POLICY AND PROCEDURE

DEPARTMENT: Claims Operations	**DOCUMENT NAME:** Coordination of Benefits (COB)/Third Party Liability/Subrogation (TPL)
PAGE: 1 of 15	**REPLACES DOCUMENT:**
APPROVED DATE: 1/12	**RETIRED:**
EFFECTIVE DATE: 2/1/12, 12/15	**REVIEWED/REVISED:** 9/14, 7/15, 9/15, 07/16, 10/16, 6/17, 6/18, 6/19, **6/20, 2/21**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.CLMS.01

SCOPE:
Louisiana Healthcare Connections (Plan) Finance/Eligibility/Claims operations.

PURPOSE:
The purpose of this document is to outline the Plan's policy and procedure for meeting the state requirements for ensuring that the Louisiana Department of Health (LDH) remains the payer of last resort.

LDH shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. Further, LDH will be notified daily upon determination of any updates or changes in Coordination of Benefits (COB) and Third-Party Liability (TPL) related to Plan membership.

POLICY:
Plan is mandated under the contracts with LDH to monitor commercial insurance eligibility and legal liability of third parties, including Medicare, for covered services obtained by a member.

Plan shall coordinate benefits in accordance with 42 CFR §433.135, et seq. and La. R.S. 46:460.71, so that costs for services otherwise payable by the managed care organization (MCO) are cost avoided or recovered from a liable party.

The two methods used are cost avoidance and post-payment recovery. Plan shall use these methods as described in federal and state law. When Plan is made aware of other third party resources, they will avoid payment by "cost avoiding" the claim and redirecting the provider to bill the other insurance as a primary payer (see Coordination of Benefits/Subrogation CCMS and Coordination of Benefits Basics Claims Processing Manual).

Due to the "pay and chase" methodology, the Plan may not become aware of another Third Party Payer until after the payment of service. For these situations, the Plan has contracted Health Management Systems, Inc. (HMS) to perform COB and TPL identification and recovery services and Rawlings for casualty identification and recovery services for the LDH population. Per LDH Policy and in accordance with the above, Plan shall cost-avoid a claim if it establishes the probable existence of TPL at the time the claim is filed, except for the "pay and chase" claims identified in RFP section 5.13.2.2. Claims for labor

and delivery and postpartum care may be cost-avoided, including the cost associated with provider and ancillary fees, pursuant to LDH requirements either by contract or Health Plan Advisory.

Plan may "pay and chase" the full amount allowed under the fee schedule for the claim and then seek reimbursement from the TPL insurer (within sixty days after the end of the month in which the payment was made) for any liable TPL of legal liability if:

- The claim is for prenatal care for pregnant women;
- The claim is for preventive pediatric services (including EPSDT and well-baby screenings); or
- The claim is 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.

If a TPL insurer requires the member to pay any co-payment, coinsurance or deductible, Plan is responsible for reimbursement, even if the services are provided outside of the MCO network.

PROCEDURE:

Prospective Cost Avoidance

- Plan stores Member eligibility information which includes COB/TPL primary coverage details.

- Primary coverage information is updated in the Plan's system daily. That data is obtained through information submitted on claims, information received from Members, information received on the Weekly Reconciliation File and Daily Incremental interface file from LDH, information received from hospitals and providers through prior authorization procedures, and information from cost avoidance files obtained through Plan's vendor, HMS.

- Plan must verify and add Medicaid recipient insurance updates to their system within five (5) business days of receipt. If a member is unable to access services or treatment, update requests for that member must be verified and added within four business hours. This includes removal of coverage that existed prior to the member's linkage to Plan.

- There are no defined dollar thresholds for cost avoidance of claims identified as having other insurance.

- HMS, the Plan's vendor is responsible for systematic identification of Members with other coverage from a national database of coverage information. On the 5th of each month, Plan provides HMS with its eligibility files which are used to 'match' to the HMS national database to identify other primary coverage for Plan's membership. Before the 20th of each month, HMS returns a data file to Plan with identification of new primary carrier information for current Members. The updated information is sent to the state for upload to the state's TPL database. This information in turn is added to the TPL Reconciliation file which is sent to the Plan weekly by Gainwell Technologies.

- Plan will not pursue cost avoidance for "pay and chase" exceptions as defined by LDH.

- If a TPL insurer requires the member to pay any co-payment, coinsurance or deductible, Plan is responsible for making these payments as defined by LDH, even if the services are provided outside of the Plan's network.

Coordination of Benefits – Retrospective TPL Savings/Recovery

Cost effectiveness of recovery is determined by, but not limited to, time, effort, and capital outlay required in performing the activity. COB collections are the responsibility of the Plan with the help of the vendor (HMS). HMS reports COB information to the Plan. The Plan and Vendor shall not pursue collection from members but directly from the third party payer or the provider. If HMS identifies recovery opportunities on behalf of the Plan for COB/TPL, reimbursement from a liable third party will not be pursued if the amount is less than $5 per claim if through carrier billing.

- HMS's system automatically searches all paid claims history and recovers from providers and insurance companies. When -other commercial insurance coverage is discovered, it is added to the Plan's systems.

- Plan must seek recovery of reimbursement within sixty (60) days after the end of the month it learns of the existence of the liable third party after a claim is paid.

- If claims are 10 months or less from date of service when other commercial coverage is identified, and claims are at least $50 per claim and $500 per provider per billing cycle, HMS will send a recoupment letter to the provider, giving them 60 days (notification period) to dispute the commercial coverage. Providers may request a 30 day extension if the provider has not received an EOB from liable third party. After the 60 days (or 90 days if extension granted), the Plan's MIS should recoup the previous payment from the Provider.

- All other recovery identifications, involving commercial Other Insurance Coverage not within the above timeframe and threshold, will be billed to the commercial carrier directly by HMS.

- The Plan allows 60 days (notification period) for providers to dispute Medicare (Part A&B) coverage. Providers who do not dispute the Medicare coverage will be instructed to bill Medicare immediately. The Plan's MIS should recoup the previous payment from the Provider within thirty (30) days from the end of the notification period, if they do not dispute that Medicare coverage exists.

- Plan will void encounters for claims that are recouped in full, and submit adjusted encounters for partially recouped claims.

- Plan may retain up to 100% of its TPL collections given the conditions defined by LDH.

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Medicare/Medicaid Dual Crossover Claims for Behavioral Health Services

- For the eligible Medicaid population that is dually enrolled in Medicare, Medicaid-covered specialized behavioral health services that are not covered by Medicare shall be paid by Plan.
- For dually eligible individuals, Medicare "crossover" claims (claims for services that are covered by Medicare as the primary payer) are excluded from coverage under the capitated rates. These services will be administered separately by the Fiscal Intermediary from the services covered under the capitation rates effective under this contract.

- In the event that a dually-eligible individual's Medicare benefits have been exhausted as of the date of service on which a Medicare covered behavioral health service was provided, Medicaid will be considered primary. Claims for those services will no longer be considered "crossover" claims, and Plan shall be responsible for payment.

- Specific payment mechanisms surrounding these populations shall be determined by LDH in the MCO Systems Companion Guide.

Subrogation – Retrospective TPL Savings/Recovery by Rawlings

- Rawlings is Plan's vendor that is contracted to identify claims paid by Plan as primary Payer, when another party is liable for the medical expenses (Tort claims/liability). Rawlings pursues recovery of claims paid by Liability Carriers/Insurance on a contingency fee.

- Rawlings identifies claims that are incurred as result of an accident or injury for which another party (other than Plan's Member) is 'at fault,' and Liability insurance of the 'at fault' party is responsible for claim expense.

- Rawlings communicates with the Member and/or the Member's representative to obtain information about the accident or injury to identify the Liability carrier responsible for the medical expenses paid by Plan.

- Rawlings edits claims as required by federal regulations for accident/trauma diagnosis codes 800 through 999.9 (excluding code 994.6) and any other applicable trauma code, including but not limited to E codes in accordance 42 CFR 433.138(e).
- Plan is required to seek reimbursement in accident/trauma related cases when claims in the aggregate equal or exceed $500 as required by the Louisiana Medicaid State Plan and federal Medicaid guidelines and the Plan may seek reimbursement when claims in the aggregate are less than five hundred dollars.

- Rawlings files a Lien against the claim filed with the Liability Carrier in the amount of the expense paid by Plan.

- The Liability insurance reimburses Plan upon settlement of the claim, less attorney's fees (if applicable), to the amount of medical reimbursement available on the liability policy. Prior to accepting a Third Party Liability settlement on claims equal to or greater than $25,000, the Plan shall obtain approval from LDH.

- When a claim matches the criteria established by Rawlings, Rawlings will utilize various data sources to determine if there is a liable third party. If they cannot make the determination through these resources, they will send a questionnaire to the member. These questionnaires solicit more information needed to determine if in fact there is TPL for the medical expenses incurred by the member.

- Plan Vendor's System includes capability for the manual setup for billings applicable to workers compensation, casualty, absent parents and other liability coverage that require manual research to determine payable claims

Provider Submission of Secondary Claims

- When Plan is the secondary payer, claims must be received within 90 calendar days of the final determination of the primary payer with a copy of the explanation of benefits.

Louisiana Health Insurance Premium Payment (LaHIPP) Program

- LaHIPP provides help for Medicaid-eligible members in a household to be covered by the family's employer-sponsored (ESI) or individual private insurance (IHI) policy. The program may pay some or all of the health insurance premiums for a policy holder and their family if the Medicaid member(s) has/have private health insurance. Under Section 1906 of the CMS regulations, LA Medicaid is required to pay the patient responsibility (co-pays, co-insurances, and deductibles) on TPL claims for LaHIPP enrollees.

* *Note: Non-Medicaid family members are eligible only to have group health plan premiums paid on their behalf if necessary to obtain access for the Medicaid enrollee. They are liable for any patient responsibility on their claims.*

- With the exception of Act 421 Children's Medicaid Option enrollees, LaHIPP enrollees will receive medical services and emergency ambulance services through Fee-For-Service Medicaid and claims will be processed through LDH's fiscal intermediary. LaHIPP enrollees will receive specialized behavioral health services (i.e. services provided by a specialized behavioral health provider) and non-emergency medical transportation (NEMT) services, including non-emergency ambulance services, through the Healthy Louisiana Managed Care Organization to which they are linked on the date of service. Claims for these services should be submitted to the MCO. See section on Act 421 Children's Medicaid Option for specific LaHIPP requirements for that population.

Payment of LaHIPP Secondary Claims

- Once claims are paid by the primary carrier, LA Medicaid processes and pays the total patient responsibility (co-pay, co-insurance, and/or

deductible) - regardless of Medicaid's allowed amount, billed charges, or TPL payment amount. However, enrollees must follow the policies of the primary plan, and only in certain circumstances will Medicaid consider payment of claims that are denied by the primary payer.

Payment of Non LaHIPP Secondary Claims

- Medicaid uses a cost comparison methodology to pay TPL claims for Non-LaHIPP recipients with primary insurance. TPL claims are processed as they were processed by the primary payer, and TPL payment amount is applied just as the primary payer indicates on the EOB. If there is only a total TPL amount on the EOB, a "spend down" methodology is used to calculate payment and process the claim. The payment will be made based on the lesser of (1) Medicaid allowed amount minus TPL payment, or (2) total patient responsibility amount (co-pay, co-insurance, and/or deductible).

ACT 421 Children's Medicaid Option (Act 421-CMO)

ACT – 421 CMO extends Medicaid eligibility to ~~children covered by § 1902(e)(3) of the Social Security Act, i.e.,~~ children under 19 (age 18 and younger) who meet institutional level of care (Nursing Facility, Hospital, Intermediate Care Facility for Individuals with Intellectual/Developmental Disabilities) and are in families with income that is too high to qualify for Medicaid, who could otherwise become Medicaid eligible if receiving extended care in an institutional setting.

- LDH will require participants to maintain pre-existing major medical private health insurance, unless a hardship exception applies. This requirement is to maximize third-party liability for healthcare needs of enrollees and thereby reduce primary Medicaid coverage costs and provide access to a greater number of participants, unless a hardship exception is granted.

- LDH will implement a hardship exception to the private insurance requirement, to ensure that the requirement does not create a barrier to healthcare access.

- LDH will offer the option of enrollment into Louisiana's Health Insurance Premium Program (LaHIPP), if eligible, to ensure cost burdens associated with maintaining private insurance are minimized as much as possible.

- With the exception of Act 421 CMO dually eligible enrollees (i.e., coverage in Medicare and Medicaid), Act 421 Children's Medicaid Option LaHIPP enrollees will receive all medical services, emergency ambulance services, specialized behavioral health services (i.e. services provided by a specialized behavioral health provider) and non-emergency medical transportation (NEMT) services, including non-emergency ambulance services, through the Healthy Louisiana Managed Care Organization to which they are linked on the date of service. Claims for these services should be submitted to the MCO. LaHIPP ESI or IHI premium payments will be processed through LDH's fiscal intermediary.

- A look back period of six months will apply for determining pre-existing coverage. LDH will impose a lock-out period on participants in cases where a family or responsible adult has discontinued privately available health insurance for the child enrolled in Act 421-CMO, either during the six-month look back period or at any time during the participant's enrollment.

- The lock-out will end when the participant demonstrates health insurance has been re-instated or that criteria for a good cause hardship exception is met. The lock-out period will extend up to six months from discontinuation of insurance or Medicaid certification, whichever date is later. At the conclusion of six months, if the participant has not re-acquired health insurance or established a good cause hardship exception, the participant will be dis-enrolled.

- LHCC will not reimburse claims once the lock-out or disenrollment period has been reported and updated via 834 eligibility process.

State Reporting

- Determination of third party liability for the medical expenses will prompt notification of the LDH TPL Administrator within 30 days as outlined in the contract.

- On a daily basis (for both cost avoidance and retrospective recovery), information stored in the Plan's claims processing system is updated in the Plan's Electronic Data Warehouse (EDW) which serves as the data repository for reporting purposes. The data stored in EDW will be extracted and submitted to LDH on the 15th calendar day of each month. The system is capable of producing reports indicating open receivables, closed receivables, amounts collected, amounts written off, and amounts avoided.

- All COB/TPL reporting from Plan will be provided to LDH in the format and medium described by LDH and shall cooperate in any manner necessary, as requested by LDH.

- Data not included in regular report submissions may be requested by LDH for administration of TPL activity. Plan data will be provided in an appropriate time frame, as determined by LDH.

- Plan will take reasonable measures to determine TPL. Plan will comply with any requests by LDH to demonstrate reasonable measures that have been taken to determine TPL, taking into account industry standards and practices.

- Plan will submit an annual report of all health insurance collections for its members plus copies of any Form 1099's received from insurance companies for that period of time. Plan shall report additions and updates of TPL information to LDH on a weekly basis as specified by LDH.

- Emergency TPL updates must be submitted to the LDH fiscal intermediary on the daily file load on the day the update is made. The Plan receives daily and weekly TPL source of truth files from LDH. Any changes, updates, additions, deletions, etc. identified on these files as compared to

the data we have must be updated in our systems within 24 hours. These files are the source of truth for all TPL information and we must have these loaded into our systems. No other sources, information gathered, or policies identified should be loaded into any systems without first validating the policy and we must notify the state of any discovered policies that are not on the TPL source files.

- Any TPL we discover by any means such as EOPs attached to claims, member calls, Syrtis, HMS CAV file, or any other source that is not currently on the TPL source files from LDH is to be reported to HMS (state side) daily via the current spreadsheets we send. HMS will then take these policies and add them to the source of truth files, which we in turn will process upon receipt to update our systems with the most current information.

- Policies obtained from the HMS LA CAV file must be compared to the LDH TPL source files. Any policies from the HMS LA CAV file that aren't on the LDH TPL source files must be sent to (HMS)via the current daily spreadsheet for updating to the source of truth files. Upon receipt of the source of truth files from LDH the TPL load job will process any changes and updated Amisys accordingly.

REFERENCES:
CC.UM.01.05 – Coordination of Benefits/Subrogation
CC.CLMS.07.325 – Coordination of Benefits Basic Claims Processing Manual
LA.CLMS.0789 – Reinstatement and Implementation of LaHIPP Third Party Liability(TPL) Claims

ACT 421 Children's Medicaid Option (Act 421-CMO)

ATTACHMENTS:

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DEFINITIONS:
Coordination of Benefits (COB) – Identification of eligibility for commercial insurance to ensure LDH is payer of last resort.

Third Party Liability (TPL) – Any other person or entity that is liable for the medical expenses incurred by a Plan member.
Emergency TPL update – TPL requests for that member must be verified and added within four business hours.

REVISION LOG

REVISION	DATE
Under scope heading added Plan Finance/Eligibility/Claims	5/8/2013
Under policy heading added care to Health and Connections is	5/8/2013
Under Subrogation heading changed 250.00 to 500.00	5/8/2013
Under Subrogation heading under the bullet that begins "The Liability Insurance" spelling was changed the wording of settlement to settlement, and added or and to	5/8/2013
Added heading of Provider Submission of Secondary Claims and policy regarding provider submission of secondary claims.	5/8/2013
Reviewed with no revisions.	9/2014
Reviewed with no revisions	7/2015
Added section: **Medicare/Medicaid Dual Crossover Claims for Behavioral Health Services**	9/15
Under policy heading added reference to 42 CFR 433.135, et. Seq. and La. R.S. 46:460.71	07/2016
Under Prospective Cost Avoidance heading added reference to five business day and four business hour time frame for updating TPL records.	07/2016
Under Prospective Cost Avoidance heading added reference to pay and chase exceptions.	07/2016
Under Prospective Cost Avoidance heading added reference to co-payments.	07/2016

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Under Coordination of Benefits – Retrospective TPL Savings / Recovery by HMS heading changed within 60 days from the date of identification to within 60 days after the end of the month	07/2016
Under Coordination of Benefits – Retrospective TPL Savings / Recovery by HMS heading added section about voiding and adjusting encounter data for fully and partially recouped claims	07/2016
Under Coordination of Benefits – Retrospective TPL Savings / Recovery by HMS heading added section about retaining 100% of TPL collections	07/2016
Under Subrogation – Retrospective TPL Savings / Recovery by HMS heading removed 90 day time frame for trauma reimbursement. And update to state plan is required to seek reimbursement for amounts exceeding $500 and may seek reimbursement for amounts under $500.	07/2016
Under State Reporting heading updated bullet 2 to comply with state reporting requirement updates and added bullets 4-8 on requirements of state reporting to comply with updated state requirements.	07/2016
Under Definitions heading added Emergency TPL Update.	07/2016
Changed all references to MCO and LHCC to equal Plan	07/2016
Changed DHH to LDH	07/2016
Updated policy to ensure language aligned with RFP Amendment 6.	10/16
Under state reporting, added weekly TPL summary report due to LDH	06/2017
Under references, added Reinstatement and Implementation of LaHIPP Third Party Liability (TPL) Claims Payment document from LDH and Gainwell Technologies as reference	06/2017
Under procedure, updated policy to include LaHIPP Third Party Liability (TPL) definition and TPL payment procedure.	06/2017
Changed time frame from 45 to 60 days in bullet 6 under Coordination of Benefits section.	06/2018
Added bullets 4 and 5 under Coordination of Benefits section	06/2018
Removed $50 per provider reference in bullet 1 under Coordination of Benefits section and added if through carrier billing.	06/2018

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Removed reference to HMS in Coordination of Benefits title section.	06/2018
Updated when files are delivered in bullet 4 under procedure. Files are delivered before the 20th.	06/2018
Added language to bullet 9 under Subrogation section to clarify what actually occurs.	06/2018
Removed bullet 6 under Subrogation section, "A questionnaire is sent to member in an effort to identify whether other third party resources may be liable to pay these medical bills". This is duplicative of bullet 9 under the same section.	06/2018
Removed references to Medicare A/B under Coordination of Benefits section as HMS does not currently provide these or recoup from Medicare A/B.	06/2018
Removed last sentence of paragraph one under policy section speaking to notifying LDH of TPL settlements. This isn't in the RFP and isn't currently being done.	06/2018
Removed bullet 8 under state reporting as this is no longer required by the state.	06/2018
Added clarification to POLICY section speaking to Rawlings role in recoveries.	06/2018
Update to bullet 4 under PROCEDURE: Prospective Cost Avoidance section to clarify delivery of TPL data to the state and from the state.	06/2018
No revisions	06/2019
Added bullets under State Reporting section regarding TPL time restrictions and updates. Added clarification to State Reporting section regarding the HMS LA CAV file. Added WF.LA.08.COB under References	06/2020
Act 421 changes included	**2/2021**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, Centene's P&P management software, is considered equivalent to a physical signature.

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Director, Operations: _____ Date: _____

Vice President, Operations: _____ Date: _____