Requirements for Third Party Liability Payment of Claims

Providers of medical services have the primary responsibility for assuring the application of third-party resources to the cost of care before billing Medicaid. Unless excluded by federal law, claims for medical services are cost-avoided when a third-party liability policy exists within the claims payment system. The Medicaid agency applies cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services. The Medicaid agency or its third-party liability (TPL) contractor pursues claims paid before the inclusion of third-party coverage information in the claims system, as described in this attachment.

I. Monitoring Provider Compliance – 42 CFR § 433.139(b)(3)(ii)(C)

A provider submitting a claim for a recipient with a third-party resource must include with the claim an explanation of benefits (EOB) from each known third-party resource. The provider must indicate the amount of payment received from each third-party resource on the claim. If payment was unavailable from a third-party resource, the provider must document the attempt to collect payment by attaching an EOB or other documentation showing denial of payment by the third-party resource.

Exceptions exist for those claims specified in 42 CFR § 433.139(b)(3)(i) and (ii) and any approved cost avoidance waivers. The Medicaid agency monitors provider compliance with insurance billing requirements through post-payment recovery responses to the TPL vendor.

If the provider or the insured person receives a report of prior payment, the amount paid by the insurer is subject to recoupment from the provider.

II. Guidelines Used to Determine When to Seek Reimbursement from a Liable Third-Party – 42 CFR § 433.139(f)(2)

Providers must bill liable third parties when providing services to an individual on whose behalf the Title IV-D agency carries out medical support enforcement unless the provider certifies that before billing Medicaid, the provider (1) billed the third party, (2) waited 100 days from the date of the service provision, and (3) has not received payment from the third-party in compliance with 1902(a)(25)(F) of the SSA.

The state makes payments without regard to potential TPL for pediatric preventive services unless it determines cost-effectiveness and access to care issues warrant cost avoidance for up to 90 days in compliance with 1902(a)(25)(E) of the SSA.

A. Health Insurance

For medical claims paid before the inclusion of the relevant TPL policy information in the eligibility or claims systems, a vendor pursues recovery from the provider within one year of the date of service for amounts greater than $0.01 once combined charges for all recipients from the provider equal or exceed $50.00.

For medical claims with a date of service greater than one year and paid before the inclusion of the relevant TPL policy information in the eligibility or claims systems, a vendor pursues recovery from the liable third-party payor for amounts greater than $0.01 within three years of the date the provider furnished the item or service. Any action by the Medicaid agency to enforce its rights with respect to the claim commences within six years of claim submission.

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B. Casualty Recovery

The threshold for casualty-related claims is $250.00 per individual claim, with no time limit on accumulating outstanding charges.

The Medicaid agency complies with Section 1902(a)(25)(B) of the Social Security Act, using the following factors and guidelines when determining whether or not to pursue recovery of benefits from a liable party after deduction of its proportionate share of attorney's fees and costs.

1. Ascertain the amount of Medicaid lien and the amount of the gross settlement;
2. Determine whether the Medicaid lien plus attorney's fees and costs will exhaust or exceed the settlement funds;
3. If the answer to (b) is yes, and if the Medicaid agency
    a. is informed that the client will not pursue the claim; or
    b. cannot handle the case once it is tendered to the Medicaid agency by the client or the client's attorney to pursue on behalf of the client; or
    c. has made a reasonable effort to ascertain the client's intention regarding the claim but could not obtain a response;

    then the Medicaid agency shall follow the procedure in (4) below.
4. The Medicaid agency shall consider the cost-effectiveness principle in determining the estimated net recovery amount based on the likelihood of collections. The Medicaid agency defines the net recovery amount as recovered dollars applicable to Medicaid costs. In determining the net recovery amount, the Medicaid agency considers the following factors:
    a. The settlement as it may be affected by insurance coverage or other factors relating to the liable party;
    b. The factual and legal issues of liability as they may exist between the client and the liable party;
    c. Any problems of proof in obtaining the award or settlement; and
    d. The estimated attorney's fee and costs as required for the Medicaid agency to pursue the claim.
5. After considering the above factors, the Medicaid agency may pursue a lesser recovery amount to the extent that the Medicaid agency determines it is cost-effective to do so.

III. Dollar Amount or Timeframe for Seeking Recovery – 42 CFR § 433.139(f)(3)

Health insurance recovery action on claim types likely to be covered by insurance occurs when payments made by the Medicaid agency are greater than $0.01.

Casualty recovery for personal injury investigative action occurs when hospital bills with trauma diagnoses for which the billed amounts are equal to or greater than $250.00