RULE

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

Children's and Adult Mental Health Services
(LAC 50:XXXIII.Chapters 23, 61, 63, and 65)

The Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health have amended LAC 50:XXXIII.Chapters 23, 61, 63, and 65 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 3. Children's Mental Health Services

Chapter 23. Services

§2301. General Provisions

A. All specialized behavioral health services must be medically necessary. The medical necessity for services shall be determined by a licensed mental health professional (LMHP) or physician who is acting within the scope of his/her professional license and applicable state law.

B. Services provided to children and youth must include communication and coordination with the family and/or legal

guardian and, for children in state custody, the custodial agency. Coordination with other child-serving systems should occur as needed to achieve the treatment goals. All coordination must be documented in the child's medical record.

1. The agency or individual who has the decision-making authority for a child or youth in state custody must request and approve the provision of services to the recipient.

C. Children who are in need of specialized behavioral health services shall be served within the context of the family and not as an isolated unit.

1. – 1.b. ...

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

C.3.c. – D. ...

E. Services may be provided at a site-based facility, in the community, or in the individual's place of residence as outlined in the treatment plan.

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2358 (November 2015), amended by the

Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018), LR 50:

§2303. Covered Services

A. The following behavioral health services shall be reimbursed under the Medicaid Program:

1. therapeutic services delivered by licensed mental health professionals (LMHP), provisionally licensed professional counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), or licensed master social workers (LMSW);

A.2. – B.5. ...

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 38:364 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:2359 (November 2015), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1892 (October 2018), LR 50:

Subpart 7. Adult Mental Health Services

Chapter 61. General Provisions

§6103. Recipient Qualifications

A. Individuals 21 years of age and older who meet Medicaid eligibility shall qualify to receive adult mental health services referenced in LAC 50:XXXIII.6307 if medically necessary in

accordance with LAC 50:I.1101, if the recipient presents with mental health symptoms that are consistent with a diagnosable mental disorder, and the services are therapeutically appropriate and most beneficial to the recipient.

B. – C. ...

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 38:358 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), LR 46:794 (June 2020), repromulgated LR 46:951 (July 2020), amended LR 50:

Chapter 63. Services

§6301. General Provisions

A. All mental health 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 professional or physician who is acting within the scope of his/her professional license and applicable state law.

B. – C.3.c. ...

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

E. – F. ...

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), repromulgated LR 46:952 (July 2020), amended LR 50:

§6303. Assessments

A. Assessments shall be performed by a licensed mental health professional (LMHP), provisionally licensed professional counselor (PLPC), provisionally licensed marriage and family therapist (PLMFT), or licensed master social worker (LMSW).

B. Assessments for community psychiatric support and treatment (CPST) and psychosocial rehabilitation (PSR) must be performed by a fully licensed mental health professional at least once every 365 days or any time there is significant change to the enrollee’s circumstances.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1014 (June 2018), amended LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 50:

§6305. Treatment Plan

A. – B.1. ...

C. The treatment plan shall be developed by the licensed mental health professional (LMHP) in collaboration with direct care staff, the recipient, family and natural supports.

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:60 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the

Office of Behavioral Health, LR 44:1014 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:951 (July 2020), amended LR 50

§6307. Covered Services

A. The following mental health services shall be reimbursed under the Medicaid Program:

1. therapeutic services delivered by licensed mental health professionals (LMHPs), provisionally licensed professional counselors (PLPC), provisionally licensed marriage and family therapists (PLMFT), or licensed master social workers (LMSW), and physicians;

A.2. – B.3. ...

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 38:359 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 46:1680 (December 2020), LR 48:1098 (April 2022), LR 50:

Chapter 65. Provider Participation

§6501. Provider Responsibilities

A. ...

B. Providers shall deliver all services in accordance with their license and scope of practice, with federal and state laws and regulations, the provisions of this Rule, the provider manual and other notices or 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 and Hospitals, Bureau of Health Services Financing, LR 38:360 (February 2012), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Behavioral Health, LR 41:378 (February 2015), LR 42:61 (January 2016), amended by the Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, LR 44:1015 (June 2018), LR 46:795 (June 2020), repromulgated LR 46:952 (July 2020), amended LR 50:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Inpatient Hospital Services
(LAC 50:V.121, 123, 125, and 127)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:V.121, 123, 125, 127 and repeal the following uncodified Rules in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to Title XIX of the Social Security Act:

Register Date	Title	Register Volume, Number	Page Number
January 20, 1994	Inpatient Psychiatric Services - Distinct Part Psychiatric Units	Volume 20, No. 01	49
February 20, 1997	Hospital Prospective Reimbursement Methodology for Long-Term Acute Hospitals	Volume 23, No. 02	202

This Rule is promulgated in accordance with the provisions of the Administrative Procedures Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part V. Hospital Services
Subpart 1. Inpatient Hospital Services

Chapter 1. General Provisions

§121. Distinct Part Psychiatric Units

A. Qualifying Criteria. Reimbursement of psychiatric services (including substance use treatment) provided by acute

care general hospitals, long-term acute hospitals, children's hospitals, and rehabilitation hospitals is allowable only for psychiatric services provided in distinct part psychiatric units that meet the following criteria:

1. Medicare prospective payment system (PPS) exempt psychiatric unit criteria in 42 CFR 412.27 and other applicable Medicare guidelines;

2. licensing standards related to hospital psychiatric units/services in LAC 48:I.Chapters 93, 94, and 95; and

3. enrolled in Medicaid and assigned a separate distinct part psychiatric unit provider number.

EXCEPTION: Emergency psychiatric admissions to non-psychiatric inpatient hospitals/units shall be paid the psychiatric rate until the beneficiary can be stabilized and transferred to a psychiatric hospital or unit.

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 50:

§123. Psychiatric Hospitals

A. Qualifying Criteria. Reimbursement of inpatient psychiatric services (including substance use treatment) provided by freestanding psychiatric hospitals is allowable only

if provided in psychiatric hospitals that meet the following criteria:

1. Medicare prospective payment system (PPS) exempt psychiatric hospital criteria in the 42 CFR 412.23(a), other applicable Medicare guidelines; and

2. licensing standards related to psychiatric services/hospitals in LAC 48:I.Chapters 93, 94, and 95.

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 50:

§125. Rehabilitation Hospitals

A. Qualifying Criteria. Reimbursement of inpatient rehabilitation services provided by freestanding rehabilitation hospitals is allowable only if provided in rehabilitation hospitals that meet the following criteria:

1. Medicare prospective payment system (PPS) exempt rehabilitation hospital criteria in 42 CFR 412.23(b) and other applicable Medicare guidelines; and

2. licensing standards related to rehabilitation services/hospitals in LAC 48:I.Chapters 93, 94, and 95.

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 50:

§127. Long-Term Hospitals

A. Qualifying Criteria. Reimbursement as a long-term hospital is only allowable for inpatient services provided in hospitals that meet the Medicare prospective payment system (PPS) exempt long-term hospital criteria in 42 CFR 412.23(e) and other applicable Medicare guidelines.

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 50:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Pharmacy Benefit Management Program
Excluded Drugs
(LAC 50:XXIX.107)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:XXIX.107 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 XXIX. Pharmacy

Chapter 1. General Provisions

§107. Prior Authorization

A. – C.3. ...

D. Drugs Excluded from Coverage. As provided by §1927(d)(2) of the Social Security Act, the following drugs are excluded from program coverage:

1. select covered outpatient drugs when used for anorexia, weight loss, or weight gain as determined by the department;

2. select covered outpatient drugs when used to promote fertility as determined by the department;

3. select covered outpatient drugs when used for symptomatic relief of cough and cold as determined by the department;

4. select prescription vitamin and mineral covered outpatient drugs as determined by the department; and

a. – o. Repealed.

D.5. – E.2. ...

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, Title XIX of the Social Security Act, and the 1995-96 General Appropriate Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:1053 (June 2006), amended by the Department of Health, Bureau of Health Services Financing, LR 43:1180 (June 2017), LR 43:1553 (August 2017), LR 45:665 (May 2019), LR 46:33 (January 2020), LR 48:1582 (June 2022), LR 49:2106 (December 2023), LR 50:

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.

Michael Harrington, MBA, MA

Secretary

RULE

Department of Health
Bureau of Health Services Financing

Provider Screening and Enrollment
(LAC 50:I.Chapter 15)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.Chapter 15 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 1. General Provisions

Chapter 15. Provider Screening and Enrollment

§1501. General Provisions

A. Pursuant to the provisions of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148, 42 C.F.R. § Part 455, Subpart E, and the 21st Century Cures Act, the Medicaid Program adopts the following provider enrollment and screening requirements. The Centers for Medicare and Medicaid Services (CMS) has established guidelines for provider categorization based on an assessment of potential for fraud, waste, and abuse for each provider type. The Medicaid Program shall determine the risk level for providers and will adopt

these federal requirements in addition to any existing requirements. Providers must comply with all applicable federal regulations and state requirements for their provider type prior to enrollment with the Medicaid Program. Additional enrollment requirements may be adopted in the future.

B. In accordance with PPACA and federal regulations, the Medicaid Program shall screen all initial applications, including applications for a new practice location, and any applications received in response to a re-enrollment or revalidation, utilizing the following guidelines. If a provider could fit within more than one risk level described in this section, the highest level of screening is applicable.

1. Provider types shall be categorized by the following risk levels:

a. high categorical risk—categories of service that pose a significant risk of fraud, waste, and abuse to the Medicaid Program;

b. moderate categorical risk—categories of service that pose a moderate risk of fraud, waste, and abuse to the Medicaid Program;

c. limited categorical risk—categories of service that pose a minor risk of fraud, waste, and abuse to the Medicaid Program.

C. Screening activities for the varying risk levels shall include the following mandates.

1. High risk level screening activities shall include:

a. fingerprinting submission by the provider and any person with a 5 percent or more direct or indirect ownership interest in the provider, within 30 days upon request from CMS or the Department of Health (LDH);

b. criminal background checks for all disclosed individuals;

c. site visits before and after enrollment by LDH and/or CMS, its agents, or designated contractors; and

i. – v. Repealed.

d. verification of provider-specific requirements including, but not limited to:

i. license verification;

ii. national plan and provider enumeration system (NPPES) national provider identifier (NPI) registry check;

iii. Office of Inspector General (OIG) exclusion check;

iv. disclosure of ownership/controlling interest information;

v. the Social Security Administration’s death master file (SSA DMF) check;

vi. Medicaid and Children’s Health Insurance Program (CHIP) state information sharing system (MCSIS) check;

vii. systems for award management (SAM) check;

viii. LA adverse actions check; and

ix. provider enrollment, chain, and ownership system (PECOS) check.

2. Moderate risk level screening activities shall include:

a. site visits before and after enrollment by LDH and/or CMS, its agents, or designated contractors; and

b. verification of provider-specific requirements including, but not limited to:

i. ...

ii. NPPES NPI check;

iii. ...

iv. disclosure of ownership/controlling interest information;

v. SSA DMF check;

vi. MCSIS check;

vii. SAM check;

viii. LA adverse actions check; and

ix. PECOS check.

3. Limited risk level screening activities shall include, but are not limited to:

a. verification of provider-specific requirements including:

i. ...

ii. NPPES NPI check;

iii. ...

iv. disclosure of ownership/controlling interest information verification;

v. SSA DMF check;

vi. MCSIS check;

vii. SAM check;

viii. LA adverse actions check; and

ix. PECOS check.

D. The Medicaid Program may rely on, but is not limited to, the results of provider screenings performed by:

1. ...

2. other Medicaid agencies; or

3. CHIP of other states.

E. Updated Medicaid enrollment forms may require additional information for all disclosed individuals.

F. Providers shall be required to revalidate their enrollments with the Medicaid Program at a minimum of five year intervals. A more frequent revalidation requirement, a minimum of three year intervals, shall apply to durable medical equipment (DME) providers and pharmacy providers with DME or home medical equipment (HME) specialty enrollments. All providers shall be required to revalidate their enrollment under PPACA and Medicaid criteria.

1. Repealed.

G. Provider Screening Application Fee

1. In compliance with the requirements of the PPACA and 42 C.F.R. § 455.460, the department shall collect an application fee for provider screening prior to executing provider agreements from prospective or re-enrolling providers other than:

a. individual physicians or non-physician practitioners; or

G.1.b. – G.2. ...

H. After deactivation of a provider enrollment number for any reason, before the provider’s enrollment may be reactivated, the department must re-screen the provider and require payment of associated provider application fees.

I. Any enrolled provider is subject to CMS, its agents, its designated contractors, or the department conducting

unannounced on-site inspections of any and all provider locations.

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 39:1051 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 44:920 (May 2018), LR 50:

§1503. Termination or Denial of Provider Enrollment

A. The department will deny or terminate a provider's enrollment in the Medical Assistance Program in accordance with 42 C.F.R. § 455.416.

1. – 2.a. Repealed.

B. The department may deny or terminate a provider's enrollment in the Medical Assistance Program for any of the grounds listed in R.S. 46:437.14.

1. – 2. Repealed.

C. The department may deny a provider's application for enrollment in the Medical Assistance Program if, based on the grounds listed in R.S. 46:437.14, the secretary determines that the denial is in the best interest of the Medical Assistance Program and the department specifies the reasons for denial, as permitted by R.S. 46:437.13(C)(2).

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 39:1052 (April 2013), amended by the Department of Health, Bureau of Health Services Financing, LR 50:

§1505. Informal Hearing

A. A provider, or their agent, who seeks to appeal a notice of action issued by the department may first request an informal hearing with the department.

1. – 3.c.ii.(d). Repealed.

B. A provider, or their agent, who has received a notice of action shall be provided with an informal hearing if the provider, or their agent, makes a written request to the department for an informal hearing within 15 days of the date of the notice of action.

C. The notice of action is presumed to be received by the provider if the notice is mailed to the provider’s mailing address listed with the Medicaid Program or if the notice is electronically mailed to the provider’s e-mail address listed with the Medicaid Program.

D. The request for an informal hearing must be made in writing and sent in accordance with the instructions in the notice of action.

E. The time and place for the informal hearing will be set out in the notice of setting of the informal hearing.

F. The informal hearing is designed to provide the opportunity:

1. for the provider or agent of the provider to informally review the situation and action proposed by the department;

2. for the department to offer alternatives based on information presented by the provider or agent of the provider, if any; and

3. for the provider or agent of the provider or other person to evaluate the necessity for seeking an administrative appeal. During the informal hearing, the provider or agent of the provider may be afforded the opportunity to talk with the department’s personnel involved in the situation, to review pertinent documents on which the alleged violations are based, to ask questions, to seek clarification, to provide additional information and be represented by counsel or other person. Upon agreement of all parties, an informal discussion may be recorded or transcribed.

G. At any time prior to the issuance of the written results of the informal hearing, the notice of action may be modified by the department.

1. If a finding or reason is removed from the notice of action by the department, no additional time will be granted to the provider, or their agent, to prepare for the informal hearing.

2. If additional reasons or actions are added to the notice of action prior to, during, or after the informal hearing, the provider, or their agent, shall be granted an additional 10 working days to prepare responses to the new reasons or actions proposed by the department, unless the 10-day period is waived by the provider, or their agent.

H. Notice of the Results of the Informal Hearing. Following the informal hearing, the department shall inform the provider, or their agent, in writing of the results of the informal hearing, which could range from modifying or upholding the termination, denial, or other actions contained in the notice. The notice of the results of the informal hearing must be signed by the director of the Bureau of Health Services Financing (BHSF) or their designee and the section chief of Medicaid Program Operations and Compliance or their designee.

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 45:273 (February 2019), amended LR 50:

§1507. Administrative Appeal

A. The provider, or their agent, has the right to request an administrative appeal within 30 days of the date of the notice of action or within 30 days of the date of the notice of the results of the informal hearing.

B. The appeal request must be adequate as to form and timely lodged with the Division of Administrative Law.

C. The notice of action and the notice of the results of the informal hearing are presumed to be received by the provider if the notice is mailed to the provider’s mailing address listed with the Medicaid Program or if the notice is electronically mailed to the provider’s e-mail address listed with the Medicaid Program.

D. The department shall not terminate an existing Medicaid provider agreement unless the provider, or their agent, has exhausted their appeal rights, the timeframe for an appeal has expired, or the termination is permitted due to the imposition of sanction(s) by the department and the director of Program Integrity pursuant to LAC 50:I.4101 et seq.

E. The provider’s termination or denial in the Medicaid Program will become final if the provider, or their agent, does not timely request an appeal in accordance with the appeal deadlines described in this Subpart or once the provider’s appeal rights are otherwise exhausted.

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 50:

§1509. Basis of Administrative Appeal

A. A provider, or their agent, may only appeal to the Division of Administrative Law a notice of action or a notice of the results of the informal hearing issued by the department that terminates or denies the provider’s enrollment in Medicaid. Other actions by the department related to Medicaid provider enrollment and screening are not appealable.

1. If the provider, or their agent, timely requests an administrative appeal, then the provider, or their agent, has the right to challenge the basis for the termination or denial imposed by the department related to the provider’s Medicaid enrollment, provider enrollment application, and/or the revalidation application.

2. The provider, or their agent, must specifically state the basis for the appeal and the actions challenged on appeal.

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 50:

§1511. Out-of-State Medicaid Provider Enrollment

A. An out-of-state provider is a provider located in a state other than Louisiana whose services are rendered in that state, excluding Louisiana Medicaid trade areas.

B. An out-of-state provider who wishes to participate in the Louisiana Medicaid Program must enroll with the Louisiana Medicaid Program and be assigned an identification number.

C. To enroll, the provider must submit a provider enrollment application to Louisiana Medicaid.

D. A retroactive provider enrollment date of no more than 365 days may be considered for approval by the department under the following circumstances:

1. A provider requests that the enrollment be retroactive to a specific date.

2. The provider submits proof of service rendered to a Louisiana Medicaid beneficiary within 365 days prior to the application received date, via submission of the claim.

3. All risk screening activities support that the provider was eligible as of the requested date of enrollment.

E. Out-of-state providers must accept Louisiana Medicaid reimbursement as payment in full for the covered services authorized. The department reserves the right to set rates for services.

F. Out-of-state providers who furnish services to Medicaid beneficiaries are not required to be enrolled if they meet the following criteria as detailed in the CMS Medicaid Provider Enrollment Compendium:

1. the item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state practice location;

2. the furnishing provider's NPI is on the claim;

3. the furnishing provider is enrolled and in an approved status in Medicare or in another state's Medicaid plan;

4. the claim represents services furnished; and

5. the claim represents either:

a. a single instance of care furnished over a 180-day period; or

b. multiple instances of care furnished to a single beneficiary over a 180-day period.

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 50:

§1513. Out-of-Network Providers

A. Out-of-network providers under single case agreements are not considered network providers and therefore are not subject to the requirements at 42 C.F.R. § 438.602(b). Out-of-

network providers do not have to be screened and/or enrolled in the department’s fee-for-service program. Additionally, emergency room physicians are only subject to 42 C.F.R. § 438.602(b) to the extent they meet the definition of a network provider in 42 C.F.R. § 438.2.

B. The department may adopt limits or thresholds that require out-of-network providers to convert to an in-network status upon reaching a specific threshold of services provided to a network beneficiary or beneficiaries. A provider’s conversion to an in-network status triggers the requirement for the provider to be screened and enrolled pursuant to 42 C.F.R. § 438.602(b)(1).

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 50:

§1515. Temporary Moratoria

A. The department will comply with 42 C.F.R. § 455.470, which pertains to the imposition of temporary moratoria on the enrollment of new providers or provider types as implemented by the secretary of the U.S. Department of Health and Human Services (HSS).

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 50:

§1517. Managed Care Organization Payment Accountability and Provider Credentialing

A. All managed care organizations (MCOs) participating in the Medical Assistance Program must comply with all requirements described in R.S. 46:460.72 and R.S. 46:460.73, which pertain to provider notices and payment accountability.

B. A provider who receives a notification of deficiency from a Medicaid MCO as described in R.S. 46:460.73(A)(1) may seek review of the matter to the department if the conditions of R.S. 46:460.73(A)(2) apply. The provider must notify the department of their intent to appeal the notification within 10 calendar days of the date of the MCO’s notification and provide a detailed request for departmental review with supporting documents within 15 calendar days of the date of the MCO’s notification.

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 50:

§1519. Definitions

A. As used in this Subpart the following terms shall have the following meanings:

1. *Agent*—a person who is employed by or has a contractual relationship with a provider or who acts on behalf of the provider.

2. *Beneficiary*—an individual who is enrolled to receive health care through the Medical Assistance Program.

3. *Claim*—any request or demand, including any and all documents or information required by federal or state law or by rule made against Medical Assistance Program funds for payment. A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. Each claim may be treated as a separate claim, or several claims may be combined to form one claim.

4. *Department*—the Louisiana Department of Health (LDH).

5. *Disclosed Individuals*—persons required to be disclosed to the department, as the Medicaid agency, by the provider, such as, but not limited to:

a. *Agents or Managing Employees*–Pursuant to 42 C.F.R. § 455.106(a), a provider must disclose to the Medicaid agency the identity of each person who is an agent or managing employee of the provider and has been convicted of certain crimes. An agent or managing employee is any individual who

exercises operational or managerial control, conducts day-to-day operations of the provider agency, or any person with authority to obligate or act on behalf of the disclosing entity, such as, but not limited to, a general manager, business manager, administrator, board member, chief operating officer, trustee, or partner.

b. *Persons with Ownership or Control Interest*– Pursuant to 42 C.F.R. §455.104(b), a provider must disclose the identity of all persons that have an ownership or control interest (either separately or in combination) of 5 percent or more in the provider.

6. *Division of Administrative Law*—the Louisiana Division of Administrative Law, which operates as Louisiana's centralized administrative hearings panel for disputes between government agencies and regulated individuals and entities.

7. *Federal Regulations*—the provisions contained in the Code of Federal Regulations (C.F.R.) or the Federal Register (FR).

8. *General Terms*—Definitions contained in applicable federal laws and regulations shall also apply to this Subpart and all department regulations. In the case of a conflict between federal definitions and departmental definitions, the department's definition shall apply unless the federal definition, as a matter of law, supersedes a departmental

definition. Definitions contained in applicable state laws shall also apply to this and all departmental definitions. In the case of a conflict between a state statutory definition and a departmental definition, the departmental definition shall apply unless the state statutory definition, as a matter of state law, supersedes the departmental definition.

9. *Informal Hearing*—an informal conference between the provider, or other persons and the section chief of Medicaid Program Operations and Compliance or his/her designee and the Medicaid director or his/her designee.

10. *Medical Assistance Program or Medicaid*—the Medical Assistance Program (Title XIX) of the Social Security Act administered by the Department of Health, commonly referred to as Medicaid, the Medicaid Program, or Bureau of Health Services Financing (BHSF).

11. *Notice of Action*—a written notification of an action taken or to be taken by the department or BHSF, including a notice of termination of enrollment in the Medicaid Program or a notice of denial of enrollment in the Medicaid Program.

12. *Person*—any natural person, company, corporation, partnership, firm, association, group, or other legal entity or as provided by law.

13. *Provider*—a health care provider as defined in R.S. 46:437.3(A)(9).

14. *Provider Agreement*—the document(s), including electronic documents, signed by or on behalf of the provider in accordance with R.S. 46:437.11-437.14, which enrolls the provider in the Medical Assistance Program and grants to the provider a provider number and the privilege to participate in the Medical Assistance Program. This definition shall not be construed to conflict with the definition of provider agreement included in R.S. 437.3(A)(21).

15. *Provider Enrollment*—the process through which a person or provider becomes enrolled in the Medical Assistance Program through the department for the purpose of providing goods, services, or supplies to one or more Medicaid beneficiaries.

16. *Provider Number*—a provider's billing or claim reimbursement number issued by the department through BHSF under the Medical Assistance Program.

17. *Rule or Regulation*—any rule or regulation promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

18. *Secretary*—the Secretary of the Department of Health.

19. *Termination*—the termination or revocation of the provider agreement with the department to participate in the Medical Assistance Program. In a termination action, the state Medicaid agency has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to:

a. fraud;

b. integrity; or

c. quality.

20. *Trade Areas*—Arkansas, Mississippi, and Texas counties directly touching Louisiana parish borders. Trade areas are treated with the same criteria as in-state providers.

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 50:

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.

Michael Harrington, MBA, MA

Secretary