



State of Louisiana
Department of Health and Hospitals
Office of the Secretary

November 26, 2013

Bill Brooks
Associate Regional Administrator
Division of Medicaid & Children's Health
DHHS/Centers for Medicare and Medicaid Services
1301 Young Street, Room #833
Dallas, Texas 75202

Dear Mr. Brooks:

RE: Louisiana Title XIX State Plan
Transmittal No. 13-45

I have reviewed and approved the enclosed Louisiana Title XIX State Plan material.

I recommend this material for adoption and inclusion in the body of the State Plan.

Sincerely,



Kathy H. Kliebert
Secretary

Attachments (1)

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

13-45

2. STATE

Louisiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

January 20, 2014

5. TYPE OF PLAN MATERIAL (Check One):

NEW STATE PLAN AMENDMENT TO BE CONSIDERED AS NEW PLAN AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.120

7. FEDERAL BUDGET IMPACT:

a. FFY 2014 (\$0)

b. FFY 2015 (\$0)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.22-B, Page 2

9. PAGE NUMBER OF THE SUPERSEDED PLAN
SECTION OR ATTACHMENT (if Applicable):

Same (TN 07-08)

10. SUBJECT OF AMENDMENT: **The SPA proposes to amend the provisions governing third party liability to discontinue the practice of allowing providers to pursue collection of the difference from liable third parties in traumatic injury cases.**

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
 COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
 NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

OTHER, AS SPECIFIED:

The Governor does not review state plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Kathy H. Kliebert

14. TITLE:

Secretary

15. DATE SUBMITTED:

November 26, 2013

16. RETURN TO:

**J. Ruth Kennedy, Medicaid Director
State of Louisiana
Department of Health and Hospitals
628 N. 4th Street
PO Box 91030
Baton Rouge, LA 70821-9030**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:

23. REMARKS:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: LOUISIANA

Requirements for Third Party Liability –
Payment of Claims

- (e) The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20 by:
1. Publishing rules and regulations.
 2. Updating provider manuals.
 3. Publishing changes in the provider newsletter.
 4. Provider enrollment agreement.
 5. Agency investigations of complaints and application of appropriate sanctions.

The Department of Health and Hospitals will no longer allow providers to pursue a liable or potentially liable third party for payment in excess of the Medicaid paid amount to a provider for health care services rendered. Existing federal law preempts such an allowance.

Recipient Responsibilities

The claims included in the initial lien calculated by the Medicaid Third Party Liability Recovery Unit and the Medicaid contracted managed care entity (s) shall be deemed as an accurate reflection of the total amount paid by Medicaid and the Medicaid contracted managed care entity (s), unless challenged in writing by the recipient or his representative within 30 days of the date of the initial lien notification to the Medicaid recipient or his representative.

Noncompliance and Violations

A provider who has filed and accepted Medicaid payment and who also accepts payment in excess of billed charges, or a duplicate payment for the same health care services, may be referred for investigation and prosecution for possible violation of either federal or state laws and may be excluded from participation in the Medicaid Program.

TN No. _____
Supersedes
TN No. _____

Approval Date _____

Effective Date _____