NOTICE OF INTENT

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, proposes to amend 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 proposed Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq.

Act 204 of the 2021 Regular Legislative Session directed the Department of Health to promulgate Rules granting mental health rehabilitation service providers the right to an independent review of an adverse determination taken by a managed care organization that results in a recoupment of the payment of a claim based on a finding of waste or fraud. In compliance with Act 204, the Department of Health, Bureau of Health Services Financing proposes to amend the provisions governing the independent review process for claims filed by managed care providers in order to add provisions that allow mental health rehabilitation providers to seek an independent review of waste and abuse recoupments by managed care organizations.

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. ~~Right of Providers to Independent Review~~Definitions

~~1. Pursuant to Act 349 of the 2017 Regular Session of the Louisiana Legislature, for adverse determinations related to claims filed on or after January 1, 2018, a healthcare~~ *Abuse*—provider ~~shall have a right to an independent review of~~practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to the ~~adverse action of the managed care organization (MCO)~~Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.

~~2. For purposes of these provisions, adverse determinations shall refer to claims submitted~~*Fraud*—an intentional deception or misrepresentation made by ~~healthcare providers for payment for services rendered~~ a person or a provider with the knowledge that the deception could result in some unauthorized benefit to ~~Medicaid enrollees and denied by a MCO, in whole~~him/her or ~~in part,~~ some other person or ~~a claim~~ entity. It includes any act that ~~results in recoupment of a~~

~~payment from the healthcare provider~~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. ~~Request for Reconsideration~~Right of Providers to Independent Review

1. ~~A provider shall submit a written request~~ Pursuant to Act 349 of the 2017 Regular Session of the Louisiana Legislature, for ~~reconsideration~~ adverse determination related to ~~the MCO. The request~~claims filed on or after January 1, 2018, a healthcare provider shall ~~identify~~ have a right to an independent review of the ~~claim(s) in dispute, the reasons for the dispute, and any documentation supporting the provider's~~

~~position or request by~~adverse action of the managed care organization (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.~~a. – c. Repealed.

2. ~~The MCO~~Pursuant to Act 204 of the 2021 Regular Session of the Louisiana Legislature, mental health rehabilitation service providers shall ~~acknowledge in writing its receipt of~~have a ~~reconsideration request submitted in accordance with §3111.B.1, within 5 calendar days after receipt~~right to an independent review of ~~the request, and render a final decision by providing~~an adverse determination taken by an MCO that results in a ~~response to the provider within 45 calendar days from the date of receipt~~recoupment of the ~~request for reconsideration, unless another time frame is agreed~~payment of a claim based upon ~~in writing by the provider and the MCO~~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. ~~Independent Review Requirements~~Request for Reconsideration

1. ~~If the MCO upholds the adverse determination, or does not respond to the reconsideration request within the time frames allowed, the~~ A provider ~~may file~~ shall submit a written ~~notice with~~request for reconsideration to the ~~department requesting~~MCO. The request shall identify the ~~adverse determination be submitted to an independent reviewer. The department must receive~~claim(s) in dispute, the ~~written request from the provider~~reasons for ~~an independent review within 60 days from~~ the ~~date~~ dispute, and any documentation supporting the ~~provider receives the MCO's notice of the decision of the reconsideration request,~~provider's position or ~~if the MCO does not respond to the reconsideration~~ request by the MCO within ~~the time frames allowed, the last date~~180 days from one of the ~~time period allowed for the MCO to respond.~~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 ~~provider~~ MCO shall ~~include~~ acknowledge in writing its receipt of 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~~submitted in accordance with §3111.C.1, within five calendar days after receipt of the request ~~shall be P.O. Box 91283~~and, ~~Bin 32~~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, ~~Baton Rouge, LA 70821-9283~~unless another time frame is agreed upon in writing by the provider and the MCO.

~~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.~~3. – 9. Repealed.

D. Independent Review ~~Costs~~Requirements

1. ~~The fee for conducting an independent review shall be paid to the independent reviewer by~~If the MCO ~~within 30 calendar days of receipt of a bill for services. A provider shall~~upholds the adverse determination, ~~within 10 days of~~or does not respond to the ~~date of the decision of the independent reviewer~~reconsideration request within the time frames allowed, ~~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~~file a written notice with the department ~~may prohibit that provider from future participation in~~requesting the adverse determination be submitted to an independent reviewer. The department must receive the written request from the provider for an independent review ~~process~~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. ~~If the MCO fails to pay the bill for~~The provider

shall include a copy of the ~~independent reviewer's services, the reviewer may~~written request ~~payment directly from~~ for reconsideration with the ~~department from any funds held by~~request for an independent review. The address to be used by the ~~state that are payable to~~provider for submission of the ~~MCO~~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 ~~Reviewer Selection Panel~~Review Costs

1. The fee for conducting an independent ~~reviewer selection panel~~review shall ~~select and identify an appropriate number of~~be paid to the independent ~~reviewers and determine a uniform rate of compensation to be paid to each~~ reviewer~~, not to~~

~~exceed $2,000 per~~ 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. ~~The panel shall consist of the secretary or his/her duly designated representative, two provider representatives and two~~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. ~~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.~~Repealed.

F. ~~Penalties~~Independent Reviewer Selection Panel

1. ~~An MCO in violation of any provision governing~~

~~the~~The independent ~~review process herein may be subject to a penalty~~reviewer selection panel shall select and identify an appropriate number of ~~up~~ independent reviewers and determine a uniform rate of compensation be paid to ~~$25,000~~each reviewer, not to exceed $2,000 per ~~violation~~review.

2. ~~An MCO may be subject to an additional penalty~~The panel shall consist ~~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 secretary or his/her duly designated representative, two provider ~~as a result of an independent review is greater than 25 percent~~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. ~~Independent Review Applicability~~Penalties

1. ~~Independent~~ An MCO in violation of any provision governing the independent review ~~shall not apply~~process herein may be subject to a penalty of up to ~~any adverse determination:~~$25,000 per violation.

~~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.~~a. – c. Repealed.

2. ~~Independent review does not otherwise prohibit or limit any alternative legal or contractual remedy available~~An MCO may be subject to ~~a provider~~an additional penalty of up 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~~$25,000 if subject to ~~limit or otherwise impede~~more than 100 independent reviews annually and the ~~appeal process as set forth~~percentage of adverse determinations overturned in ~~this Section shall be null, void, and deemed to be contrary to~~favor of the ~~public policy~~provider as a result of ~~this state~~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.

Family Impact Statement

In compliance with Act 1183 of the 1999 Regular Session of the Louisiana Legislature, the impact of this proposed Rule on the family has been considered. It is anticipated that this

proposed Rule will have no impact on family functioning, stability and autonomy as described in R.S. 49:972.

Poverty Impact Statement

In compliance with Act 854 of the 2012 Regular Session of the Louisiana Legislature, the poverty impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on child, individual, or family poverty in in relation to individual or community asset development as described in R.S. 49:973.

Small Business Analysis

In compliance with Act 820 of the 2008 Regular Session of the Louisiana Legislature, the economic impact of this proposed Rule on small businesses has been considered. It is anticipated that this proposed Rule will have a positive impact on small businesses, as described in R.S. 49:965.2 et seq, as it will allow them to obtain independent review for claims.

Provider Impact Statement

In compliance with House Concurrent Resolution (HCR) 170 of the 2014 Regular Session of the Louisiana Legislature, the provider impact of this proposed Rule has been considered. It is anticipated that this proposed Rule will have no impact on the staffing level requirements or qualifications required to provide the same level of service, no direct or indirect cost to the provider to provide the same level of service, and will have

no impact on the provider's ability to provide the same level of service as described in HCR 170.

Public Comments

Interested persons may submit written comments to Patrick Gillies, Bureau of Health Services Financing, P.O. Box 91030, Baton Rouge, LA 70821–9030. Mr. Gillies is responsible for responding to inquiries regarding this proposed Rule. The deadline for submitting written comments is at 4:30 p.m. on October 30, 2021.

Public Hearing

Interested persons may submit a written request to conduct a public hearing by U.S. mail to the Office of the Secretary ATTN: LDH Rulemaking Coordinator, Post Office Box 629, Baton Rouge, LA 70821-0629; however, such request must be received no later than 4:30 p.m. on October 12, 2021. If the criteria set forth in R.S. 49:953(A)(2)(a) are satisfied, LDH will conduct a public hearing at 9:30 a.m. on October 28, 2021 in Room 118 of the Bienville Building, which is located at 628 North Fourth Street, Baton Rouge, LA. To confirm whether or not a public hearing will be held, interested persons should first call Allen Enger at (225) 342-1342 after October 12, 2021. If a public hearing is to be held, all interested persons are invited to attend and present data, views, comments, or arguments, orally or in writing. In the event of a hearing, parking is available

to the public in the Galvez Parking Garage, which is located between North Sixth and North Fifth/North and Main Streets (cater-corner from the Bienville Building). Validated parking for the Galvez Garage may be available to public hearing attendees when the parking ticket is presented to LDH staff at the hearing.

Dr. Courtney N. Phillips

Secretary