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 and 42 CFR Part 455, Subpart E, 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. 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.

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 and criminal background checks for all disclosed individuals;

b. unannounced site visits before and after enrollment; and

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

i. license verification;

ii. national provider identifier (NPI) check;

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

iv. disclosure of ownership/controlling interest information; and

v. the Social Security Administration's death master file check.

2. Moderate risk level screening activities shall include:

a. unannounced site visits before and after enrollment; and

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

i. license verification;

ii. NPI check;

iii. OIG exclusion check;

iv. disclosure of ownership/controlling interest information; and

v. the Social Security Administration's death master file check.

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

a. verification of provider-specific requirements including:

i. license verification;

ii. NPI check;

iii. OIG exclusion check;

iv. disclosure of ownership/controlling interest information verification; and

v. the Social Security Administration's death master file check.

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

1. Medicare contractors;

2. Medicaid agencies; or

3. Children's Health Insurance Programs (CHIP) of other states.

E. Updated Medicaid enrollment forms shall 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. Existing providers shall be revalidated in phases, with completion scheduled for March 23, 2015.

G. Provider Screening Application Fee

1. In compliance with the requirements of the Affordable Care Act and 42 CFR 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; and

b. providers who:

i. are enrolled in title XVIII of the Social Security Act;

ii. are enrolled in another state's title XIX or XXI plan; or

iii. have paid the applicable application fee to a Medicare contractor or another state.

2. The department shall return the portion of all fees collected which exceed the cost of the screening to CMS.

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).

§1503. Temporary Moratoria

A. The secretary of the U.S. Department of Health and Human Services (HSS) will consult with the Department of Health and Hospitals (DHH) regarding the imposition of temporary moratoria on enrollment of new providers or provider types prior to imposition of the moratoria.

1. DHH shall impose temporary moratoria on enrollment of new providers or provider types identified by the HHS secretary as posing an increased risk to the Medicaid program.

2. DHH shall not be required to impose such a moratorium if it is determined that imposition of a temporary moratorium would adversely affect recipient's access to medical assistance.

a. If making such a determination, DHH must notify the HHS secretary in writing.

B. DHH may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits that the department identifies as having a significant potential for fraud, waste or abuse, and that the HHS secretary has identified as being at high risk.

1. Before implementing the moratoria, caps or other limits, DHH must determine that its action would not adversely impact beneficiaries' access to medical assistance.

2. DHH must notify the HHS secretary in writing in the event the department seeks to impose such moratoria, including all details of the moratoria, and obtain the secretary's concurrence with imposition of the moratoria.

C. The department must impose the moratorium for an initial period of six months, and if necessary, extend the moratorium in six month increments.

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).

§1505. Managed Care Organization Payment Accountability and Provider Credentialing

A. In compliance with the requirements of Act 489 of the 2018 Regular Session of the Louisiana Legislature, the Department of Health adopts the following payment accountability and provider credentialing requirements for managed care organizations (MCOs) participating in the Medical Assistance Program.

1. Managed care organizations shall ensure that contracted or enrolled providers have met and continue to meet Medicaid provider enrollment, credentialing and accreditation requirements and other applicable state or federal requirements in order to receive reimbursement for services provided to Medicaid recipients.

2. Managed care organizations that fail to ensure proper compliance with Medicaid provider enrollment, credentialing or accreditation requirements shall be liable for reimbursement to providers for services rendered to Medicaid recipients, until such time as the deficiency is identified by the MCO and notice is issued to the provider pursuant to R.S. 46:460.72.

3. Managed care organizations shall withhold reimbursement for services provided during the 15 day remedy period after notice of the deficiency is identified by the MCO, or during a longer period if allowed by LDH, if the provider elects to continue rendering services while the deficiency is under review.

a. If the deficiency is remedied, the MCO shall remit payment to the provider.

b. If the deficiency is not remedied, nothing in this Section shall be construed to preclude the MCO from recouping funds from the provider for any period in which the provider was not properly enrolled, credentialed or accredited.

c. If the deficiency cannot be remedied within 15 days, the provider may seek review by the department if he/she believes the deficiency was caused by good faith reliance on misinformation by the MCO and asserts that he/she acted without fault or fraudulent intent, there is no deficiency, or because of reliance on misinformation from the MCO, an exception should be made to allow reasonable time to come into compliance so as to not disrupt patient care.

i. After the initial notification of deficiency, the provider shall notify the department of his/her intent to appeal the decision within 10 calendar days of receipt of the MCO's notification, and provide a detailed request for departmental review with supporting documents within 15 calendar days of receipt of the MCO's notification.

(a). The provider shall prove absence of fault or fraudulent intent by producing guidance, applications or other written communication from the MCO that bears incorrect information, including whether the misinformation or guidance was contradictory to applicable Medicaid manuals, rules, or policies.

ii. The department shall review all materials and information submitted by the provider and shall review any information necessary that is in the custody of the MCO to render a written decision within 30 days of the date of receipt for review submitted by the provider.

(a). If the department's decision is in favor of the provider, a written decision shall be sent to the provider and the MCO via certified mail and the provider shall be afforded reasonable time to remedy the deficiency caused by the misinformation of the MCO. During this time, the

provider shall be allowed to provide services and submit claims for reimbursement.

(i). The MCO shall be responsible for payment to the provider and may be subject to penalties by the department in accordance with contract provisions, or rules and regulations promulgated pursuant to the Administrative Procedure Act.

(b). If the department's decision is in favor of the MCO, the provider's contract shall be terminated immediately, pursuant to the notice provided for in R.S. 46:460.72(C).

(c). If the department's decision is that the provider acted with fault or fraudulent intent, the provisions of R.S. 46:460.73(B) shall apply.

(d). The written decision by the department is the final administrative decision and no appeal or judicial review shall lie from this final administrative decision.

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).