§437.11. Provider agreements

A. The department shall make payments from medical assistance programs funds for goods, services, or supplies rendered to recipients to any person who has a provider agreement in effect with the department, who is complying with all federal and state laws and rules pertaining to the medical assistance programs, and who agrees that no person shall be subjected to discrimination under the medical assistance programs because of race, creed, ethnic origin, sex, age, or physical condition.

B. Each provider agreement shall require the health care provider to comply fully with all federal and state laws and rules pertaining to the medical assistance programs, to licensure, if required, and the practice of medicine, osteopathy, surgery, and midwifery. The provider agreement shall require the health care provider to provide goods, services, or supplies only if medically necessary and that are within the scope and quality of standard care.

C. Each provider agreement shall be a voluntary contract between the department and the health care provider in which the health care provider agrees to comply with federal and state laws and rules pertaining to the medical assistance programs when furnishing goods, services, or supplies to a recipient and the department agrees to pay a sum, determined by fee schedule, payment methodology, or other method, for the goods, services, or supplies provided to the recipient. However, a provider agreement shall not be construed to be a contract for the purposes of R.S. 42:1113(D).

D.(1) Unless the provider agreement is terminated by the secretary for cause as provided in Paragraph (2) of this Subsection, a health care provider agreement shall be effective for a stipulated period of time, shall be terminable by either party thirty days after receipt of written notice, and shall be renewable by mutual agreement.

(2) The secretary may terminate a provider agreement immediately and without written notice if a health care provider is the subject of a sanction or of a criminal, civil, or departmental proceeding.

E. Each health care provider who has a provider agreement with the department shall receive at least one provider number but may receive more than one provider number.

Acts 1997, No. 1142, §2.

§437.12. Provider agreement requirements

A. In addition to the requirements specified in R.S. 46:437.11, the provider agreement developed by the department shall require the health care provider to comply with the following:

(1) At the time of signing the provider agreement, have in his possession a valid professional or facility license or certificate pertinent to the goods, services, or supplies being provided, as required by applicable federal and state laws and rules, and maintain such license or certificate in good standing with the department throughout the effective period of the provider agreement.

(2) Maintain medical assistance programs-related records in a systematic and orderly manner that the department requires and determines are relevant to the goods, services, or supplies being provided.

(3) Retain medical assistance programs-related records for a period of five years to satisfy all necessary inquiries by the department.

(4) Safeguard the use and disclosure of information pertaining to current or former recipients and comply with federal and state laws and rules pertaining to confidentiality of patient information.

(5) Permit the department, the attorney general, the federal government, and any authorized agent of each of these entities access to all medical assistance programs-related records pertaining to goods, services, or supplies billed to the medical assistance programs, including access to all patient records and other health care provider information if the health care provider cannot easily separate records for recipients from other records.

(6) Bill other insurers and third parties, including the Medicare program, before billing the medical assistance programs, if after reasonable inquiry it is known that the recipient is eligible for payment for health care or related services from another insurer or person, and comply with all applicable federal and state laws and rules in regard to this billing.

(7) Report and refund any monies received in error or in excess of the amount to which the health care provider is entitled from the medical assistance programs.

(8) Be liable for and indemnify, defend, and hold the department harmless from any cause of action or recovery arising out of the negligence or omission of the health care provider in the course of providing goods, services, or supplies to a recipient or a person believed to be a recipient.

(9) At the option of the department, provide proof of liability insurance and maintain such insurance in effect for any period of time during which goods, services, or supplies are furnished to recipients.

(10)(a) Accept payment from the medical assistance programs as payment in full, and prohibit the health care provider from billing or collecting any additional amount from the recipient or the recipient's responsible party except, and only to the extent the department permits or requires, a co-payment, coinsurance, or a deductible to be paid by the recipient for the goods, services, or supplies provided.

(b) The payment-in-full policy shall not apply to goods, services, or supplies provided to a recipient if the goods, services, or supplies are not covered by the medical assistance programs or the recipient is determined not to be covered by medical assistance programs.

(11) Agree to be subject to claims review.

B. A provider agreement shall provide that, if the health care provider sells or transfers a business interest or practice that substantially constitutes the entity named as the health care provider in the provider agreement, or sells or transfers a facility that is of substantial importance to the entity named as the health care provider in the provider agreement, the health care provider shall maintain and make available to the department medical assistance programs-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the health care provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement and provides a copy of this agreement to the department.

C. A provider agreement shall provide that any sale, merger, consolidation, or other disposition of a health care provider shall be subject to any and all outstanding debts and liabilities owed or which may be owed to the medical assistance programs.

D. A provider agreement shall provide that, if the department withholds payment or is entitled to recovery, such withholding or assessment of recovery may be imposed on any and all provider numbers in which the health care provider has an interest or in which he may have an interest.

Acts 1997, No. 1142, §2.

§437.14. Grounds for denial or revocation of enrollment

A. The department may deny or revoke enrollment in the medical assistance programs to a health care provider if any of the following are found to be applicable to the health care provider, his agent, a managing employee, or any person having an ownership interest equal to five percent or greater in the health care provider:

(1) Misrepresentation.

(2) Previous or current exclusion, suspension, termination from, or the involuntary withdrawing from participation in, the medical assistance programs, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(3) Conviction under federal or state law of a criminal offense relating to the delivery of any goods, services, or supplies, including the performance of management or administrative services relating to the delivery of the goods, services, or supplies, under the medical assistance programs, any other state's Medicaid program, Medicare, or any other public or private health or health insurance program.

(4) Conviction under federal or state law of a criminal offense relating to the neglect or abuse of a patient in connection with the delivery of any goods, services, or supplies.

(5) Conviction under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

(6) Conviction under federal or state law of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.

(7) Conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more which involves moral turpitude, or acts against persons who are elderly, children, or persons with infirmities.

(8) Conviction under federal or state law of a criminal offense in connection with the interference or obstruction of any investigation into any criminal offense listed in Paragraphs (3) through (9) of this Subsection.

(9) Sanction pursuant to a violation of federal or state laws or rules relative to the medical assistance programs, any other state's Medicaid program, Medicare, or any other public health care or health insurance program.

(10) Violation of licensing or certification conditions or professional standards relating to the licensure or certification of health care providers or the required quality of goods, services, or supplies provided.

(11) Failure to pay recovery properly assessed or pursuant to an approved repayment schedule under the medical assistance programs.

(12) Failure to meet any condition of enrollment.

B. Before signing a provider agreement and at the discretion of the department, a person may become eligible to receive payment from the medical assistance programs from the time the goods, services, or supplies were furnished, if:

(1) The goods, services, or supplies provided were otherwise compensable.

(2) The person met all other requirements of a health care provider at the time the goods, services, or supplies were provided.

(3) The person agrees to abide by the provisions of the provider agreement to be effective from the date the goods, services, or supplies were provided.

Acts 1997, No. 1142, §2; Acts 2014, No. 811, §24, eff. June 23, 2014.

RS 46:460.61

SUBPART B. PROVIDER CREDENTIALING

§460.61. Provider credentialing

A. Any managed care organization that requires a health care provider to be credentialed, recredentialed, or approved prior to rendering health care services to a Medicaid recipient shall complete a credentialing process within ninety days from the date on which the managed care organization has received all the information needed for credentialing, including the health care provider's correctly and fully completed application and attestations and all verifications or verification supporting statements required by the managed care organization to comply with accreditation requirements and generally accepted industry practices and provisions to obtain reasonable applicant-specific information relative to the particular or precise services proposed to be rendered by the applicant.

B.(1) Within thirty days of the date of receipt of an application, a managed care organization shall inform the applicant of all defects and reasons known at the time by the managed care organization in the event a submitted application is deemed to be not correctly and fully completed.

(2) A managed care organization shall inform the applicant in the event that any needed verification or a verification supporting statement has not been received within sixty days of the date of the managed care organization's request.

C. In order to establish uniformity in the submission of an applicant's standardized information to each managed care organization for which he may seek to provide health care services until submission of an applicant's standardized information in a paper format shall be superseded by a provider's required submission and a managed care organization's required acceptance by electronic submission, an applicant shall utilize and a managed care organization shall accept either of the following at the sole discretion of the managed care organization:

(1) The current version of the Louisiana Standardized Credentialing Application Form or its successor, as promulgated by the Department of Insurance.

(2) The current format used by the Council for Affordable Quality Healthcare (CAQH) or its successor.

Acts 2013, No. 358, §1, eff. Jan. 1, 2014.