Louisiana Medicaid Management Information System (LMMIS)

Provider Enrollment Portal Application User Manual For MCO Administration (Provider Enrollment Application Search)

Date Created: 06/28/2021
Date Revised: 09/27/2021

Prepared By
Technical Communications Group

PROJECT INFORMATION

Document Title	Louisiana Medicaid Management Information System (LMMIS) – Provider Enrollment Portal MCO Admin User Manual
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	Revision History		
Date	**Description of Change**	**LIFT**	**By**
June 28, 2021	Initial draft.	12133	LIFT 122133 development team
July 29, 2021	Updated 6.0.	12133	Randy Sheehan with Karen Chapman
September 27, 2021	Updated Participation and Attestation Screenshots	12133	Jody Lavigne

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1.0 OVERVIEW

The Provider Enrollment Portal MCO Administrative (Provider Enrollment Application Search) application is designed to enable an MCO to validate the status and progress of the enrollment process for MCO providers.

The application is “View Only.” The user of the application is not enabled to edit any information while viewing the enrollment data.

2.0 Accessing the Application

2.1 Louisiana Medicaid Web Site Registration

Before an MCO can access the Provider Enrollment Portal, registration is required. In order to register, follow the instructions located here:

https://www.lamedicaid.com/Provweb1/Provweb_Enroll/Web_Registration.pdf

Please validate that the enrolling MCO’s email given in the registration process is correct, as all correspondence will go to the registration email for the enrollment process.

Once you have your Louisiana Medicaid account, management of the account (changing passwords, creating new user profiles, etc.) is explained here:

https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid_Provider_Login_Admin_Manage_Users.pdf

Once registration is complete, you are enabled to login here:

https://www.lamedicaid.com/account/login.aspx

2.2 Other Accounts

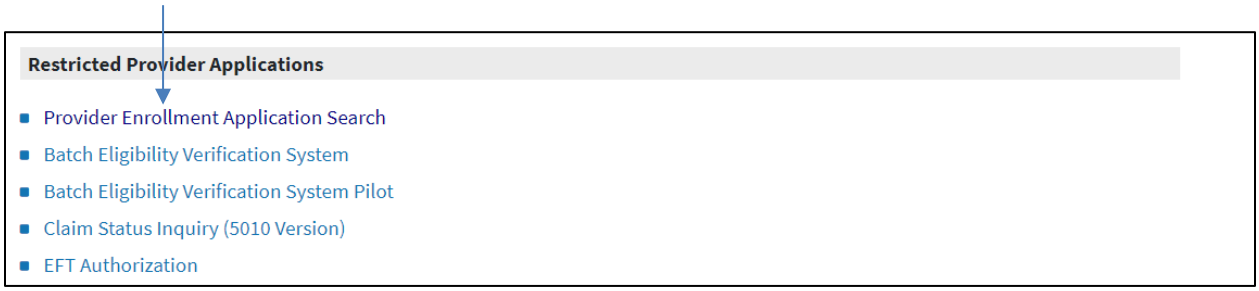
Once the MCO has created an account on the www.lamedicaid.com web site, other accounts can be created and managed from the MCO’s account. Contact the MCO to receive your credentials if you are a user who has a requirement to use the Provider Enrollment Portal.

2.3 Log In

Detailed instructions for logging in are provided here:

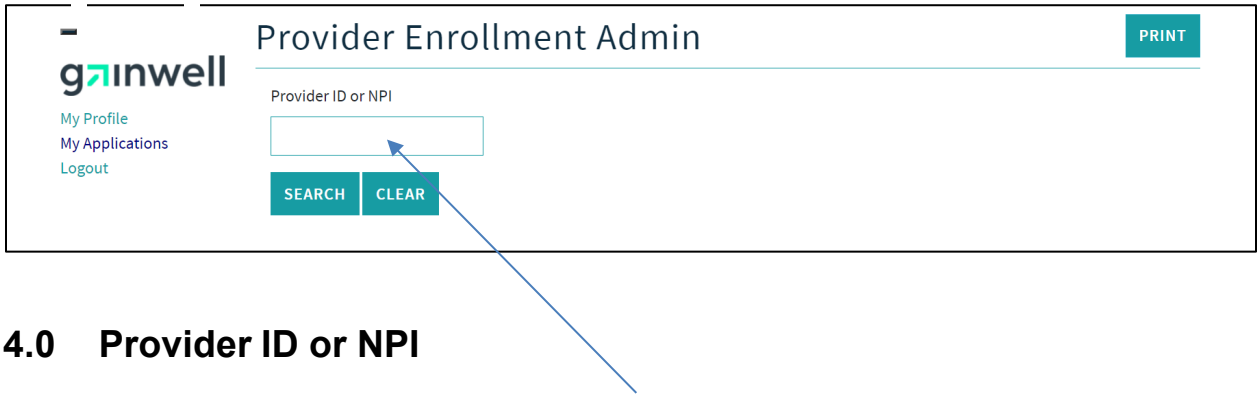
https://www.lamedicaid.com/Provweb1/Forms/UserGuides/LAMedicaid_Provider_Login_User_Manual.pdf

After login, look for and click on the **Provider Enrollment Application Search** link, as shown below:



3.0 Provider Enrollment Admin Home Page

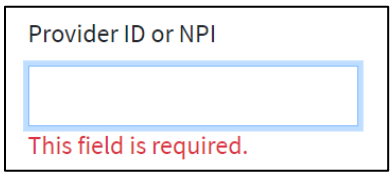
The Provider Enrollment Admin home page displays three control buttons: **Print**, **Search** and **Clear**. Also displayed is the text box for **Provider ID or NPI**.



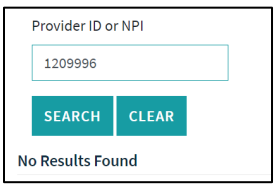
4.0 Provider ID or NPI

Enter a valid 7-digit Louisiana Medicaid Provider ID or a valid 10-digit NPI, then click on the **Search** button. There is no other way to search.

If no data is entered into the **Provider ID or NPI** field and the Search button is clicked, the following message is displayed:



If data is entered into the **Provider ID or NPI** field, but no results are found, the following message is displayed:

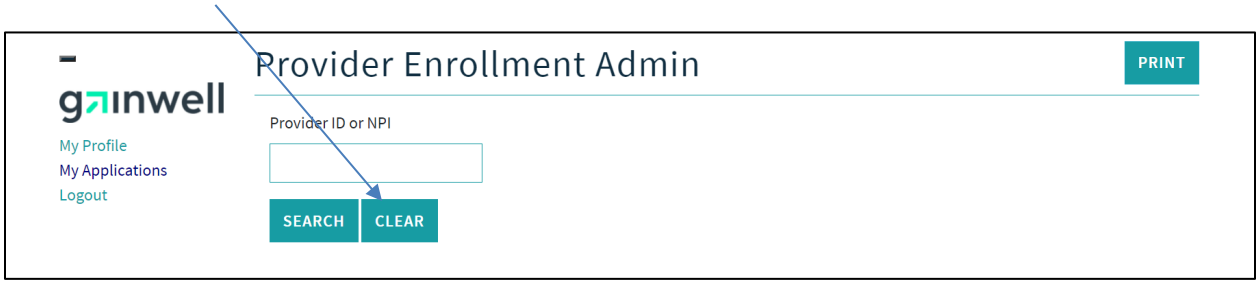


If no results are found,

- A provider may have joined after May 30, 2021, and has not yet been contacted to enroll and/or assigned a user ID.
- A provider may have no claims encounter activity in the previous 18 months.

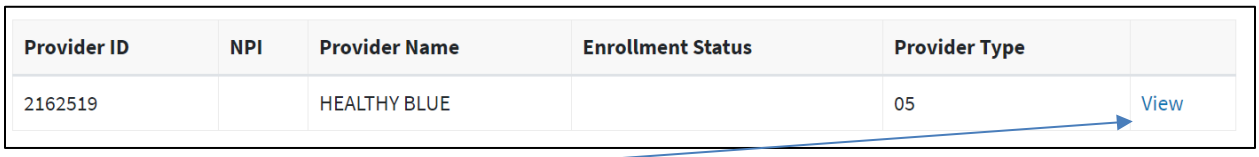
5.0 Clear

Click on the **Clear** button to erase any existing search parameter(s).



6.0 View

If data is entered into the **Provider ID or NPI** field and results are found, they are displayed in a manner similar to that shown below:



Provider ID	NPI	Provider Name	Enrollment Status	Provider Type	
2162519		HEALTHY BLUE		05	View

Click on a **View** link to see the Provider Detail associated with the selected provider. The record will be similar to the one shown below.

The Enrollment Status is displayed right after the License Information in the Provider Details (see page 5, below).

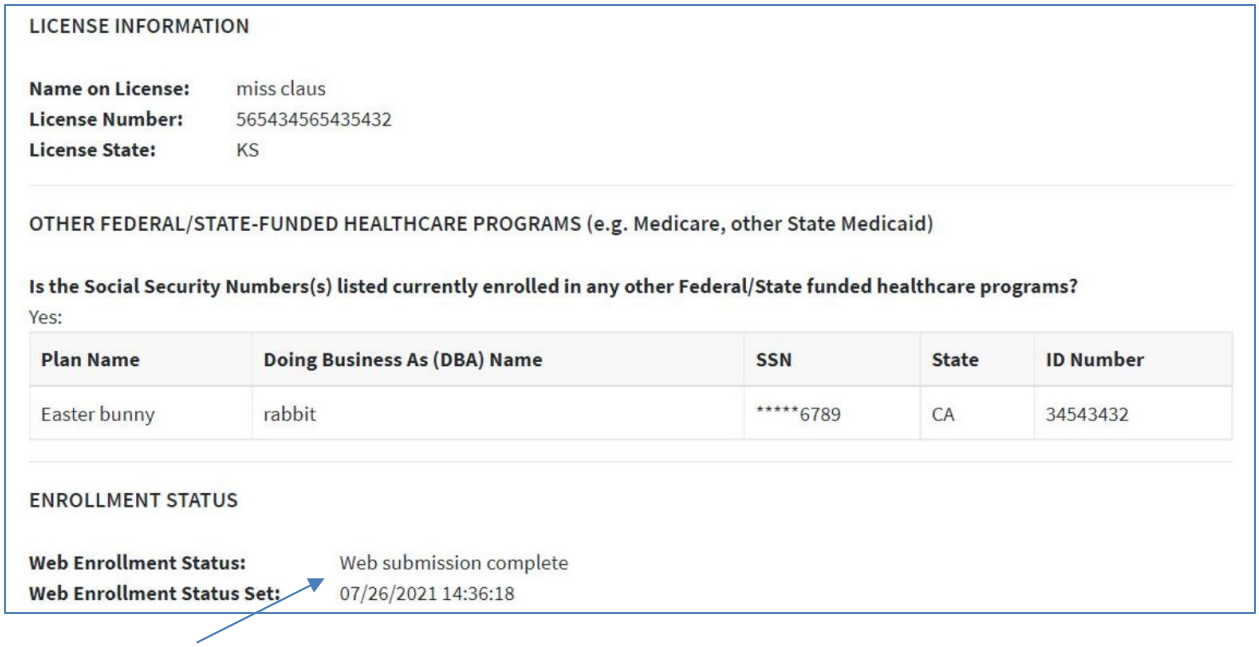
Provider Detail

PRINT

Application Type: Individual
Provider ID: [redacted]
Provider Name:
NPI:
Provider Type: 20 - PHYSICIAN (IND & GP)
Provider Specialty: 16 - OB/GYN
Provider Sub-Specialty: 3A - Critical Care Medicine
Primary Taxonomy: 207VC0200X - Obstetrics & Gynecology - Critical Care Medicine
Other Taxonomy: 2083A0300X - Preventive Medicine - Addiction Medicine
Other Taxonomy: 202K00000X - Phlebology

ADDRESS INFORMATION

Address Type	Provider SSN	Date of Birth	Street Address 1	Street Address 2	City	State	Zip	Contact Name	Contact Phone	Contact Fax
Main Practice Address	*****6863	N/A	3600 PRYTANIA ST STE 47	N/A	NEW ORLEANS	N/A	70115	N/A	N/A	N/A
Main Mail-To Address	N/A	N/A	1419 AMELIA ST	N/A	NEW ORLEANS	LA	N/A	N/A	N/A	N/A



LICENSE INFORMATION

Name on License: miss claus
License Number: 565434565435432
License State: KS

OTHER FEDERAL/STATE-FUNDED HEALTHCARE PROGRAMS (e.g. Medicare, other State Medicaid)

Is the Social Security Numbers(s) listed currently enrolled in any other Federal/State funded healthcare programs?
Yes:

Plan Name	Doing Business As (DBA) Name	SSN	State	ID Number
Easter bunny	rabbit	*****6789	CA	34543432

ENROLLMENT STATUS

Web Enrollment Status: Web submission complete
Web Enrollment Status Set: 07/26/2021 14:36:18

Note Enrollment Status.

ATTESTATION OF OWNERSHIP INFORMATION

I, the undersigned, certify the following:

With my signature below, I attest:

1. That the provider has disclosed all necessary information;
2. That I am the authorized representative of this entity/business and, as such, have the authority to enter into a provider agreement with the Louisiana Medicaid Program;
3. That the provider has reviewed the information on this entity/business Disclosure form and attest that it is true, accurate and complete;
4. That the provider understands that knowingly and willfully failing to fully and accurately disclose the information requested may result in the denial of any request to participate in Louisiana's Medicaid Program, or where the entity/business already participates, a termination of the provider agreement or contract with the State Agency or the Secretary, as appropriate;
5. That the provider understands that a denial or termination of the provider agreement or contract with the State Agency or the Secretary will prohibit me from any participation in Louisiana's Medicaid Program;
6. That the provider understands that whoever knowingly and willfully makes or causes to be made any false statement or fraudulent representation on any form submitted to the State Agency or the Secretary may be prosecuted under applicable Federal or state laws;
7. That the provider understands it is their responsibility to ensure that all information is continuously kept up to date on the Louisiana Medicaid Provider File;
8. That the provider understands that the failure to maintain current and correct information may result in payments being delayed or closure of this Medicaid provider number;
9. That the provider understands if this number is closed due to inaccurate information or inactivity, they will have to complete a new Portal Application in its entirety for consideration to reactivate this provider number;
10. The provider understands that under Federal Regulations, a provider or disclosing entity must disclose to the Medicaid agency, prior to enrolling, the name and address of each person, entity or business with an ownership or control interest in the disclosing entity. (See Federal Regulations 42 CFR § 455.104(b)(1). A provider or disclosing entity must also disclose to the Medicaid agency, prior to enrolling, whether any person, entity or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling. (See Federal Regulations 42 CFR § 455.104(b)(2). Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the provider/ disclosing entity also has an ownership or control interest.
11. That the provider understands that as part of the Louisiana Medicaid enrollment/re-enrollment process, pursuant to Louisiana Medicaid Rules and Regulations, they must provide Social Security numbers for each of the following persons:
    - All Individuals with Direct or Indirect Ownership or Control Interest of 5% or more;
    - All Individuals acting as Board of Director;
    - All Individual Corporate Officers, Directors, Partners, or Shareholders;
    - All Individual Managing Employees or Agents who exercise operational or managerial control or who directly or indirectly manage the conduct of day-to-day operations.

12. I attest that I am a United States citizen or have legal status and work privilege in the US.
13. The provider understands that it is their responsibility to ensure that all managing employees, employees, agents, affiliates, or subcontractors are U.S. Citizens or have legal status and work privilege in the U.S.
14. The provider understands that it is their responsibility to ensure that it is disclosed on this form if any Owner, Board Member, Corporate Officer, Partner, Board of Director, Shareholder, Managing employee, Employee, Agent or Affiliate, have ever:
    - been denied enrollment from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been suspended or excluded from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been terminated from participation from Medicare, Medicaid or any other Federally funded healthcare Program;
    - been employed by a corporation, business or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid, or any other Federally funded healthcare Program in any state; or
    - been convicted of any crimes.
15. The provider understands that pursuant to 42 CFR § 455.104(a)(1) and 42 CFR § 455.105(a)(1)(2), they are required to provide certain data pertaining to subcontractors within 35 calendar days of the date of the request.
16. The provider understands that they shall report any of the above conditions to the Louisiana Department of Health (LDH). Once enrolled, the provider understands that upon discovery of any of the above conditions, it is their responsibility to report immediately in writing to LDH, Program Integrity Section, P.O. Box 91030, Baton Rouge, LA 70821-9030.
17. I understand if I answered "Yes" to questions regarding being convicted of a felony or any criminal offense, or if I have ever had any disciplinary action taken against my professional license (board actions, board consent order, restriction, suspension, revocation or voluntary surrender to avoid disciplinary action), or if I have ever been denied enrollment or been excluded, terminated from participation, suspended, or voluntarily withdrawn to avoid disciplinary action from any Federally funded healthcare program, I am required to submit this information and the requested documentation.
18. The provider understands that they are being placed on notice of Louisiana state law, R.S. 14:126.3.1 entitled "Unauthorized participation in medical assistance programs." The provider understands that this criminal statute means that if any owners, managing employees, employees, agents, affiliates, or subcontractors, are excluded now, or become excluded in the future or have been terminated from participation in the Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, it is a crime to "participate" in any medical assistance program. The provider also understands that "participation" includes providing any services which will be billed, directly or indirectly, to Medicare, Medicaid, or any other Federal or State Funded Healthcare Program, and "participation" also includes to seek or to be employed, directly or by contract, or have an ownership interest in any individual or entity that provides such services which will be billed to these programs. The provider also understands that this crime can be punishable as a felony for up to five (5) years imprisonment with or without hard labor, as well as a maximum fine of $20,000.00. I also understand that any claims for payment with a date of service during a period of exclusion will be subject to recoupment in addition to other fines, penalties, or restitution resulting from the criminal prosecution (LA R.S. 14.126.3.1).

Printed Name of the Authorized Representative: test, Test
Attestation Electronically Signed: 09/17/2021 16:11:31

PARTICIPATION AGREEMENT

I, the undersigned, certify the following:

I, the undersigned, certify and agree to the following:
Enrollment in Louisiana Medicaid
1. The provider has read the contents of this Louisiana Medical Assistance Program Portal Application and the information supplied herein is true, correct and complete;
2. The provider understands that it is their responsibility to ensure that all information is kept up to date on the Louisiana Medicaid Provider File;
- the provider must send notice to the LDH Provider Enrollment section for any changes such as the provider's address and change of ownership/management. Failure to do so may negatively affect attempts to revalidate the provider's information and result in account closure;
- The provider understands that failure to maintain current information may result in payments being delayed or closure of their Medicaid provider number;
3. The provider understands that if the provider number is closed due to inaccurate information or for inactivity, the provider will have to complete a new Portal Application in its entirety to reactivate the provider number. A new application fee may be required for certain provider types.
4. The provider understands that it is their responsibility to ensure that all employees and/or authorized representatives are U.S. citizens or have legal status and work privilege in the U.S.
5. The provider understands that it is a violation if they fail to comply with any or all federal or state laws, regulations, policies, rules, criteria, or procedures, applicable to the Medical Assistance Program or a program of the Medical Assistance Program in which the provider, provider-in-fact, agent of the provider, billing agent, affiliate or other person is participating (Louisiana Administrative Code Title 50, Subpart 5, Chapter 41, Subchapter A, §4147.
6. The provider understands that individuals who meet one or more of the following conditions may not be eligible to participate in the Medicaid program and that it is the provider's responsibility to immediately report to the Program Integrity Unit at LDH if I, or any owners, managing employees or agents meet one or more of the noted conditions upon discovery of such information.
- denied enrollment;
- suspended, or excluded from Medicare, Medicaid, or other Health Care Programs in any state;
- employed by a corporation, business, or professional association that is now or has ever been suspended or excluded from Medicare, Medicaid or other Health Care Programs in any state;
- convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs or any offense delineated in the Louisiana Medical Assistance Programs Integrity Law; 42 CFR 455.106.
- terminated/revoked by Medicare or another state's Medicaid program;
- negative balances must be paid in full before enrollment, or reenrollment.
7. The provider understands that, as a part of the Louisiana Medicaid enrollment/re-enrollment process, the Social Security Numbers of any person with an ownership or control interest of 5% in the disclosing entity, any managing employees and any agents must be disclosed.
- The provider understands that failure to provide the Social Security Numbers will result in the rejection and/or denial of enrollment or re-enrollment request.?
8. The provider acknowledges that they have read and are familiar with LA R.S. 46:437.10. A&B, continuing liability; assumption of liability by the seller and buyer. Both parties are responsible for recoverable obligations.
9. The provider understands that On-Site Visits, per 42 CFR 455:432, may be conducted by LDH Staff, LDH Representative, CMS, CMS Agents and CMS Designated Contractors:
- Either announced or unannounced,?
- For both pre-enrollment and/or post-enrollment?
- Failure to cooperate with these On-Site Visits shall result in denial or termination of participation.?
10. The provider understands that all providers assessed as high risk are required to submit to fingerprint and background checks for all owners with 5% or more ownership interest.

Providing Services to Louisiana Medicaid Recipients
11. The provider agrees to conduct activities/actions in accordance with the Medical Assistance Program Integrity Law (MAPIL Louisiana R.S. Title 46, Chapter 3, Part VI-A) as required to protect the fiscal and programmatic integrity of the medical assistance programs;
12. The provider understands that the Medicaid Provider Agreement is voluntary between the LDH and the health care provider and shall be effective for a stipulated period of time;
- This agreement may be terminated by the LDH for cause without notice;
- Either party shall terminate the agreement for no cause 30-days after written notice; and
- The agreement shall be renewable upon mutual agreement.

13. The provider understands that services and/or supplies provided must be medically necessary and medically appropriate for each individual recipient based on needs presented on the date the service is provided and/or delivered;
14. The provider agrees to charge no more for services to eligible recipients than is charged on the average for similar services to others;
15. The provider understands that the provider is held responsible for any and all claims submitted under any Louisiana Medicaid provider number issued;
16. The provider agrees to maintain all records necessary for full disclosure of services provided to individuals under the program and to furnish, at no cost and within the time requested, information regarding those records as well as payments claimed/received for providing such services that the State Agency, the LDH Secretary, the Louisiana Attorney General, or the Medicaid Fraud Control Unit may request for five years from the date of service;
17. The provider agrees to report and refund any discovered overpayments within sixty (60) days of discovery;
18. The provider agrees to submit all requested medical records within the time frames allowed to the CMS Payment Error Rate Measurement (PERM) contractor if/when claims are selected in a random sample. Failure to do so may result in sanctions.
19. The provider agrees to participate as a provider of medical services and shall bill Medicaid for all covered services performed on behalf of an eligible individual who has been accepted as a Medicaid patient;
20. The provider agrees to accept Medicaid payment for covered services as payment in full and not seek additional payment from any recipient for any unpaid portion of a bill, with the exception of state-funded spend-down Medically Needy recipients as indicated by the agency's form 110-MNP or any recipient co-payments as established by LDH;
21. The provider agrees to adhere to the published regulations of the LDH Secretary and the Bureau of Health Services Financing, including, but not limited to, those rules regarding recoupment and disclosure requirements as specified in 42 CFR 455, Subpart B;
22. The provider agrees to adhere to the Federal Health Insurance Portability and Accountability Act (HIPAA) and all applicable HIPAA regulations issued by the Federal HHS, including, but not limited to, the requirements and obligations imposed by those regulations regarding the conduct of electronic health care transactions and the protection of the privacy and security of individual health information and any additional regulatory requirements imposed under HIPAA;
23. The provider understands the Louisiana Medicaid Program must comply with HHS regulations promulgated under Title VI of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973, as amended; and the American Disabilities Act of 1990 which require that:

- No person in the United States shall be excluded from participation in, denied the benefits of, or subjected to discrimination on the basis of age, color, handicap, national origin, race or sex under any program or activity receiving Federal financial assistance. Under these requirements, LDH, Bureau of Health Services Financing (BHSF) cannot pay for medical care or services unless such care and services are provided without discrimination based on age, color, handicap, national origin, race or sex. Written complaints of non-compliance should be directed to Secretary, LDH, PO Box 91030, Baton Rouge, LA 70821-9030 or DHHS Secretary, Washington, DC or both.

24. The Deficit Reduction Act of 2005, Section 6032 Implementation: As a condition of payment for goods, services and supplies provided to recipients of the Medicaid Program, providers and entities must comply with the False Claims Act employee training and policy requirements in 1902(a)(68) of the Social Security Act, set forth in that subsection and as the Secretary of the United States DHHS may specify. As an enrolled provider/entity, the provider understands that it is their obligation to inform all of their employees and affiliates of the provisions of the Federal False Claims Act, and any Louisiana laws and/or rules pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws and/or rules. When monitored or audited, the provider will be required to show evidence of compliance with this requirement.
25. The Anti-Trust Assignment: The provider assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed by the State and/or its offices, agencies, departments or political subdivisions through any programs or payment mechanisms. For purposes of this assignment clause, the "provider" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

Certification of Claims (Paper & Electronic)
26. The provider agrees that all claims submitted to LDH or its fiscal agent will be for medically necessary and needed services or supplies and that these services and/or supplies will be rendered by an individual or business who is enrolled as a LDH Medicaid provider;
27. The provider understands that all claims submitted to Louisiana Medicaid will be paid and satisfied from Federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws;
28. The provider attests that all claims submitted under the conditions of this Agreement are certified to be true, accurate, and complete.

*** The provider understands only an authorized representative may sign this form. This authorized representative must be someone designated to enter into a legal and binding contract with Louisiana Medicaid. This person must be someone currently listed on the Disclosure of Ownership as either an owner or manager. Any other signature will be grounds for rejecting this form.

Printed Name of the Authorized Representative: test, Test
Participation Agreement Electronically Signed: 09/17/2021 16:13:42

Web Enrollment Status	Explanation
SaaS screening in progress	Screening is in process
Enrollment is Complete	The provider's enrollment with the State is complete
Enrollment is Denied	The provider's enrollment with the State is denied and a letter is being mailed
Application fee ACH submitted	The provider's application fee has been submitted and is in process
Application fee ACH rejected	The provider's application fee has been rejected; you will need to correct your ACH information and resubmit
Web submission complete	The provider's submission has been received

Use your browser's back button to return to the application.

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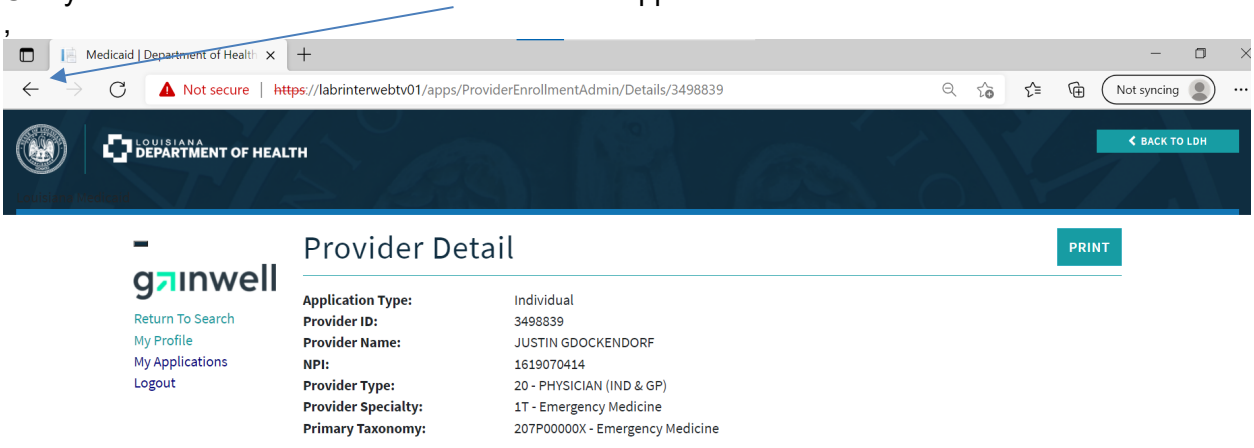

7.0 Print

Click on the **Print** button to open the print dialogue feature.