U-0000 FRAUD AND RECOVERY

U-100 FRAUD, WASTE AND ABUSE

Fraud is willful misrepresentation of facts or concealment of information relevant to a recipient's eligibility to obtain Medicaid benefits or payment for which no entitlement exists. In order to be considered fraud, the act must be performed knowingly or intentionally and may be committed for the recipient's own benefit or for the benefit of another party.

Waste and abuse is inconsistent fiscal, business or medical practices that result in unnecessary costs to the Medicaid program or that fail to meet professionally recognized for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

U-110 SUSPECTED RECIPIENT FRAUD OR ABUSE

Cases of suspected recipient fraud or abuse shall be referred to the Medicaid Recipient Fraud Investigative Unit (MRFIU).

Refer all cases involving one or more of the following circumstances for suspected recipient fraud:

- An individual misrepresenting facts or providing misleading or fraudulent documents and/or information in order to become or remain eligible to receive Medicaid benefits or obtain greater benefits;

- A recipient altering, duplicating, selling or otherwise allowing another person to use their medical eligibility card to obtain Medicaid covered services;

- An individual purchasing, altering, duplicating or otherwise using a medical eligibility card issued to another person to obtain Medicaid covered services; or

- Altering a prescription or going to multiple doctors to obtain multiple prescriptions for the same drug or selling drugs to others.

U-110.1 Recipient Fraud or Abuse Complaints

If Medicaid recipient fraud or abuse is suspected, the public should submit a complaint for review. The complaint may be made anonymously if preferred.

A complaint should contain as much information as possible, if known, such as recipient's name, Medicaid ID number, gender, telephone number, address, and a description of the suspected fraud or abuse. If reporting fraud committed by a parent of a Medicaid recipient, include the names of the child(ren) and their Medicaid ID numbers.

There are several ways to report suspected recipient fraud or abuse:

1. Call toll-free 1-833-920-1773.

2. Submit the Recipient Fraud Form electronically – http://ldh.la.gov/index.cfm/form/23.

3. Submit the Recipient Fraud complaint by mail to:

   Customer Service Unit
   Louisiana Department of Health
   P O Box 91278
   Baton Rouge, LA 70821-9278

4. Fax the Recipient Fraud complaint to 225-389-2610.

U-120 SUSPECTED PROVIDER FRAUD OR ABUSE

Refer any reports of provider fraud, waste, or abuse to the Surveillance Utilization Review Subsystem (SURS). The following circumstances may indicate provider fraud has occurred:

- Billing for services or items that were not provided or misusing billing codes;

- Billing for services or items that are unnecessary, such as excessive services or testing;

- Collaborating with recipients to file false claims and/or use multiple Medicaid ID cards;

- Writing unnecessary prescriptions, or altering prescriptions to obtain drugs for personal use or to sell;
- Offering, soliciting, or paying for recipient referrals; or
- Failing to refund and/or report overpayments.

U-120.1 Provider Fraud, Waste, or Abuse Complaints

For suspected provider fraud, waste, or abuse, the public should submit a complaint for review. The complaint may be made anonymously if preferred.

A complaint should contain as much information as possible, if known, such as, provider's name, gender, business name, type of business, Medicaid provider number, telephone number, and address.

There are several ways to report the suspected fraud, waste, or abuse.

1. Call toll-free 1-800-488-2917.
2. Submit the Provider Fraud Form electronically – http://ldh.la.gov/index.cfm/form/22.
3. Submit the Provider Fraud complaint by mail to:

   Gainwell Technologies
   SURS Department
   8591 United Plaza Blvd.
   Baton Rouge, LA 70809

4. Fax the Provider Fraud complaint to 225-216-6129.

U-130 INELIGIBLE MEDICAID PAYMENTS

An ineligible Medicaid payment is a payment made on behalf of a recipient, at a time when that recipient did not meet the eligibility requirements for Medicaid coverage, was ineligible for the service(s) received, or exceeds the amount that is allowable for the service(s) furnished. All ineligible Medicaid payments are subject to fraud review/investigation.

An ineligible Medicaid payment may result in:

- Recoupment from the provider, or
- Criminal prosecution.

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U-200 RECOVERY

Recovery is the process of collecting the amount of medical assistance payments made on behalf of a Medicaid recipient. The Medicaid Enterprise System (MES)/Recovery and Premium Assistance (RPA) Unit handles the following categories of recovery:

- Restitution - recovery from an offender pursuant to a court order or as part of an agreement with a prosecutorial agency, which is facilitated by Department of Corrections, Division of Probation and Parole.
- Annuities – recovery upon the death of an individual from funds remaining in an annuity naming the State as the remainder beneficiary, not to exceed the total amount of medical assistance expended on behalf of the individual during their lifetime.
- Special Needs Trust (SNT) – recovery upon the death of an individual from assets remaining in an SNT that includes a Medicaid payback provision, not to exceed the total amount of medical assistance expended on behalf of the individual during their lifetime.
- ABLE Accounts – upon the death of the account beneficiary, any amounts remaining in the account, up to the total medical assistance paid for the beneficiary (including Medicaid Buy-In programs), after the establishment of the account under any State Medicaid plan, shall be distributed to the State, subject to any outstanding payments due for qualified disability expenses.
- Estate Recovery (see U-300).

- Trauma Recovery (see U-400) - recovery from liable third parties for subrogation, workman's compensation, medical malpractice, or personal injury claims.

U-300 ESTATE RECOVERY

As required by federal regulations, the State must seek recovery of Medicaid payments for Long Tterm Care (LTC) facility services, Home and Community-Based Services (HCBS), and related hospital and prescription drug services from the estate of an individual who was age 55 or older when such services were received.

Medicaid Estate Recovery is not a condition of eligibility. LTC and HCBS applicants/recipients shall be informed at the time of application and renewal that claims for Medicaid assistance received may be subject to recovery from their estate.

U-310 RECOVERY LIMITATIONS

Recovery for services received prior to the date the recipient or responsible party was initially informed of Estate Recovery provisions will not be pursued.

Recovery can only be made after the death of the recipient's surviving spouse, if any, and only at the time when the recipient has no surviving child under age 21, or a child who is blind or disabled as defined by SSA.

Recovery may be reduced in consideration of reasonable and necessary documented expenses incurred by the decedent's heirs to maintain the homestead during the period in which the recipient was in a long term care facility or received home and community-based services, if the homestead is part of the estate.

Homestead consists of a residence occupied by the recipient and the land on which the residence is located, including any buildings and appurtenances located thereon, and any contiguous tracts up to five acres if the residence is within a municipality.

If the residence is not located in a municipality, the homestead may contain up to a total of 200 acres. This same homestead shall be the individual's home which was occupied by the recipient immediately prior to their admission to a LTC facility or HCBS services.

U-315 RECOVERY EXCLUSIONS

If an individual was insured under a qualifying long-term care insurance partnership policy and was enrolled in Medicaid as a result of resources being disregarded in the eligibility determination, the agency shall not seek adjustment or recovery from the individual's estate for the amount of the resources disregarded.

The agency shall not seek recovery or adjustment from an individual's estate for the amount of Medicare cost-sharing benefits paid on behalf of an individual that was enrolled in any of the following Medicare Savings Programs (MSP):

- Qualified Medicare Beneficiary (QMB),
- QMB Plus,
- Specified Low-Income Medicare Beneficiary (SLMB),
- SLMB Plus,
- Qualified Disabled Working Individual (QDWI), or
- Qualifying Individual (QI).

U-320 COST EFFECTIVENESS

Recovery may be waived in cases in which it is not cost effective for the state to recover from the recipient's estate. Cost effectiveness is a process whereby the Medicaid agency balances and weighs that which it may reasonably expect to recover against the time and expense of recovery.

Recovery will be considered cost effective when the amount reasonably expected to be recovered exceeds the cost of recovery and is equal to or greater than $1,000.

U-330 UNDUE HARDSHIP

If recovery would place an unreasonable burden on an heir; and if an heir's family income is equal to or less than 300 percent of the Federal Poverty Income Guideline (FPIG), adjustment or recovery may be waived. An undue hardship waiver is limited to the period during which the undue hardship circumstances continue to exist.

An undue hardship may exist when:

- The estate is the sole income-producing asset of an heir and income from the estate is limited (e.g., a family farm or other family business which produces a limited amount of income when the farm or business is the sole asset of the heir.

- Recovery would result in the heir's necessity to apply for and become eligible for public assistance, including but not limited to Medicaid.

- Other compelling circumstances would result in placing an unreasonable burden on the heir.

Undue hardship does not exist if the circumstances of the hardship were created by or as the result of estate planning methods under which assets were sheltered or divested in orderto avoid Estate Recovery. If the individual obtained estate planning advice from legal counsel and followed this advice, the resulting financial situation does not qualify for an undue hardship waiver.

It is the obligation of the heirs to prove undue hardship by a preponderance of the evidence. Determinations of undue hardship will be made by RPA.

U-330.1 Hardship Notice

Family or heirs affected by recovery of amounts of medical assistance will be given advance written notice of the proposed action and the opportunity to apply for an undue hardship waiver. The notice is issued by RPA.

The notice shall be served on the executor, legally authorized representative or succession attorney of the decedent's estate. If there is no executor, legally authorized representative or succession attorney, the notice shall be sent to the family or heirs.

This notice shall include:

- the deceased recipient's name, and Medicaid identification number

- the action the State intends to take,
- the reason for the action,
- the dates of services associated with the recovery action and the amount of the department's claim, i.e., amount to be recovered against the recipient's estate,
- the right to and procedure for applying for a hardship waiver,
- the authorized representative's right to a hearing,
- the method by which the authorized representative may obtain a hearing, and
- the time periods involved in requesting a hearing or in exercising any procedural requirements under the Medicaid Estate Recovery Program.

The notice will request that copies of all pleadings filed in connection with the succession of the decedent, including any judgment(s) of possession, be provided to BHSF. In the event no succession has been judicially opened, BHSF is to be advised as to when such documents will be available and/or when the succession is expected to be opened.

Appeal requests will be processed by the Division of Administrative Law (DAL).

U-340 METHOD OF PAYMENT

Checks, money order, cashier checks, and treasurer's checks will be accepted for payment in full.

Transfer of property will not be accepted.

U-350 RESERVED

U-360 RESERVED

U-400 TRAUMA RECOVERY

As a condition of eligibility, Louisiana Medicaid is given the right to any money owed for expenses paid on behalf of an applicant/enrollee that were incurred as the result of an accident or injury.

Since Medicaid is the payor of last resort, Federal law mandates that Louisiana Medicaid take necessary measures to recover any trauma-related payments where there is a third party responsible for paying claims.

Third party payments may come from sources, i.e. insurance settlements, workman's compensation claims, motor vehicle insurance, homeowner's insurance, etc.

U-410 ACCIDENT/INJURY REPORTS

The monthly Accident/Injury Report (AIR) identifies claims with trauma-related procedure and diagnosis codes. AIR recovery cases are automatically created in the BHSF MES/Recovery and Premium Assistance Unit, if there is no indication of previous recovery surrounding the identified date(s) of service.

An AIR notice (as well as follow-up notices after 30, 60, and 90 days) are automatically generated to the enrollee or his/her parent/guardian, requesting that contact be made directly to Recovery and Premium Assistance (RPA) Unit staff, who will either close the AIR case or pursue recovery, as appropriate.

MES/Medicaid Recovery:

- Must be emailed at Medicaid.TraumaEstateRecovery@la.gov information as it becomes available (include attachments).
- Responds to direct requests and/or inquiries from the enrollees, legal representatives or providers.
- Receives payments from a third party.

BHSF Eligibility Policy Unit will be notified when a Medicaid recovery case has been settled. The amount of the settlement will be given when known.

Note:
Benefits shall be terminated for an individual who refuses to cooperate. Notice and hearing requirements must be met.