Medicaid Providers & Third-Party Liability

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MONTANA DPHHS

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Today's Training Topics

- Coordination of Benefits
- Private Pay Agreements
- Blanket Denials
- Pay & Chase
- Tort Recoveries

What is a Liable Third Party:
Administrative Rules of Montana (ARM) 37.85.407

No payment shall be made by the department for any medical service for which there is a known third party who has a legal liability to pay for that medical service except for services that qualify as an exception and are allowed under the Pay and Chase provisions.

- Defined as an individual, institution, corporation, or public or private agency that is or may be liable to pay all or part of the cost of medical treatment and medical-related services for personal injury, disease, illness, or disability of a recipient of medical assistance from the department or a county.

Includes but is not limited to:

- Insurers
- health service organizations
- parties liable or who may be liable in tort
  - Indian health services is not a third party within the meaning of this definition.

Known- Liable Third-Party Source

A known third party is a third party for which the provider has sufficient information to submit a claim and which if billed for a medical service is likely to pay the claim within a reasonable time.

- Casualty Insurance that has accepted responsibility
- Primary health insurance carrier

Provider Responsibility

- Bill the known liable third party primary to billing Medicaid
- Use its same usual and customary procedures for inquiring about possible third-party resources as is done for non-recipients.
- If the provider gives a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.
  - If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.
  - "Medicaid has assignment of or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

Potential- Liable Third-Party Source

A potential third party is a third party for which the provider either has insufficient information to submit a claim or which if billed for a medical service, is likely to deny the claim as having no contractual or legal obligation to pay.

- Worker's Compensation claims that have not been filed or approved

Provider Responsibility

- Use its same usual and customary procedures for inquiring about possible third-party resources as is done for non-recipients.
- If the provider gives a copy of a billing statement for services which have been or may be billed to the department, the statement must clearly indicate that third party benefits or payments have been assigned to the department by the patient or that the department may have a lien upon such benefits.
  - If a provider does not meet the notification requirements of this section, the department may withhold or recover from the provider an amount equal to any amounts paid by a third party towards the services described in the statement given to the recipient.
  - "Medicaid has assignment of or may have a lien upon third party benefits or payments" shall be sufficient to meet the notification requirement of this section.

Payor of Last Resort

Payor of Last Resort Exceptions

- Crime Victims Compensation Fund
- Parts B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Women, Infants, and Children Program
- Veteran's benefits, for emergency treatment provided to certain veterans in a non-VA facility
- Veteran's benefits for state nursing home per diem payments
- State health agencies
- State vocational rehabilitation agencies
- Grantees under Title V of the Social Security Act (Maternal and Child Health Service Block Grant).

Coordination of Benefits

DPHHS Policy Discoveries

1. Information provided by Medicaid members at time of application or redetermination
2. Provider claim submissions
3. Notifications received from members and providers through Conduent's call-center and group email
4. Recipient replies to trauma questionnaires
5. Recipient legal counsel for tort incidents
6. Federal program reports
7. Health Insurance Premium Payment referrals

Provider TPL Policy Discoveries

1. MATH Web Portal
   a) Known TPL carrier policies are available when verifying Medicaid coverage
2. The Patient
   a) Ask them: do you have other insurance coverage?
   b) Was this related to an accident?
      i. Auto? Workers Compensation?
      ii. Do you have the insurance policy or claim information?
      iii. Resources for discovering a liable third party to bill

Updating Changes to Health Coverage Policy

Email changes to Conduent, Montana Medicaid's Fiscal Agent, for updates. This includes Healthy Montana Kids. Please allow 5 to 10 business days for the changes to be updated in the eligibility and MMIS systems.

MTTPL@CONDUENT.COM

- Please include as much information as possible:
  - Medicaid ID,
  - Insurance Carrier Name,
  - Member's Covered by Policy,
  - Subscriber: Name, Date of Birth, Social Security Number
  - Group Number,
  - Policy Number,
  - Policy Effective Dates

Private Pay Agreements: When is billing a patient directly permissible?

Situations that Do Not Allow Providers to Bill Medicaid Recipients Directly:
Administrative Rules of Montana (ARM) 37.85.406 (11)

1. Providers are required to accept, as payment in full, the amount paid by the Montana Medicaid program for a service or item provided to an eligible Medicaid member in accordance with the rules of the department. (Federal Law: 42 CFR 447.15)
2. A provider that bills Medicaid for services rendered will be deemed to have accepted the individual as a Medicaid member.
3. A provider may not bill a member for services as a private pay patient if, prior to provision of the services, the member informed the provider of Medicaid eligibility.
4. Providers must not seek any payment in addition to or in lieu of the amount paid by the Montana Medicaid program from a member or his representative.
5. Provider may not bill a member after Medicaid has denied payment for covered services because the services are not medically necessary for the member.
    - If a primary carrier denies a claim for not medically necessary, a Medicaid claim will be denied until the provider can show that they have satisfied the requirements of the carrier. For example, providing adequate medical notes to support the medical necessity.
    - Medicaid may pay for services found to be medically necessary after the primary carrier's denial, with proof of meeting the primary carrier's request for information.

6. An ambulance service provider may bill a member ***after*** Medicaid has denied payment ***for*** lack of medical necessity.
7. A provider may not bill a member for services as a private pay patient if, prior to provision of the services, the member informed the provider of Medicaid eligibility.
    - Exception: The provider informed the member of its refusal to accept Medicaid ***before*** services are rendered ***and*** the member agreed to pay privately for the services by signing the Advanced Beneficiary Notice.
8. In service settings where the individual is accepted as a Medicaid member by an arranging provider that arranges for provision of services by other providers (including, but not limited to, a facility, institution, or other entity), ***all other providers performing services for the individual in conjunction with the arranging provider will be deemed to have accepted the individual as a Medicaid member.***
    - Exception: The other provider, may bill the member if prior to providing services, the member was of the provider's refusal to accept Medicaid and the member agreed to pay privately by signing the Advanced Beneficiary Notice.
9. The provider may not bill a member for services when Medicaid does not pay as a result of the provider's failure to comply with applicable enrollment, prior authorization, billing, or other requirements necessary to obtain payment.

10. Acceptance of an individual as a Medicaid member applies to all covered services
11. Acceptance of an individual as a Medicaid member applies to non-covered services unless the member has signed an Advanced Beneficiary Notice ***before*** services are rendered.
12. A provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid for other covered services.
13. Subject to the requirements of ARM 37.85.402(4), a provider may terminate acceptance of Medicaid for a member in accordance with the provider's professional responsibility, by informing the member of the termination and the effect of the termination on provision of and payment for any further services.
14. Providers are not permitted to refuse to accept an individual as a Medicaid member where the provider is otherwise required by law to accept an individual as a Medicaid member.

Balance Billing

Providers cannot bill for:

- Copays and Deductibles
- Balances remaining after primary carrier payment
- Services not covered by Medicaid; without the Advanced Beneficiary Notice. (Example: eyeglass coatings, hardware, not medically necessary circumcision)
- Balances for services covered by Medicaid, that have reached and exceeded the annual coverage limit (Dental)

Situations that Allow Providers to Bill Patients Directly:

1. Providers may bill certain members for amounts above the ***Medicare*** deductibles and coinsurance as allowed in ARM 37.83.825.
2. A provider may bill a member for noncovered services:
   a) In advance of providing the services, the provider has informed the member they will be required to pay privately for the services Medicaid does not cover, and the member has agreed to pay privately for the services by signing the Advanced Beneficiary Notice.
      - Noncovered services are services that may not be reimbursed for the particular member by the Montana Medicaid program under any circumstances
      - Covered services are services that may be reimbursed by the Montana Medicaid program for the particular member if all applicable requirements, including medical necessity, are met.
3. A provider may bill a member for covered but medically unnecessary services, including services for which Medicaid has denied payment for lack of medical necessity:
   a) In advance of providing the services, the provider has informed the member, Medicaid rule does not consider the medically necessary, and the member will be required to sign the Advanced Beneficiary Notice, agreeing to pay privately for the services rendered.

4. With documented proof, a provider may bill a member for services as a private pay patient if, prior to provision of the services, the member did not inform the provider of Medicaid eligibility.
    - Exception: the provider has already billed Medicaid ***or*** has billed Medicaid for previous services rendered to the member within a reasonable timeframe.
5. A provider may choose to accept the individual as a Medicaid member with respect to the services or to seek payment in accordance with the original payment agreement, if an individual has agreed prior to receipt of services that payment will be made from a source other than Medicaid (ex. primary healthcare insurance), but later is determined retroactively eligible for Medicaid.
    4. Recommend having an internal office policy to ensure consistency among Medicaid members in this scenario.

Advanced Beneficiary Notice

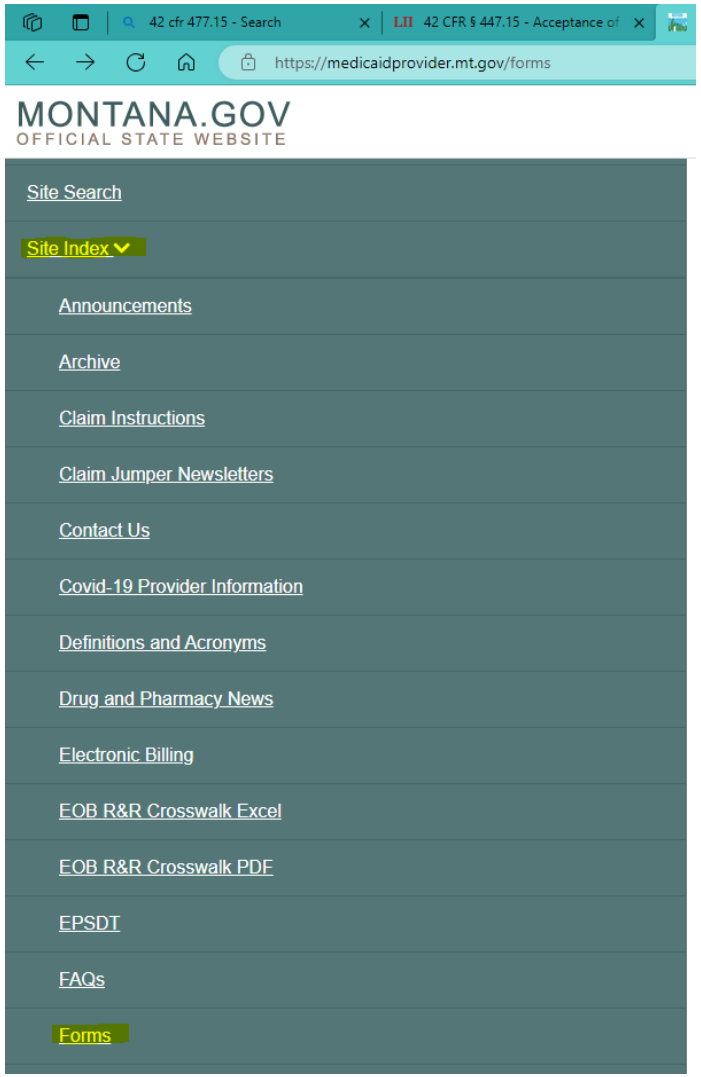
The agreement to pay privately must be based upon definite and specific information given by the provider to the member indicating that the service will not be paid by Medicaid.

The provider may not bill the member under this exception when the provider has informed the member only that Medicaid may not pay or where the agreement is contained in a form that the provider routinely requires members to sign.

Provider's admission form's standard patient financial responsibility language by law ***is not*** permitted as a Medicaid member's private pay agreement.

Advanced Beneficiary Notice

- Go to MedicaidProvider.MT.Gov
- Choose Resources by Provider Type
- Accept End User Agreement
- Choose your Site Index
- Select Forms
  - Forms M – O
- Non-Covered Services Agreement



CUSTOM AGREEMENT
FOR MEDICAID NON-COVERED SERVICES

Medicaid member name _____

Medicaid ID number _____

I understand the medical service listed below is a service not covered by Medicaid for me. By signing this agreement, I agree to pay this provider for this service to be provided on the date below.

Service(s) I will receive not covered by Medicaid

_____

_____

_____

Date(s) I will receive the services(s) _____

Cost I must pay for the service(s) _____

Member signature _____ Date _____

Provider name _____

Provider address, city, state, zip code _____

Provider telephone number _____

By signing this agreement, provider agrees not to bill Medicaid for services covered by this agreement.

Provider signature _____ Date _____

This agreement must be signed by both the Medicaid member and the provider prior to the member receiving the service(s).

Medicaid member or representative must be legally authorized to sign this document.

Blanket Denials

Blanket Denials

Blanket denials are available under these conditions:

1. The primary carrier was billed the exact same member, dates of service, charges, diagnosis codes, and procedure codes.
2. Application for blanket denial is submitted to Conduent with supporting EOB.
3. Primary carrier's claim denial must be a valid denial for Medicaid.
4. Approved blanket denials must be included with all claim submissions related to the denied procedure.
5. Blanket denials are valid for 1 year.

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Request for Blanket Denial Letter

State of Montana Medicaid

Effective Date Requested _____ Provider/NPI _____

Member Name _____

Medicaid ID Number _____

Name of Insurance Company on File _____

Procedure Codes Requested

1. _____
2. _____
3. _____
4. _____
5. _____

Requesting Agency _____

Fax Number _____

Contact Person _____

Contact Phone Number _____

Number of Pages that Follow Request _____

Fax all requests to 406-442-0357.

Request must include an explanation of benefits (EOB) stating the services are not covered.

Pay & Chase

Pay & Chase

When there is a Medical Support Enforcement on file, or the service rendered are Preventative pediatric services (including EPSDT), Pay and chase allows providers to bill Medicaid if:

- the provider submits evidence that the third party has been billed;
- the claim is submitted to the department 30 or more days beyond the date of service and in compliance with the timely filing rules;
- the provider certifies on the claim that notice of payment or denial of the claim has not been received from the third party; **and**
- the claim is submitted directly to the Conduent third party liability unit (hereafter referred to as the TPL unit).

- Per federal law, prenatal to include labor, delivery, and postpartum care are no longer allowed for pay & chase purposes, and fall under regular claims processing rules

Pay & Chase

Provider's may request Pay and Chase if the provider has billed the third party and has not received a reply from the third party either allowing or denying payment, if the following provisions are met:

- the provider submits evidence of the date the third party was billed;
- the claim is submitted 100 or more days beyond the date the third party was billed and in compliance with the timely filing rules.
- the provider certifies on the claim that notice of payment or denial has not been received; **and**
- the provider submits the claim directly to the Conduent TPL unit.

Refunding the Department

In the event the provider receives a payment from a third party after the department has made payment, and the liable third-party was billed ***before*** the provider shall refund to the department, within 60 days of receipt of the third-party payment, the lesser of the amount the department paid or the amount of the third-party payment.

The refund shall be made payable to Montana Medicaid and submitted to the department's fiscal office and shall indicate the name of the third-party payor.

Tort Recoveries

Protecting a Providers Payment from a Liable Third-Party Settlement, Agreement, or Award

For any service where an identified third party has only a potential liability as a tort-feasor, the provider may file a medical lien against that third party. The provider may bill the department prior to determination of liability of the third party when:

- the provider notifies the Department's TPL unit of the identity of the third party and its name and address if known by emailing the information to hhstraumaprogram@mt.gov.
- The provider may keep its lien in place and receive payment from the third party.
- If payment is received from the third party, the provider must refund to the department within 60 days

Frequently Asked Questions:

What do we do when there is a known liable third-party and the member's attorney tells us to just bill Medicaid.

Answer: It is against Medicaid law for providers to bill Medicaid primary to the liable third-party; therefore, providers ***must*** bill the primary party first.

What if we discovered the liable third-party after we bill Medicaid, can we refund Medicaid and bill the liable third party?

Answer: No, it is against Medicaid's acceptance of Medicaid's payment as full and final law for providers to refund Medicaid and pursue payment from the liable third-party, the member, or associates of the member.

Do we have to place a lien against a potential liable third-party in order to recover a payment?

Answer: By statute, the provider forfeits any right to payment if you bill Medicaid before the third-party. The provider lien allows you to protect your rights to the payment and bill Medicaid.

Remember, Medicaid must be bill according to timely filing rules. So it is best to file the provider lien, notify the Department, and file the claim within 365 days of service.

TPL Statutes & Rules

Federal

- Social Security Act 1902
- 42 CFR 433 Subpart D

Montana Code Annotated

- MCA 53-2-612- Lien of Department Upon Third-Party Recoveries

Administrative Rules of Montana

- 37.85.407- Third Party Liability
- 37.85.406- Billing, Reimbursement, Claims Processing and Payment

Questions & Answers

Fiscal Agent- Contacts

Conduent- Montana Medicaid Fiscal Agent

Provider Hotline Number:
1-800-362-8312

TPL Fax Line:
406-442-0357

TPL Group Email:
MTTPL@CONDUENT.COM

MT DPHHS-TPL Contacts

TPL Recovery Leads:

Lori Cole
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Thank You

Have a great rest of your day!