



Mississippi Medicaid
Provider Reference Guide
For Part 306
Third Party Recovery

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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Billing Procedures

Assignment of Benefits

Any time the provider bills third party insurance, it is the responsibility of the provider to obtain assignment of benefits. Providers are required by state law and/or the Medicaid program to indicate the following information on the third party claim form:

1. The person is a Medicaid beneficiary,
2. His/her Medicaid ID number; and
3. The bill has been paid by Medicaid or will be submitted to Medicaid.

The above information is required on the Third Party Claim form, whether or not the charges have been paid or will be paid by Medicaid.

In situations where the beneficiary is, due to circumstances beyond his/her control, prevented from making assignment to the provider, the provider may submit a Medicaid claim through the DOM Bureau of Third Party Recovery. The claim must contain the third party information as well as an attachment of the beneficiary's signed statement giving the reason he/she is unable to assign benefits. The Bureau of Third Party Recovery will research and either instruct the fiscal agent to pay the claim or return the claim to the provider for further contact with the beneficiary.

In the event the beneficiary fails to assign benefits to the provider when it is within his/her rights to do so, the provider may choose to pursue payment from the beneficiary rather than filing with Medicaid. However, if the provider files the claim with Medicaid, he/she must not violate beneficiary liability as protected by law.

Beneficiary Denies Insurance Coverage

If a Medicaid beneficiary tells the provider that his/her insurance policy (recorded in the Medicaid claims payment system) is no longer in effect, that the policy never existed, or that the policy is for something other than medical insurance, the provider should obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage. The signed statement should be forwarded to the DOM Bureau of Third Party Recovery. Upon receipt of this information, the beneficiary's statement will be researched and, if necessary, the third party resource file will be updated.

Billing Medicare

If a claim has been denied for "Bill Medicare for these services," the provider must file and obtain Medicare payment for the service or obtain a Medicare denial before Medicaid payment can be made. The denial can be in the form of a letter from the Social Security Administration or

Supplemental Security Income Division, Form SSA-1600 or Form SSA-2458. Upon receipt of the denial, resubmit the Medicaid claim to the Medicaid fiscal agent, indicating the internal control number (ICN) of the denied original claim, and attach a copy of the Medicare denial. The claim is then paid according to Medicaid payment policies.

Billing Medicare and a Private Third Party Source

When the provider determines that a Medicaid beneficiary is eligible for Medicare in addition to being covered by private insurance, the provider must follow these guidelines:

Medicare Part A

The Medicare Part A intermediary will only crossover claims to Medicaid; therefore, submit separate claims to Medicare Part A (with no listing of Medicaid involvement) and the private third party source. When the third party payments or explanation of benefits (EOB) of denial are received from Medicare Part A and the private third party source, file the Medicaid claim as required.

Medicare Part B

The Medicare Part B intermediaries will crossover all claims to the appropriate third party source; therefore, the provider should complete the CMS-1500 listing the private third party source but with no mention of Medicaid. When the third party payments or EOBs of denial are received from Medicare Part B and the third party source, file the Medicaid claim as required.

Third Party Money Received

In the event the third party amount is less than 20 percent of the provider's charges, the provider must attach the EOB from the third party source that lists the TPL amount. Even when it is necessary to attach the third party EOB that lists the third party payment, the third party amount must still be written in the appropriate field on the Medicaid claim form. If the third party amount is less than 20 percent of the billed charges and no attachment is included, the claim will be returned to the provider requesting verification of the third party amount. If no response is received within the 20 day allotted response period, the claim will be denied. After denial, the provider must resubmit the denied claim including the appropriate EOB.

Third Party Denial Received

If the third party denies the claim because (1) the service is not covered by insurance, (2) insurance benefits have been exhausted, or (3) insurance coverage has expired, the provider must attach a copy of the denial EOB or denial letter to the Medicaid claim. The claim will be processed according to Medicaid payment policies. The third party resource file is updated appropriately. All claims billed with third party denials must be submitted in hard copy. ESC billing of TPL claims is allowed only in cases where the amount paid by other health insurance is entered on the claim.

If a claim is filed with the third party source as listed on the payment register and a denial is received as either service not covered, benefits exhausted, or coverage expired, submit the claim to the Medicaid fiscal agent with the denial EOB attached. The third party resource file is updated as appropriate.

The claim is denied if a Medicaid claim is filed without a TPL amount, without the TPL insurer's denial EOB, without the NCPDP override code, and the Medicaid TPL file indicates that the beneficiary is covered for the services billed on the dates of service listed on the claim. The provider's payment register will indicate the name, address, and policy number of the third party source of coverage. The provider should submit the claim to the third party source.

No Response from Third Party Source

When a provider bills a third party insurer and does not receive a prompt response, the provider should:

- Submit a written inquiry to the insurance company if no response has been received within 30 to 40 days from the date of original claim submission.
- File the claim with DOM's fiscal agent if no response has been received in 60 days from the date of the original claim submission. You must attach a completed copy of form DOM TPL 407 (example located at the end of this section). This form must be signed and dated by the provider or the billing clerk. The claim is processed according to the Medicaid payment policies.

The fiscal agent forwards copies of the "No Response" attachments to the DOM Bureau of Third Party Recovery for research. If the research reveals that no claim had been filed with the third party source or that the delay was solely due to the provider's failure to supply adequate information, the Medicaid payment for the services are voided on the provider's next payment register with the message, "Bill Third Party Source."

Receipt of Duplicate Third Party Money and Medicaid Payment

The provider may choose to have the excess payment amount adjusted from a future payment register or may attach a refund check to the Adjustment/Void Request form to satisfy the duplicate payment. Refer to the section "Completing the Adjustment/Void Request Form" in the Medicaid Provider Billing Manual for specific instructions on how to file an Adjustment/Void Request.

Causality Cases

In the event a provider has knowledge that an individual is a Medicaid recipient 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 recipient or his representative or (2) pursuing collection of any type against the Medicaid recipient or his representative. Nothing in this policy shall prevent a provider from demanding payment from, or pursuing any type of collection efforts for the difference against any liable or potentially liable third party, directly or through the Medicaid recipient or his representative who is demanding payment from any liable or potentially liable third party.

Request for Medical Information

Requests from Attorneys

Since the vast majority of personal injury cases are settled out of court on the basis of medical reports, it is the provider's responsibility to comply as fully and promptly as possible with the request for medical information from a Medicaid beneficiary's attorney as follows:

1. Obtain signed authorization from the patient before giving oral or written reports concerning the patient to any source.
2. Upon receipt of a written request and authorization, compile requested information, which may include a complete medical history, clinical findings, test results, diagnosis, treatment and prognosis or billing information. As required by state law, the data requested must be clearly marked with the three pieces of information listed above.
3. Promptly forward the medical information to the attorney. The provider may enclose a statement of regular billing charges for copying these records.
4. Mail a copy of the written request and authorization to the DOM Bureau of Third Party Recoveries. Send the DOM Bureau of Third Party Recovery copies of the records only upon request.
5. Subpoena of medical records: Production of relevant medical records may be required by subpoena served on the provider or custodian of the records. The required medical records must contain the data elements listed in the initial paragraph of this subject. The subpoena requires the person served to attend the deposition or trial at the time or place stated in the subpoena and to produce the specified records. The provider must immediately comply with the subpoena. A copy of the subpoena must be mailed to the DOM Bureau of Third Party Recovery.

Requests from Other Sources Requiring No Notification

Medical records or billing information requested by the Disability Determination Service (DDS) or a school system (for educational evaluation) should be sent directly to the requester. As required by law, the data must be marked with the information listed above. Notification to

DOM is not necessary when medical records or billing information are remitted to DDS or to a school system.