Administrative Code

Title 23: Medicaid
Part 306
Third Party Recovery

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Part 306 Chapter 1: Third Party Recovery

Rule 1.1: Definitions

The Division of Medicaid defines:

A. Third party as any individual, entity or program that is, or maybe, liable to pay all, or part of the expenditures for medical assistance furnished under the State Plan.

B. Cost Avoidance as a method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary.

C. Pay and Chase method as reimbursing the provider for a specific covered service and pursuing recovery of the payment from a third party source.

D. Casualty Cases as claims that involve the treatment of injuries arising out of vehicular collision, industrial accident, product liability, malpractice cases, etc. in which collection from the third party may be contingent upon legal action.

E. Preferred provider organization (PPO) as a medical care arrangement in which medical professionals and facilities provide services to subscribed beneficiaries at reduced rates. PPO medical and healthcare providers are called preferred providers.

Source: 42 CFR §§ 433.136, 433.137, 433.145; Miss. Code Ann. §§ 43-13-121, 43-13-125, 43-13-305, 43-13-311, 43-13-313.

History: Revised eff. 04/01/2021; Revised Miss. Admin. Code Part 306, Rule 1.1.A. eff. 06/01/2015.

Rule 1.2: Provider Requirements

A. Medicaid providers must:

1. Identify and report any third party source to the Division of Medicaid.

2. Cooperate with the Division of Medicaid in the recovery of payments from the third party source. Providers will be held liable, to the extent of the Division of Medicaid's payment, for failure to cooperate with the Division of Medicaid's staff when they have knowledge of third party coverage.

3. Accept either the third party payment or the Division of Medicaid's payment for services provided as payment in full.

B. Providers cannot refuse to furnish Medicaid covered services to a beneficiary because of a third party's potential liability for the services.

C. The beneficiary is not liable for any more than the co-payment that has been established by the Division of Medicaid for services rendered.

D. The Division of Medicaid may reduce any payment amount otherwise due the provider by up to three (3) times the amount incorrectly received from the beneficiary if the provider is found in violation of Miss. Admin. Code Part 306, Rule 1.3.C.

E. The provider must obtain a signed statement from the beneficiary if beneficiary indicates they no longer have third party insurance. The statement must include the name of the insurance company, the policy number, and the beginning and ending date of coverage and must be submitted to the Division of Medicaid.

F. Requests for Medical Information

1. The Division of Medicaid requires that any medical information concerning a Medicaid beneficiary released by a provider must contain the following information:

   a) The person is or was a Medicaid beneficiary at the time the services were rendered,

   b) His/her Medicaid identification number, and

   c) The claim has been submitted to the Division of Medicaid or has been paid by the Division of Medicaid.

2. If a provider receives a request for medical claims or other medical information from a Medicaid beneficiary or someone acting on the beneficiary's behalf, such as an attorney, insurance company, etc., release of said information will be restricted as follows:

   a) Copies of claims or medical records requested by a beneficiary or the beneficiary's parent, guardian or legal representative must be furnished if the provider receives a written authorization for release of the information.

   b) Information requested by an insurance carrier with whom a claim has been filed must be furnished directly to the carrier.

   c) The provider must comply promptly to a request for medical information from a Medicaid beneficiary's attorney once a signed authorization from the beneficiary has been received.

   d) Medical records or billing information requested by the Disability Determination Service (DDS) or a school system, for educational evaluation, must be sent directly to the requester. Notification to the Division of Medicaid is not necessary.

Source: 42 CFR §§ 433.136, 433.137, 433.145; Miss. Code Ann. §§ 43-13-121, 43-13-125, 43-13-305, 43-13-311, 43-13-313.

History: Revised eff. 04/01/2021.

Rule 1.3: Billing

A. Providers must file a claim with the third party prior to billing Medicaid. Documentation of payment or denial must be submitted to the Division of Medicaid with the claim including but not limited to:

   1. The explanation of benefits (EOB),

   2. Any amount paid by the third party, and

   3. If the claim is denied by the third party, the reason for the denial.

B. In the event there is no response from the third party source in sixty (60) days from the date of submittal, the provider may submit the claim to Medicaid as directed in Miss. Admin. Code Part 306, Rule 1.3.J.

C. When a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization (PPO) in which the Medicaid provider:

   1. Does not participate, the provider must submit the claim to the Division of Medicaid with a statement indicating the provider is not a member of a particular PPO, the insurance company name and address, and specific third party filing data and follow the Division of Medicaid's instruction regarding the claim.

   2. Does participate, the Division of Medicaid does not reimburse for the difference between a third party payment and the provider's charges as the provider has agreed to accept the PPO's payment as payment in full.

D. The provider must obtain or make reasonable efforts to obtain an assignment of benefits from the beneficiary prior to billing third party insurance.

E. If a provider is unable to obtain an assignment of benefits, the provider must submit the claim to the Division of Medicaid and include the third party information.

F. The provider must file and obtain Medicare payment for the service or obtain a Medicare denial before the Division of Medicaid can pay the claim.

G. If the beneficiary has Medicare A, B, and/or C and private insurance, the provider must bill Medicare and the private insurer prior to submitting the claim to Medicaid.

H. If Medicare coverage is found after Medicaid has paid the claim, the Division of Medicaid will recoup the payments from the provider and the provider must bill Medicare.

I. The provider must attach the EOB from the third party to the claim submitted to the Division of Medicaid.

J. The provider must make every effort to acquire payment from the third party source before filing the claim with Medicaid. When a provider bills a third party insurer and does not receive a response, the provider must:

1. Submit a written inquiry to the third party if no response has been received within thirty (30) days from the date of original claim submission,

2. File the claim with the Division of Medicaid, attaching a completed copy of the "TPL Edit Override Attachment: No Response Form" if no response has been received in sixty (60) days from the date of original claim submission. This form must be signed and dated by the provider or an authorized provider representative. The claim is adjudicated according to the Medicaid payment policies.

K. If a provider receives payment from a third party and the Division of Medicaid for the same service, the provider must refund the full Medicaid payment and may refile the claim with Medicaid if the third party payment is less than Medicaid fee.

L. For hospitals having a PPO contract with an insurance company with payments subject to retroactive adjustments, the amount to be reported as third party liability on the claim must be as follows:

1. If the third party insurer pays a final amount, which is not subject to change, then the third party payment should be reported as the third party liability amount.

2. If the third party insurer makes an interim payment, which may be adjusted or settled later based on contractual agreements with the provider, the maximum third party reimbursement should be reported as the third party liability amount.

a) If future settlements with other third party insurers result in the provider refunding amounts to the third party insurer, the Division of Medicaid makes no additional payment.

b) If future settlements with third party insurers result in the third party insurer making an additional payment to the provider, the following should be adhered to:

1) If third party liability amounts have been reported as benefits as required in item Miss. Admin. Code Part 306, Rule 1.3.O.2, no amounts are due the Division of Medicaid.

2) If third party liability amounts have been reported at less than the maximum

amount payable by the third party insurer, the provider will be liable for the overpayment by the Division of Medicaid, plus interest and penalty when applicable.

Source: 42 CFR §§ 433.139, 433.145-433.148; Miss. Code Ann. § 43-13-121.

History: Revised eff. 06/01/2022; Revised eff. 04/01/2021.

Rule 1.4: Casualty Cases

A. In the event a provider has knowledge that an individual is a Medicaid beneficiary and is receiving or has received health care services which may be covered by Medicaid as a result of the accident or incident, the provider is prohibited from:

   1. Demanding any payment from the Medicaid beneficiary or his representative, or

   2. Pursuing collection of any type against the Medicaid beneficiary or his representative.

B. A provider who has filed and accepted Medicaid payment and who fails to notify the Division of Medicaid that the provider has also received payment from a third party will be referred to the Medicaid Fraud Control Unit for investigation/prosecution for any possible violation of federal or state laws.

C. A provider may be excluded from participation in the Medicaid Program if the provider:

   1. Accepts payment from a third party and fails to comply with the provisions of this policy, or

   2. Fails to refund to Medicaid a duplicate payment within thirty (30) days of receipt of the duplicate payment.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-313.

History: Revised eff. 04/01/2021.

Rule 1.5: Reimbursement

A. The Division of Medicaid must be billed as the payor of last resort.

B. Providers are required to file a claim with the third party prior to filing with the Division of Medicaid except in the following circumstances:

   1. Preventive pediatric service, including EPSDT services, claims must be paid in accordance with the usual payment schedule.

   2. Covered services furnished to an individual on whose behalf child support enforcement is

being carried out by the state Title IV-D program must be paid in accordance with the usual payment schedule.

C. Medicaid will not pay for services denied by Medicare due to lack of medical necessity but may pay claims denied for other reasons as long as the services are covered under the Medicaid program.

Source: 42 U.S.C. § 1396(a)(25); Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2021.

Rule 1.6: Third Party Sources

Third party sources that must be used to reduce Medicaid program cost include, but are not limited to the following:

A. Medicare Parts A and B,

B. Health Insurance:

1. Includes both reimbursement policies and indemnity policies that make payment because medical care and/or services are rendered. Indemnity policies that restrict payment to periods of hospital confinement are considered a third party source.

2. Does not include policies that provide for income supplementation for lost income due to disability (without regard to hospital confinement), or policies that make payment for disability (without regard to hospital confinement), such as weekly disability policies.

C. Major medical, dental, drug, vision care or other supplements to basic health insurance contracts,

D. CHAMPUS provides coverage for off-base medical services to dependents of uniformed services personnel, active or retired,

E. Veterans Administration (CHAMP-VA) provides coverage for medical services to dependents of living and deceased disabled veterans,

F. Railroad Retirement,

G. Automobile Medical Insurance,

H. Worker's Compensation,

I. Liability Insurance includes automobile insurance and other public liability policies, such as home accident insurance, etc.,

J. Family Health Insurance carried by an absent parent,

K. Black Lung Benefits,

L. United Mine Workers of America Health and Retirement Fund, or

M. Donated Funds.

Source: 42 CFR §§ 433.136, 433.138; Miss. Code Ann. § 43-13-121.

Rule 1.7: Coordination of Benefits

A. Coverage available through the Mississippi Medicaid program is secondary to any third party benefits to which a beneficiary may be entitled. If a beneficiary has other insurance, the primary insurance should be used before billing Medicaid. Benefits available from insurance or other third party liability are used to reduce costs to the Medicaid program. To be eligible for Medicaid reimbursement, all Division of Medicaid policies including prior authorization requirements must be followed.

B. Policies that provide wage or income supplementation for lost income due to disability are not considered third party resources. However, policies, including indemnity policies that provide for payment while the beneficiary receives medical care and services such as during a period of hospitalization covered by Medicaid, are considered third party resources. The assignment of third party medical payments is a condition of eligibility for Medicaid per federal and state laws.

Source: 42 CFR §§ 433.138, 433.145; Miss. Code Ann. § 43-13-121.

Rule 1.8: Estate Recovery Requirements

A. The Division of Medicaid is required to seek recovery of payments for nursing facility services and Home and Community-Based Services (HCBS) as well as related hospital and prescription drug services from the estates of deceased Medicaid recipients who were fifty-five (55) or older when Medicaid benefits were received.

B. The estate recovery provision applies to all Medicaid recipients in a nursing facility as of July 1, 1994, and all Medicaid recipients who entered the Home and Community-Based Waiver (HCBS) Program on or after July 1, 2001, who:

    1. Are age fifty-five (55) or older at time of death;

    2. Own real or personal property at time of death that can be considered an estate.

C. Individuals who entered the HCBS Waiver Program prior to July 1, 2001, are "grandfathered in" and will not have their case referred to estate recovery unless the individual is discharged from the program and readmitted after July 1, 2001. In which case, "grandfathered" status is

lost and the individual will be referred to estate recovery as a new HCBS client subject to the provision**.**

D. Estate property includes any real or personal property owned by the recipient in its entirety or by shared ownership. Ownership of life estate interests or ownership of property that has been transferred into a trust is not subject to estate recovery.

E. Real property includes the home and any other real property, including ownership of mineral rights and/or timber rights.

F. Personal property includes ownership of any cash reserves, stocks, bonds, automobiles, RVs, mobile homes or any other type of property with value known to be owned by the recipient in full or in part.

G. Estate recovery rules do not apply to a deceased recipient if at the time of death the recipient has:

1. A legal surviving spouse living in the home, or

2. A surviving dependent child under the age of twenty-one (21) living in the home, or

3. A dependent blind or disabled child of any age living in the home, or

4. An undue hardship condition exists that causes estate recovery not to apply.

H. An undue hardship that would exempt estate recovery includes:

1. A blood relative living in the home who meets all of the following requirements:

a) The relative resided in the home at least one continuous year immediately prior to the date of the Medicaid recipient's admission to a nursing facility or HCBS waiver program.

b) The relative provided care to the Medicaid recipient which delayed entrance into a nursing facility or allowed the recipient to avoid entering a nursing facility.

c) The relative has no other residence.

2. The property is a source of income for the family, such as a family farm.

I. The following assets and resources of American Indians and Alaska Natives are exempt from estate recovery:

1. Interest in and income derived from Tribal land and other resources currently held in trust Status and Judgment funds from the Indian Claims commission and the U.S. claims court.

2. Ownership interest in trust or non-trust property, including real property and improvements located on a reservation.

    a) Reservation payments to special populations.

Source: P.L. 111-5 American Recovery and Reinvestment Act of 2009 § 5006, Miss. Code Ann. § 43-13-317.

History: New Rule moved from Miss. Admin. Code Part 306, Rule 1.8 eff. 08/01/2020.