# PART 9: THIRD PARTY LIABILITY

Pursuant to federal and state law, the Medicaid program by law is intended to be the payer of last resort. This means all other available third party liability (TPL) resources must meet their legal obligation to pay claims before the MCO pays for the care of an individual eligible for Medicaid.

The following third parties must be billed prior to billing Medicaid. This list is not exhaustive.

- Health insurance:
  - Policies and indemnity policies that make payment when a medical service is provided and that restrict payment to the period of hospital confinement.
  - Policies that pay income supplements for lost income due to disability or policies that make a payment for a disability, such as weekly disability policy, are not included;
- Major medical, drug, visions care and other supplements to basic health insurance contracts;
- TRICARE-provides coverage for off base medical services to dependents of uniformed service personnel, active or retired;
- Veteran Administration (CHAMP-VA) provides coverage for medical services to dependents of living and deceased disabled veterans;
- Railroad Retirement;
- Automobile medical insurance;
- Worker's compensation;
- Liability insurance-includes automobile insurance and other public liability policies, such as home accident insurance, etc.; and
- Family health insurance carried by an absent parent.

When an enrollee has other insurance, the enrollee must follow any and all requirements of that insurance since it is primary. If the enrollee does not follow private insurance rules and regulations, the MCO will not be responsible for considering reimbursement of those services. Thus, the enrollee will be responsible for the payment of the services.

Providers must determine, prior to providing services, to which commercial plan the enrollee belongs and if the provider of service is a part of the network of that particular plan. Enrollees must be informed prior to the service that they will be responsible for payment if they choose to obtain services from an out-of-network provider and their commercial plan does not offer out-of-network benefits.

When an enrollee has other insurance, with the exception of specialized behavioral health services, the provider shall first seek authorization from the primary payer; if authorized by the primary payer, the provider shall bill the MCO as secondary payer. If not authorized by the primary payer, the provider may seek authorization from the MCO for evaluation of medical necessity.

The MCO shall process these claims as they were processed by the primary payer. The payment information indicated on the primary payer's EOB will be used to process the claim. Additionally, Medicaid TPL payments will be calculated differently for enrollees enrolled through the Louisiana Health Insurance Premium Payment Program (LaHIPP). Refer to the *LaHIPP* section for LaHIPP TPL calculation.

# COST AVOIDANCE

Except for "pay and chase" claims identified in this section, the MCO shall cost-avoid a claim if it establishes the probable existence of another health insurance at the time the claim is filed. The MCO shall deny the claim for coordination of benefits (COB) and return it back to the provider noting the third party the MCO believes to be legally responsible for payment.

If a balance remains after the provider bills the liable third party or the claim is denied payment for a substantive reason, the provider may submit a claim to the MCO for payment of the balance up to the maximum allowable Medicaid reimbursement amount.

# PAY AND CHASE VS. WAIT AND SEE

The "pay and chase" method occurs when payment is made by the MCO for submitted claims even if a third party is likely liable, and the MCO then seeks to recoup payments from the liable third party.

The MCO shall reimburse no less than the full amount allowed under Medicaid's payment schedule, and then seek recovery of payment from the third party within 60 days after the end of the month in which payment is made (or within 60 days after the end of the month the MCO learns of the existence of a liable third party) when:

- The service is Preventive Pediatric Care (PPC), including Early and Preventive Screening, Diagnostic, and Treatment (EPSDT), EPSDT referral and when well-baby procedure codes 99460, 99462, and 99238 are billed with diagnosis codes Z38 through Z38.8.

  NOTE: The MCO shall use the pay and chase method of payment for preventive pediatric services for individuals under the age of 21 with other Health Insurance when the pediatric preventive diagnosis code is reported in the primary position of the claim. Hospitals are not included and must continue to file claims with the health insurance carriers. Primary preventive diagnoses are confined to those listed on www.lamedicaid.com [link]. EPSDT referral is indicated as "Y" in block 24H of the CMS-1500 claim form or "A1" as a condition code on the UB-04 (form locators 18-28).

- ~~Third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State's Title IV-D agency and the service is a Medicaid covered service. The MCO shall identify third party liability enforced by the State Title IV-D agency by initiator code 02 in TPL files transmitted by LDH's fiscal intermediary. Refer to the **MCO System Companion Guide** for the TPL file layout and initiator codes.~~

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 removes prenatal care from pay and chase services.

The MCO must "wait and see" on claims for a service that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV D agency. "Wait and see" is defined as payment of a claim only after the documentation is submitted to the MCO demonstrating that 100 days have elapsed since the provider billed the responsible third party and remains to be paid. The MCO shall identify third party liability enforced by the State Title IV-D agency by initiator code 02 in TPL files transmitted by LDH's fiscal intermediary. Refer to the **MCO System Companion Guide** for the TPL file layout and initiator codes.

The provider can only bill Medicaid for the balance not paid for by the liable third party and payment can only be made for up to the Medicaid allowable amount.

# MANAGING THIRD PARTY LIABILITY FILE EXCHANGES AND ENROLLEE UPDATES

The LDH TPL contractor discovers, verifies, and adds/updates insurance coverage leads for all Medicaid enrollees. The TPL contractor completes all insurance coverage lead update requests from MCOs, LDH, providers, and enrollees within four business hours for urgent requests, and within five business days for non-urgent requests. Additionally, the TPL contractor performs a monthly data match against all Medicaid enrollees and deliver verified insurance data to the fiscal intermediary within 30 days of the match.

LDH defines urgent TPL requests as the inability of an enrollee to have a prescription filled or the inability of an enrollee to access immediate care because of incorrect third party insurance coverage.

The LDH TPL contractor is the sole source for electronic TPL resource file add/updates. Responsibilities for each entity are as follows[11]:

- The TPL contractor sends daily TPL file exchanges to the fiscal intermediary.
- The fiscal intermediary sends daily incremental TPL files to the MCOs every business day.
- Every Monday, the fiscal intermediary sends weekly TPL full reconciliation files to the MCO.
- The MCOs submit daily general TPL add/update requests to the TPL contractor via e-mail or fax on the Daily General MCO TPL Request Form.
    - E-mail: latpr@hms.com
    - Fax: 1-877-204-1325
    - Phone: 1-877-204-1324
    - Hours of Operation: Monday - Friday, 8 a.m. - 5 p.m. Louisiana state holidays are excluded.
- If the MCO receives a **non-urgent** TPL add/update request from a provider or enrollee (past or current P or B enrollment), the MCO shall refer the provider or enrollee to the TPL contractor and provide contact information.
- When the MCO identifies TPL via claims data (an Explanation of Benefits from the primary carrier), the MCO shall verify and effectuate the verified update in its system, and process the claim. By close of business the same day, the MCO shall send the add/update record to the TPL contractor via the Daily General MCO TPL Update Request Form.
- For **urgent** TPL update requests:
    - The MCO shall be responsible for all urgent TPL update requests for P-enrolled enrollees.
        - The MCO shall verify the request and update its system within four business hours of receipt of the urgent request. This includes updates on coverage, including removal of coverage that existed prior to the enrollee's linkage to the MCO that impacts the current provider adjudication or enrollee service access (i.e., pharmacy awaiting TPL update to fulfill prescription).
        - These updates shall be submitted to the TPL contractor on the day the updates are made in the MCO's system. The updates shall be submitted via fax or e-mail on the LDH Medicaid Recipient Insurance Information Update Form. The Submission Status shall be reported as "Urgent Update: pharmacy awaiting update to fill prescription/member

[11] Except as approved by LDH. As of the original date of publication, two of the MCOs submit TPL updates directly to the fiscal intermediary.

unable to access immediate care". Urgent TPL requests originating from providers and LDH via fax and e-mail may be submitted to the TPL contractor using the same Medicaid Insurance Recipient Information update form submitted to the MCO. Missing policy and enrollee information shall be added to the request prior to sending to the TPL contractor.

- All urgent TPL requests for B-enrolled enrollees shall be sent to the TPL contractor via phone, e-mail, or fax.
  - If the MCO receives an urgent request from a provider or enrollee for a B-enrolled enrollee, the MCO shall refer the provider or enrollee to the TPL contractor and provide contact information.

# POST-PAYMENT RECOVERIES FROM PROVIDERS AND LIABLE THIRD PARTIES

Post-payment recovery for third party liability (TPL)/coordination of benefits (COB) is necessary in cases where the MCO has not established the probable existence of third party liability for payments already made when a legally obligated third party is later identified.

The following requirements apply to MCOs and their subcontractors for recoveries from providers for TPL:

- The MCO or its subcontractor shall seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party.
- The MCO or its subcontractor shall seek recovery from the provider where dates of services (DOS) are 10 months or less from the date stamp on the provider recovery letter.
- The MCO or its subcontractor shall not seek recovery from the provider where DOS is older than 10 months but shall seek recovery directly from liable third parties. The MCO or its subcontractor may utilize Act 517 of the 2008 Regular Legislative Session to seek recovery of reimbursement from liable third parties for up to 36 months from the date of service reported on the claim.
- Providers shall have 60 days from the date stamp of the recovery letter to refute the recovery, otherwise recoupment from future RAs shall occur.
- Providers shall be given an additional 30 day extension at their request when the provider billed the liable third party and hasn't received an EOB.
- If after 60 days of the recovery letter, or 90 days if a 30-day extension was requested, the MCO or its subcontractor has not received a response from the provider, the recovery shall be initiated.

The provider post-payment recovery notification letter should, at a minimum, include the following:

- Provider information (provider number, provider name, provider NPI/Tax ID);
- Policy Holder information (name, policy number, group number);
- Carrier information (carrier name, address, phone);
- Type of coverage (major medical, major medical no maternity, RX only etc.);
- Patient information (name, Medicaid ID, DOB);
- Line item payment information (Medicaid claim reference number, patient Medicaid number, Medicaid remit date, dates of service, amount to be recouped);
- Recovery totals; and
- Contact information to request an extension.

The MCO shall initiate an automatic recoupment at the expiration of the 60-day period if an extension request is not received from the provider and at the expiration of the 90-day period if an extension is requested by the provider if the provider has not remitted the payment to the MCO.

## Exclusions to Post-Payment Recoveries from Providers

- Pay and chase claims will always be referred directly to the liable third parties, as required in the Contract.
- Claims billed with EOB denial from other health insurance are excluded.
- If the liable third party is traditional Medicare, Tricare, or Champus VA, and more than 10 months have passed since the DOS, the MCO shall recover from the provider.
- Point of Sale (POS) will always be referred directly to liable third parties.

## Encounters for Post-Payment Recoveries

The MCO shall adjust both the provider claim record and the encounter record to include the other payer payment information and report the adjusted MCO payment amount.

# TPL Scope Of Coverage

The type of enrollee's other health insurance coverage is defined by LDH as scope of coverage. Scope of coverage codes with associated definitions are specified in the **MCO System Companion Guide**.

The MCO must accept scope of coverage codes from LDH's fiscal intermediary in daily and weekly TPL file transmittals. The fiscal intermediary's TPL file transmittal schedule and file layout are specified in the **MCO System Companion Guide**.

## Provider Portal Response for TPL Scope of Coverage

The MCO shall provide its enrollee's scope of coverage on its provider web portal. This may be the description of the scope of coverage (e.g., Major Medical No Maternity) or the scope of coverage code associated with the description (e.g., 27).

TPL scopes of coverage are available on www.lamedicaid.com [link].

## Utilization of Scope of Coverage 27 (Major Medical, No Maternity Benefits) and 33 (HMO, No Maternity Benefits)

It is possible for Medicaid beneficiaries to have Major Medical Health coverage that excludes maternity benefits. The LDH TPL contractor will assign scope of coverage (SOC) 27 to Major Medical Health Insurance Policies without Maternity Benefits and HMO Major Medical Insurance Policies without Maternity Benefits. HMO Major Medical Insurance Policies without Maternity Benefits (formerly SOC 33) has been consolidated into SOC 27.

The MCO shall not cost avoid maternity claims for enrollees with other health insurance whose Major Medical Health Insurance benefit (SOC 27) or HMO Major Medical Health Insurance benefit (SOC 27) excludes maternity

benefits. If the MCO or its subcontractor identifies TPL, it must determine if the coverage being added or updated meets the maternity exclusion.

MCOs must work with its staff and subcontractors who identify and/or verify TPL to determine if the coverage being added meets the maternity exclusion criteria.

MCOs must work with their providers to develop a process to allow providers to update the scope of coverage to 27.

*Both the diagnosis code and the TH modifier are required.

# LaHIPP

LaHIPP participants may be identified in 834 eligibility files by CAP codes as specified in the Healthy LA MCO MVX COA Crosswalk or by TPL initiator code 25 in the TPL file layout as specified in the **MCO System Companion Guide**.

LDH is responsible for issuing payment for all or part of LaHIPP participants' health insurance premium~~, unless the LaHIPP participant is an Act 421 Children's Medicaid Option enrollee~~.

LaHIPP enrollees are mandatorily enrolled in Medicaid managed care for specialized behavioral health services, and non-emergency medical transportation, including non-emergency ambulance transportation, unless residing in an institution. LaHIPP participants who receive coverage via the Act 421 Children's Medicaid Option are mandatorily enrolled in Medicaid managed care for all Medicaid covered services

## Calculation of Payment for LaHIPP Secondary Claims

Claims processed by the MCO as secondary payer for LaHIPP enrollee claims shall be processed and paid by the MCO at the full patient responsibility (co-pay, co-insurance, and/or deductible) regardless of Medicaid's allowed amount, billed charges or TPL payment amount if the participant uses a provider that accepts the enrollee's insurance as primary payer and Medicaid as secondary payer. If the provider does not accept this payment arrangement, the participant shall be responsible for the enrollee liability. The MCO pays only after the third party has met the legal obligation to pay. The MCO is always the payer of last resort, except when the MCO is responsible for payment as primary payer for Medicaid covered services not covered by commercial insurance as primary payer (e.g., mental health and transportation services).

The following is a LaHIPP claims processing example:

| Procedure Code | Billed Charge | TPL Paid Amount | Medicaid Allowed Amount | Patient Responsibility Amount | Medicaid Payment |
|---|---|---|---|---|---|
| 99213 | 70.00 | 40.00 | 36.13 | 10.00 | 10.00 |

Because this is a LaHIPP enrollee, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

NOTE: Refer to the *Resources* section for a link to the **Reinstatement and Implementation of LAHIPP Third Party (TPL) Claims Payment** manual for more LaHIPP claims processing examples.

# TPL PAYMENT & TPL PAYMENT CALCULATION

If a TPL insurer requires the enrollee to pay any co-payment, coinsurance or deductible, the MCO is responsible for making these payments under the method described below, even if the services are provided outside of the MCO network.

## Scenario 1 Professional Claim

| Procedure Code | Billed Charge | TPL Paid Amount | Medicaid Allowed Amount | Patient Responsibility Amount | Medicaid Payment |
|---|---|---|---|---|---|
| 99212 | 55.00 | 0.00 | 24.10 | 36.00 (Ded) | 24.10 |
| 83655-QW | 30.00 | 0.00 | 11.37 | 28.20 (Ded) | 11.37 |
| Totals | 85.00 | 0.00 | 35.47 | 64.20 (Ded) | 35.47 |

The Medicaid allowed amount minus the TPL paid amount is LESS than the patient responsibility; therefore, the Medicaid allowed amount is the payment.)

## Scenario 2 Outpatient Claim

| Procedure Code | Billed Charge | TPL Paid Amount | Medicaid Allowed Amount | Patient Responsibility Amount | Medicaid Payment |
|---|---|---|---|---|---|
| HR270 | 99.25 | 74.44 | 22.04 | 0.00 | 0.00 |
| HR450 | 316.25 | 137.19 | 70.24 | 100.00 | 0.00 |
| Total | 415.50 | 211.63 | 92.28 | 100.00 | 0.00 |

(Medicaid "zero pays" the claim. When cost-compared, the private insurance paid more than Medicaid allowed amount for the procedure. When compared, the lesser of the Medicaid allowed amount minus the TPL payment AND the patient responsibility is the former; thus, no further payment is made by Medicaid. The claim is paid in full.)

## Scenario 3 Inpatient Claim

| Procedure Code | Billed Charge | TPL Paid Amount | Medicaid Allowed Amount | Patient Responsibility Amount | Medicaid Payment |
|---|---|---|---|---|---|
| Multiple HR | 12,253.00 | 2,450.00 | 5,052.00 | 300.00 | 300.00 |

(The Medicaid allowed amount minus the TPL payment is greater than the patient responsibility; thus, the patient responsibility is paid on this covered service.)

## Scenario 4: FQHC/RHC/American Indian Clinic

| Provider's PPS Rate (Medicaid allowable) | Procedure Code | Billed Charge | TPL Paid Amount | Patient Responsibility Amount | Medicaid Payment |
|---|---|---|---|---|---|
| 150.00 | T1015 | 150.00 | 50.00 | 40.00 (Ded) | 100.00 |

Provider's PPS rate is $150.00. The third party paid $50.00. Medicaid pays the difference from the PPS rate and third party payment making the provider whole.

MCOs may not establish a cost-sharing payment methodology for enrollees with third party liability for FQHC, RHC and American Indian Clinic services at less than the Louisiana Medicaid State Plan rate (PPS). MCOs must pay the difference between the third party payment and the PPS for the service.

MCO payment = Medicaid PPS Rate - TPL paid amount

## Scenario 5 Outpatient Pharmacy Claim

| Amount Billed | TPL Paid Amount | Medicaid Maximum Allowable | Patient Responsibility Amount from Primary | Medicaid Pharmacy Co-Pay | Medicaid Payment |
|---|---|---|---|---|---|
| 38.55 | 28.55 | 31.36 | 10.00 (Copay) | 0.50 | 2.31 |
| 613.00 | 60.00 | 40.73 | 553.00 (Ded) | 0.00 | 0.00 |
| 177.97 | 5.22 | 14.39 | 172.75 (Ded) | 0.50 | 8.67 |

If third party liability (TPL) is involved, the MCO as the secondary payer may not deny the claim for a high dollar amount billed for claims less than $1,500. If the TPL pays $0.00 or denies the claim, then the pharmacy claims should be treated as a straight Medicaid pharmacy claim. Taxes on the primary claim should be subtracted before calculating the Medicaid Maximum Allowable. Maximum Medicaid allowable is defined as professional dispensing fee plus ingredient cost (quantity * price per unit) or usual and customary, whichever is less.

The pricing calculation is ingredient cost (quantity * price per unit) + Dispensing Fee – TPL amount paid – copayment = Medicaid payment. If U&C is less than the Medicaid allowable, then the calculation is U&C – TPL amount paid – copayment = Medicaid payment. If there is other third party liability (TPL) payment greater than $0.00, the MCO should electronically bypass prior authorization requirements and Point of Sale edits that would not be necessary as the secondary payer. Safety edits should still apply.

TPL claims should process with the same PCN and BIN number as primary claims.

## Scenario 6: LaHIPP Enrollee Claim

| Procedure Code | Billed Charge | TPL Paid Amount | Medicaid Allowed Amount | Patient Responsibility Amount | Medicaid Payment |
|---|---|---|---|---|---|
| 99213 | 70.00 | 40.00 | 36.13 | 10.00 | 10.00 |

Because this is a LaHIPP enrollee, Medicaid pays the co-pay even though the private insurance payment is more than the Medicaid allowable. Medicaid pays the patient responsibility on Medicaid covered services regardless of Medicaid's allowed amount, billed charges, or TPL payment.

# LIENS

## Approval Guidelines for Lien Settlements Equal to or Greater Than $25,000

The process for obtaining LDH approval for settlements on liens equal to or greater than $25,000 is as follows:

- ❖ The LDH subject matter expert (SME)/business owner for the TPL Trauma Recovery process is the point of contact for these submissions. The MCO must provide LDH with its contact for this process.
- ❖ The MCO (not its subrogation vendor) must submit these requests directly to LDH via e-mail, marked with High Importance, using the following subject format: "[MCO Name], Settlement Request".
- ❖ At minimum, the MCO must include the following in the body of the e-mail and/or in the corresponding attachment(s):
    - o Enrollee's identifying information (name, SSN, Medicaid ID#);
    - o DOA/DOI (Date of Accident/Date of Incident);
    - o Third party (i.e., liable party/insurance companies, defense and plaintiff attorneys), with contact information;
    - o MCO's lien amount;
    - o Case settlement amount;
    - o Requested settlement amount (suggested reduced amount);
    - o Description of incident and injuries;
    - o Reason for request and MCO's recommendation;
    - o Other liens to be considered; and
    - o Attorney's fees and expenses.
- ❖ Once received, the LDH SME/business owner will consult with LDH Bureau of Legal Services and provide its decision to the MCO's contact via secure e-mail.

# COORDINATION OF BENEFITS

## Other Coverage Information and Third Party Liability Data Exchange

In a format and medium specified by LDH in the **MCO System Companion Guide**, the MCO shall submit to LDH or its contractor a daily TPL file reporting verified TPL additions and updates for each enrollee that has not otherwise been provided by LDH's fiscal intermediary.

The MCO shall review daily response files from LDH, or its contractor, and rejected records shall be corrected and completed within five business days.

If an enrollee is unable to access services or treatment until an update is made, the MCO shall verify and update its system within four business hours of receipt of an update request. This includes updates on coverage, including removal of coverage that existed prior to the enrollee's linkage to the MCO that impacts current provider adjudication or enrollee service access. Such updates shall be submitted to LDH and/or its TPL vendor on the Medicaid Recipient Insurance Update Form [link].