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CHAPTER TWENTY

THIRD PARTY

Chapter 20. Third Party

Rule No. 560-X-20-.01 Third Party Program

(1) General

(a) The purpose of the Third Party Division of Alabama Medicaid Agency is to fulfill the requirements pertaining to third party liability and to ensure that Medicaid is the payer of last resort.

(b) In general third party resources are primary to Medicaid.

(c) Federal law requires that state Medicaid agencies take all reasonable measures to identify third party resources which may have legal/fiscal/contractual liability as a result of medical assistance furnished to a Medicaid recipient.

(d) Where third party liability is known or reasonably expected, the Medicaid Agency ensures that Providers collect third party resources prior to filing Medicaid.

(e) Where Medicaid payment has not been reduced by third party benefits, the Medicaid Agency is required to take reasonable measures to obtain reimbursement from third parties for the cost of medical assistance furnished to Medicaid recipients to the extent that the third party may have legal/fiscal/contractual liability. This may be done through postpayment billing to the third party or through recoupment of Medicaid payment from the provider who must then file with the primary payor.

(f) Claims for services which are filed with Medicaid and paid in full or in part by a third party will be applied against program benefit limitations.

(2) Definitions

(a) Third Party - Any individual, entity or program that is or may be liable (contractually or otherwise) to pay all or part of the medical cost of any medical assistance furnished to a recipient under a State plan. A third party benefit may be available at any time through contract, court award, judgment, settlement, or agreement.

(b) Private insurer - a third party which may be:

1. Any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-rated insurance contracts and indemnity contracts.

2. Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis or treatment of an injury, disease, or disability.

3. Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

4. Any health insurer, including group health plans, as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, self-insured plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

Author: Wanda Wright, Administrator, Third Party Liability

Statutory Authority: 42 CFR Section 432, 433, and 447.20; Section 1902(a)(25), Social Security Act; Section 22-6-6, Code of Alabama, 1975.
History: Rule amended March 11, 1985, October 9, 1985, March 24, 1986, June 9, 1986, and January 13, 1993. This amendment effective July 13, 1993. Amended: Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-20-.02 Third Party Cost Avoidance and Recovery

(1) General

(a) All providers must file claims with a third party as specified by this rule.

(b) Providers should not file with Medicaid until the third party responds with a payment or denial.

Exceptions: Providers may file Medicaid and Medicare simultaneously if the Medicare intermediary crosses over claims to the Medicaid fiscal agent. Providers may also file Medicaid prior to actual payment being received from a third party when the benefit is paid on a "set fee per day basis"; however, the provider must indicate the amount to be paid by the third party on the Medicaid claim.

(c) Providers must file claims with a primary third party within sufficient time for the third party to make payment. If the provider has difficulty obtaining a response from the third party or with the processing of Medicaid claims due to third party procedures, the provider should contact the Third Party Division, Alabama Medicaid Agency.

(d) An aged, outdated claim which is timely submitted to Medicare or another third party must be received by the fiscal agent within one hundred twenty (120) days of the notice of the disposition of such claim to the provider.

(2) Health Insurance Resources

(a) Cost Avoidance - Medicaid requires all providers (except as excluded through CMS - approved cost avoidance waivers or those excluded from cost avoidance requirements by federal regulations) to file for and obtain available third party health insurance benefits or a valid denial for all services. Cost avoidance is a way to ensure that Medicaid is the payer of last resort.

(b) Pay and Chase – Pay-and-Chase occurs when the Alabama Medicaid Agency pays providers for submitted claims and then attempts to recover payments. This may be done through post payment billing to the third party insurance or through recoupment of Medicaid payment from the provider who must then file with the primary payer. Medicaid recoups certain claims from the provider when the insurance carrier requires additional medical information that Medicaid cannot provide or when Medicaid pays for medical services under a managed care/global rate, for example: Maternity Waiver services. Alabama Medicaid will pay and chase claims when TPL insurance is identified after payment of claims.

(3) Casualty and Other Third Party Resources

(a) All providers are required to file for liability insurance and other third party benefits when the recipient is insured with the plan and/or the recipient is eligible for worker's compensation benefits.

(b) The Third Party Division, Alabama Medicaid Agency, will file for third party benefits in situations where there is a third party other than the recipient's Health insurance and an injury

is involved. Medicaid will file for casualty related resources to insure that all related medical care paid by Medicaid will be considered in a settlement. Therefore, once a provider has filed a claim with Medicaid on a casualty/litigation case, the provider cannot submit an adjustment request to Medicaid's fiscal agent in order to bill the liability insurance. Once a claim has been paid by Medicaid, Medicaid has a subrogation interest with the liable third party.

(c) In the case of a recipient who receives medical assistance through a managed care organization, the amount used in Medicaid's subrogation claim shall be the amount the managed care organization pays (if available) for medical assistance rendered to the recipient or the amount captured through encounter data that represents the amount Medicaid would have paid if fee for service.

(d) If a provider files with a third party resource other than the recipient's own insurance, the provider must notify the Third Party Division, Alabama Medicaid Agency, within five days of filing with the third party.

(4) Credit Balances

(a) Credit balances owed to Alabama Medicaid occur when a provider's reimbursement for services exceeds the allowable amount or when the provider receives payments from multiple parties for the same service. Any credit balance resulting from an excess payment, as a result of patient billing or claims processing error, must be conveyed to the Alabama Medicaid Agency.

(b) A provider must refund to Alabama Medicaid any overpayments, duplicate payments, and erroneous payments which are paid to a provider by Medicaid as soon as the payment error is discovered.

Author: Wanda Wright, Administrator, Third Party Liability Division.
Authority: 42 CFR Section 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama; 42 CFR Section 447.45; Title XIX, Social Security Act.
History: Rule effective October 1, 1982. Amended March 11, 1985, April 11, 1986, May 11, 1987. Effective date of this amendment January 13, 1993. Amended: Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-20-.03 Identification of Third Party Resources

(1) The Claim - All providers are required to question Medicaid recipients to obtain information about third party resources which may pay for medical services provided to the recipient. All providers must complete third party fields on the Medicaid claim as required in the Alabama Medicaid Provider billing Manual.

(2) Refunds - All third party payments must be applied toward services for which payment was made. These payments may not be applied against other unpaid accounts. If providers receive duplicate payments from a third party and Medicaid, all duplicate party payments must be refunded within 60 days by:

a) Sending a refund of payment to the Third Party Division, Medicaid; or
b) Requesting an adjustment of Medicaid payment via Medicaid's fiscal agent.

(3) The Policy File - The Third Party Division, Medicaid, maintains a Policy File which identifies specific coverage provided by a recipient's health insurance. Under limited circumstances good cause may be indicated so that other insurance is not filed.

(4) Eligibility Verification - Third party benefit data is available for inquiry by providers through various resources. Providers should access available systems for third party health insurance information prior to filing Medicaid.

Author: Wanda Wright, Administrator, Third Party Liability Division.
Statutory Authority: 42 C.F.R. Section 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama.
History: Effective date of this amendment January 13, 1993. Amended: Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-20-.04 Third Party Payments/Denials

(1) Third Party Payments other than Medicare

(a) Third Party payments must be applied to the services for which the third party paid.

(b) Providers receiving a third party payment prior to filing Medicaid must document in the appropriate field on the claim the amount of the third party payment.

(c) Providers receiving a third party payment after Medicaid is filed must within 60 days of receiving duplicate payment:

1. Refund the lessor of the insurance paid amount or the Medicaid paid amount to the Third Party Division, Alabama Medicaid Agency; or

2. Submit an adjustment request to the Medicaid Fiscal Agent that resolves the duplicate payment.

(d) If the third party pays the recipient or source other than the provider, the provider is responsible for obtaining the third party payment prior to filing Medicaid. If the Third Party pays a source other than Medicaid, as a result of information released by the Provider and Medicaid has paid the Provider, Medicaid may recoup its payment.

(e) If the provider accepts a patient with a third party resource and Medicaid, the provider cannot bill the patient for Medicaid covered services if:

1. The third party pays more than Medicaid allows and Medicaid zero pays the claim.

2. Medicaid denies a claim because a third party resource exists and recipient has provided third party information in a timely manner.

(f) A provider may bill a Medicaid patient if Medicaid denies a claim because of available third party benefits and the provider cannot obtain sufficient information needed to file a third party claim from either the recipient, AVRS, MACSAS or the Medicaid Agency.

(2) Third Party Payments - Medicare

(a) Providers must attach a copy of the Medicare EOB to the Medicaid claim.

(b) Within 60 days of receiving duplicate Medicaid and Medicare payments the provider must:

1. Refund the Medicaid payment to the Medicaid fiscal agent and state the reason for the refund; or

2. Request that the Medicaid fiscal agent adjust the Medicaid claim.

(3) Third Party Denials

(a) Providers must attach third party denials of benefits to their Medicaid claim when filing for Medicaid benefits. These claims must be filed as paper claims.

(b) Providers must state on the Medicaid claim "Denied by Third Party" if third party benefits are denied.

(c) Only true denials of benefits are acceptable, i.e., policy has lapsed, benefits applied to deductible, non-covered services, etc.

(d) Denials due to the Third Party's requirement to use participating plan providers, service requires pre-certification, etc. will not be accepted as valid denials, unless further documentation is provided that justifies that the third party requirement cannot be met.

(4) Recipient responsibility regarding third party requirements – A recipient must fulfill the primary insurance's requirement before Medicaid will pay. Claims that are denied by a third party payer because of precertification requirements, failure to use participating providers, etc., may be denied by Medicaid as an invalid denial reason. A recipient cannot be billed if the failure to meet the primary plan's requirements are due to the provider's error. If failure to meet the primary plan's requirement is due to the recipient's failure to notify the provider of the other insurance, then the recipient can be held responsible for the charges.

(5) Questions regarding third party payment/denials should be referred to the Third Party Division, Alabama Medicaid Agency.

(6) Balance Billing – Federal law prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing. All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs are prohibited from billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

Authority: Wanda Wright, Administrator, Third Party Liability Division.
Statutory Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama. Sections 1902(N)(3)(b) of the Social Security Act.
History: Effective date of this amendment January 13, 1993. Amended: Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-20-.05 Release of Information - All Providers

(1) Requests for copies of recipient's medical bills, histories, and statements provide Medicaid with third party resource leads. Therefore, information that is released by providers and that pertains to the care and treatment of a Medicaid recipient must be documented and reported

to Medicaid in the following manner. Failure on the part of the provider to meet these requirements may result in recoupment of Medicaid payment.

(a) Claims submitted by the provider to a health plan or other entity for the purpose of the provider obtaining payment must include an assignment of benefits to the provider.

(b) Billing statements, itemized billings, and medical records released for reasons other than the provider obtaining payment must include the following statement clearly printed on the documents released: **Medicaid has a subrogation/assignment interest. Contact Medicaid.**

(c) Complete a "Request for Medical Records" form to identify the requestor and reason for the request for medical records information. A "Request for Medical Records" can be obtained from the Alabama Medicaid Agency website and submitted to the address or fax # listed on the form.

(2) When a Provider receives a subpoena they should respond immediately and send a copy of the subpoena to the Third Party Division of the Alabama Medicaid Agency, indicating the records have been released. Sending a copy of the subpoena to the Third Party Division will serve as sufficient notice of a medical record request, therefore, completing a "Request for Medical Records" form is not required.

(3) Excluded from this requirement to notify Medicaid's Third Party Division is information released to the following entities:

(a) The Medicaid Fiscal Agent,
(b) The Social Security Administration,
(c) The Alabama Vocational Rehabilitation Agency,
(d) The Alabama Medicaid Agency,
(e) Requests from insurance companies for information pertaining to a claim filed by the provider and for which an assignment of benefits to the provider was furnished to the insurance company.
(f) Requests by insurance companies for information to process an application for insurance, to pay life insurance benefits, or to pay on a loan.
(g) Requests from other providers for medical information needed in the treatment of patients.

(4) This rule is not intended to deny release of information; however, requests for information pertaining to a recipient's charges are a source of third party information and, as such, must be reviewed by the Third Party Section. It does not permit providers to deny individuals access to their records. Providers are to ensure that all HIPAA Privacy and Security rules are met regarding an individual's "right of access to inspect and obtain a copy of protected health information about the individual"

Author: Wanda Wright, Administrator, Third Party Liability Division.
Statutory Authority: 42 CFR Sections 432,433 and 164.524; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.

History: Effective date of this amendment January 13, 1993. Amended: Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-20-.06 Fiscal Agent Responsibility

(1) Medicaid's fiscal agent is responsible for monitoring all claims for possible third party liability and utilizing information on the claim to identify potential Third Party liability. The fiscal agent will utilize Medicare coverage dates, the Commercial TPL policy file and Medicare Advantage enrollment dates to ensure that Medicaid properly processes claims as the payer of last resort.

(2) The fiscal agent is responsible for editing claims for third party coverage in accordance with State requirements to ensure that claims are either cost avoided, recouped from the provider, or identified for post payment billing to third party payers.

(3) The fiscal agent is responsible for retroactively identifying third party liability, including Medicare, and either cost avoiding covered claims, recouping Medicaid payment from the provider or producing post payment billings to an insurance carrier to obtain reimbursement for Medicaid paid claims in accordance with State and Federal requirements.

Author: Wanda Wright, Administrator, Third Party Liability Division.
Statutory Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; Section 22-6-6 of 1975 Code of Alabama.
History: Effective date of this amendment January 13, 1993. Amended: Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-20-.07 Recipient Responsibility

(1) The Alabama Medicaid Agency by statute is subrogated to the rights of a Medicaid recipient against any third party arising out of injury, disease, or sickness. Medicaid recipients are required to assist and cooperate fully with Alabama Medicaid Agency in its effort to secure such rights including the requirement to:

(a) Notify Alabama Medicaid Agency within ten days of filing suit against a third party;

(b) Notify Alabama Medicaid Agency, Third Party Division, prior to entering any settlement with a third party;

(c) Immediately pay to Alabama Medicaid Agency all funds received from any third party to the extent necessary to satisfy the subrogation rights of the State of Alabama;

(d) Disclose information regarding health insurance or other third party resources when applying for Medicaid;

(e) Notify providers of medical care of health and casualty coverage and other third party resources when requesting medical care. Recipients are required to comply with their primary plans guidelines by utilizing network providers and obtaining prior authorizations when required.

(f) Notify Alabama Medicaid Agency of any health insurance obtained after becoming eligible for Medicaid;

(g) Notify Alabama Medicaid Agency, Third Party Division, of any casualty/liability insurance which may cover medical treatment received due to an injury;

(h) Execute and deliver all instruments and papers needed by Alabama Medicaid Agency in pursuit of its subrogation claim.

(2) The State of Alabama by statute is assigned any and all rights to benefits payable and/or payments made by any person, firm or corporation which result from medical care received by the recipient, together with the rights of any other individuals eligible for Medicaid for whom the recipient can make assignment. This assignment shall be effective to the extent of the amount of medical assistance actually paid by the Agency and shall, effective 11/9/84, exclude Medicare. The recipient is required to assist and cooperate fully with Alabama Medicaid Agency in its effort to secure such rights.

(3) Failure of the applicant or recipient to cooperate with the Medicaid Program to secure its rights to subrogation and assignment may result in denial or termination of Medicaid eligibility. Recipients terminated under this Rule will be notified in writing of the agency action and afforded the opportunity for a Fair Hearing under the provisions of Chapter 3 of these Rules.

Author: Wanda Wright, Administrator, Third Party Liability Division.
Statutory Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Code of Alabama Sections 22-6-6 & 22-6-6.1.
History: Rule effective October 1, 1982. Effective date of amendment February 9, 1987. Amended: Filed January 9, 2015; effective date February 13, 2015.

Rule No. 560-X-20-.08. Payment of Health Insurance Premiums

(1) The Alabama Medicaid Agency may pay health insurance premiums of certain Medicaid eligibles or recipients when the Agency determines that payment of the premium would be cost effective. The primary objective of paying certain health insurance premiums is to reduce Medicaid expenditures by enrolling Medicaid eligibles in or continuing existing health insurance coverage so that Medicaid becomes a secondary payor.

(2) Cost effectiveness is defined as meaning the expenditure of Medicaid funds for a set of services is likely to be greater than the cost of paying the health insurance premium. Criteria for determining cost effectiveness will be determined by the Alabama Medicaid Agency.

Authority: 42 CFR Sections 432 & 433; Section 1902(a)(25), Social Security Act; Consolidated Omnibus Reconciliation Act of 1985; Section 4402 of the Omnibus Reconciliation Act of 1990. Emergency rule effective April 1, 1991. Effective date of this amendment August 16, 1991.