



LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

**BULLETIN 2010-03
(REVISED AND REISSUED)**

TO: ALL HEALTH INSURANCE ISSUERS, HEALTH MAINTENANCE ORGANIZATIONS, THIRD PARTY ADMINISTRATORS, AND MEDICAL NECESSITY REVIEW ORGANIZATIONS

FROM: JAMES J. DONELON, COMMISSIONER OF INSURANCE

RE: FRAUD INVESTIGATIONS AND CLAIMS AUDITS BY HEALTH INSURANCE ISSUERS AND HEALTH MAINTENANCE ORGANIZATIONS

DATE: OCTOBER 5, 2020

Bulletin 2010-03, originally issued on September 3, 2010, is being revised and reissued to conform with amendments to La. R.S. 22:1923, La. R.S. 22:1926, and to add a citation to Regulation 90 without changing the substance of the provision.

It has been brought to the attention of the Louisiana Department of Insurance (LDI) that there is confusion regarding the length of time that a health insurance issuer or health maintenance organization (hereinafter referred to jointly as "issuer") has to investigate a claim that is suspected to be a fraudulent insurance act as defined in La. R.S. 22:1923. Specifically, La. R.S. 22:1923 states:

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

- (1) "Claim" shall mean any request or demand for payment or benefit, whether paid or not, made by a person either in writing or filed electronically.
- (2) "Fraudulent Insurance Act" shall include but not be limited to acts or omissions committed by any person who, knowingly and with intent to defraud:
 - (a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, reinsurer, purported insurer or reinsurer, producer, or any agent thereof, any oral or written statement which he knows to contain materially false information as part of, or in support of, or denial of, or concerning any fact material to or conceals any information concerning any fact material to the following:

- (i) An application for the issuance of any insurance policy.
 - (ii) The rating of any insurance policy.
 - (iii) A claim for payment or benefit pursuant to any insurance policy.
 - (iv) Premiums paid on any insurance policy.
 - (v) Payments made in accordance with the terms of any insurance policy.
 - (vi) An application for certificate of authority or the application for a certificate of authority by a health insurer that has ceased writing health and accident insurance in the state within the prior five years.
 - (vii) The financial condition of any insurer, reinsurer, purported insurer or reinsurer.
 - (viii) The acquisition of any insurer or reinsurer.
- (b) Solicits or accepts new or renewal insurance risks by or for an insolvent insurer, reinsurer, or other entity regulated under the insurance laws of this state.
- (c) Removes or attempts to remove the assets or record of assets, transactions, and affairs of such material part thereof, from the home office or other place of business of the insurer, reinsurer, or other entity regulated under the insurance laws of this state, or from the place of safekeeping of the insurer, reinsurer, or other entity regulated under the laws of this state, or who conceals or attempts to conceal the same from the department.
- (d) Diverts, attempts to divert, or conspires to divert funds of an insurer, reinsurer, or other entity regulated under the laws of this state, or other persons in connection with:
- (i) The transaction of insurance or reinsurance.
 - (ii) The conduct of business activities by an insurer, reinsurer, or other entity regulated under the insurance laws of this state.
 - (iii) The formation, acquisition, or dissolution of an insurer, reinsurer, or other entity regulated under the insurance laws of this state.

- (e) Supplies false or fraudulent material information pertaining to any document or statement required by the Department of Insurance.
- (f) Commits any fraudulent viatical settlement act, as defined by R.S. 22:1791.
- (g) Solicits or accepts new or renewal insurance risks by or for an unauthorized insurer, except as provided by Subpart O of Part I of Chapter 2 of this Title, R.S. 22:431 et seq., and Part III of this Chapter, R.S. 22:1941 et. seq.
- (h) Manufactures, sells, distributes, presents, or causes to be presented a fraudulent proof of insurance card or document.
- (i) Alters a legitimate proof of insurance card or document.
- (j) Presents, causes to be presented, or prepares with the knowledge or belief that it will be presented to a self-insured governmental entity any oral or written statement which he knows to contain materially false information as part of, in support of, denial of, or concerning any fact material to or conceals any information concerning any fact material to any claim for payment under such self-insured governmental entity's loss fund or risk pool. For the purposes of this Subparagraph, "self-insured governmental entity" shall mean any agency of the state, political subdivision of the state, or agency thereof, or consortium of governmental entities that maintains a self-insured loss fund or risk pool.
- (k) Impersonates an insurance company, or a representative of an insurance company, without the authorization or consent of the insurance company for the purpose of executing a scheme or artifice to defraud a person.
- (l) Impersonates another person or entity, whether real or fictitious, and purports himself to have the authority to direct healthcare treatment for the purpose of executing a scheme or artifice to defraud a person.
- (m) Receives money or any other thing of value from any person, firm, or entity as a means of compensation for the acts of solicitation or criminal conspiracy done for the purpose of executing a scheme or artifice to defraud a person.
- (n) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to the Property Insurance Association of Louisiana, any written statement which he knows to contain materially false information in connection with the grading by the Property Insurance Association of Louisiana of a municipality or fire district.

(o) Acts in violation of any of the following provisions of law related to public adjusters and public adjusting:

- (i) R.S. 22:1693(B).
- (ii) R.S. 22:1703.
- (iii) R.S. 22:1704.
- (iv) R.S. 22:1705.
- (v) R.S. 22:1706.

(3) "Statement" includes but is not limited to any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, test results, x-rays, or other evidence of loss, injury, or expense.

Bulletin 2010-03 is intended to clarify the rights and obligations of issuers, third party administrators, health care providers, health care facilities and/or any other affected parties in the event a fraudulent insurance act as defined in La. R.S. 22:1923 is suspected, investigated, or if any civil and/or criminal action in connection with such fraudulent insurance act is contemplated by an issuer.

It is important to clearly establish the differentiation between a claim audit/review (claim audit) and a fraud investigation. The time limits governing these activities are significantly different. A claim audit is an activity undertaken by an issuer for the purpose of reconsidering the validity of a claim. The time frame for a claim audit is enumerated in La. R.S. 22:1834(C), La. R.S. 22:1856(B) and Regulation 74 entitled Payment of Health Coverage Claims and Regulation 90 entitled Payment of Pharmacy and Pharmacist Claims. Issuers that limit the time period in which to file a claim shall have the same time period in which to conduct a claim audit. The time period does not apply to investigations of fraudulent insurance acts. Provisions of the Louisiana Civil Code and the Louisiana Criminal Code control any time period or prescriptive period to undertake a civil or criminal action for a fraudulent insurance act.

If an issuer has a rational basis to believe that a fraudulent insurance act has occurred, the duties of the issuer are clearly defined and the procedure to be followed are delineated in La. R.S. 22:1926. This includes the requirement that the issuer shall notify the LDI when the issuer believes a fraudulent insurance act has taken place. La. R.S. 22:1926 states the following:

- A. Any person, company, or other legal entity including but not limited to those engaged in the business of insurance, including producers and adjusters, that suspects that a fraudulent insurance act will be, is being, or has been committed shall, within sixty days of the receipt of such notice, send to the division of insurance fraud, on a form prescribed by the commissioner, the information requested and such additional information relative to the insurance

act and the parties claiming loss or damages because of an occurrence or accident as the commissioner may require. The division of insurance fraud shall review such reports and select such insurance acts as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such insurance act to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the insurance act.

- B. The division of insurance fraud shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency, the insurance fraud investigation unit of the office of state police, the insurance fraud support unit of the Department of Justice, and the prosecutive authority having jurisdiction with respect to any such violation. These units shall work jointly on criminal referrals.

As stated above, a fraud investigation is an investigation undertaken to determine if a fraudulent insurance act, as defined in La. R.S. 22:1923, might have occurred. The nature of insurance fraud and the subsequent investigation dictates that each case must be assessed on its own merits based on the evidence obtained by the issuer in order to uncover and/or discover any fraudulent activity. While various stages and recognition factors precede the determination of an act suspected of insurance fraud, a threshold must be established to eliminate premature and erroneous information being forwarded to the Division of Insurance Fraud of the LDI while maintaining and upholding the requirements of La. R.S. 22:1923. Such provision places a mandatory duty upon health insurance issuers, producers, brokers, and others to report suspected insurance fraud to the Division of Insurance Fraud of the LDI within sixty (60) days from the date such determination is made. To illustrate, on one hand a mere "flag" or simple suspicion based upon an anomaly with no corroborating evidence to support and confirm that a material misrepresentation (with intent to deceive) has been made may not singularly be cause to report a suspected fraudulent insurance act to the Division of Insurance Fraud. On the other hand, a pattern of deceptive behavior or material misrepresentation (with intent to deceive) along with objective evidence that demonstrates an attempt to obtain monetary benefits in violation of La. R.S. 22:1923 and La. R.S. 22:1924 shall be reported to the LDI in accordance with La. R.S. 22:1926.

In addition to the reporting duties of an issuer, and others listed in La. R.S. 22:1926, each issuer shall provide notice to the LDI of all civil and/or criminal actions pending against a health care provider, health care facility, or any other person or entity for a fraudulent insurance act committed against the issuer. If requested by the LDI, the issuer shall provide a copy of relevant court documents relating to those legal actions including, but not limited to, any judgment, settlement, or other documents representing the closure of such civil and/or criminal actions against the health care provider, health care facility, or any other person or entity. In addition to the confidentiality requirements of La. R.S. 22:1927, criminal background information in the possession of the Division of Insurance Fraud shall be confidential and shall not be disclosed to others outside the Division of

Insurance Fraud except as necessary for action on the application of the affected person, pursuant to La. R.S. 22:1928.

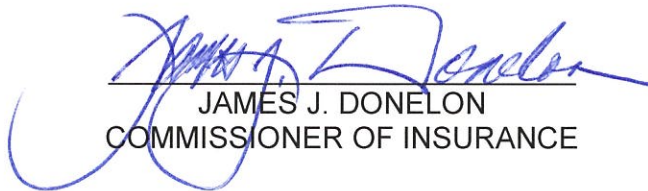
Another differentiation between a claim audit and a fraudulent insurance act is the issue of recoupment. If an issuer undertakes a fraud investigation of a claim, and it is determined that a fraudulent insurance act has not occurred, but an erroneous payment has occurred, the issuer's right to recoupment is limited to those claims subject to the prescribed time frames set forth in La. R.S. 22:1834(C), La. R.S. 22:1856(B), Regulation 74 and Regulation 90. If an issuer undertakes a fraud investigation of a claim and the issuer determines that a fraudulent insurance act might have occurred, the remedy available to the issuer is to take independent legal action relative to the alleged fraud when an issuer has demonstrable evidence of the existence of fraud. As such, issuers may pursue such legal redress by obtaining a final monetary judgment in a civil proceeding or an order of restitution in a criminal proceeding.

All reports of suspected fraudulent insurance acts shall be submitted to the Division of Insurance Fraud of the LDI and shall be made through the Online Fraud Reporting System of the National Association of Insurance Commissioners accessible through the LDI website (www.lidi.la.gov).

Please be governed accordingly.

If there are any questions regarding this Bulletin please contact the Deputy Commissioner for the Division of Insurance Fraud or the Deputy Commissioner for the Office of Health, Life & Annuity electronically at public@ldi.la.gov.

Baton Rouge, Louisiana, this 5th day of October, 2020.



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