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 and regulations and policies established by the Centers for Medicare and Medicaid Services (CMS) and the Department of Health and Hospitals (DHH). 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.

Therefore, providers are responsible for knowing the terms of the provider agreement, program standards, statutes and the penalties for violations. The providers' signature on a claim form serves as 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:

- To adhere to all the requirements of administrative rules governing the Medical Assistance Program found in the *Louisiana Register;*
- To comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
- To comply with Title VI of the 1964 Civil Rights Act and Title VII of the *1964 Civil Rights Act* (where applicable), not to discriminate based on race, color, creed or national origin;
- To comply with Section 504 of the *Rehabilitation Act of 1973*; and
- To 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 the DHH 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 LSA-RS 46:437.11-46:437:14.

The following is merely a brief outline of some of the terms and a condition imposed by MAPIL and is not an all inclusive list:

- Comply with all federal and state laws and regulations;
- Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care;
- Maintain all necessary and required licenses or certificates;
- Allow for inspection of all records by governmental authorities, including but not limited to, DHH, the State Attorney General's Medicaid Fraud Control Unit, and the Department of Health and Human Services;
- Safeguard against the disclosure of information in the recipient's medical records;
- Bill other insurers and third parties prior to billing Medicaid;
- Report and refund any and all overpayments;
- Accept the Medicaid payment as payment in full for services rendered to Medicaid recipients, providing for the allowances for co-payments authorized by Medicaid. A recipient may be billed for services that have been determined as non-covered or exceeding the services limit for recipients over the age of 21. Recipients are also responsible for all services rendered after his/her eligibility has ended;
- Agree to be subject to claims review;
- Accept liability for any administrative sanctions or civil judgments by the buyer and seller of a provider;
- Allow inspection of the facilities; and
- Post bond or a letter of credit, when required.

Note: In order to bill a recipient for a non-covered service, the recipient 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 enrollment or revoke enrollment under specific conditions.

Disclosure of Ownership

Providers are required to update their ownership information preferably using a web-based application available at www.lamedicaid.com. Information must be disclosed on all owners with 5% or greater interest and all members of management/Board of Directors in the business/entity. Information includes, but is not limited to:

- Name
- Social Security Number
- Tax Identification Number
- Address

Currently, providers without Internet access may contact the fiscal intermediary's Provider Enrollment Unit for paper forms.

Acceptance of Recipients

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

Confidentiality

All Medicaid recipient 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 use the same health care transactions, code sets and identifiers. The privacy requirements of HIPAA limit the release of patient protected health information without knowledge or consent. The HIPAA security regulation requires safeguards to prevent unauthorized access to protected health care information. HIPAA also requires health care providers to 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 the HIPAA, providers must obtain and use their NPI number on all claims submissions. Providers who do not provide medical services are exempt from this requirement (i.e. non-emergency transportation, case management, 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 7-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 recipients 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 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 lack 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. The Bureau 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 and rules and regulations to ensure each record is valid and secure.

BHSF reserves the right to require modifications of the provider's policy if it is determined that the policy does not adequately ensure the security and validity of the records. Providers who maintain electronic records must be able to provide the records in a paper format within a reasonable amount of time when requested to do so by BHSF.

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: DHH, the State Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services. Providers must allow access to all Medicaid recipient 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 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 in a disaster such as a fire, flood or hurricane and rendered unreadable and unusable, such records must be properly disposed of in a manner which protects recipient confidentiality. A letter of attestation must be submitted to the fiscal intermediary 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 Provider Enrollment Unit **in writing**. **Faxes will not be accepted except for change of address and Clinical Laboratory Improvement Amendments (CLIA) status.** Each change request requires the original signature (no stamped signatures or initials) of the individual provider or an authorized representative of an enrolled entity. Third party billers/agents cannot request changes to a provider's enrollment records.

Correspondence must be mailed to the Provider Enrollment Unit. (Refer to Appendix B for contact information)

Contact Information

Providers must notify the Provider Enrollment Unit 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 can have only one pay-to address. This address **must** be the address where the provider wishes to receive all **remittance advice (RA)** notices for 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 Provider Enrollment Unit of any changes in internal operations that affects the originally reported information. This includes 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 Provider Enrollment Unit **must be notified in writing** of these changes. Failure to timely notify the Provider Enrollment Unit could result in payment delays.

The Bureau does not allow informal agreements between parties. The provider should contact the Provider Enrollment Unit 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 (EIN), 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 should be taken when reporting a CHOW:

- Notify the Provider Enrollment Unit in writing 60 days prior to the anticipate date of the CHOW and include the seven digit Medicaid ID number and other identifying information.
- For providers who are enrolled to participate in the Medicare Program, notify DHH Health Standards Section 60 days prior to the anticipated date of the CHOW.
- For providers who submit cost reports, notify the Rate and Audit Section 60 days prior to the anticipated date of the CHOW.
- Submit the completed enrollment application and the required documentation to the Provider Enrollment Unit 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 the Provider Enrollment Unit. 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:

- Decision to discontinue accepting Medicaid.
- Business Closure.
- Any change in licensing status (a copy of the updated license must be submitted with the change request).
- Death of a provider. The Medicaid provider number of a deceased provider cannot be used for any reason.
- Any 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).
- Any change in account information affecting **Electronic Funds Transfer** (EFT)/ (direct deposit).
    - Changes must be submitted with a copy of a voided check (deposit slips are not accepted).

- Failure to update EFT information may result in payments being sent to incorrect accounts.
- A hardcopy check will not be reissued until the inappropriately routed funds are returned to the Department's account.

- Any change in the pay-to mailing address. RAs and 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 Provider Enrollment Unit immediately.

- Any change in provider name must be reported.
  - The correspondence must include the current provider name, new provider name and the effective date of the change.
  - If a license is required, the updated license must be submitted with the notification.
- Any change in telephone number. This telephone number should be a number where the provider or authorized agent may be contacted for questions. It should 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 Provider Enrollment Unit 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 should include:

- A request that the provider's file be updated with the current information.
- The 7-digit provider number.
- An indication of whether the change is for a physical address and/or a "pay-to" address. The request requires the original signature of the provider who is officially enrolled under the provider number (stamped signatures/initials are not accepted).

Group Linkages Definitions

Individual Provider Number – a seven-digit identification number issued to individuals who meet all enrollment requirements. This number is then used for billing purposes.

Professional Group Provider Number – a seven-digit Medicaid provider number issued to any professional group who meets all eligibility requirements. This number is then used for billing purposes.

Linkages of Professionals to Groups – an individual practitioner's provider number can be "linked" to a group provider number for purposes of billing services furnished through the relationship between the individual practitioner and the group. Claims submitted under the group number, with an individual's practitioner's provider number included as the attending provider, will be processed and the remittance will be sent directly to the group's pay-to address. It is not necessary for the individual practitioner's pay-to address to be the same as the group's pay-to address for these remittance advice notices to be sent to the group.

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 Bureau to withhold 31% of the interest, dividends, and certain other payments that are made to your 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 taxpayer identification number must be reported to the Provider Enrollment Unit. Providers who obtain a new TIN must send a letter to the Provider Enrollment Unit 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 Provider Enrollment Unit 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 his/her EFT record is accurate. The Provider Enrollment Unit 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 can result in extensive delays in the subsequent receipt of payments.

Providers should be aware that the processing time for EFT information changes 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 Provider Enrollment Unit. Providers should contact the Provider Enrollment Unit for inquiries regarding EFT and the Provider Relations Unit regarding missing checks. Refer to Appendix B for contact information.