PROVIDER REQUIREMENTS

Provider participation in the Medicaid program is voluntary. When enrolled in the Medicaid program, a provider agrees to abide by all applicable state and federal laws, regulations and policies established by the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Department of Health (LDH). The provider manual assists providers with program operations and Medicaid reimbursement. The provider manual does not contain all Medicaid rules and regulations. In the event the manual conflicts with a Rule, the Rule prevails.

Providers are responsible for knowing the terms of the provider agreement, program standards, statutes and the penalties for violations. The providers' signature on the Provider Enrollment Packet (PE-50 Addendum - Provider Agreement) is an agreement to abide by all policies and regulations. This agreement also certifies that, to the best of the providers' knowledge, the information contained on the claim form is true, accurate and complete.

Providers agree to the following requirements:

1. Adhere to all the requirements of administrative rules governing the Medical Assistance Program found in the *Louisiana Register;*

2. Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA);

3. Comply with Title VI and Title VII of the *1964 Civil Rights Act* (where applicable), not to discriminate based on race, color, creed or national origin;

4. Comply with Section 504 of the *Rehabilitation Act of 1973*; and

5. Adhere to all federal and state regulations governing the Medicaid program including those rules regulating disclosure of ownership and control requirements specified in the 42 CFR 455, Subpart B.

Provider Agreement

The provider agreement is a contract between LDH and the provider that governs participation in the Louisiana Medicaid program. This contract is statutorily mandated by the Medical Assistance Program Integrity Law (MAPIL) and is voluntarily entered into by the provider.

MAPIL contains a number of provisions related to provider agreements. Those provisions which deal specifically with provider agreements and the enrollment process are contained in RS 46:437.11 - 46:437:14.

The provider must agree to terms and conditions imposed by MAPIL. The following list is not an all-inclusive:

1. Comply with all federal and state laws and regulations;

2. Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;

3. Maintain all necessary and required licenses or certificates;

4. Allow for inspection of all records by governmental authorities, including, but not limited to, LDH, the State Attorney General's Medicaid Fraud Control Unit, and the Department of Health and Human Services;

5. Safeguard against the disclosure of information in the beneficiary's medical records;

6. Bill other insurers and third parties prior to billing Medicaid;

7. Report and refund any and all overpayments;

8. Accept the Medicaid payment as payment in full for services rendered to Medicaid beneficiaries, providing for the allowances for co-payments authorized by Medicaid. A beneficiary may be billed for services that have been determined as non-covered or exceeding the services limit for beneficiaries over 21 years of age. Beneficiaries are also responsible for all services rendered after their eligibility has ended;

9. Agree to be subject to claims review;

10. Accept liability for any administrative sanctions or civil judgments by the buyer and seller of a provider;

11. Allow inspection of the facilities; and

12. Post bond or a letter of credit, when required.

Note: In order to bill a beneficiary for a non-covered service, the beneficiary must be informed both verbally and in writing that he/she will be responsible for payment of the services.

The provider agreement provisions of MAPIL also grant authority to the Secretary to deny or revoke enrollment under specific conditions.

Disclosure of Ownership

Providers are required to update their ownership information using a web-based application available at www.lamedicaid.com. Providers without internet access may contact the fiscal intermediary's (FIs) Provider Enrollment Unit (PEU) for paper forms. Information must be disclosed on all owners with five percent or greater interest and all members of management/Board of Directors in the business/entity. Information includes, but is not limited to:

1. Name;

2. Social Security number (SSN);

3. Tax identification number(TIN); and

4. Address.

Acceptance of Beneficiaries

Providers are not required to accept every beneficiary requesting service. When a provider does accept a beneficiary, the provider cannot choose which services will be provided. Providers must treat Medicaid beneficiaries equally in terms of scope, quality, duration and method of delivery of services (unless specifically limited by regulation). The same services must be offered to a Medicaid beneficiary as those offered to individuals not receiving Medicaid, provided the services are reimbursable by the Medicaid program.

Confidentiality

All Medicaid beneficiary and applicant records and information are confidential. Providers are responsible for maintaining confidentiality of health care information, subject to applicable laws.

HIPAA

The **Health Insurance Portability and Accountability Act (HIPAA) of 1996** requires more standardization and efficiency in the health care industry. HIPAA requires providers to:

1. Use the same health care transactions, code sets and identifiers;
2. Prevent the release of patient protected health in formation (PHI) without knowledge or consent of the beneficiary (except as HIPAA regulations permit or require);
3. Provide safeguards to prevent unauthorized accessPHI; and
4. Use a standard national provider number, called the National Provider Identifier (NPI), for identification on all electronic standard transactions.

National Provider Identifier

As a provision of HIPAA, providers must obtain and use their National Provider Identifier (NPI) number on all claims submissions. Providers who do not provide medical services are exempt from this requirement (i.e. non-emergency transportation, and some home and community-based waiver services). Although HIPAA regulations address only electronic transactions, Louisiana Medicaid requires both the NPI number and the legacy seven digit Medicaid provider number on hard copy claims.

Record Keeping

Providers must maintain and retain all medical, fiscal, professional and business records for services provided to all Medicaid beneficiaries for a period of five years from the date of service; however, if the provider is being audited, records must be retained until the audit is complete, even if the five years is exceeded. The records must be accessible, legible and comprehensible.

Any error made in the record must be corrected using the legal method, which is to draw a line through the incorrect information, write “error” by it and initial the correction. Correction fluid or correction tape must never be used.

These records may be paper, magnetic material, film or electronic, except as otherwise required by law or Medicaid policy. All records must be signed and dated at the time of service. Rubber stamp signatures must be initialed.

Providers who fail to comply with the documentation and retention policy are subject to administrative sanctions and recoupment of Medicaid payments. Payments will be recouped for services that are not accompanied by the required signatures and documentation.

NOTE: Upon agency closure, all provider records must be maintained according to applicable laws, regulations and the above record retention requirements. LDH must be notified of the location of the records.

Electronic Records

Providers that maintain electronic records must develop and implement a policy to comply with applicable state and federal laws, rules and regulations to ensure each record is valid and secure.

Right to Review Records

Authorized state and federal agencies or their authorized representatives may audit or examine a provider's or facility's records without prior notice. This includes, but is not limited to, the following governmental authorities: LDH, the State Attorney General's Medicaid Fraud Control Unit (MFCU) and the Department of Health and Human Services (DHHS). Providers must allow access to all Medicaid beneficiary records and other information that cannot be separated from the records.

If requested, providers must furnish, at the provider's expense, legible copies of all Medicaid related information to the Bureau of Health Services Financing (BHSF), federal agencies or their representatives.

Destruction of Records

Records may be destroyed once the required record retention period has expired. Confidential records must be incinerated or shredded to protect sensitive information. Non-paper files, such as computer files, require special means of destruction. Disks or drives can be erased and reused, but care must be taken to ensure all data is removed prior to reuse. Commercially available software programs can be used to ensure all confidential data is removed.

In the event that records are destroyed or partially destroyed, and rendered unreadable and unusable in a disaster such as a fire, flood or hurricane, such records must be properly disposed of in a manner which protects beneficiary confidentiality. A letter of attestation must be submitted to the FI documenting the event/disaster and the manner in which the records were disposed.

Changes to Report

Providers have the responsibility to timely report all changes that may impact the provider's Medicaid enrollment status. Requests for changes to provider records must be submitted to the PEU in writing. Each change request requires the original signature of the individual provider or an authorized representative of an enrolled entity. Stamped signatures and initials are not accepted. Third party billers/agents cannot request changes to a provider's enrollment records.

NOTE: Faxes will not be accepted except for change of address and Clinical Laboratory Improvement Amendments (CLIA) status.

Correspondence must be mailed to the PEU. (Refer to Appendix B of this manual chapter for contact information).

Contact Information

Providers must notify the PEU when a mailing or physical address and/or telephone number changes. It is the provider's responsibility to keep all provider information current and accurate.

If the provider type requires a license, a copy of the updated license showing the new physical address must be submitted with the change request.

An individual Medicaid provider number may have only one pay-to address. This address **must** be the address where the provider wishes to receive all Medicaid documents related to claims billed under that particular provider number. For those providers who furnish services at multiple locations, the "pay –to" address must be the address of the provider's main location.

Failure to furnish accurate information for the provider file may result in closure of the Medicaid provider number. If mail is returned and the provider cannot be located, the provider number will be closed pending updated information. Once the number has been closed, a complete enrollment packet may be required to re-activate the number.

Changes in the Internal Operations

Providers must immediately notify the PEU of any changes in internal operations that affect the originally reported information. These include changes in administrators, board of directors or other major management staff for federally qualified health centers, rural health clinics, nursing facilities, hospitals and any other facilities or programs in which the provider is enrolled. The PEU must be notified in writing of these changes. Failure to timely notify the PEU could result in payment delays.

BHSF does not allow informal agreements between parties. The provider should contact the PEU for additional information regarding reporting changes in operational structure.

Change in Ownership

A new provider enrollment packet must be completed when a change in ownership (CHOW) or change in business organization (change from corporation to LLC, partnership, etc.) and a transfer of stock greater than five percent occurs. A change of five percent or more in stock ownership or profit sharing may require a new provider number. If the name of the company changes with no change in ownership or tax identification number, a CHOW is not considered to have occurred.

The new owner shall be subject to any restrictions, conditions, penalties, sanctions or other remedial action taken by the BHSF, any federal agency or other state agency against the prior owner or facility.

The following steps must be taken when reporting a CHOW:

1. Notify the PEU, in writing, 60 days prior to the anticipated date of the CHOW. Include the seven-digit Medicaid ID number and other identifying information;

2. For providers who are enrolled to participate in the Medicare program, notify LDH Health Standards 60 days prior to the anticipated date of the CHOW;

3. For providers who submit cost reports, notify the Rate Setting and Audit Section 60 days prior to the anticipated date of the CHOW; and

4. Submit the completed enrollment application and the required documentation to PEU immediately after the CHOW occurs. For those providers who are enrolled to participate in the Medicare Program, CMS approval must be received prior to submitting the application to PEU. The new provider agreement is subject, but not

limited to prior statements of deficiencies cited by BHSF, including plans of compliance and expiration dates.

Failure to timely report a change in ownership may result in fines and/or recoupment of any and all payments made in the interim of the CHOW taking place and the agency approving the action.

Other Changes Required to be Reported

The following changes must be reported:

1. Decision to discontinue accepting Medicaid;

2. Business closure;

3. Change in licensing status (a copy of the updated license must be submitted with the change request);

4. Death of a provider. The Medicaid provider number of a deceased provider cannot be used for any reason;

5. Change in Medicare certification, provider number or status. A claim will not crossover unless the correct Medicare provider number is in the Medicaid Management Information System (MMIS);

6. Change in account information affecting Electronic Funds Transfer (EFT)/ (direct deposit);

    a. Changes must be submitted with a copy of a voided check (deposit slips are not accepted);

    b. Failure to update EFT information may result in payments being sent to incorrect accounts;

    c. A hardcopy check will not be reissued until the inappropriately routed funds are returned to the Department's account.

7. Change in the "pay to" mailing address. Official Medicaid documents, including any checks, are mailed to the provider's "pay to" address as listed on Medicaid files, not to the address written on a claim form. Therefore, it is imperative

that any change in address be reported to the PEU immediately.

8. Change in provider name must be reported;

   a. Correspondence must include the current provider name, new provider name and the effective date of the change.

   b. If a license is required, the updated license must be submitted with the notification.

9. Change in telephone number. This telephone number must be a number where the provider or authorized agent may be contacted for questions. It must not be the corporate office unless all information is maintained at that location.

Linking Professionals to Group Practice

A request for linkage of an individual professional practitioner to a group practice provider number requires the submission of a completed provider enrollment (PE-50) form. If the provider has an active Medicaid provider number, a group linkage (LNK-01) form must be completed and must include the effective date of the linkage. The form must be signed by the professional practitioner who is officially enrolled under the number being linked. The PE-50 and the LNK-01 forms can be found at www.lamedicaid.com.

Professional practitioners who change group affiliation should notify the PEU to ensure payments are sent to the correct provider/group. Payments and remittance advices may be delayed due to incorrect mailing addresses on the Medicaid file. When submitting a change of address for linkage or office relocations, the request must include the following:

1. Request that the provider's file be updated with the current information;

2. Seven-digit provider number; and

3. Indication of whether the change is for a physical address and/or a "pay to" address.

Note: The request requires the original signature of the provider who is officially enrolled under the provider number. Stamped signatures and initials are not accepted.

Group Linkages Definitions

Refer to Appendix B for Group Linkages Definitions.

Taxpayer Identification

An Employer Identification Number (EIN), also known as a Federal Taxpayer Identification Number (TIN), is assigned to a business by the Internal Revenue Service (IRS). The EIN must be exactly as it appears on the IRS file and the "pay to" name must be exactly how it appears on the Medicaid provider file. All individuals must report their Social Security number to the Bureau of Health Services Financing, but may also use a TIN for tax reporting purposes. The IRS considers the TIN incorrect if either the name or number shown on an account does not match a name or number combination in their files. The IRS sends the Department a tape identifying mismatches from our Medicaid provider files and the IRS files for previous years.

If appropriate action is not taken to correct the mismatches, the law requires the BHSF to withhold 31 percent of the interest, dividends, and certain other payments that are made to a provider's account. This is called backup withholding. In addition to backup withholding, a provider may be subject to a $50.00 penalty by the IRS for failing to give the correct name, TIN and/or EIN combination.

Any change in the TIN must be reported to the PEU. Providers who obtain a new TIN must send a letter to PEU as notification of the new number and include any provider number affected by the change. Any pre-printed IRS document that shows the name and TIN is acceptable verification and should be forwarded to the PEU upon receipt. **W-9 forms are not acceptable.**

Electronic Funds Transfer/Direct Deposit

Electronic Funds Transfer (EFT), also referred to as direct deposit, is mandatory for the reimbursement of all Medicaid providers. All new applications will be returned if EFT information is not included. The EFT enrollment process requires that a voided check, or a letter from the bank identifying the provider's account and routing number, be submitted with the provider agreement papers. A deposit slip for the account will not be accepted.

It is the provider's responsibility to ensure that the information contained in their EFT record is accurate. The PEU must be notified prior to a change in the provider's bank account in order to ensure that payments are made to the appropriate account. EFT payments that are sent to incorrect accounts may result in extensive delays in the subsequent receipt of payments.

Providers should be aware that the processing time for information changes to the EFT is approximately two to three weeks. In the interim, paper checks are mailed to the provider's "pay-to" address.

Providers should review their monthly bank statement to identify payments made by the Department. The deposit account number on the bank statement consists of the middle five digits of the Medicaid provider number with two leading zeros, plus the remittance advice number. The amount of the deposit is the same as the total payment shown on the financial page of the remittance advice.

Providers should attempt to resolve deposit problems with their accounting department or bank before contacting the PEU. Providers should contact the PEU for inquiries regarding EFT and the Provider Relations Unit regarding missing checks. (Refer to Appendix B of this manual chapter for contact information).