Louisiana

LSA-R.S. 46:437.1

§ 437.1. Short title

This Part may be cited as the “Medical Assistance Programs Integrity Law”.

LSA-R.S. 46:437.2

§ 437.2. Legislative intent and purpose

A. This Part is enacted to combat and prevent fraud and abuse committed by some health care providers participating in the medical assistance programs and by other persons and to negate the adverse effects such activities have on fiscal and programmatic integrity.

B. The legislature intends the secretary of the Louisiana Department of Health, the attorney general, and private citizens of Louisiana to be agents of this state with the ability, authority, and resources to pursue civil monetary penalties, liquidated damages, or other remedies to protect the fiscal and programmatic integrity of the medical assistance programs from health care providers and other persons who engage in fraud, misrepresentation, abuse, or other ill practices, as set forth in this Part, to obtain payments to which these health care providers or persons are not entitled.

LSA-R.S. 46:437.3

§ 437.3. Definitions

As used in this Part the following terms shall have the following meanings:

(1) "Administrative adjudication" means adjudication and the adjudication process contained in the Administrative Procedure Act.[1]

(2) "Agent" means a person who is employed by or has a contractual relationship with a health care provider or who acts on behalf of the health care provider.

(3) "Billing agent" means an agent who performs any or all of the health care provider's billing functions.

(4) "Billing" or "bills" means submitting, or attempting to submit, a claim for goods, services, or supplies.

(5) "Claim" means any request or demand, whether under a contract or otherwise, for money or property, whether or not the state or department has title to the money or property, that is drawn in whole or in part on medical assistance programs funds that are either of the following:

(a) Presented to an officer, employee, or agent of the state or department.

(b) Made to a contractor, grantee, or other recipient, if the money or property is to be spent or used in any manner in any program administered by the department under the authority of federal or state law, rule, or regulation, and if the state or department does either of the following:

(i) Provides or has provided any portion of the money or property requested or demanded.

(ii) Reimburses the contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

A claim may be based on costs or projected costs and includes any entry or omission in a cost report or similar document, book of account, or any other document which supports, or attempts to support, the claim. A claim may be made through electronic means if authorized by the department. Each claim may be treated as a separate claim or several claims may be combined to form one claim.

(6) "Department" means the Louisiana Department of Health.

(7) "False or fraudulent claim" means a claim which the health care provider or his billing agent submits knowing the claim to be false, fictitious, untrue, or misleading in regard to any material information. "False or fraudulent claim" shall include a claim which is part of a pattern of incorrect submissions in regard to material information or which is otherwise part of a pattern in violation of applicable federal or state law or rule.

(8) "Good, service, or supply" means any good, item, device, supply, or service for which a claim is made, or is attempted to be made, in whole or part.

(9) "Health care provider" means any person furnishing or claiming to furnish a good, service, or supply under the medical

assistance programs, any other person defined as a health care provider by federal or state law or by rule, and a provider-in-fact.

(10) "Ineligible recipient" means an individual who is not eligible to receive health care through the medical assistance programs.

(11) "Knowing" or "knowingly" means that the person has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information.

(12) "Managing employee" means a person who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operations of a health care provider. "Managing employee" shall include but is not limited to a chief executive officer, president, general manager, business manager, administrator, or director.

(13) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(14) "Medical assistance programs" means the Medical Assistance Program (Title XIX of the Social Security Act), commonly referred to as "Medicaid", and other programs operated by and funded in the department which provide payment to health care providers.

(15) "Misrepresentation" means the knowing failure to truthfully or fully disclose any and all information required, or the concealment of any and all information required on a claim or a provider agreement or the making of a false or misleading statement to the department relative to the medical assistance programs.

(16) "Obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor, grantee, or licensor-licensee relationship, from a free-based or similar relationship, from statute or regulation, or from the retention of any overpayment.

(17) "Order" means a final order imposed pursuant to an administrative adjudication.

(18) "Ownership interest" means the possession, directly or indirectly, of equity in the capital or the stock, or the right to share in the profits, of a health care provider.

(19) "Payment" means the payment to a health care provider from medical assistance programs funds pursuant to a claim, or the attempt to seek payment for a claim.

(20) "Property" means any and all property, movable and immovable, corporeal and incorporeal.

(21) "Provider agreement" means a document which is required as a condition of enrollment or participation as a health care provider under the medical assistance programs.

(22) "Provider-in-fact" means an agent who directly or indirectly participates in management decisions, has an ownership interest in the health care provider, or other persons defined as a provider-in-fact by federal or state law or by rule.

(23) "Recipient" means an individual who is eligible to receive health care through the medical assistance programs.

(24) “Recoupment” means recovery through the reduction, in whole or in part, of payment to a health care provider.

(25) “Recovery” means the recovery of overpayments, damages, fines, penalties, costs, expenses, restitution, attorney fees, or interest or settlement amounts.

(26) “Rule” means any rule or regulation promulgated by the department in accordance with the Administrative Procedure Act and any federal rule or regulation promulgated by the federal government in accordance with federal law.

(27) “Sanction” shall include but is not limited to any or all of the following:

(a) Recoupment.

(b) Posting of bond, other security, or a combination thereof.

(c) Exclusion as a health care provider.

(d) A monetary penalty.

(28) “Secretary” means the secretary of the Louisiana Department of Health, or his authorized designee.

(29) “Secretary or attorney general” means that either party is authorized to institute a proceeding or take other authorized action as provided in this Part pursuant to a memorandum of understanding between the two so as to notify the public as to whether the secretary or the attorney general is the deciding or controlling party in the proceeding or other authorized matter.

(30) “Withhold payment” means to reduce or adjust the amount, in whole or in part, to be paid to a health care provider for a pending or future claim during the time of a criminal, civil, or departmental investigation or proceeding or claims review of the health care provider.

LSA-R.S. 46:437.4

§ 437.4. Claims review and administrative sanctions

A. (1) Pursuant to rules and regulations promulgated in accordance with the Administrative Procedure Act, the secretary shall establish a process to review a claim made by a health care provider to determine if the claim should be or should have been paid as required by federal or state law or by rule.

(2) Claims review may occur prior to or after payment is made to a health care provider.

(3) The secretary may withhold payment to a health care provider during claims review if necessary to protect the fiscal integrity of the medical assistance programs.

(4) The administrative rules promulgated by the department to implement the claim review process established pursuant to this Subsection shall provide for procedures to ensure that providers receive or retain the appropriate reimbursement amount for claims in which the department determines that services delivered have been improperly billed but were reasonable and necessary.

B. The secretary may establish various types of administrative sanctions pursuant to rules and regulations promulgated in accordance with the Administrative Procedure Act which may be imposed on a health care provider or other person who violates any provision of this Part or any other applicable federal or state law or rule related to the medical assistance programs.

C. (1) The department shall conduct a hearing in compliance with the Administrative Procedure Act at the request of a person who wishes to contest an administrative sanction imposed on him by the secretary.

(2) A party aggrieved of an order may seek judicial review only in the Nineteenth Judicial District Court for the parish of East Baton Rouge.

(3) Judicial review of the order shall be conducted in compliance with the Administrative Procedure Act.

D. All state rules and regulations issued on or before August 15, 1997, shall be deemed to have been issued in compliance with and under the authority of this Section.

LSA-R.S. 46:437.5

§ 437.5. Settlement

A. The secretary or the attorney general may agree to settle a matter for which recovery may be sought on behalf of the medical assistance programs or for a violation of this Part. The terms of the settlement shall be reduced to writing and signed by the parties to the agreement. The terms of the settlement shall be public record.

B. At a minimum, the settlement shall ensure that the recovery agreed to by the parties covers the estimated loss sustained by the medical assistance programs. The settlement shall include the method and means of payment for recovery, including but not limited to adequate security for the full amount of the settlement.

LSA-R.S. 46:437.6

§ 437.6. Injunctive relief; lis pendens; disclosure of property and liabilities

A. (1) Concurrently with a withholding of payment, a sanction being imposed, or the institution of a criminal, civil, or departmental proceeding against a health care provider or other person, the secretary or the attorney general may bring an action for a temporary restraining order or injunction under Code of Civil Procedure Articles 3601 through 3613 to prevent a health care provider or other person from whom recovery may be sought from transferring property or to protect the business.

(2) To obtain such relief, the secretary or the attorney general shall demonstrate all necessary requirements for the relief to be granted.

(3) If an injunction is granted, the court may appoint a receiver to protect the property and business of the health care provider or other person from whom recovery may be sought. The court shall assess the cost of the receiver to the nonprevailing party.

B. Pursuant to Code of Civil Procedure Articles 3751 through 3753, the secretary or the attorney general may place a notice of pendency of action, lis pendens, on the property of a health care provider or other person during the pendency of a criminal, civil, or departmental proceeding.

C. When requested by the court, the secretary, or the attorney general, a health care provider or other person from whom recovery may be sought shall have an affirmative duty to fully disclose all property and liabilities to the requester.

LSA-R.S. 46:437.7

§ 437.7. Forfeiture of property for payment of recovery

A. In accordance with the provisions of Subsection B of this Section, the court may order the forfeiture of property to satisfy recovery under the following circumstances:

(1) The court may order the health care provider or other person from whom recovery is due to forfeit property which constitutes or was derived directly or indirectly from gross proceeds traceable to the violation which forms the basis for the recovery.

(2) If the secretary or the attorney general shows that property was transferred to a third party to avoid paying of recovery, or in an attempt to protect the property from forfeiture, the court may order the third party to forfeit the transferred property.

B. Prior to the forfeiture of property, a contradictory hearing shall be held during which the secretary or the attorney general shall prove, by clear and convincing evidence, that the property in question is subject to forfeiture pursuant to Subsection A of this Section. No such contradictory hearing shall be required if the owner of the property in question agrees to the forfeiture.

C. If property is transferred to another person within six months prior to the occurrence or after the occurrence of the violation for which recovery is due or within six months prior to or after the institution of a criminal, civil, or departmental investigation or proceeding, it shall be prima facie evidence that the transfer was to avoid paying recovery or was an attempt to protect the property from forfeiture.

D. The health care provider or other person from whom recovery is due shall have an affirmative duty to fully disclose all property and liabilities, and all transfers of property which meet the criteria of Subsection C of this Section, to the court, the secretary and the attorney general.

LSA-R.S. 46:437.8

§ 437.8. Venue

An action instituted pursuant to R.S. 46:437.6 or 437.7 may be brought in any of the following courts:

(1) The Nineteenth Judicial District Court for the parish of East Baton Rouge.

(2) A district court in the parish in which a health care provider or other person from whom recovery may be sought has its principal place of business or is domiciled.

LSA-R.S. 46:437.9

§ 437.9. Privilege; nondischargeability

A. Recovery shall be granted a privilege under state law as to all property owned by the health care provider or other person from whom recovery is due and shall be effective as to third parties only if notice of pendency, lis pendens, is placed on the property, if recorded and reinscribed in accordance with Civil Code Articles 3320 through 3327, or if the conditions of Subsection C of this Section are applicable.

B. As to the property owned by the health provider, the privilege provided in Subsection A of this Section shall rank ahead of any other privilege, mortgage, or secured interest possessed by the health care provider, his agent, or his managing employee except the first mortgage executed upon the property.

C. If property is transferred to a third party to avoid paying of recovery, or in an attempt to protect the property from forfeiture, the privilege provided in Subsection A of this Section shall rank ahead of any other privilege, mortgage, or secured interest on the transferred property obtained or possessed by the person who obtains an ownership interest in the transferred property.

D. Recovery for a violation of R.S. 46:438.2 or R.S. 46:438.3 shall be considered a nondischargeable liability under the provisions of Title 11, U.S.C. Chapters 7, 11, and 13.

LSA-R.S. 46:437.10

§ 437.10. Continuing liability; assumption of liability

A. A health care provider or person from whom recovery is due shall remain liable for the recovery regardless of any sale, merger, consolidation, dissolution, or other disposition of the health care provider or person, provided the obligation is recorded and reinscribed in accordance with Civil Code Articles 3320 through 3337.

B. Any person who obtains an ownership interest, whether by sale, merger, consolidation, or other disposition, in a health care provider or other person from whom recovery is due shall assume the liability and be responsible for paying the amount of any outstanding recovery. Such person shall remain liable, provided the obligation is recorded and reinscribed in accordance with Civil Code Articles 3320 through 3337.

LSA-R.S. 46:437.11

§ 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.

LSA-R.S. 46:437.12

§ 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.

LSA-R.S. 46:437.13

§ 437.13. Powers and duties of the department

A. The department shall:

(1) Make payment timely at the established rate for goods, services, or supplies furnished to a recipient by the health care provider upon receipt of a properly completed and properly supported claim.

(2) Require certification on the claim form that the goods, services, or supplies have been completely furnished to a recipient eligible to receive the goods, services, or supplies and that, with the exception of those goods, services, or supplies specified by the department, the amount billed does not exceed the health care provider's usual and customary charge for the same goods, services, or supplies.

(3) Not demand repayment from the health care provider in any instance in which the medical assistance programs overpayment is attributable to error of the department in the determination of eligibility of a recipient.

B. The department may:

(1) Adopt, and include in the provider agreement, such other requirements and stipulations on either party as the department finds necessary to properly and efficiently administer the medical assistance programs.

(2)(a) Revoke any provider agreement as the result of a change of ownership in the named health care provider.

(b) Require a health care provider to give the department sixty days written notice before making any change in ownership of the person named in the provider agreement as the health care provider.

(3) Require, as a condition of participating in the medical assistance programs and before entering into the provider agreement, the following:

(a) An on-site inspection of the health care provider's service location by department representatives or other personnel designated by the secretary to assist in this function.

(b) A letter of credit, a surety bond, or a combination thereof, from the health care provider not to exceed fifty thousand dollars. The letter of credit, surety bond, or combination thereof may be required only if either of the following conditions is met:

(i) A letter of credit, surety bond, or any combination thereof is required for each health care provider in that category of health care provider.

(ii) The health care provider is the subject of a sanction or of a criminal, civil, or departmental proceeding.

(c) The submission of information concerning the professional, business, and personal background of the health care provider, any person having an ownership interest in the health care provider, and any agent of the health care provider. Such information shall include:

(i) Proof of holding a valid license or operating certificate, as applicable, if required by federal or state law or by rule or by a local jurisdiction in which the health care provider is located.

(ii) Any prior violation, fine, suspension, termination, or other administrative action taken under federal or state law or rule or the laws or rules of any other state relative to medical assistance programs, Medicare, or a regulatory body.

(iii) Any prior violation of the rules or regulations of any other public or private insurer.

(iv) Full and accurate disclosure of any financial or ownership interest that the health care provider, or a person with an ownership interest in that health care provider, may hold in any other health care provider or health care related entity or any other entity that is licensed by the state to provide health or residential care and treatment to persons.

(v) If a group health care provider, identification of all members of the group and attestation that all members of the group are enrolled in or have applied to enroll in the medical assistance programs.

C. Upon receipt of a completed, signed, and dated application, and after any necessary investigation by the department, which may include the Department of Public Safety and Corrections, office of state police background checks, the department shall either:

(1) Enroll the applicant as a Medicaid provider.

(2) Deny the application if, based on the grounds listed in R.S. 46:437.14, the secretary determines that it is in the best interest of the medical assistance programs to do so, specifying the reasons for denial.

D. In accordance with the provisions of 42 CFR 433.318(d)(2)(ii), the department is hereby granted the authority to certify that a provider enrolled in the Medical Assistance Program is out of business and that any overpayments made to the provider cannot be collected under state law.

LSA-R.S. 46:437.14

§ 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.