STATE PLAN UNDER TITIE XIX OF THE SOCIAL SECURITY ACT

Requirements for Third Party Liability - Payment of Claims

(1) For cases active with the Department of Human Services Child Support Enforcement Division to establish paternity and obtain medical support and payment from, or derived from, the parents on behalf of a child:

The Department must pay the full amount of the claim and seek payment from liable third parties, if liability is derived from absent parents with obligations to pay medical support, and payment has not been made within 100 days. However, claims are cost avoided if one or more of the following conditions occur:

(a) No insurance paid amount is entered on the claim.
(b) No valid insurance denial reason code is entered on the claim.
(c) No documentation of non-payment is attached to the claim.

Documentation must include evidence that the claim was billed at least 30 days prior to the current submission and provider certification that no payment was received.

(2) Threshold amounts

Following is the threshold amount used to determine whether to seek recovery of payment from a liable third party:

Production of diagnosis and trauma follow-up - $100.00
Production of health insurance claims - $50.00

(3) Other guidelines for recovery

Following are the other guidelines used to determine whether to seek recovery of payment from a liable third party:

(a) Workers' compensation litigated cases are filed when medical and/or subsistence expenses are $500.00 or greater. This guideline reflects the additional case preparation time and legal counsel required for the intervention, settlement, and hearing processes. Claims under this dollar limit may be filed if the time limit on the Department's ability to file an intervention claim is nearing expiration and the nature of the injury suggests that additional expenses may be incurred.

cont. Requirements for Third Party Liability Payment of Claims

(b) Assigned automobile claims for minors or passengers in a vehicle driven by an uninsured person are filed when medical expenses are $200.00 or greater. This guideline reflects increased cost factors of case preparation. Health insurance claims are followed up to produce system-generated notices (1-3). Claims in excess of $500.00 will produce 4+ notices, until a closing or payment amount is entered.

(4) Determination of cost-effectiveness in seeking recovery from third parties

The Department considers a variety of cost and success factors on a case-by-case basis to determine whether (i) recovery of a claim is not cost-effective, or (ii) it is more cost-effective to pursue an amount less than the full cost of care. The factors considered include:

(A) an estimate of the cost of pursuing the claim, including attorney time required, travel and court fees, clerical and technical support expenses;

(B) the amount of the claim;

(C) factual and legal issues of liability as may exist between the Medicaid recipient and the liable party, including issues of causation and comparative fault;

(D) total funds available for settlement such as insurance policy limits or other factors relevant to the liable third party; and

(E) client involvement, such as cooperation or decision not to pursue the claim.

(5) In making the decision to seek recovery of payment, billings are accumulated by dollar amount. See number 2 above.

(6) Inpatient hospital coordination

Payment for inpatient hospital admission of patients who are simultaneously covered by medical assistance and a liable third party other than Medicare is the lesser of:

(a) the patient liability according to the provider/insurer agreement

cont. Requirements for Third Party Liability Payment of Claims

(b) Covered charges minus the third party payment amount.

(c) The medical assistance rate established under this plan minus the third party payment amount

A negative difference will not be implemented.

Medical assistance payment will not be made when either covered charges are paid in full by a third party or the provider has an agreement to accept payment for less than charges as payment in full.

(7) Payment by liable third parties: Medical Assistance eligibility or Medical Assistance benefits

Health insurers (including group health plans, HMOs and service benefit plans) must not take into account a recipient's medical assistance eligibility or a recipient's medical assistance benefits when enrolling the recipient or making any payments for benefits to the recipient or on the recipient's behalf.

Providers are required to bill liable third parties for services furnished under a long-term care insurance policy.

The state has in effect laws for the following:

- A responsible third party that requires prior authorization for an item or service must accept the state's authorization that the service is covered under the State plan as if such authorization were the prior authorization made by the third party;

- A responsible third party must not deny a claim submitted by the State solely based on a failure to obtain prior authorization from the third party for an item or service; and

- A responsible third party must respond to any inquiry regarding a claim within 60 days of receiving the inquiry.

(8) When processing claims for prenatal services, including labor and delivery and postpartum care, the Department uses standard coordination of benefits cost avoidance to reject, but not deny the claim when a third party is likely liable for the claim. If, after the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to the SMA for payment of the balance, up to the maximum Medicaid payment amount established for the service in the state plan.

(9) The Department makes payments without regard to third party liability for pediatric preventive services unless a determination has been made related to cost-effectiveness and access to care that warrants cost avoidance within 90 days.