compared to same age peer group in two of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation;

(b). Standard II

(i). substantial functional limitations as compared to same age peer group in four of the following areas: learning, communication, self-care, mobility, social competency, money management (for children 18 and older), work, and meal preparation;

iii. an individual meets hospital level of care when he/she demonstrates the following, assessed in accordance with the Act 421 children’s Medicaid 0ption assessment tool:

(a). the need for frequent and complex medical care that requires the use of equipment to prevent life-threatening situations, with skilled medical care required multiple times during each 24-hour period;

(b). the need for complex skilled medical interventions that are expected to persist for at least six months; and

(c). an overall health condition that is highly unstable and presents constant potential for complications or rapid deterioration, with the result that he/she requires continuous assessment by professional nurses, parents, or other properly instructed individuals, in order to detect unstable and life-threatening conditions and respond promptly with appropriate care.

C. Ineligibility for Services

1. 421-CMO enrollees shall be terminated from the 421-CMO program if admitted to an ICF/IID, nursing facility, or hospital without the intent to return to 421-CMO services.

a. A 421-CMO enrollee is deemed to intend to return to 421-CMO services when documentation is received from

the treating physician that the admission is temporary and shall not exceed 90 days

b. The 421-CMO enrollee will be discharged from the 421-CMO program on the ninety-first day after admission if the 421-CMO enrollee is still in the ICF/IID, nursing facility, or hospital.

D. Cost Effectiveness

1. On an annual basis, each 421-CMO enrollee's expenditures will be measured against the average cost of care in an institution that corresponds to his/her level of care (i.e. hospital, ICF/IID, nursing facility) to ensure that home and community-based care is more cost effective than institutional care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 47:

Part XXII. 1115 Demonstration Waivers
Subpart 9. Act 421 Children's Medicaid Option

Chapter 81. General Provisions

§8101. Purpose

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1676 (December 2020), repromulgated LR 47:43 (January 2021), repealed LR 47:

§8103. Effective Date and Administration

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1677 (December 2020), repromulgated LR 47:43 (January 2021), repealed LR 47:

§8105. Enrollee Qualifications and Admissions Criteria

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, LR 46:1677 (December 2020), repromulgated LR 47:43 (January 2021), repealed LR 47:

§8107. Admission Denial or Discharge Criteria

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1678 (December 2020), repromulgated LR 47:44 (January 2021), repealed LR 47:

§8109. Allocation of Act 421 Children's Medicaid Option Opportunities

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1678 (December 2020), repromulgated LR 47:44 (January 2021), repealed LR 47:

§8111. Eligibility and Enrollment

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:45 (January 2021), repealed LR 47:

Chapter 83. Services

§8301. Covered Services

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:46 (January 2021), repealed LR 47:

§8303. Service Delivery

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for

Citizens with Developmental Disabilities, LR 46:1679 (December 2020), repromulgated LR 47:46 (January 2021), repealed LR 47:

Chapter 85. Reimbursement

§8501. Reimbursement Methodology

Repealed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, 46:977.21-977.25, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office for Citizens with Developmental Disabilities, LR 46:1680 (December 2020), repromulgated LR 47:46 (January 2021), repealed LR 47:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Behavioral Health Services
Services for Targeted Populations
(LAC 50:XXXIII.Subpart 8)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have adopted LAC 50:XXXIII.Subpart 8 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH—MEDICAL ASSISTANCE
Part XXXIII. Behavioral Health Services
Subpart 8. Services for Targeted Populations

Chapter 71. General Provisions

§7101. Introduction

A. The Medicaid program hereby adopts provisions to provide coverage under the 1915(b)(3) waiver for services rendered to the targeted population of adults with mental health disorders who have transitioned from a nursing facility or been diverted from nursing facility level of care. These services shall be administered under the authority of the Department of Health, in collaboration with the managed care organizations

(MCOs), which shall be responsible for the necessary operational and administrative functions to ensure adequate service coordination and delivery.

B. Personal care services (PCS) rendered to adults shall be necessary to assist and provide supervision with activities of daily living or to restore the individual to his/her best possible functioning level in the community.

C. Individual placement and support (IPS) services rendered to adults shall be necessary to reduce the disability resulting from mental illness and to restore the individual to his/her best possible functioning level in the community.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:

§7103. Recipient Qualifications

A. The targeted population for the 1915(b)(3) services shall be Medicaid recipients who:

1. are at least 21 years of age;

2. have a qualifying mental health diagnosis;

3. meet medical necessity in accordance with LAC 50:I.1101; and

4. have transitioned from a nursing facility or been diverted from nursing facility level of care.

B. Recipients of personal care services (PCS) must meet the following additional recipient eligibility criteria:

1. recipients must be medically stable;

2. recipients shall not be enrolled in a Medicaid-funded program which offers a personal care service or related benefit; and

3. recipients' care needs do not exceed that which can be provided under the scope and/or service limitations of PCS.

C. An adult with a diagnosis of a substance use disorder or intellectual and developmental disability without an additional co-occurring qualifying mental health diagnosis shall not meet the criteria for mental health services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:

Chapter 73. Services

§7301. General Provisions

A. All services must be medically necessary, in accordance with the provisions of LAC 50:I.1101. The medical

necessity for services shall be determined by a licensed mental health practitioner or physician who is acting within the scope of his/her professional license and applicable state law.

B. All services must be prior authorized. Services which exceed the initial authorization must be approved for re-authorization prior to service delivery.

C. There shall be recipient involvement throughout the planning and delivery of services.

1. Services shall be:

a. delivered in a culturally and linguistically competent manner; and

b. respectful of the individual receiving services.

2. Services shall be appropriate to individuals of diverse racial, ethnic, religious, sexual, and gender identities and other cultural and linguistic groups.

3. Services shall be appropriate for:

a. age;

b. development; and

c. education.

D. Anyone providing services must operate within their scope of practice license.

E. Evidence-based practices require prior approval and fidelity reviews on an ongoing basis as determined necessary by department.

F. Services must be delivered in home and community-based settings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:

§7303. Covered Services

A. The following services for the targeted populations shall be reimbursed under the Medicaid Program:

1. personal care services (PCS); and

2. individual placement and support (IPS) services.

B. Service Exclusions. The following shall be excluded from Medicaid reimbursement:

1. components that are not provided to, or directed exclusively toward the treatment of, the Medicaid eligible individual; and

2. services provided at a work site which are not directly related to the treatment of the recipient’s needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:

Chapter 75. Provider Participation

§7501. Provider Responsibilities

A. Each provider of services for the target populations shall enter into a contract with one or more of the managed care organizations (MCOs) in order to receive reimbursement for Medicaid covered services.

B. Providers shall deliver all services in accordance with their license and scope of practice, federal and state laws and regulations, the provisions of this Rule, and other directives issued by the department. The provider shall create and maintain documents to substantiate that all requirements are met.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:

Chapter 77. Reimbursement

§7701. Reimbursement Methodology

A. The department, or its fiscal intermediary, shall make monthly capitation payments to the MCOs. The capitation rates

paid to the MCOs shall be actuarially sound rates and the MCOs will determine the rates paid to its contracted providers. No payment shall be less than the minimum Medicaid rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 47:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Federally Qualified Health Centers and Rural Health Clinics
Community Health Worker Services Alternative Payment Methodology
(LAC 50:XI.10703 and 16703)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XI.10703 and §16703 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH-MEDICAL ASSISTANCE
Part XI. Clinic Services
Subpart 13. Federally Qualified Health Centers

Chapter 107. Reimbursement Methodology

§10703. Alternate Payment Methodology

A. – H. ...

I. Effective for dates of service on or after January 1, 2022, the Medicaid Program shall reimburse for community health worker services through a separate payment outside the PPS rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health

Services Financing, LR 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1894 (October 2018), LR 44:2162 (December 2018), LR 45:434 (March 2019), amended LR 46:182 (February 2020), LR 47:1528 (October 2021), LR 47:

Subpart 15. Rural Health Clinics

Chapter 167. Reimbursement Methodology

§16703. Alternate Payment Methodology

A. – H. ...

I. Effective for dates of service or after January 1, 2022, the Medicaid Program shall reimburse for community health worker services through a separate payment outside the PPS rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:1036 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 44:1903 (October 2018), LR 44:2168 (December 2018), LR 45:435 (March 2019), amended LR 46:185 (February 2020), LR 47:1528 (October 2021), LR 47:

Dr. Courtney N. Phillips

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Managed Care for Physical and Behavioral Health
Independent Review Process for Provider Claims
(LAC 50:I.3111)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.3111 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50

PUBLIC HEALTH-MEDICAL ASSISTANCE
Part I. Administration
Subpart 3. Managed Care for Physical and Behavioral Health

Chapter 31. General Provisions

§3111. Independent Review Process for Provider Claims

A. Definitions

Abuse—provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

Fraud—an intentional deception or misrepresentation

made by a person or a provider with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person or entity. It includes any act that constitutes fraud under applicable federal or state law.

Mental Health Rehabilitation Provider—an outpatient healthcare program provider of any psychosocial rehabilitation (PRS), crisis intervention (CI) and/or community psychiatric support and treatment (CPST) services that promotes the restoration of community function and well-being of an individual diagnosed with a mental health or mental or emotional disorder.

Waste—over-utilization of services, or practices that result in unnecessary cost to the Medicaid program. Waste is generally not considered to be caused by criminally negligent actions but rather by misuse of resources. Any overpayment which is not considered either fraud or abuse, is considered waste.

B. Right of Providers to Independent Review

1. Pursuant to Act 349 of the 2017 Regular Session of the Louisiana Legislature, for adverse determination related to claims filed on or after January 1, 2018, a healthcare provider shall have a right to an independent review of the adverse action of the managed care organization (MCO).

a. – c. Repealed.

2. Pursuant to Act 204 of the 2021 Regular Session of the Louisiana Legislature, mental health rehabilitation service providers shall have a right to an independent review of an adverse determination taken by an MCO that results in a recoupment of the payment of a claim based upon a finding of waste or abuse.

3. For purposes of these provisions, adverse determinations shall refer to claims submitted by healthcare providers for payment for services rendered to Medicaid enrollees and denied by an MCO, in whole or in part, or a claim that results in recoupment of a payment from the healthcare provider.

C. Request for Reconsideration

1. A provider shall submit a written request for reconsideration to the MCO. The request shall identify the claim(s) in dispute, the reasons for the dispute, and any documentation supporting the provider's position or request by the MCO within 180 days from one of the following dates:

a. the date on which the MCO transmits remittance advice or other notice electronically;

b. 60 days from the date the claim was submitted to the MCO if the provider receives no notice from an MCO, either partially or totally, denying the claim; or

c. the date on which the MCO recoups monies

remitted for a previous claim payment.

2. The MCO shall acknowledge in writing its receipt of a reconsideration request submitted in accordance with §3111.C.1, within five calendar days after receipt of the request and, render a final decision by providing a response to the provider within 45 calendar days from the date of receipt of the request for reconsideration, unless another time frame is agreed upon in writing by the provider and the MCO.

3. – 9. Repealed.

D. Independent Review Requirements

1. If the MCO upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the provider may file a written notice with the department requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review within 60 days from the date the provider receives the MCO's notice of the decision of the reconsideration request, or if the MCO does not respond to the reconsideration request within the time frames allowed, the last date of the time period allowed for the MCO to respond.

2. The provider shall include a copy of the written request for reconsideration with the request for an independent review. The address to be used by the provider for submission

of the request shall be LDH/Health Plan Management, P.O. Box, 91030, Bin 24, Baton Rouge, LA 70821-9283, Attn: Independent Review.

3. If the MCO reverses the adverse determination pursuant to a request for reconsideration, payment of the claim(s) in dispute shall be made no later than 20 days from the date of the MCO’s decision.

4. Subject to approval by the department, a provider may aggregate multiple adverse determinations involving the same MCO when the specific reason for nonpayment of the claims aggregated involve a dispute regarding a common substantive question of fact or law.

5. Within 14 calendar days of receipt of the request for independent review, the independent reviewer shall request to be provided all information and documentation submitted for reconsideration regarding the disputed claim or claims within 30 calendar days.

6. If the independent reviewer determines that guidance on a medical issue from the department is required to make a decision, the reviewer shall refer this specific issue to the department for review and concise response to the request within 90 calendar days after receipt.

7. The independent reviewer shall examine all materials submitted and render a decision on the dispute within

60 calendar days. The independent reviewer may request in writing an extension of time from the department to resolve the dispute. If an extension of time is granted by the department, the independent reviewer shall provide notice of the extension to the provider and the MCO.

8. If the independent reviewer renders a decision requiring a MCO to pay any claims or portion of the claims, within 20 calendar days, the MCO shall send the provider payment in full along with 12 percent interest calculated back to the date the claim was originally denied or recouped.

9. Within 60 calendar days of an independent reviewer’s decision, either party to the dispute may file suit in any court having jurisdiction to review the independent reviewer’s decision to recover any funds awarded by the independent reviewer to the other party.

E. Independent Review Costs

1. The fee for conducting an independent review shall be paid to the independent reviewer by the MCO within 30 calendar days of receipt of a bill for services. A provider shall, within 10 days of the date of the decision of the independent reviewer, reimburse a MCO for the fee associated with conducting an independent review when the decision of the MCO is upheld. If the provider fails to submit payment for the independent review within 10 days from the date of the decision,

the MCO may withhold future payments to the provider in an amount equal to the cost of the independent review, and the department may prohibit that provider from future participation in the independent review process.

2. If the MCO representatives fails to pay the bill for the independent reviewer’s services, the reviewer may request payment directly from the department from any funds held by the state that are payable to the MCO.

3. Repealed.

F. Independent Reviewer Selection Panel

1. The independent reviewer selection panel shall select and identify an appropriate number of independent reviewers and determine a uniform rate of compensation be paid to each reviewer, not to exceed $2,000 per review.

2. The panel shall consist of the secretary or his/her duly designated representative, two provider representatives and two MCO representatives.

3. Each MCO shall utilize only independent reviewers who are selected in accordance with Act 349 of the 2017 Regular Session of the Louisiana Legislature, and shall comply with the provisions of this Section in the resolution of disputed adverse determinations.

G. Penalties

1. An MCO in violation of any provision governing

the independent review process herein may be subject to a penalty of up to $25,000 per violation.

a. – c. Repealed.

2. An MCO may be subject to an additional penalty of up to $25,000 if subject to more than 100 independent reviews annually and the percentage of adverse determinations overturned in favor of the provider as a result of an independent review is greater than 25 percent.

H. Independent Review Applicability

1. Independent review shall not apply to any adverse determination:

a. associated with a claim filed with an MCO prior to January 1, 2018, regardless of whether the claim is re-filed after that date;

b. associated with an adverse determination involved in litigation or arbitration;

c. not associated with a Medicaid enrollee.

2. Independent review does not otherwise prohibit or limit any alternative legal or contractual remedy available to a provider to contest the partial or total denial of a claim for payment for healthcare services. Any contractual provision executed between a provider and a MCO which seeks to limit or otherwise impede the appeal process as set forth in this Section shall be null, void, and deemed to be contrary to the public

policy of this state.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:283 (February 2018), amended LR 47:

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Dr. Courtney N. Phillips

Secretary