POLICY AND PROCEDURE

POLICY NAME: Coordination of Benefits (COB)/Third Party Liability/Subrogation (TPL)	**POLICY ID:** LA.CLMS.01
BUSINESS UNIT: LHCC	**FUNCTIONAL AREA:** Claims Operations
EFFECTIVE DATE: 2/1/12	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 9/14, 7/15, 9/15, 07/16, 10/16, 6/17, 6/18, 6/19, 06/22, 032/23	
REGULATOR MOST RECENT APPROVAL DATE(S): n/a	

POLICY STATEMENT:
The document outlines 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.

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

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

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**.**

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 with Health Management Systems, Inc. (HMS) to perform COB and TPL identification and recovery services and with Rawlings for casualty identification and recovery services for the LDH population. HMS is contracted to perform the identification/recovery of COB and Rawlings all casualty related recovery services including the timely reporting of any settlement and/or recoveries received by Plan for LDH members.

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~~Model Contract section 4.13.2. 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 PLAN shall "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 documentation is submitted to the PLAN demonstrating that one hundred (100) Calendar Days have elapsed since the provider billed the responsible third party and the provider has not received payment for such services. (4.13.2.3)
- ~~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 making these payments under the method described below, even if the services are provided outside of the MCO network.

~~Please also refer to work process LA.CLMS.07.89.~~

PROCEDURE:

Cost Sharing

The PLAN shall ensure cost sharing incurred by all individuals in the Louisiana Medicaid Program household does not exceed an aggregate limit of five percent (5%) of the household's income applied on a quarterly or monthly basis as instructed by LDH. (4.12.3)

TPL Data Exchange (4.13.1)

The PLAN shall:

- **Receive, process, and update all records included in TPL files sent by LDH or it's designee. Update its TPL database within one (1) Business Day of receipt of said files.**
- **Transmit to LDH or its designee, in the formats and methods specified by LDH, TPL files the PLAN or its subcontractor discovers that have not otherwise been provided by LDH or its designee.**

Prospective Cost Avoidance

- Plan has an interface in its eligibility system that stores details of Members with other primary coverage, to include the primary coverage details.
- Primary coverage information is updated in Plan's system on an ongoing basis. 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 for their members to their system within five business days of receipt. If a member is unable to access services or treatment until an update is made, update requests for that member must be verified and added within four business hours. This includes removal of coverage that existed prior to the members linkage to Plan.
- The PLAN shall review response files sent daily from LDH (or its designee) and rejected records shall be corrected and completed within five (5) Business Days. The PLAN shall ensure its records reconcile to the TPL reconciliation files received weekly from LDH or its designee. Failure to comply may result in Monetary Penalties in accordance with Attachment G, Table of Monetary Penalties. (4.13.1.9)
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- There are no defined dollar thresholds for cost avoidance of claims identified as having other insurance.
- HMS is Plan's vendor 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, and that information is provided to the state contracted department with HMS for upload to the state TPL database. This information in turn is added to the TPL Reconciliation file which is sent to the Plan every Monday by Molina.
- 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 the Member 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 paid claim history and recovers from providers, insurance companies or in a nationally accepted billing format for all claim types whenever other commercial insurance coverage is discovered and added to the Plan's MIS that was unknown to the Plan at the time of payment of a claim or

when a claim could not be cost avoided due to federal regulations (pay and chase) which should have been paid by the health plan.

- Plan must seek recovery of reimbursement within sixty (60) calendar days after the end of the month it learns of the existence of the liable third party after a claim is paid.
- If the liable third party is traditional Medicare, Tricare or Champus, and more than ten (10) months have passed since the DOS, the PLAN shall recover from the provider. (4.14.1.3)
- Not perform post-payment recovery for TPL from providers for Claims with dates of service (DOS) older than ten (10) months, except when the primary carrier is traditional Medicare, Tricare, or Champus. (4.14.1.2)
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- 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 calendar 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 (or 90 days if extension granted), the Plan's MIS should recoup the previous payment from the Provider.
- Refer POS pharmacy Claims directly to the carrier. (4.14.1.6)
- Refer pay and chase Claims directly to the liable third parties (4.14.1.5)
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- 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.

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 amount of any recoveries collected by the PLAN outside of the Claims processing system shall be treated by the PLAN as offsets to medical expenses for the purposes of reporting. (4.14.1.12)
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- 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.

- Upon receipt of a subpoena duces tecum, the PLAN shall produce documents responsive to said subpoena by the date of return indicated therein (or shall contact the party who caused issuance of the subpoena, in order to request additional time to respond) if the production is authorized under La. R.S. 13:3715.1. Upon receipt of a request for records not sent via subpoena, the PLAN shall release PHI or a response explaining why PHI cannot be released to the individual or entity making the request, within fifteen (15) Calendar Days of receipt of the request and a written authorization, as set forth in La. R.S. 40:1165.1(A)(2)(c). The PLAN is solely responsible for any sanctions and costs imposed by a court of competent jurisdiction for failure to comply with the requirements of La. R.S. 40:1165.1(A)(2)(c) or for failure to respond Timely to a subpoena duces tecum. Additionally, LDH may impose sanctions against the PLAN for failure to properly or Timely respond to requests for PHI. (4.14.1.14)
- The PLAN shall notify LDH when subpoenas duces tecum are received and report the resulting recoveries to LDH.
- All records requests received by the PLAN shall be investigated by the ~~Contractor~~PLAN (or its vendor) for possible TPL recoveries, resulting in issuance of a lien statement (or notice of lack thereof) to the requesting party, as provided for in La. R.S. 46:446. (4.14.1.5)
- 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
- When the PLAN has actual knowledge that an insurer or other risk bearing entity of an Enrollee has filed for bankruptcy and the provider files a Claim for reimbursement with the PLAN with dates of service prior to the date the insurer or other risk bearing entity filed bankruptcy, the PLAN shall reimburse the provider with the Louisiana Medicaid Program as the primary insurer only if the Enrollee was enrolled with the PLAN at the time the service was provided and the provider has not been paid. The PLAN shall seek reimbursement as a creditor in the bankruptcy proceeding or from a liable third party. If the provider files a Claim for reimbursement with the PLAN with dates of service after the date the insurer or other risk bearing entity filed for Chapter 11 bankruptcy, the insurer or other risk bearing entity shall continue to be the primary insurer. If the provider files a Claim for reimbursement with the PLAN with dates of service after the date the insurer or other risk bearing entity filed for Chapter 7 bankruptcy, the Louisiana Medicaid Program shall be the primary insurer. (4.14.1.16)

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 Program (LaHIPP)

LaHIPP provides help for a Medicaid-eligible member of a household to be covered by the family's employer-sponsored private insurance policy. The program may pay some or all of the health insurance premiums for an employee and their family if they have insurance available through their jobs and someone in the family has Medicaid. Those getting Medicaid will also be able to have health insurance. * *Note: Non-Medicaid-eligible 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.* 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 these recipients.

- LaHIPP recipients will receive their medical services and emergency ambulance services through Fee-For-Service Medicaid and claims will be processed through Molina. LaHIPP recipients will receive their specialized behavioral health services (i.e., services provided by a specialized behavioral health provider) and 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.

PAYMENT OF LaHIPP SECONDARY CLAIMS

- For recipients enrolled in LaHIPP, once the claim has been processed and paid by the primary carrier, LA Medicaid processes and pays the full patient responsibility (co-pay, co-insurance, and/or deductible) - regardless of Medicaid's allowed amount, billed charges, or TPL payment amount. However, recipients 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.
- The PLAN is responsible for payment of LaHIPP participants' total member liability (co-payments, co-insurance and deductibles) if the participant uses a provider that accepts the insurance as primary payer and the Louisiana Medicaid Program as secondary payer. If the provider does not accept this payment arrangement, the participant shall be responsible for the member liability. The PLAN pays only after the third party has met the legal obligation to pay. The PLAN is always the payer of last resort, except when the PLAN 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).
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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).

MENTAL HEALTH SERVICES

The services listed below are typically not reimbursed by commercial health plans. MCOs should accept the following claims billed directly from the provider without requiring an explanation of benefits from the primary carrier and pay as primary payer.

- H0018-Therapeutic Group Home
- H0039-Assertive Community Treatment per diem
- H0045-Crisis Stabilization
- H2017-Psychosocial Rehabilitation Services
- H0036-Community psychiatric support and treatment
- H2033-Multi-systemic Therapy
- H2011-Crisis Intervention Service, per 15 minutes
- S9485-Crisis Intervention Mental Health Services
- S9484-Behavioral Health Crisis Care
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- T1019-Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Personal Care Services (PCS)
- T1025, T1026, T2002-Pediatric Day Health Care

Distribution of TPL Recoveries (4.14.2.1)

The PLAN may retain up to one hundred (100%) of its TPL recoveries if all of the following conditions exist:

- Total TPL recoveries received do not exceed the total amount of the PLAN's financial liability for the enrollee.
- There are no payments made by LDH related to FFS, reinsurance, or administrative cost (e.g., lien filing) for the enrollee.
- Such recovery is not prohibited by State or Federal law.
- LDH shall utilize the TPL recovery data in calculating future Capitation rates.
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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. The PLAN shall provide TPL information it or its Subcontractor discovers for each Enrollee that is not included in the reconciliation files received weekly from the FI. The PLAN shall submit a TPL file sent daily reporting verified additions and updates of TPL information in a format and medium specified by LDH in the MCO Manual. The PLAN shall

review response files sent daily from the FI and correct and resubmit rejected records until the record is correctly reported on TPL reconciliation files received weekly from the FI.

- 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.
- PLAN shall include the TPL recoveries and claims information in the Encounter Data submitted to LDH, including any retrospective findings via Encounter adjustments or voids. (4.14.3.2)
- 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.

REFERENCES:
CC.UM.01.05 – Coordination of Benefits/Subrogation (TruCare)
CC.CLMS.07.325 – Coordination of Benefits Basics Claims Processing Manual
~~LA.CLMS.07.89~~
Reinstatement and Implementation of LaHIPP Third Party Liability (TPL) Claims Payment
~~Emergency contract 17.13.6 LAHIPP Mental Health~~LDH Model Contract

ATTACHMENTS:

ROLES & RESPONSIBILITIES:

REGULATORY REPORTING REQUIREMENTS:
Which regulator(s) require reporting, what should be reported, when to report, and how to report/who to contact.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Under scope heading added Plan Finance/Eligibility/Claims Under policy heading added care to Health and Connections is Under Subrogation heading changed 250.00 to 500.00 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 Added heading of Provider Submission of Secondary Claims and policy regarding provider submission of secondary claims.	05/08/13
Annual Review	Reviewed with no revisions.	9/2014
Annual Review	Reviewed with no revisions	7/2015
Ad Hoc Review	Added section: **Medicare/Medicaid Dual Crossover Claims for Behavioral Health Services**	09/15
Annual Review	Under policy heading added reference to 42 CFR 433.135, et. Seq. and La. R.S. 46:460.71 Under Prospective Cost Avoidance heading added reference to five business day and four business hour time frame for updating TPL records. Under Prospective Cost Avoidance heading added reference to pay and chase exceptions. Under Prospective Cost Avoidance heading added reference to co-payments. 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 Under Coordination of Benefits – Retrospective TPL Savings / Recovery by HMS heading added section about retaining 100% of TPL collections 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. 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. Under Definitions heading added Emergency TPL Update. Changed all references to MCO and LHCC to equal Plan Changed DHH to LDH	
Ad Hoc Review	Updated policy to ensure language aligned with RFP Amendment 6.	10/16
Annual Review	Under state reporting, added weekly TPL summary report due to LDH Under references, added Reinstatement and Implementation of LaHIPP Third Party Liability (TPL) Claims Payment document from LDH and Molina as reference Under procedure, updated policy to include LaHIPP Third Party Liability (TPL) definition and TPL payment procedure.	06/2017
Annual Review	Changed time frame from 45 to 60 days in bullet 6 under Coordination of Benefits section. Added bullets 4 and 5 under Coordination of Benefits section Removed $50 per provider reference in bullet 1 under Coordination of Benefits section and added if through carrier billing. Removed reference to HMS in Coordination of Benefits title section. Updated when files are delivered in bullet 4 under procedure. Files are delivered before the 20th. Added language to bullet 9 under Subrogation section to clarify what actually occurs. 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. Removed references to Medicare A/B under Coordination of Benefits section as HMS does not currently provide these or recoup from Medicare A/B. 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. Removed bullet 8 under state reporting as this is no longer required by the state. Added clarification to POLICY section speaking to Rawlings role in recoveries. 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
Annual Review	No revisions	06/2019
Annual Review	Emergency Contact Amendment update 17.13.1-17.13.6	06/22
Annual Review	Reformatted to latest Policy Template 2023 Contract language updates	3/142/23

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.