

BUREAU OF RECOVERY MANUAL



Division of Medicaid
Office of the Governor
State of Mississippi



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INTRODUCTION

PURPOSE

The purpose of the Bureau of Third Party Recovery (BTPR) is to administer the Third Party Liability (TPL) program as established by federal and state laws.

POLICY

Our policy is to ensure that Medicaid is the payor of last resort and to recover monies due Medicaid from any third party responsible for paying medical expenses of beneficiaries.

RESPONSIBILITIES

Our responsibility is to identify liable third party sources to prevent Medicaid payments, recover medical payments made on behalf of beneficiaries after discovering a liable source, and assist providers and others in complying with regulations governing Medicaid.

TPL OPERATION

FEDERAL AND STATE OVERSIGHT

Federal regulations 42 CFR 433, Subpart D control the TPL operation. These regulations contain strict deadlines for the identification of TPL resources, the inclusion of these third party sources in the MMIS claims payment process, and the recovery of potential third party money. Federal financial participation penalties can be applied to the state agency when the TPL operation is not handled as prescribed in the federal regulations. As of 1987, the TPL functions are also a part of the Systems Performance Review (SPR) conducted by the federal agency that manages the Medicaid program. Failure to comply with the TPL-related SPR factors risks potential financial sanctions.

Mississippi Code of 1972, as amended, Section 43-13-125, 127, 301, 303, 305, 313, 315, and 317 govern third party liability. TPL functions are also included in the State Audit process.

BUREAU OF RECOVERY

PROGRAM OVERVIEW

The function of the Bureau of Third Party Recovery (BTPR) is to administer the Third Party Liability (TPL) program as established by federal and state laws. Federal and state laws require Medicaid to pay secondary to any third party benefits to which a Medicaid beneficiary is entitled. The Bureau must cost avoid expenditures and recover monies due Medicaid from any third party source responsible for paying medical claims of Medicaid beneficiaries.

A third party is defined as any individual, institution, corporation, or public or private agency that is liable to pay all or part of the medical cost of injury, disease, or disability for a Medicaid beneficiary. Third party sources which must be utilized are Medicare Parts A and B, health insurance (including indemnity policies that make payment during hospital confinement), CHAMPUS, CHAMP-VA, railroad retirement, automobile medical insurance, Workers' compensation, liability insurance, family insurance carried by an absent parent, black lung benefits, United Mine Workers of America, and donated funds.

The responsible party ranges from absent parents, insurance companies and estates. Medicaid expenditures are cost avoided or reduced when the third party is identified prior to Medicaid receiving medical bills. Medicaid will deny the claim and ask the provider to file with the responsible party. When the responsible party is discovered after Medicaid paid the claim, a bill is sent to the health insurance carrier asking for reimbursement. Therefore, the function of BTPR is two fold, cost avoid by making sure that Medicaid is the payor of last resort and recover money that Medicaid paid.

The Bureau of Third Party Recovery is also responsible for writing the TPL policy for the Medicaid provider to follow and for helping to ensure that the provider understands and abides by this policy. The Medicaid Provider Manual, Section 6, contains third party liability-related requirements.

The TPL responsibilities are handled by two Divisions within BTPR, the Third Party Identification and Verification Division and the Fiscal Accounting Division.

THIRD PARTY IDENTIFICATION AND VERIFICATION DIVISION

This Division maintains the recipient insurance files, assists providers with third party claims problems, recovers Medicaid's payments from health plans and estates and audits medical providers for compliance with federal TPL regulations.

File Maintenance Branch

Federal regulation 42CFR433.138 mandates states to identify liable third parties and incorporate this information into the Medicaid Management Information System (MMIS). This mechanized process prevents Medicaid from paying claims prior to the provider billing the liable party.

The File Maintenance Branch receives reports of private health insurance coverage from each agency approving individuals for Medicaid. This Branch also receives third party leads from medical providers, insurance companies, beneficiaries, and other sources mandated to report private health insurance coverage. All leads are verified and entered into the MMIS. At the end of the month in which the record was added, MMIS reviews the claims paid by DOM on behalf of this beneficiary. Any claims for services covered by the health plan without a third party payment or a TPL attachment code will be sent to the insurance company for processing. This procedure is called retro-recovery.

TPL Health Branch

The function of the Health Branch is to monitor the processing of subrogated claims sent to private insurance companies. The staff follows up on pending claims and provides additional information for processing. This Branch also assists the medical providers with third party billing issues.

In 1986, Congress enacted COBRA legislation that mandated three (3) exceptions to cost avoiding Medicaid payments: prenatal, preventive pediatrics and IV-D (child support) related services. Mississippi has operated under a waiver since 1985 to pay prescription claims and bill the insurance later. At the end of the month that DOM pays these claims, MMIS bills the health plan. The TPL Health Branch posts all subrogated claims indicating payments and denials.

The Estate Recovery Program

The Mississippi Legislature, due to a mandate in OBRA 1993, Section 13612, enacted Estate Recovery provisions which the governor signed into law effective July 1, 1994. These legislative provisions enable the state to recover Medicaid expenditures from the estate of individuals who, at the age of 55 or older, die while a resident of a Nursing Facility or receive home and community based services. The Bureau of Third Party Recovery implemented and currently administers the Estate Recovery Program. Notices of specified beneficiary deaths are received from the Medicaid Regional Offices.

The survivors are contacted by mail with the estate values and the amount of Medicaid's interest. The survivors have a right to a hearing process if extenuating circumstances exist that may meet the hardship waiver. The Estate Recovery staff forwards hearing requests to the Hearing Officer in another bureau. He conducts the hearings, sends the Executive Director of DOM the transcription of the hearing, along with his opinion. The Executive Director renders the final decision. The survivor has the right to seek further decision from a court of the proper jurisdiction.

Provider Audit

State law requires Medicaid providers to determine if a beneficiary has medical coverage and file and collect all third party liability prior to billing Medicaid. The Provider Audit team reviews admission records and account receivable files of providers for compliance with Medicaid policy. The provider must refund Medicaid's payment when payments are received from DOM and the third party. The provider auditors also review the credit balance reports for refund compliance. All hospitals are audited every two years. The sample includes the top 25% institutional providers and 1/2 of the remainder with a 2 year look back period on the 1/2. In that way, all the institutional provider's accounts receivables are reviewed for each year. Standard operating procedures also require that a sample of physicians is selected for auditing as well. The number and type of providers audited is subject to change should the need arise. Since no federal law or regulation mandates the TPL provider audit program, the standard operating procedures is flexible as management sees fit and the program requires.

THE FISCAL ACCOUNTING DIVISION

This Division is responsible for the integrity of third party collections. It also houses a recovery Branch that pursues reimbursements for trauma related services, tort situations, and paternity related medical support. This Division also recovers payments for nursing home related and home and community based services from estates.

Bookkeeping Branch

The TPL Bookkeeping Branch receives, researches, and dispositions the third party payments resulting from subrogated claim filing, casualty-related efforts, and recoveries from estates. The fiscal agent processes third party refunds from providers. The TPL Bookkeeping Branch also maintains the MMIS TPL financial files and the in-house financial database. This Branch produces the weekly status reports, monthly bureau budgetary reports, and the TPL section of the quarterly federal HCFA 64.9 report.

TPL Casualty Related Recoveries

Federal law mandates that the state agency take necessary measures to recover Medicaid payments made as a result of trauma diagnosis claims. The TPL Casualty Branch has the responsibility of recovering Medicaid trauma-related claims' payments. This Branch receives and investigates leads as a result of MMIS generated beneficiary questionnaires concerning trauma diagnosis on paid claims. The injuries may be caused as a result of product liability, malpractice, and any tort situation. The Branch also receives inquiries from the legal community, the Medicaid beneficiaries, and the medical providers. The staff supplies accurate accounts of Medicaid paid claims associated with any trauma-related case, and appear as fact witness in court, if necessary. State law requires the legal community to protect Medicaid as payer of last resort when representing an individual who has had medical services paid by Medicaid.

Federal law requires data matches to be affected with specific state agencies in order to learn of third party responsibility for accident-related claims. The Bureau of Third Party Recovery directs and monitors annual data matches with Workers Compensation Commission and the Department of Public Safety. The TPL Casualty Branch also has the responsibility of pursuing recovery on any leads received as a result of the data matches.

Beneficiary Recoupment and Medicare Buy-In

The Beneficiary Recoupment (BR) Branch recovers money from beneficiaries who received benefits during an ineligible period. The ineligibility may have been from beneficiary error, agency error or suspected fraud. Referrals are received from the Bureau of Eligibility. The BR staff determines the amount Medicaid paid for services during the ineligible period and mail demand letters to the beneficiary requesting repayment of this amount. Payments are collected and follow up letters are mailed. At the end of the calendar year, names of beneficiaries who have not paid within a given period are sent to the Mississippi State Tax Commission to offset any state tax refunds.

The Buy-In functions deals with monitoring the Buy-In files for CMS billing. Staff uses MMIS reports to determine if Medicaid was billed by CMS for payment of the Medicare Part A and Part B premiums. Discrepancies are resolved by verifying Medicare eligibility and updating the Medicare and Medicaid files.

THE TPL OPERATION

FEDERAL AND STATE OVERSIGHT

Federal regulations that control the TPL operation contain strict deadlines for the identification of TPL resources, the inclusion of these third party sources in the MMIS claims payment process, and the recovery of potential third party money. Federal financial participation penalties can be applied to the state agency when the TPL operation is not handled as prescribed in the federal regulations.

TPL functions are included in the State Audit process. As of 1987, the TPL functions are also a part of the Systems Performance Review (SPR) conducted by the federal agency that manages the Medicaid program. Failure to comply with the TPL-related SPR factors risks potential financial sanctions.

THIRD PARTY PROVIDER POLICY

Federal and state laws, rules, and regulations require that the Medicaid program liability be secondary to any third party benefits to which a beneficiary is entitled. "Third party" means any entities or individuals who are legally responsible for paying the medical expenses of Medicaid beneficiaries.

As a condition of eligibility for Medicaid, the beneficiary is required by law to assign his/her rights to any third party benefits to DOM. By law, DOM legally stands in place of the beneficiary to pursue recovery of Medicaid's payment from any liable third party.

State law requires the provider to identify to DOM any third party source and to cooperate with DOM in the recovery of Medicaid's payment from the third party.

Federal law requires that a provider may not refuse to furnish covered Medicaid services to a beneficiary because of a third party's potential liability for the services.

Federal law also protects the Medicaid beneficiary when a third party source is involved. The provider must accept either Medicaid's established reimbursement or the third party payment as payment in full. The beneficiary is legally responsible for the **lesser of** the applicable co-payment as formulated by DOM, or the difference in the third party payment and Medicaid's established reimbursement.

When a third party payment is involved, the following restrictions to beneficiary liability apply:

1. If the third party payment is equal to or greater than Medicaid's established fee schedule, no collection from the beneficiary or a financially responsible person can be attempted.
2. If the third party payment is less than the established Medicaid fee schedule, the provider may collect from the beneficiary the lesser of:
 - a. The co-payment amount established by Medicaid, or
 - b. The difference in Medicaid's fee schedule and the third party payment.

The beneficiary is not liable for any more than the co-payment that has been established by DOM.

When violation of the above beneficiary liability is discovered, DOM may reduce any payment amount otherwise due the provider up to three times the amount incorrectly received from the beneficiary.

Federal law requires that for reimbursement of covered services, other than those outlined in the General Information section, Medicaid must use the cost avoidance claims payment method. "Cost Avoidance" means the Medicaid agency pays claims involving third party liability only to the extent Medicaid's established reimbursement exceeds the amount paid by the third party. To protect the rights of DOM, the provider must file with the third party source before filing with Medicaid.

Exception to Medicaid Cost Avoidance Procedures for Practitioners

Federal law requires the Medicaid agency to reimburse the practitioner for certain covered services even when a third party source exists. There are specific covered services in which the Medicaid agency is required to use the pay and chase method of payment. “Pay and Chase” means the Medicaid agency will reimburse the practitioner for specific covered services and then pursue recovery of the Medicaid

payment from the third party source. Services which require a mandatory use of the pay and chase method include:

- (1) pregnancy related services for women (prenatal, labor and delivery, and post partum),
- (2) preventive pediatric services (including EPSDT services), and
- (3) covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

Claims submitted for pregnancy related services and/or preventive pediatric services must be submitted on separate claim forms.

Claims submitted for individuals for whom child support services are enforced by the state’s Title IV-D program will pay without any additional coding by the provider. The Medicaid third party record contains the necessary coding that allows these claims to bypass third party edits. The Title IV-D program for Mississippi is managed within the Department of Human Services (DHS).

Claims submitted for inpatient and outpatient hospital charges for labor and delivery and postpartum must be cost avoided. Hospital claims must be filed with the third party prior to billing Medicaid. As indicated above, practitioner claims must be handled by the “Pay and Chase” method.

Exception to Medicaid Cost Avoidance for Pharmacists

Pharmacists must pursue any third party benefits to the extent of the paid drug claims except for covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

Neither of these exceptions to cost avoidance relieve the provider of the responsibility of notifying the DOM Bureau of Third Party Recovery of known third party cases arising out of injuries, disease, or sickness of the beneficiary as a result of products liability, a malpractice matter, etc. Refer to Sections 6.01 and 6.04 of this manual.

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This also includes beneficiaries who are Medicare/Medicaid eligible. The law further provides that providers will be held liable, to the extent of the Medicaid payment, for failure to cooperate with Medicaid staff when they have knowledge of third party coverage.

Therefore, the Medicaid program requires that claims with third party coverage should not be submitted to the Medicaid fiscal agent until payment or denial notification is received from the third party resource. However, in the event there is no response from the third party source in 60 days from the date of filing, the provider may file a claim with Medicaid as directed in the paragraph below, "**No Response from the Third Party Source.**" Pharmacists must use the appropriate National Council for Prescription Drug Programs (NCPDP) override codes.

Any provider failing to cooperate with DOM in the protection and the recoupment of its payments from a legally liable third party or parties shall be liable to DOM to the extent of the payments made to the provider for services rendered to the beneficiary for which the third party or parties are or may be liable.

The exceptions to initially filing with the third party source are discussed in the "Medicaid Cost Avoidance Procedures" in Section 6.02 of this manual and "Casualty Cases" in Section 6.04 of this manual.

Preferred Provider Organizations

In the event a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization in which the Medicaid provider does **not** participate, the provider should choose one of the following methods of billing:

1. Submit the claim to the DOM Bureau of Third Party Recovery along with a statement indicating the provider is not a member of a particular preferred provider organization, the insurance company name and address, and specific third party filing data. The DOM Bureau of Third Party Recovery will research the claim and either instruct the fiscal agent to pay the claim or return the claim to the provider with further third party filing instructions, or
2. File the claim with the third party source and hold the patient liable for the amount the insurance company pays him/her for the service rendered. It must be noted, however, that if the provider files with the third party source and then decides to file with Medicaid via the DOM Bureau of Third Party Recovery, the patient cannot be held liable for payment.

When a Medicaid beneficiary is covered by a private insurance policy whose administrator of the policy has a preferred provider organization in which the Medicaid provider participates, the following applies:

Pursuant to the State Medicaid Manual as written by CMS, "Medicaid is to make no payment when billed for the difference between the third party payment and the provider's charges. The provider's agreement as a member of the preferred provider organization to accept payment of less than his charges constitutes receipt of a full payment of his/her services; therefore, the Medicaid recipient who is insured has no further responsibility.

Medicaid is intended to make payment only when there is a recipient legal obligation to pay."

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 intermediary 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.

Claims Paid by Medicaid for Beneficiaries with Medicare Coverage

If a beneficiary is found to have Medicare coverage after Medicaid claims have been paid, the fiscal agent may automatically recoup the payments from the provider and print a message on the payment register that explains the action to the provider with instructions to bill Medicare. The fiscal agent may perform this process monthly.

Billing Medicaid After Receiving a Third Party Payment or Denial

After receiving payment or denial from all third party sources, the provider is required to file a claim with the Medicaid fiscal agent. The amount of third party payment must be indicated in the appropriate claim field. The claim is processed and Medicaid either pays the balance due on the claim (the total Medicaid payment amount less the third party payment amount) or makes no additional payment if the third party payment is equal to or greater than the total amount due from Medicaid. In either situation, the beneficiary's history of services is updated.

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.

The exceptions to the requirement for the provider to file with the third party source prior to filing with Medicaid are found in Section 6.02 - "Medicaid Cost Avoidance Procedures" and Section 6.04 - "Casualty Cases."

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

If the provider receives third party payment(s) and Medicaid payment for the same services, the provider must accept either the third party payment(s) or the Medicaid payment as payment in full for the Medicaid covered services. The other payment(s) must be refunded to Medicaid. **The provider is required to make the refund to the Medicaid fiscal agent within 30 days from the receipt of the duplicate payment(s).**

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.

The exception to a Medicaid provider being allowed to refund or adjust the receipt of third party monies is explained in Section 6.04 of this manual.

Hospital Retroactive Settlements

When a hospital has a preferred provider organization (PPO) contract with an insurance company and payments are subject to retroactive adjustments, the amount to be reported as third party liability on the claim form must be as follows:

1. If the third party payor pays a final amount (i.e., per diem or per discharge 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 payor pays an interim payment, which may be adjusted or settled later based on contractual agreements with the provider, the maximum third party reimbursement (i.e., contractual benefit) should be reported as the third party liability amount.

- a. If future settlements with other third party payors result in the provider refunding

amounts to the third party payor, DOM makes no additional payment because of such refunds.

- b. If future settlements with third party payors result in the third party payor making an additional payment to the provider, the following should be adhered to:
- Third party liability amounts have been reported as benefits as required in item 2 above, therefore no amounts are due DOM.
 - Third party liability amounts have been reported at less than the maximum amount payable by the third party payor, the provider will be liable for the overpayment by DOM, plus interest and penalty.

Casualty

In casualty cases involving 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, the provider is authorized to submit claims immediately to the Medicaid fiscal agent. At the time the claim is submitted, the provider is obligated to notify the DOM Bureau of Third Party Recovery so that the collection of DOM's claim against the identified third party or parties can be pursued. The notice should contain the beneficiary's name and Medicaid ID number, the name and address of the potentially liable third party, the date and nature of the accident, and a copy of the claim submitted to the Medicaid fiscal agent. Once Medicaid has paid, the provider is not permitted to recoup from the beneficiary or the third party the differences between the provider's billed charges and the amount paid by the Medicaid agency.

If the provider elects not to bill the Medicaid agency in casualty cases, the provider may seek recovery of the full charges against the potentially liable third party. Should the provider elect to pursue the collection of the claim directly against the legally liable third party unsuccessfully and the Medicaid agency pursues the collection of all other claims against the legally liable third party, the provider is not then authorized to make claim against DOM or the beneficiary for the services rendered on behalf of the injured Medicaid beneficiary.

State law requires that any medical information concerning a Medicaid beneficiary that is released by a provider must contain the following information:

- The person is a Medicaid beneficiary,
- His/her Medicaid identification number, and
- The bill has been paid by Medicaid or will be submitted to Medicaid.

Pharmacy providers are prohibited from assisting a beneficiary to collect directly from a third party carrier for drugs or other items covered by Medicaid.

If a provider receives a request for medical bills 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:

Requests from Beneficiary or Family Member

Copies of bills or medical records requested by a beneficiary or family member should be furnished if the provider receives a written authorization for release of the information. Any data released must reflect the required three elements listed above.

Requests from Insurance Companies

Information requested by an insurance carrier with whom a claim has been filed may be furnished directly to the carrier. The requested information must be clearly marked with the required three elements of information listed above.

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 is remitted to the Disability Determination Services office or to a school system.

Third Party Sources

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

1. Medicare Parts A and B
2. Health Insurance
 - a. 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.
 - b. 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.
3. Major medical, dental, drug, vision care or other supplements to basic health insurance contracts.
4. CHAMPUS – provides coverage for off-base medical services to dependents of uniformed services personnel, active or retired.
5. Veterans Administration (CHAMP-VA) – provides coverage for medical services to dependents of living and deceased disabled veterans.
6. Railroad Retirement
7. Automobile Medical Insurance
8. Worker’s Compensation
9. Liability Insurance – includes automobile insurance and other public liability policies, such as home accident insurance, etc.
10. Family Health Insurance carried by an absent parent
11. Black Lung Benefits
12. United Mine Workers of America Health and Retirement Fund
13. Donated Funds

ADMINISTRATIVE SUPPORT

BUREAU OF RECOVERY

PURPOSE

This position exists to provide administrative support to the Bureau, and Division Directors of the Bureau of Recovery. The position ensures that all administrative matters are carried out in a timely and efficient manner to ensure the speedy recovery of monies due Medicaid from third party sources.

RESPONSIBILITIES

The Administrative Assistant assigned to each division (Identifications/Verification and Fiscal Accounting) covers a vast spectrum of administrative duties: Organizes, designs, and maintains filing system for classifying, retrieving and disposing of such materials as correspondence, records, reports, and other documents, screens incoming calls and office visitors, referring each to the appropriate person or department, request a variety of office equipment, supplies, publication materials, and maintenance services as need, ensures distribution of information i.e. letters, faxes, memos, etc...

ADMINISTRATIVE ASSISTANCE

STANDARD OPERATING PROCEDURES

Daily

1. Check all incoming correspondence i.e. voice mail, email, fax, and letters from customers
2. Date Stamp and log all incoming correspondence
3. Operate bureau's telephone switchboard and direct caller to appropriate area and/or person
4. Conduct routine checks of each area of responsibility i.e. supply closet, fax in box, mail log, mail distribution, supply order log, suspense item list etc...

Weekly

1. Complete supply order request
2. Check status of previous week's supply request
3. Check and arrange supply closet
4. Interface with supervisor to resolve problems and/or discuss future changes
5. Interface with Bureau Director to resolve problems and/or discuss future changes

Monthly

1. Complete request for transmittals to forward files to state storage
2. Maintain "Tickler" file and alert appropriate Division Director and Supervisor when an employee's Performance appraisal is due

Quarterly

1. Purge and forward closed files to State Storage
2. Conduct property inventory

As required

1. Attend various meetings
2. Attend training sessions, and workshops
3. Complete assigned projects
4. Type documents

PROGRAMMATIC FUNCTIONS

The Bureau of Recovery is responsible for administering the Third Party Liability (TPL) program as established by federal and state laws. Federal and state laws require Medicaid to pay secondary to any third party benefits to which a Medicaid beneficiary is entitled. The Bureau must cost avoid expenditures and recover monies due Medicaid from any third party source responsible for paying medical claims of Medicaid beneficiaries.

The responsible party ranges from absent parents, insurance companies and estates. Medicaid expenditures are cost avoided or reduced when the third party is identified prior to Medicaid receiving medical bills. Medicaid will deny the claim and ask the provider to file with the responsible party. When the responsible party is discovered after Medicaid paid the claim, a bill is sent to the health insurance carrier asking for reimbursement. Therefore, the function of BTPR is two fold, cost avoid by making sure that Medicaid is the payor of last resort and recover money that Medicaid paid.

This Bureau is also responsible for writing the TPL policy for the Medicaid provider to follow and for helping to ensure that the provider understands and abides by this policy. The Medicaid Provider Manual, Section 6, contains third party liability-related requirements.

The TPL functions are handled by two Divisions within BTPR: the Third Party Identification and Verification Division and the Fiscal Accounting Division.

THIRD PARTY IDENTIFICATION AND VERIFICATION DIVISION

PURPOSE

The purpose of the Division of Third Party Identification and Verification is to determine the validity of third party health benefits and pursue liable reimbursements.

This Division identifies third parties responsible for medical expenses to ensure Medicaid is payor of last resort and collect Medicaid payments in accordance with state and federal regulations.

RESPONSIBILITIES

This Division maintains the recipient insurance files, assist providers with third party claims problems and audits medical providers for compliance with federal TPL regulations. This Division also recovers payments from estates for nursing home and related services and home and community based services.

FILE MAINTENANCE BRANCH

PURPOSE

The purpose of the File Maintenance Branch is to identify and verify the existence or nonexistence of health insurance coverage as reported from various sources and maintain accurate recipient insurance records. This is in accordance with federal regulations 42CFR433.138.

RESPONSIBILITIES

The File Maintenance Branch is responsible for investigating each report of third party coverage and maintaining accurate recipient insurance files.

REPORTING REQUIREMENTS

This Branch completes a monthly report of third party leads, the number of files updated and the percentage of completion.

FILE MAINTENANCE BRANCH

STANDARD OPERATING PROCEDURES

Policy and procedures for governing the activities for this Division has been establishing by both State and Federal law. File Maintenance operates under laws established by the Code of Federal Regulations 42CFR433.138 which mandates that states identify liable third parties and incorporate this information into the MMIS within 45 days of discovery. Federal and state law mandates that Medicaid liability be secondary to any third party benefits that a beneficiary might be entitled to. It is the responsibility of the Branch to identify and verify the existence of third parties for medical paid services by Medicaid. The Branch is responsible for the maintenance of two subsystems in the MMIS, the Resource Sub-system which contains information regarding the beneficiaries' third party liability, and the Carrier Sub-system which contains information regarding insurance carriers.

The MS ENVISION MMIS/TPL Support System

The MS ENVISION MMIS TPL Support System consists of the Resource Subsystem and the Carrier Sub-system

- Medicaid Recipient Name and Medicaid Identification Number
- Insurance Company State Assigned Number
- Effective and Term dates of Coverage
- Employer or Group Name and Address
- Subscriber's name and Number
- Relationship of policy holder to recipient
- Policy and/or Group Number
- Verification Code
- Scope of Benefits
- Absent Parent Name, Address, Social Security Number

The CIM contains the identifying information on each third party source contained in the resource; for example, the state assigned carrier number, the name, and the address for mailing claims.

Preparing Source Documents for Verification

Alphabetize all documents according to the source of contact- insurance carrier, employer, beneficiary, certifying agency. Label each stack according to source.

To contact insurance carriers use the Carrier Listing. Access the web eligibility file or contact the carrier by phone. When contacting an insurance carrier verify the address of the claim office, names used by the carrier, any distinctive description of the policy number, group number or the claim office.

Make sure the documents contain all the necessary information including the carrier number, prior to keying.

In order to determine whether a document should be keyed into MMIS, the appropriate verification code should be written on the source document. The verification codes are ATR, UDC, AIR, NCR, DIN, LIN, NDC, MDC, MNT, RET, REA.

Procedures for Verifying Third Party Coverage

Check to see if a record is already in the resource file before verifying the source document. To determine whether a record is already in the resource subsystem compare the Carrier name, Employer name/Group, Policyholder's name/SSN and the Policy number if indicated. If the document is already in the resource subsystem, or if insurance coverage is not verified, it should be filed. If a record is already in the resource subsystem, but updating is needed, the screen should be printed and attached to the source document with an indication of what should be updated.

When discrepancies are discovered in the new information and the existing the resource subsystem data, the verifier should determine what the discrepancies are and what information is needed. Under no circumstances should the data entry employee review a record, add or update a record without verifying the validity of each existing policy when a discrepancy appears. If the effective date of a policy has zeroes (00/00/00), MM/DD/YY, or any other characters that are not legitimate dates, verify the effective date and key in the actual date that the policy became effective. Use the keying guide, or a resource screen print as a review to know the exact questions to ask.

In order to create a resource record the form or resource document must have a Medicaid number, carrier number, policy number, and an effective date. Although only the items mentioned are mandatory, any data on the resource document must be clarified during the verification process.

A keying guide is used to verify policies on beneficiaries who do not have an existing resource record. Source documents should be verified before determining whether the document should be keyed into MMIS. Source documents sent to Medicaid directly from the provider should be verified with the insurance company or the policyholder's employer.

When verifying coverage with the insurance company or employer, verify all policies (major medical, prescriptions, dental and vision, etc.) and addresses to submit claims. If insurance is reported to Medicaid on a Medicaid beneficiary, it should be verified with the insurance company or the policyholder's employer. The name of the verifier, date, telephone number and the auditors' initials should be recorded on all documents completed. Documents can be verified by telephone, fax, e-mail, web sites, Passport, and Access Blue. Source documents should be accompanied by a keying guide when documents are verified.

When documents are verified in Access Blue, screen two (2) should be printed and the carrier number (s) should be recorded on the "screen print." The Medicaid number and the number of beneficiaries to be keyed should also be recorded. Also, print Verification Screen when documents are verified through the TRICARE web site.

A minimum of thirty-five (35) documents must be verified daily with only 15 percent being no action verification codes (AIR, NCR, DIN, LIN, RET, REA). The daily production for each auditor will be captured from the ROL report # RT435.

AIR - Already in resource
NCR - No Health coverage resource N/A
DIN - Disability Insurance
LIN - Life Insurance
RET - Referred to Trauma
REA - Referred to Health

Procedures for Keying Third Party Coverage

Each document must be reviewed for the necessary information to change or create a new record. The Medicaid ID number, policy number and carrier number must be known in order to create a Third Party resource file. Documents ready for keying will be placed in a tray.

Forms of the same type should be kept together. Separate the documents (346, 406, 407, 8019) into two stacks, those with Medicaid ID numbers and those without Medicaid ID numbers. Set questionnaires aside.

Take the stack of documents needing Medicaid numbers. Go to the Envision MMIS beneficiary detail screen to inquire. Find the Medicaid number and write it on the document. If no Medicaid number is found, write next to the recipient's name the date you checked the Envision MMIS beneficiary detail screen and NOF (not on file). Put these documents in a stack. File the documents in an accordion folder by date. Every 20 days review the documents in this box by inquiring for a Medicaid Number on the Envision MMIS beneficiary detail screen.

Take the questionnaires (RT391 and RT009) and inquire on the resource screen. If a record is found, compare the resource file with information on the questionnaire. File questionnaires if no update is needed. If the records are different, update if necessary or add a new record. Study the records carefully. If the policyholder is the same and both records indicate major medical coverage, verification may be necessary. If so, print copy of the screen and attach to questionnaire and verify. If no resource record is found and the questionnaire indicates no medical coverage, file.

If no resource record is found and the questionnaire shows coverage the document must be verified and keyed into resource if there is an indication of insurance within the last two years.

A minimum of one-hundred fifty (150) source documents must be keyed on a daily basis. The daily production for each auditor will be captured from the ROL report number RTO80 or the

COGNOS report # SIR0528E.

Instructions for keying Source Documents

Enter new records or update records in resource by choosing “TPL” from the control panel. Select the “Resource” file. Enter “New” to add a new record or “Search” and “Select” to update an existing recording.

1. Policy number:

- a. Enter the policy number in the field. Both alphanumeric and numeric characters should be entered.
- b. If the carrier # begins with 2 and no policy # is given, use the Social Security # of the policyholder.
- c. If the carrier # begins with 1 and a group # or employer is listed use the SS# of the policyholder.

2. Carrier #: 10 digit-number systematically assigned.

3. Relationship: The field is used to show the relationship of the beneficiary to the policyholder. Use the codes below:

- 1 - If the beneficiary is the same as policyholder.
- 2 - If the beneficiary is the spouse of the policyholder.
- 3 - If the beneficiary is a child of the policyholder.
- 4 - If the beneficiary is a step child of the policyholder.
- 5 - If the relationship is unknown or other than the relation listed above.

4. Resource Type:

- 01- Absent Parent
- 02- Casualty
- 03- EPSDT
- 04- Health Insurance
- 05- Other
- 06- Pregnant
- 07- Unassigned

5. **Telephone #:** Enter insurance company's telephone # if known.
6. **Effective dates:** Use these assumptions if effective date is unknown.
 - a. First day of the month that the document was signed.
 - b. If the Rim record on file has no effective date, use first day of the year that the record was added.
 - c. If no date at bottom of resource document, use first day of the month that the document was stamped.
7. **Term dates:** Use these assumptions if term date is unknown.
 - a. If the insurance company has no record of insurance except for the fact that the beneficiary has had insurance, however, it was two years or more and they cannot retrieve the information, close the policy based on the period in which the insurance company said the policy dropped off the system, two years prior to the current date.
 - b. If the insurance company says that the policy has terminated, however, the insurance company only has the month and year of the termination date, close policy using the last day of the month.
8. **Verification Codes:** Once the document has been coded, this will determine whether the document should be keyed into MMIS. The verification codes are ATR, UDC, AIR, NCR, DIN, LIN, NDC, MDC, MNT, RET, REA.
9. **Scope of Benefits (Coverage Indicators):** A single stroke will automatically code the scope of the policies listed below. Use these indicators when the benefits have been verified by the insurance company or employer.

- 01- Major Medical
- 02- Major Medical w/no RX
- 03- Inpatient Hospital
- 04- Hospital
- 05- Individual
- 06- Supplement A and B
- 07- Supplement A
- 08- Supplement B
- 09- Accident
- 10- Cancer
- 11- Pharmacy
- 12- Long Term Care

13- Mental Health

14- Vision

15- Dental

Use these assumptions if coverage is unknown.

- a. If carrier # begins with 2, enter “Major Medical scope.”
 - b. If carrier # begins with 1 and a group # or employer is given, use “Major Medical Scope.”
 - c. If carrier # is 1 and no group # or employer is listed, use Individual Scope.”
 - d. If Medicare supplement is checked, code A & B.
10. **Policyholder:** If the relationship is 1 do not enter any information on these 2 lines. This information will automatically be entered when you hit the right control key. Otherwise, enter name, SS# and address of policy holder.
 11. **Beneficiary Group:** Enter as listed on resource document.
 12. **Policyholder employer:** Enter as listed on resource document.
 13. **Absent Parent:** Enter from resources document if given.
 14. **Click “Save” to enter:** Record saved – enter next record

When to add a new policy or update an existing policy in the resource file

1. A policyholder cannot have two active major medical policies.
2. A beneficiary can have two active major medical policies with different policyholders.
3. A policy must be closed and added back to the system when there is a different policy number, a different carrier number, or change of policy coverage.
4. The policy coverage can not be changed when a policy is already in the resource file. The policy must be closed and added back to resource.
5. A policy that has terminated in the resource file should be not reopened. A new policy must be added.

6. A policy should not be voided from resource if the beneficiary has had insurance within the last two years. The policy should be terminated; but not voided. The two year period begins with the policy "Begin Date."

Procedures for keying documents into resource con't

1. If you find a resource record with no effective date enter the first day of the year that the record was added.
2. If you find a resource record with no coverage indicated enter the scope using the assumptions.
3. Policies that have been termed for two years or more should not be keyed into the resource file. The two year period starts with the policy "Begin Date."
4. If a beneficiary has not been eligible for Medicaid in the last two years and an insurance policy is verified, the policy should not be added to resource. The two year period begins on the first date of the beneficiary's Medicaid eligibility date.
5. Future term dates should not be keyed into the resource file.
6. To show an active policy 12/31/9999 should be keyed in filed eight.

Clearing the RT050 (FORMERLY TP-0-19) Report

Before completing a keying guide always check Rim for an existing Record and compare the information on the claim and EOB with what's on screen.

Record the total number of beneficiaries appearing on this week's RT050 Report and the auditor's initials in the upper left hand corner. The date each claim is processed should be recorded in the right margin of the RT050 Report. It is essential that this information be recorded on the RT050 Report. Beginning with the first 20 claims, make two stacks - attachments and no attachments. If there is a \$ amount in the Third Party Field (29 or 54) and no attachment, check resource for a record. If the Record exists compare Third Party information on claim with information on the screen. Code and file if the information is the same. Complete keying guide to update. If carrier is different or the dollar amount is not supported by the Third Party information in Fields 7, 9, and 11 on the CMS 1500, call the provider to verify. Record Third Party information on the keying guide. Use "5" as the relationship unless otherwise known.

If there is a zero amount in the Third Party field and no attachment, put in the folder for supervisory review.

Claims with Attachments

EOB from an insurance carrier - review EOB; check for resource record, if a record exists, compare information; if one does not complete the keying guide.

Medicare EOB- check this EOB carefully to determine if it is a Medicare EOB or a MEDICARE Supplement EOB. Medicare EOB's will have an ID number that is a social security number followed by a letter, usually A, B, C, or D. The ID number is sometimes referred to as a "Medicare ID number" or a "CMS ID number." The Medicare supplement EOB will have a policy number listed and may refer to how much Medicare paid on the claim as well as how much the private supplemental policy paid on the same claim. Check resource for a record. If no record exists, verify coverage with carrier.

If the attachment is an edit override sheet (407), check resource, etc. If no record exists, verify coverage with carrier. If carrier paid the recipient, verify payment information. Complete a keying guide. Give the payment information and a copy of the claim and 407 to appropriate health investigator.

Claims with no Attachments

If there is a dollar (\$) amount in the Third Party Field (29 or 54) and no attachment, check resource for a Record. If record exists compare Third Party Information on claim with information on the screen. To determine if the policy is AIR (already in resource) compare the Carrier name, Employer name/Group name, Policyholders' name/SSN and the policy number if indicated. If the information is the same, the claim should be coded AIR, unless the policy is active and has not been updated within the last year. In this case, the claim should be coded UDR, and the necessary updates should be made. If Carrier is different or the dollar amount is not supported by third party information in fields 7, 9 and 11 on the CMS 1500, call the provider to verify. Record third party information on the keying guide. Use "5" as the relationship unless otherwise known. If there is a zero in the third party field and no attachment, submit to supervisor for review.

Coding the RT050 Report

The RT050 Report is received weekly from the Division of Medicaid's Fiscal Agent, ACS. Attachments from providers are included in the report. The attachments should be researched, verified and coded. Once the document has been coded, this will determine whether the document should be keyed into MMIS. The following verification codes should be recorded in the right hand margin of the RT050 Report for each claim listed.

ATR - Added to resource

UDC - Updated resource

AIR - Already in resource

NCR - No Health coverage resource N/A

DIN - Disability Insurance

LIN - Life Insurance

NDC - No Dependent Coverage

MDC - Medicare

MNT - Money Listed not TPL

RET - Referred to Trauma

REA - Referred to Health

All of the above listed codes are used when coding the RT050 Report, however, the verification code that require a resource record is ATR. The code UDC require an update to the resource record. When a document require codes AIR, NCR, DIN, LIN, NDC, MDC, and MNT, it should be date stamped, initialed, a phone number should be recorded on the document and the name of the person the document was verified with. The document should be filed. If a source document require the code RET, it should be referred to the Trauma Branch. If a source document require the code REA, it should be referred to the Health Branch.

A minimum of thirty-five (35) documents must be verified daily with only 15 percent or 5 documents being no action verification codes (AIR, NCR, DIN, LIN, RET, and REA).

Clearing the Work Files

The work files contain beneficiary insurance data from the DHS Child Support Enforcement Agency and the Social Security Administration (SSA) that can be coded and transferred to resource automatically. Prior to establishing the work files in 1994, this data was transmitted via paper...DHS form 635 and SSA 8019. Occasionally we may receive these forms from the agencies due to unusual circumstances.

The insurance data that appears weekly from DHS Child Support Enforcement is transmitted by the Mississippi Enforcement Tracking Support System (METSS) interface system. A tape is received by ACS weekly from DHS and its downloaded weekly to be research and/or added to the Resource Information Module. The files that include sufficient data can be cleared while others may require research. Records that have not been added will drop off the work file after 6 months.

The third party data from Social Security is downloaded into a work file as well. The format, features and operations are the same as METSS.

The work files are accessed by choosing "TPL" from the control panel. Select the 'Resource' file. The "TPL Resource Selection" screen will appear. The user can view the number of files received and pending for a given week. To view the file, enter "Resource Pending" as the first search criteria and "(MP) METSS Pending" as the second search criteria.

After the pending resources appear, select the oldest load date. The work file should be worked in ascending order. The resource files for each load date must be researched and verified. The research sometimes result in an update in the resource file. Regardless of the reason, resource shall be assessed for possible maintenance.

Some resource records may all ready be in resource (AIR). To identify those records, compare the policy number, carrier number, carrier name, and the Medicaid number. If the record is AIR and has been updated within the last year, no further action is required. The verification code should be documented and the document should be prepared for scanning.

To determine whether a document should be keyed into MMIS, the appropriate verification code should be written on the source document. The verification codes are ATR, UDC, AIR, NCR, DIN, LIN, NDC, MDC, MNT, RET, REA. The carrier number will be determined and the keying instructions followed.

All METSS records added must have a "CT ACT" code. The remarks field must include the work file name..."METSS" or 8019", the load date, keyer's initial and the date keyed.

Procedure for Clearing 8019

This resource information is received from Social Security and downloaded into the Medicaid Management Information System (MMIS). The process is the same as METSS

MMIS Work Files

MP-METSS	-Mississippi Enforcement Tracking Support System
SP-SSA (8019s)	-Social Security Administration
DP-DEERS	-Defense Enrollment Eligibility Reporting System
EP-MEDS	-Mississippi Eligibility Detection System
CP-TP050s	-Claims
OP-ONLINE TPL	-TPL Files
WP-WEB PORTAL	-TPL Files

The Branch is responsible for the maintenance the above work files. All work file processes are same. Each auditor will be assigned a specific work file. The supervisor will check the work files each week for assignments to the Data Entry Staff. The keyer will collect, to verify and enter the necessary information in order to add the record to resource.

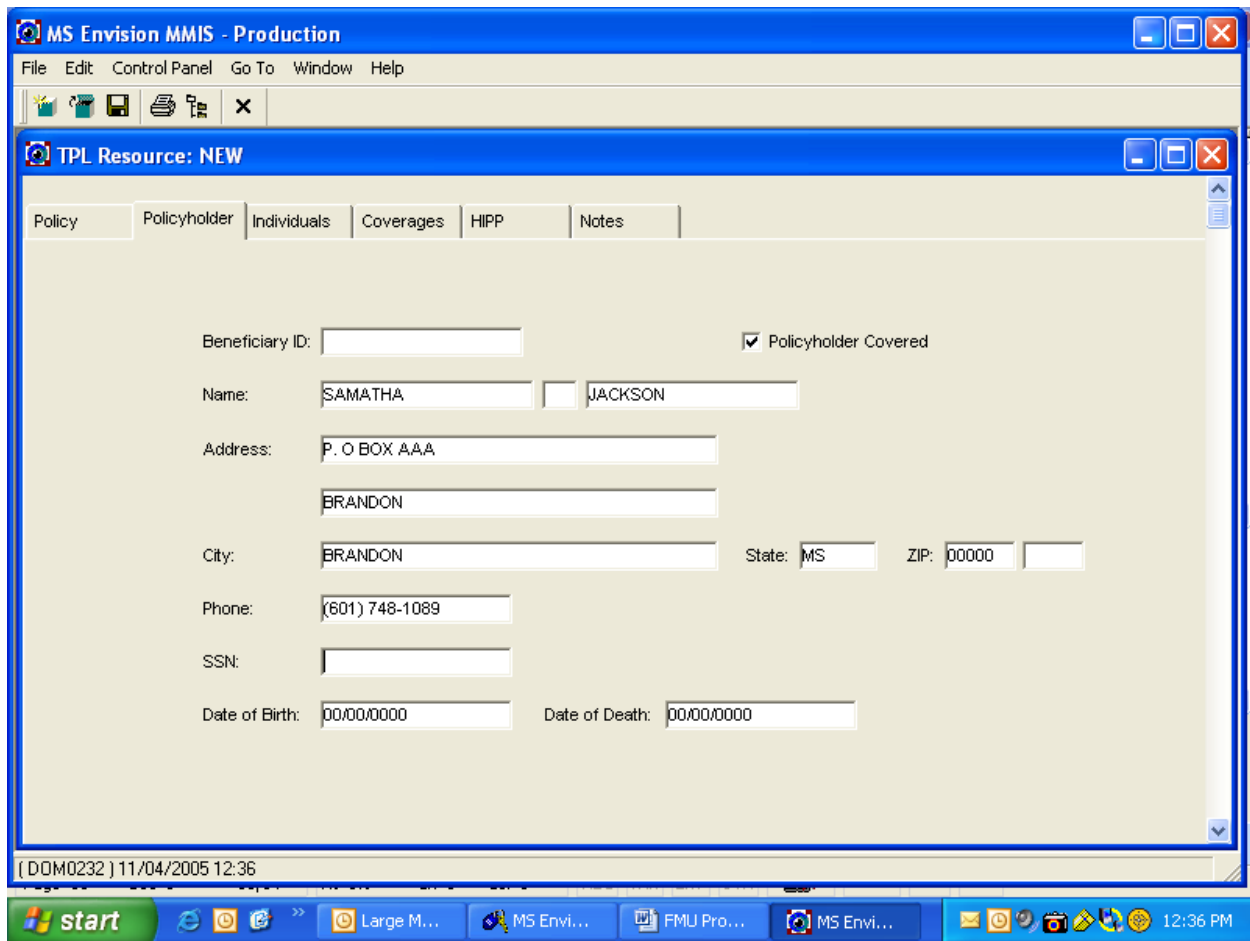
“POLICY” SCREEN

The screenshot displays the 'MS Envision MMIS - Production' application window. The main form is titled 'TPL Resource: NEW' and contains the following data:

Policy	Policyholder	Individuals	Coverages	HIPP	Notes
Policy Number:	YAC429378855		Begin Date:	07/08/2004	
Resource Type:	04-Hlth Ins		End Date:	12/31/9999	
Carrier Information					
ID:	0001004410 BLUE CROSS & BLUE SHIELD OF MS				
Address:	P.O. BOX 1043				
City/State/Zip:	JACKSON MS		39215 1043		
Phone:	(601) 932-3800		Ext:		
Employer/Group Information					
Group ID:	999999999				
Employer Name:					
Address:					
City/State/Zip:					

The status bar at the bottom of the window shows the user ID [DOM0232] and the date/time 11/04/2005 12:31. The Windows taskbar at the bottom includes the Start button and several open applications: Large M..., MS Envi..., FMU Pro..., and MS Envi... The system clock shows 12:31 PM.

“POLICYHOLDER” SCREEN



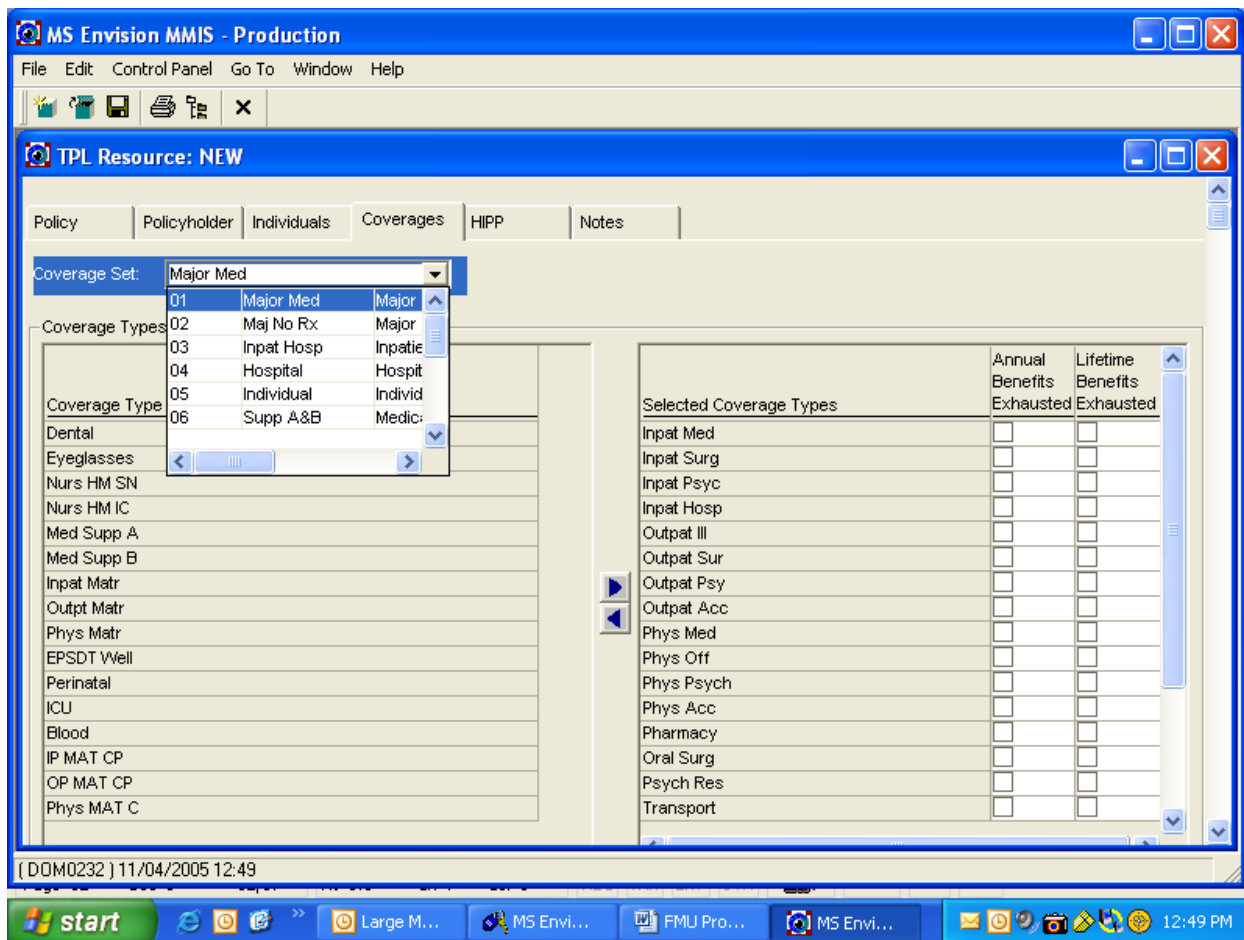
“INDIVIDUAL” SCREEN

The screenshot shows a software window titled "MS Envision MMIS - Production" with a menu bar (File, Edit, Control Panel, Go To, Window, Help) and a toolbar. Below the toolbar is a sub-window titled "TPL Resource: NEW" with a tabbed interface. The "Individuals" tab is selected, displaying a table with the following data:

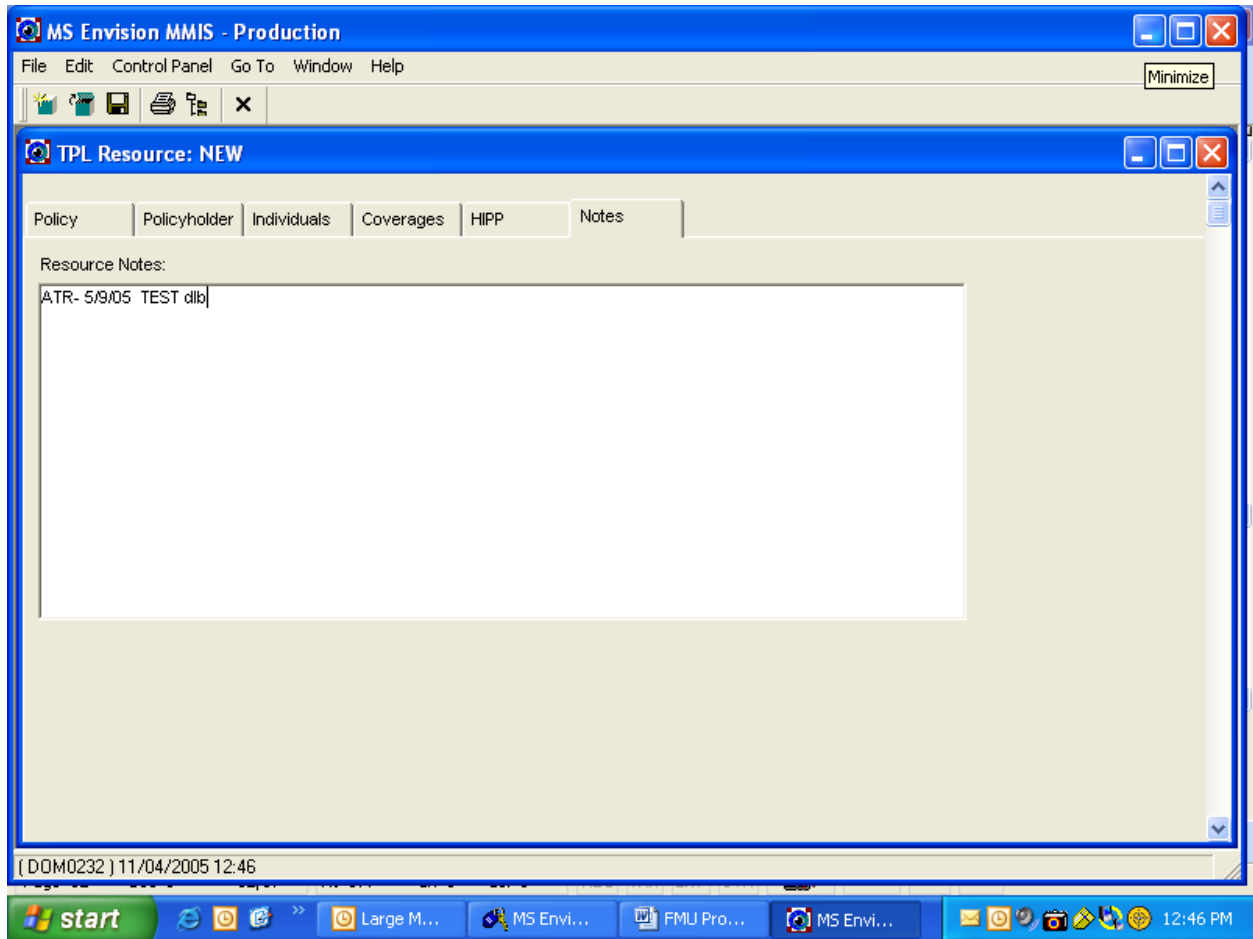
Beneficiary ID	Beneficiary Name	SSN	Date of Birth	Begin Date	End Date	Void	Rel	Court Action	Source of Information
0000037428728	BAILEY, JERRICK	587-93-6905	07/31/2003	07/08/2004	12/31/9999	<input type="checkbox"/>	1-Self		

The status bar at the bottom of the window shows "[DOM0232] 11/04/2005 12:39". The Windows taskbar at the bottom includes the Start button, several application icons, and the system tray showing the time as 12:39 PM.

“COVERAGE” SCREEN



“NOTES” SCREEN



**SAMPLE OF LETTERS AND FORMS USED
BY FILE MAINTENANCE STAFF**

DATE

FIELD(Beneficiary)

FIELD(Address)

Re: Medicaid Beneficiary: FIELD(Beneficiary)

Medicaid Number: FIELD(Medicaid #)

Dear FIELD(Salutation):

The Division of Medicaid is in the process of updating its files. We are seeking information regarding the insurance coverage of the following beneficiaries. Please find enclosed beneficiaries listed on the attached inquiry form in which we need an explanation of insurance coverage.

Please return the completed inquiry form in the self-addressed stamped envelope.

Thank you for your assistance in this matter. Should you need any additional information, please contact our office at (601) 359-6095 or fax to (601) 359-9531. We look forward to hearing from you.

Sincerely,

FIELD(Auditor's Name)

Medicaid Auditor

Third Party Liability Branch

Division of Medicaid

Enclosure

M:users:prrw/data/filemaintenance/fm01.let

DATE

FIELD(Beneficiary)

FIELD(Address)

Re: Medicaid Beneficiary: FIELD(Beneficiary)

Medicaid Number: FIELD(Medicaid #)

Dear FIELD(Salutation):

Medicaid has been advised that you or someone on your behalf has been provided medical information from FIELD(Source). The attached authorization will serve as an authorization to release medical information to the insurance company.

As a Medicaid Beneficiary, you are required by law to cooperate with Medicaid in identifying any other health insurance you may have. In order to protect your Medicaid eligibility, you must sign the enclosed medical authorization and return it within ten (10) days.

A self-addressed, stamped envelope is enclosed for your immediate response. Should you need additional information, please contact our office at (601) 359-6095 or fax to (601) 359-9531.

Sincerely,

FIELD(Auditor's Name)

Medicaid Auditor

Third Party Liability Branch

Division of Medicaid

Enclosure

M:users:prrw/data/filemaintenance/fm02.let

-Authorization-

I authorize any doctor, hospital, employer, or other person to whom a signed authorization or photocopy of this authorization is delivered to furnish any information, reports, or copies of records which may be requested by The Division of Medicaid or its representative. This authorization is valid for the duration of the claim. I agree to this document being photocopied and the photocopy will be as valid as an original.

Name of Patient: _____
(Please Print)

Date of Birth: _____

Social Security number: _____

Address: _____
(Street) (City) (State) (Zip Code)

Date: _____ Signature _____

KEYING GUIDE

Form _____
Date of From _____

1. _____ Medicaid Recipient

2. _____ Medicaid Number

3. _____ Relationship

4. _____ Carrier Number & Name _____

Carrier Phone Number

5. _____ Policy Number

6. _____ Effective Date: _____ Term Date: _____

7. Coverage (circle one) MAJOR MEDICAL IND MED SPP. (A/B)

Is there a separate address for the following policies?

	Prescription	Dental	Vision
Carrier Number:	_____	_____	_____
Address:	_____	_____	_____
Phone Number:	_____	_____	_____
Contact Person:	_____	_____	_____

8. Policy Holder Name/SSN: _____ - - -
Address: _____

9. Group Number & Name: _____
Address: _____

10. Employer Phone Number:
Did you verify? Yes No

Contact Person: _____

Company: _____ Phone: _____

Auditor's Name: _____ Date: _____

**CARRIER MASTER MAINTENANCE
CARRIER ADD SCREEN**

CARRIER ID_____

CARRIER: NAME_____ CITY_____
STREET_____

STATE_____ ZIP_____-_____

AFFILIATION CODE _____ INSURANCE CODE_____ PARENT NO_____

CARRIER REP: NAME_____ PHONE_____-_____-_____

*Set CIM (Carrier Information Module) to automatically assign carrier numbers in chronological order. When **Y** is entered in the AFFILIATION CODE FIELD, set system to highlight PARENT NUMBER FIELD. When **N** is entered in the AFFILIATION CODE FIELD, set system to highlight INSURANCE CODE FIELD. The affiliation codes are **Y** & **N**. **Y** indicates a parent number. **N** indicates no parent number. The insurance codes are 1, 2 & 3. When one (1) is the insurance code, the carrier should be assigned a 100 # (insurance company), when two (2) is the insurance code, the carrier should be assigned a 200 # (employer), and when three (3) is the insurance code, the carrier should be assigned a 300 # (absent parent). A parent number will be assigned to all new carriers not listed in CIM. Additionally, create a screen in MMIS to reflect records updated since the last generated report.

Log 5

CARRIER MASTER MAINTENANCE UPDATE FORM

CARRIER MASTER MAINTENANCE UPDATE
FORM

	CARRRIER #	CARRIER NAME	DATE	UPDATE INDICATOR			I N F O R M A T I O N
				PHONE	(P)		
				ADDRESS	(A)		
				ALSO KNOWN AS (AKA)			
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							

CREATED 8/19/98
FORMCIMB.WK4

REQUESTOR'S NAME _____

DATE _____



VERIFIED MATERIALS

VERIFIED BY _____

DATE _____



KEYED MATERIALS

KEYED BY _____

DATE _____

General Instructions

1. Alphabetize all documents according to the source of contact- insurance carrier, employer, beneficiary, certifying agency.
2. Contact insurance carriers using the Carrier Listing.
3. Check for an existing file to determine information needed to verify coverage.
4. Enter third party data into the TPL Subsystem.

TPL HEALTH BRANCH

The function of the Health Branch is to monitor the processing of subrogated claims sent to private insurance companies. The staff follows up on pending claims and provides additional information for processing. This Branch also assists the medical providers and beneficiaries with third party billing issues.

In 1986, Congress enacted COBRA legislation that mandated three (3) exceptions to cost avoiding Medicaid payments: prenatal, preventive pediatrics and IV-D (child support) related services. Mississippi has operated under a waiver since 1985 to pay prescription claims and bill the insurance later. At the end of the month that DOM pays these claims, MMIS bills the health plan. The TPL Health Branch monitors the subrogated claims and posts non- payment reason codes.

PURPOSE

The purpose of this Branch is to recover Medicaid payments from liable health insurance carriers, assist the Medicaid beneficiaries and providers with TPL claims issues, and educate this group regarding TPL policy and procedures for compliance with federal and state laws.

RESPONSIBILITIES

This Branch investigates TPL claims issues, follow-up on the processing of subrogated 'pay and chase' claims, and provides additional information to expedite processing.

REPORTING REQUIREMENTS

MMIS is designed to generate production reports for this Branch.

TPL HEALTH BRANCH

STANDARD OPERATING PROCEDURES

When Third Party sources are identified and Medicaid has paid for services for which the Third Party source would be liable, the following procedures are followed:

1. The TPL Health threshold is \$100.00. Therefore, the TPL Health Branch will not pursue recovery of cumulative claims of less than \$100.00. This policy applies to recipients, insurers, providers, etc.
2. All information necessary to pursue the TPL monies or to reconcile case discrepancies are obtained by the Investigator, i.e., beneficiary's name, policy number, effective date of coverage, scope of benefits, etc. This information should be forwarded to the Medicaid Auditor in the Health Branch to record into the MMIS System.
3. The Investigator, research and follow-up on claims filed through the Billing Program. This is done to ensure that any Third Party that is liable for the medical expenses of a MS Medicaid beneficiary is held accountable for these costs paid by Medicaid.
4. Claims with third party coverage are downloaded into the Billing System. These claims are filed with the third party carrier for reimbursement to Medicaid.
5. The Health Branch investigates the results of third party liability (TPL) billings within sixty (60) days after mail-out.
6. Thirty (30) days later a second request letter is sent.
7. Response from claims filed to Carriers generates explanations of benefits (EOB's).

The explanation of benefit is the turn around documents from subrogated claims filed with the carrier. In MMIS claims are downloaded to the Billing tracking system. Posting is necessary to terminate the "chasing" efforts of the Third Party Health Branch to recoup monies that Medicaid has paid out on a beneficiary.

Posting Billing System

Health Investigator/Auditor are responsible for posting exception codes and follow-up codes corresponding with the actions taken on a particular claim. These codes are listed as follows:

RESPONSE CODES

DB5 – non-covered (for ex: non-covered, preexisting, benefits exhausted)

D05 – under \$100 (threshold amount)

DB8 – prior effective date

D09 – not timely

D13 – dependent not-covered

D16 – no pharmacy

D19 – coverage termed

FOLLOW-UP CODES

1 – payment forthcoming

3 – re-file revenue code

4 – re-file – ad (address needs correcting or claims not received)

6 – other (follow-up, W-code, etc)

Investigator/Auditor is to enter a “response code” or “follow-up code”. Upon entering the code, the system will automatically enter that days’ date and the Investigator or Auditor’s DOM’s number.

The following procedures are to be used to enter into Pay & Chase System and to post a response or follow-up code: (See power point)

As each document is resolved it should then be determined if this information should be referred to update the Resource Sub-System and/or verified.

Investigator/Auditor is to enter a “response code” or “follow-up code”. Upon entering the code, the system will automatically enter that days’ date and the Investigator or Auditor’s initials. Once a response code is entered it is not to be changed. A follow-up code may be changed but not removed entirely in order to measure the results of follow-up efforts.

The following procedures are to be used to enter into Billing System and to post an exception or follow-up code:

1. Log into Billing System.

2. Click on the field that corresponds to the information that you can provide in order to find the record (i.e. Medicaid ID#, name, etc.).
3. Enter that information.
4. The beneficiaries' records will appear and you may begin your search for the particular date of service for this claim by using the "select" button on the bottom of the screen.
5. Once the record has been found, select and enter the response code or the follow-up code required for that claim.
6. After having entered the code, click on "Save" field and the code will be accepted and the record is now completed.
7. Simply click on the green icon on the tool bar to move to your next record.

As each document is resolved it should then be determined if this information should be referred to update the Resource Information Module (resource) System and/or verified.

Follow-up Schedule

The claims that are entered in Billing are monitored and reviewed based on the schedule listed below.

<u>Type of Transaction</u>	<u>Days Allowed</u>
Claim filed with insurance company	60
Second request of same	30
Beneficiary questionnaire	30
Second request of same	30
Miscellaneous correspondence with beneficiary	30
Miscellaneous correspondence with insurance company	30
Data request	10
Claim request	10
Input TPL information into system	15
Input TPL changes	5
Phone call follow-up	5

Health Investigator Duties

Daily procedures are performed to comply with policies and guidelines set by the Division of Medicaid.

1. Read and sort daily incoming mail to follow-up with TPL procedures.
1. Review EOB's for denied claims to close out the pending recovery cases.
2. Pull data from the MMIS System to research regular health and drug cases.
3. Contact insurance carriers on rejected claims to request additional information not received.
5. Research claims that were previously paid to the provider or beneficiary that is due Medicaid.
6. Complete recovery request letters to be sent to the provider to request a refund.
7. Complete recovery request letters to set-up beneficiaries on a monthly payment plan (MP)
8. Send out letters to the beneficiaries requesting other policy information, accident details and claim forms completed to be provided to the insurance company per their request.
9. Send out letters to the providers requesting detail claim information to process our claims with various information requested which may require a follow-up call.
10. Verify Medicaid's eligibility and payment for insurance carriers.
11. Contact providers to assist in filing procedures for payment of their claims when a TPL check is pending the Medicaid's payment.
12. Review monthly pay cases to determine if a payment has been received within (60) days, if not, take necessary actions.

13. Close monthly pay cases per policy.
14. Research and request insurance refunds for payments that were made to Medicaid in error.
15. Make referrals by completing a Keying Guide to add and update carrier information.
16. Review documents and entering corresponding exception codes into the Billing System.
17. Information is researched for new carrier information after the policy for the beneficiary has cancelled.
18. Compile all information to be placed into a folder, labeled and filed.

Health Auditor Duties

Daily procedures are performed to comply with policies and guidelines set by the Division of Medicaid.

1. Read and sort daily incoming mail to follow-up with TPL procedures.
2. Review EOB's for denied claims to close out the pending recovery case.
3. Pull data from the MMIS System for researching of new carriers after the beneficiary's policy has cancelled.
4. Send out letters to beneficiaries requesting updated policy information.
5. Complete Keying Guides to add and update resource records to the File Maintenance Branch.
6. Enter Exception Codes into the Billing System for all denied claims from the health and drug Investigators.
7. Send insurance questionnaires to beneficiaries who requested personal medical records.
8. Contact insurance carriers to clarify information listed on their EOB's to update into the Billing System.
9. Documents are reviewed and corresponding exception codes are posted.
10. Compile all information to be placed in a folder, labeled and filed.

Procedures for Setting up Cases

All Explanation of Benefits, subrogated claims should be filed in one file folder per beneficiary. The beneficiary's name and MID must appear on the tab. Since the Investigator is responsible for resolving all subrogated claims, all documents pertinent to the beneficiary (EOB's, letters, claims, etc.) are necessary to completely reconcile all claims. Proper documentation must be in place for the Bookkeeping Branch to follow our cases to apply overage to other claims. In the event the Bureau is audited, documentation is crucial.

The EOB's for the reconciled claims should be placed in one file folder. By checking the TPL Tracking System to verify if a check has been collected, you may find that a case folder may already exist. Locate the file and place your documentation into it.

If an EOB is received prior to receiving a check, set up a file. Pull all the claims for that beneficiary according to the program involved. Place all documentation in the same folder. A out-card is placed in the filing cabinet if you remove a case folder for more than a day.

With mail being worked daily, no more than four days should be spent setting up a folder, pulling subrogated claims and posting exception codes. In the event a case is needed by the Bookkeeping Branch prior to completion, cooperation is required from all parties involved.

A case activity sheet with case documentation should be included when setting up a case.

Maintenance of case files:

1. Case files should be maintained in chronological order with most current documents on top.
2. Phone calls should be properly documented i.e., dated and content listed. This should be done on either an activity sheet or in memo form.
3. Duplicate letters, EOB's, claim listings, etc., are unnecessary unless they are accompanying forwarded correspondence, in which case they should be attached. Only one copy of any document is necessary, preferably the original.
4. It is the Investigator's responsibility to assure that all correspondences are dated and/or date stamped. In order to ensure that urgent matters are handled, mail should be reviewed daily.

Claims Payments to Beneficiary

Procedures for pursuit of TPL funds paid directly to the beneficiary are as follows:

1. The beneficiary/payee will be contacted by mail twice in an effort to reconcile the matter.
2. A third effort will be completed in the form of a certified letter informing the payee that unless a response is received within ten (10) days the source of eligibility will be contacted to begin termination procedures of the adult's Medicaid eligibility.
3. Closure procedures will be initiated in accordance with Transmittal Notice #433.09139018 dated September 13,1990.

NOTE: Termination of Medicaid Eligibility will not be initiated on cases involving less than \$100.00.

An agreement to repay the Division of Medicaid is required on all cases in which the termination procedure has been initiated or completed.

1. During the ten (10) days notice period a negotiated agreement is met and the beneficiary will be required to sign a legal agreement to repay Medicaid, in order to maintain Medicaid

eligibility.

2. If the notice period has lapsed without contact by the beneficiary and/or termination procedure is completed, repayment will be arranged in the following manner. The beneficiary will be required to sign agreement to repay Medicaid in accordance with the TPL Repayment Schedule.
This agreement will further indicate that Medicaid eligibility will not be available to this beneficiary until full restitution is made.
3. The MMIS System should be used first to reconcile discrepancies.
Beneficiary data is available using the beneficiary's MID, SSN, name and case number.
4. If the MMIS prove futile, then a call to the source of the receipt should be placed to reconcile the discrepancy. As a last alternative, written correspondence should be utilized.

Please note that Good Cause Waiver may affect eligibility reinstatement.

Monthly Pay (MP) Cases

A monthly pay case is one where Medicaid paid for services and the insurance company paid the beneficiary for the same services. If the Division of Medicaid has paid for this same service and the insurance company sent the payment to the beneficiary, then the Investigator will notify the beneficiary to refund Medicaid's payment.

The monthly pay cases are kept in separate file drawers. The monthly payment will be in the form of a money order or a personal check. Monthly payments are processed by the Bookkeeping Branch and the cases are returned to the files. A balance statement along with a self-addressed envelope with Third Party written in the lower left hand corner to return the next month's payment is sent to the beneficiary. Since other Divisions within Medicaid receive Beneficiary's refund payments, this notation on the envelope will assist in routing these payments to TPL.

Health Cases

Health cases address refunds due Medicaid when claims were not filed through the Pay & Chase System. MMIS Claims History is used to determine if Medicaid paid for these services.

This determination is made based on claim type, provider's name/number, claim's modifier, diagnosis, date of service, billed provider and billed amount. References are available to decode the claims and determine if Medicaid paid for the services for the received refund payment.

Claims Inquiry has "go-to" keys to assist in determining how to read a claim. Identifying through research if Medicaid is due a refund payment is determined by how well the Investigator understands Claims Inquiry. Any questions should be addressed to the supervisor.

A few helpful hints are suggested below:

Provider Numbers: 1. Physician's provider numbers usually begin with the number (1).
2. Hospital's provider numbers usually begin with the number (2).
3. Pharmacist's provider numbers usually begin with the number (3).

Claim Type: (This list is not complete)
Claims History is in order by claim type
Claim Type I – Inpatient hospital services
Claim Type O – Outpatient hospital services
Claim Type R – Drugs
Claim Type N – Nursing homes
Claim Type A – Medicare Crossover institutional
Claim Type B – Medicare Crossover professional

Claim Modifier: 0 – Original claim
3 – Debit Adjustment-Repaid claim
2 – Credit Adjustment-Medicaid's payment (recouped)
1 – Void

ESTATE RECOVERY BRANCH

The Mississippi Legislature, due to a mandate in OBRA 1993, Section 13612, enacted Estate Recovery provisions which the governor signed into law effective July 1, 1994. These legislative provisions enable the state to recover Medicaid expenditures from the estate of individuals who, at the age of 55 or older, die while a resident of a Nursing Facility or receive home and community based services. The Bureau of Third Party Recovery implemented and currently administers the Estate Recovery Program. Notices of specified beneficiary deaths are received from the Medicaid Regional Offices.

PURPOSES

This Branch recovers Medicaid payments from estates.

RESPONSIBILITIES

This Branch determines the estate value and Medicaid payments for long term care related services and home and community based services. The survivors are contacted by mail with the amount due Medicaid.

REPORTING REQUIREMENTS

The Branch compiles a weekly productivity report of incoming correspondence, cases transferred to Legal, liens computed, initial liens pending, cases closed, and follow ups completed.

ESTATE RECOVERY PROGRAM

Background

The Estate Recovery staff collects Medicaid payments from estates of deceased beneficiaries for various services. This process requires assistance from the Agency's legal staff.

On August 10, 1993, the President signed into law the Omnibus Budget Reconciliation Act (OBRA) OF 1993, Public Law 103-66. Section 13612 of OBRA 1993 addressed "Medicaid Estate Recovery" and amended Title XIX of the social Security Act, Section 1917 (b).

Prior to the amendments enacted by OBRA 1993, the language of the law "permitted" the states to recover Medicaid benefits paid on behalf of a beneficiary who was age 65 or older when he/she received the services. The recoveries may only be made from the individual's estate (after death) or from the sale of property subject to a lien (during the individual's lifetime).

OBRA 1993 changed the language to "require" the States to seek recovery of payments for nursing facility services, home and community based services, and related hospital and prescription drugs. The law specified that the person must be 55 years or older when assistance was received. The recoveries may come either from the estate (after death) or from the sale of property subject to a lien (during the person's lifetime). Since Mississippi has no lien law and does not act under the TEFRA lien law, recoveries are made from the estate.

CMS's instructions to the States for meeting the requirements of OBRA 1993, Section 13612, are contained in the State Medicaid Manual, Chapter 3, Section 3810. The language is "You must seek adjustment or recovery from the estate of an individual who was age 55 or older when that person received medical assistance." The required services to be recovered are identified as nursing facility; home and community based, and related hospital and prescription drug services.

CMS outlined the recovery limitations. Recoveries can be made only when there is no surviving spouse, no children under 21, no disabled dependent children. It speaks to no recovery if a sibling is residing in the home, has resided there for at least a year prior to the date of the beneficiary's admission to the institution, and has resided there on a continuous basis. Also, no recovery if a son or daughter resides in the home, has resided there for at least one year immediately before the date of the beneficiary's admission to the institution, has resided there on a continuous basis, and can show that he or she has been providing care that permitted the individual to reside at home rather than in an institution.

CMS gave Undue Hardship examples for the States to use in developing their own definitions. Suggestions are 1) the estate is the sole income-producing asset of the survivors, 2) a homestead of modest value, or 3) other compelling circumstances. States may conclude that undue hardship does not exist if the individual created the hardship by resorting to estate planning methods under which assets were divested in order to avoid estate recovery.

It is required that the States give the survivors advance notice of the right to apply for a hardship waiver, of the hearing and appeals rights, and the time frames involved. The States must also be able to offer the survivor a payment plan in case they do not want to sell the estate property to satisfy the Medicaid recovery claim. CMS defined the effective dates of the OBRA 1993 Estate Recovery provision. The provision does not apply to individuals who died before October 1, 1993, but it does apply to Medicaid payments beginning on or after October 1, 1993. CMS allowed a delayed compliance date for State legislation to meet the requirements.

Due to the mandate in OBRA 1993, Section 13612, the Mississippi Legislature enacted Estate Recovery provisions which the Governor signed into law effective July 1, 1994. Mississippi Code of 1972, Annotated as Amended, Section 43-13-317. The State Code follows the OPBR 1993 writing by allowing for recovery of nursing facility services, home and community based services, and related hospital and prescription drug services from the estate of a deceased Medicaid beneficiary who was 55 years or older at the time of receiving the services. Section 43-13-317 refers to Section 91-7-145 to require that Medicaid be noticed as a creditor against the estate of the specified deceased Medicaid beneficiary. The hardship waiver is also spoken to in Section 43-13-317 of the Mississippi Code.

The State Plan was amended to include Estate Recovery provisions as required and instructed by CMS. The Plan was approved by CMS on 11/21/95 to be effective 07/01/95. Just to mention a couple of things that are particular to Mississippi, due to personal knowledge of the cost of burial, an estate is allowed \$6,000 for this expense. Also, it is not deemed cost effective to recover if the amount to be recovered is less than \$2,000 or the value of the estate is less than 25% of the recovery amount and the attempted recovery will require protracted litigation.

The Bureau of Recovery within the Division of Medicaid has the responsibility of the Estate Recovery Program. The attached Standard Operating Procedures and Administrative Hearing Procedures detail the in-house procedures. It is noted that no notice is sent to a survivor until at least 30 days after the date of death of the Medicaid beneficiary. Undue hardship factors and other recovery limitations are explored when a case is first read, prior to any notice to a survivor. The survivor is noticed concerning his/her rights to a fair hearing. The Hearing Officer is an impartial Medicaid employee who has no duties related to the Estate Recovery program other than those of conducting the requested hearings. The Executive Director makes the final decision when there is a hearing. The survivor has the right to seek judicial review in the court of proper jurisdiction.

Any legal actions or negotiations of settlement are handled by one of the attorneys assigned to the Division of Medicaid by the State Attorney General's Office.

**ESTATE RECOVERY PROGRAM
STANDARD OPERATING PROCEDURES**

The Estate Recovery Program began in July 1994. The federal government made the recovery retroactive from 10/01/93. The eligibility files and referral forms 411 (green folder, assets above \$5,000), come from the Medicaid Regional Offices daily. The Estate Recovery process begins as follows:

- 1) From Envision (MMIS), copy, and print the base recipient History Screen Detail, Long Term Care section, and the Buy-in section.
- 2) View the case for assets such as: patient account, vehicles less than 10 years old, bank accounts, and tax receipts. Write the type of asset and its value on the bottom half of the detail page. (Life insurance and burial is not an asset, but is recorded as a guide when allowing for burial expense.) Add the value of the bank account, auto, home and any other asset for the total estate value.
- 3) Enter data into the MMIS Estate Recovery Database (TPL Recovery Case):
- 4) Check MMIS TPL file for private health insurance with prescription coverage, record on MMIS Recovery Case Detail Tab Sheet.
- 5) Calculate payments for home and community based services and Medicare Part B premium when it applies to Estate Recovery. (Information on the Buy-In tab is used to calculate Medicare Part B) See example below:

Date of Death **04/18/2002** **Premium: \$54.00 @ 10 Mos.**

Begin Date Of Service	End Date of Service	Billing Provider	Billed Amount	Paid Amount
07/01/2001	04/18/2002	Medicare Part B	\$540.00	\$540.00

			SUM:	\$540.00
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- 6) Send Initial Estate Recovery letter to the responsible relative found in the file showing the value of the estate and the amount owed Medicaid, after 30 days of beneficiary's death. If there is no response from the initial letter after 30 days, the Investigator

researches property and court records prior to forwarding a second letter, to determine if probate has been filed, changes in the deed and location of property etc.

- 7) If there is contact, establish as much information as possible, i.e., exceptions to Estate Recovery, undue hardship, estate value less than \$5,000 (if so, close case), property reappraisals, out of pocket burial expenses, taxes on the property, insurance payments, anything that can legitimately adjust the estate value.
- 8) Adjust the value of the estate in MMIS and document the activity sheet. Forward the case to Legal within two (2) days.
- 9) If requested information or payment in full is promised but is not delivered within 30 days, contact the RR/attorney. Following the second request, if information or payment in full is not received within 15 days, the responsible relative is contacted by phone. If not able to reach by phone, a letter is sent requesting that the relative contact the Investigator. If no response is received after 10 days, the file is referred to Legal.
- 10) If waiver or hearing request is unclear, call and ascertain which is requested. Do not attempt to dissuade the Responsible Relative or attorney from the right to a hearing. If the Responsible Relative or attorney decides to forego a hearing and prefers to negotiate, document the file and send the file to Legal.
- 11) If it is obvious that a hardship exists, close the case.
- 12) If the heir requests a fair hearing, forward to the Hearing Officer within three (3) days, if the issues for hearing cannot be immediately cleared up by the investigator/legal. If an heir wishes to withdraw a request for fair hearing after these issues are cleared up, the case record should have the request to withdraw in writing from the heir. Within two (2) days, forward the case to Legal for negotiation.
- 13) After an administrative decision is rendered, forward the case to Legal within two (2) days.
- 14) Refer all requests to negotiate to the attorney within 2 days of receipt.
- 15) return all files involving property transfers prior to the beneficiary's death, to the Regional Eligibility Office.

Note: **Threshold for closing Estate Recovery case is \$5000 or less.**

PROVIDER AUDIT UNIT

STANDARD OPERATING PROCEDURES

Sample Selection

The sample selection for provider audits performed will include the top 25 hospitals and the remainder hospitals, plus 200 other providers. The other providers are defined as Physicians, Home Health, Nurse Services, Kidney Dialysis, Rural Health Clinics, Personal Care Givers, Therapists, Mental Health Facilities and Nursing Facilities.

Reports

The fiscal agent produces the following reports annually:

1. All providers' records selected for the current data sample
2. Hospitals by Medicaid Payments selected for the current data sample
3. Hospitals by TPL amounts selected for the current data sample
4. Randomly selected records for the current data sample
5. Physicians & dentist only selected for the current data sample

The reports are available in Reports Online. The records are downloaded into TPL Provider Audit Case Tracking System by the fiscal agent.

Scope of Audit

Supervisor groups' providers based on demographics and decide whether the audits are on-site visits or desk audits and assigns to each auditor in TPL Case Tracking System. The Provider Auditor examines the records with dates of service within the fiscal year being audited. The sample claims will be for dates of service within the specific fiscal year. The credit balance report is requested for all Medicaid patient's having a credit balance. Any questions asked by the provider outside the scope of the TPL claims review audit are forwarded to the provider representative assigned to that particular area of the state.

Travel

Hospital audits will be conducted on-site; physicians and other audits may be field or desk audits. Audits will be assigned with cost effective travel in mind. The desk audits will be performed on specified physicians or other providers in order to save travel expense.

Time Frame for Completion

The supervisor will assign audits with a particular time frame for completion in mind. For example, the auditor may conduct field audits for one or two weeks of the month and take the remaining two weeks to complete paper work. All audits completed and supervisory review should be done by the end of the month following the fiscal year end. Auditor will forward all original adjustment/void forms collected during audit to fiscal agent within three days. The objective is to ensure that accurate monetary findings are adjusted in the system.

Phase I - Preaudit

The auditor will prepare the sample claims list of fifteen patients that the provider submitted for payment of services rendered using the COGNOS reports (Top 10 with TPL and Top 10 without TPL, ten regular claims and five crossover claims). These claims will serve as samples for the auditor to determine the provider's documentation procedures, billing procedures, and account posting procedures. The sample claims will include Medicaid only claims, Medicaid/Medicare claims, and claims with other third party liabilities. The sample claims list is attached to the provider's record in the case tracking system.

No later than two weeks prior to the auditor's planned visit to the provider's facility the auditor will make telephonic contact with the provider. The purpose of this initial contact is to exchange the following information:

1. **Schedule Audit.** The auditor and the provider will select a date and time to conduct the audit that is mutually agreeable.
2. **Obtain Provider Location.** The auditor will need to find out exactly which location the provider would like the audit to take place. The auditor will also determine if the facilities are suitable for conducting the TPL audit i.e. availabilities of telephone, computer data port, desk space, etc... The auditor accesses Map Quest or Rand McNally online to determine the most advantageous route to provider's location.
3. **Initial Contact Sheet.** The auditor will complete Initial Contact Sheet which serves as supporting documentation for the supervisor's review and also as a source document for obtaining information about the provider. This would include such information as the providers representative that will work with the auditor, the providers fax number and mailing address or any other information the auditor deems pertain to conduct the audit. This sheet is completed during the initial telephone contact and serves as the source document for entering information into the TPL Provider Audit Case Tracking System.

4. Prepare Confirmation Letter. The auditor accesses the case tracking system and enters essential information. Confirmation letter is produced by system and forwarded to provider which confirms the purpose, date, time, and location of the TPL audit.
5. Mail and/or Fax to Provider. Auditor will either mail and/or fax the provider the original confirmation letter and the list of sample claims.
6. Confirmation Call (not less than 1 week prior). Auditor will make telephonic contact with the provider at least one week prior to scheduled audit to ensure all arrangements are still valid and answer any questions from the provider concerning the audit. The date of the call is entered in the case tracking system and on the initial contact sheet.
7. Prepare for approval travel itinerary. Once all arrangements have been made with the provider the auditor will prepare and submit a travel itinerary for supervisor's approval.

Phase II – Conducting Audit

Analysis of the sample claims provides the auditor with the insight needed to assess the providers' claim preparation, verification of services and ensure that claims are billed correctly. Examining the patients' accounts receivable allows the auditor to look at posting procedures for charges and payments, as well as identify third party sources credited to the account. The audit is conducted as follows:

1. Provider Interview. Auditor meets with designated representative for provider to review three-part questionnaire involving the admitting, billing and cash receipts procedures.
2. Reviewing documents. Auditor reviews sample claims for requested information such as Medicaid and Medicare remittance advices, patients' accounts receivable, doctor progress notes, assignment of benefits statement and explanation of benefits, where applicable. The auditor also examines providers' credit balance report for overpayments due back to the Medicaid program.
3. Exit interview. After reviewing the documents, the auditor meets with the representative to address issues that impacted the audit, suggest recommendations for improvement and discuss Medicaid recoupments. Provider is asked to prepare adjustment/void forms and submit to fiscal agent for overpayments. A copy of forms should be forwarded to auditor within seven days of the audit. As a courtesy, the auditor will forward original forms to fiscal agent if forms were prepared prior to audit. The auditor completes exit interview sheet with the recommendations.

Phase III – Post Audit

1. **Clean-up.** Clean-up audit is usually done at the office. The auditor makes sure all required documentation is received from provider. The Auditor enters information obtained from provider during interview using audit summary program spreadsheet. The document is attached to the provider's record in the case tracking system. The auditor will issue their findings in a formal letter to management which will include recommendations and recoupments, if any, and any follow-up actions needed. Auditor enters all information into database to generate management letter. File is forwarded to supervisor for review. Supervisor reviews file and returns to auditor with review sheet and notes any changes that need to be made. Supervisor also updates master tracking spreadsheet in Excel. The spreadsheet tracks audits completed, audits pending and overpayments identified.

Note: Auditor will produce management letter on-site if there are no recommendations or recoupments.
2. **Travel reimbursement.** Auditor submits voucher for reimbursement, activity report, travel itinerary and printout of directions to supervisor for approval. Supervisor initials travel forms and forwards to Bureau Director.
3. **Follow-up.** Auditor checks EnVision claims subsystem thirty days (30) after the audit to verify whether or not Medicaid was reimbursed for overpayments noted during the audit. The provider is contacted if additional information is needed. Auditor updates appropriate fields in case tracking and prepares a follow-up sheet and to submit Supervisor to record reimbursements in master tracking spreadsheet in Excel.

Setting Up Provider Audit Cases

1. Supervisor groups audits and assign to auditors. Auditor establishes case by inserting the following information:
 - a. provider demographics - log into EnVision and click provider tab, then maintenance, type in provider id, print provider information on name address tab, then click the Goto button, then claims financial, print the information on the payment summary tab
 - b. sample claim list – prepare the list of recipients by running the Top 10 with TPL and Top 10 without TPL COGNOS reports and saving document on the m: drive in TPL folder titled Sample claims.
 - c. initial contact sheet – call provider to set up appointment, record all information in relation to audit (i.e. contact person name and number, date and time of audit, & etc.)
 - d. questionnaire - questionnaire contains questions that address the admitting, billing and cash receipts procedures and can either be requested during the audit or faxed to provider prior to audit (**See Attachment 4**)
2. Log into the case tracking system thru EnVision, click the on the cases in (**See Attachment 1**), then right click on Case Name field to sort by providers, select the appropriate provider, then click (+) sign (**See Attachment 2**), then add the following fields & enter information in value field
 - a. Appointment date
 - b. Appointment time
 - c. Auditor phone number (with dashes)
 - d. Contact 1 name, title, phone number, & fax number (no dashes)
 - e. Initial contact date
 - f. Confirmation date/call
3. Click **Steps** tab
 - a. Close steps as task are completed
 - b. One step must always remain active until case is completed
4. Click **Response** tab
 - a. Click (+) sign located directly above ID
 - b. Click ok on address screen
 - c. Click <not specified> drop down in Template field
 - d. Select your letter, click created document icon (located directly under General tab at top of screen)
 - e. Edit letter, if necessary, make sure provider's complete name & address are on the letter (see attachment 3)
 - f. Add reporting period to letter (ex: 7/01/06 – 6/30/07)
 - g. Close letter, in Notes box enter type of document

5. Attach all documents (i.e. sample claims list, audit summary & etc.) created thru the **Attachment** tab (**See Attachment 3**)
 - a. Click (+) sign under Attachment tab
 - b. Find document to be attached, click open, file will attach to case

Cleaning Up Cases

1. Log into the case tracking system thru EnVision, click the on the cases in (**see Attachment 1**), then right click on Case Name field to sort by providers, select the appropriate provider, then click (+) sign (see Attachment 2), then add the following fields & enter information in value field
 - a. Date AVR/check forwarded to FA, if needed, (Adjustment/void memo is located in letters under **Response** tab (see directions above)
 - b. Recommendations (click star * to the right of field & enter recommend(s) alphabet)
 - c. Date of management letter
 - d. Enter dollar amounts in Medicaid, Medicare or TPL overpayments identified field
2. Click **Response** tab
 - a. Click (+) sign located directly above ID.
 - b. Click ok on address screen.
 - c. Click <not specified> drop down in Template field.
 - d. Select your letter, click created document icon (located directly under General tab at top of screen).
 - e. Edit letter, if necessary, make sure provider's complete name & address are on the letter.
 - f. Close letter, in Notes box enter type of document (i.e. management letter).
3. Attach audit summary spreadsheet to **Attachment** tab.
 - a. Click (+) sign under Attachment tab.
 - b. Find audit summary spreadsheet for provider on m: drive, click open, file will attach to case.

Follow Up

Click the (+) then choose the following fields & enter information in value field.

- a. Enter amount of Overpayments Reimbursed .
- b. Enter follow up information on **Notes** tab such as date provider was contacted & conversation that was held.
- c. Set tickler on **Dates/tickler** tab.
- d. Check the recipient file in EnVision to verify if there is a TPL Resource Record for all recipients on the sample claims list. If no resource record is on file, print beneficiary

detail screen and refer TPL information (i.e EOB's or any other TPL related information) to the File Maintenance Unit Supervisor.

Description of Tabs in Case Tracking

Routing tab – contains history of case

Attachments tab – attach files to case (ex: sample claims list, audit summary & etc.). Clicking the (e) sign allows you to find documents in the Central Repository such as adjustment/void request, correspondence with provider & etc. and attach to case

CRS tab – correspondence tab (we will probably not use)

Notes tab – document any notes such as conversations with providers during the follow up process

Dates tab – set up ticklers for follow up. Can have ticklers emailed to you.

Steps tab – indicates steps needed to complete case. Auditors close steps as they are completed.

Entity tab – contains provider affiliations & addresses

Response tab – contains written responses to providers such as initial contact letters, management letters & adjustment/void memos

GOTO Button – located at top of screen. Use to go to MMIS (provider, TPL, claims, recipient, & financial. (Note: MMIS must already be opened.)

Attachment 1

Cases In Screen (Sort providers by right clicking on Case Name field)

Select Refresh Control Files from the menu if you haven't updated your files since then.

Shortcuts

- CR's
- Watchlist
- Queries
- Cases In
- Cases Out
- Reports
- Ticklers

You have 1 ticklers that need to be addressed

Due Today: 1
Due Tomorrow: 0
Due In 2 Days: 0
Due In 3 + Days: 0

Case ID	Opened Date	Case Type	Case Name	Priority	Status	User/Work Unit
57	07/28/2007	Non-Hospital Audit	00011257-STONE HENRY	4	Open	vWorkUnit - DOM-TPL Pro
58	07/28/2007	Non-Hospital Audit	00014186-STEWARD EDWARD	4	Open	vWorkUnit - DOM-TPL Pro
59	07/28/2007	Non-Hospital Audit	00014378-HAIRE WILLIAM	4	Open	vWorkUnit - DOM-TPL Pro
60	07/28/2007	Non-Hospital Audit	00015687-PUROHIT RAMESH	4	Open	vWorkUnit - DOM-TPL Pro
61	07/28/2007	Non-Hospital Audit	00015803-PUROHIT PURNIMA	4	Open	vWorkUnit - DOM-TPL Pro
62	07/28/2007	Hospital Audit	00020229-TRI-LAKES MEDICAL CEN	4	Open	vWorkUnit - DOM-TPL Pro
64	07/28/2007	Non-Hospital Audit	00060140-LANDRY RALPH	4	Open	vWorkUnit - DOM-TPL Pro
65	07/28/2007	Non-Hospital Audit	00111534-WHITE PATRICIA	4	Open	vWorkUnit - DOM-TPL Pro

Case Number: 57 Case Name: 00011257-STONE HENRY Assigned To: DOM-TPL Provide

Type: Non-Hospital Auc Status: Open

Opened Date: 7/28/2007

Notes:
Created via TPL Load

Attachment 2

Click + sign on right side of screen directly above FY End Date

Auditor enters contact information, date contacted, appointment date, appointment time, and auditor's phone number in appropriate fields.

The screenshot shows the OmniTrack software interface. The main window is titled "Maintain Case: [00000319-COMPASSION WORKS]". It contains several input fields and a table of financial data.

Case Information Fields:

- ID: 395
- Priority: Low
- Bureau: TPL
- Title: 00000319-COMPASSION WORKS
- Status: Open
- Unit: PROVIDER AUDIT
- Type: Non-Hospital Audit
- Sub-Unit: ALL
- Step: Route Case from Load
- Description: TPL PROVIDER AUDIT
- Created via TPL Load

Financial Data Table:

Field	Value
FY End Date	2007/06/30
Total Medicaid Dollars Paid	19349.69
Total TPL Dollars Paid	0.00
Provider Type	w01
Servicing Provider	00000319
County Name	wWALTHALL
County Number	74
Effective Begin Date	2004/02/01
Effective End Date	9999/12/31

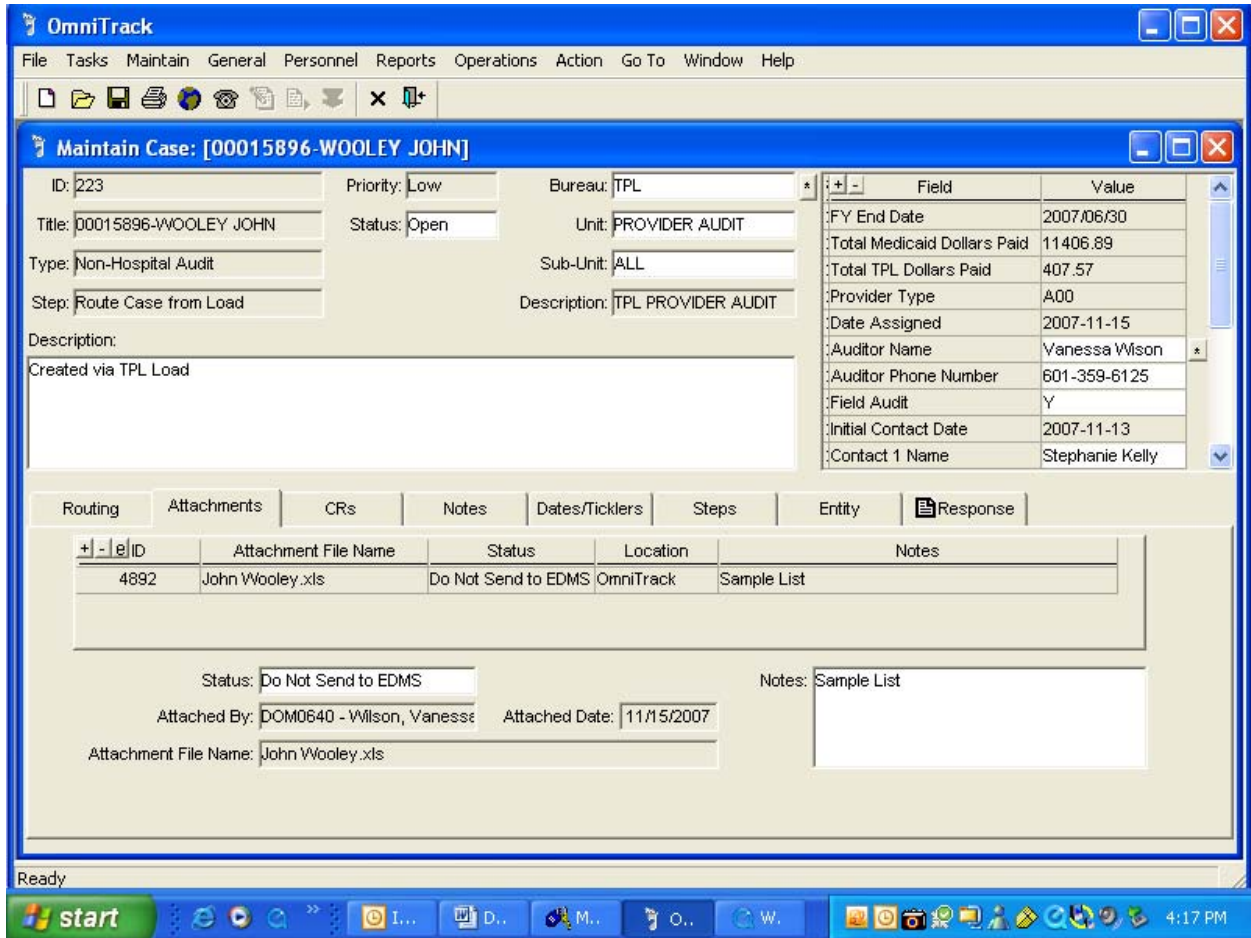
Steps Table:

Step Description	Order	Route To	Step Status	Template
Route Case from Load	1	WorkUnit = DOM-TPL Provide	Active	
Validate Sample/Report	2		Open	
Assign Case	3		Open	
Print Provider Financials & Demographics for File	4		Open	
Contact Provider/Schedule Appointment	5		Open	
Prepare Sample Claims List	6		Open	
Appointment Confirmation/Sample Claims List	7		Open	
Request Documentaton for Desk Audit	8		Open	

The interface also shows a taskbar at the bottom with the Windows Start button, several application icons, and the system clock showing 3:33 PM on 3/31/07.

Attachment 3

Attach all documents (i.e. sample claims list, audit summary, initial contact letter and management letter) associated with case on Attachment tab



**Attachment 4
Provider Audit Questionnaire**

Provider Name: _____

Provider Number: _____

Representative(s): _____

Date: _____

Insurance Information

3. A.) How is the Medicaid beneficiary's eligibility verified?

B.) How is eligibility verified if the beneficiary does not have their card available upon admission? _____

4. If a third party liability is indicated, is the beneficiary asked about the coverage?

1. If the beneficiary is not aware of this coverage, what procedures are followed?

4. Are beneficiaries asked about other potential insurance? _____

5. Are you a member of Preferred Provider Organization? _____

A.) Do you report your TPL discount as part of your TPL payment? _____

Notes: _____

BILLING PROCEDURES

1. A.) Are all other known insurances billed prior to Medicaid? _____
B.) Are beneficiaries asked to sign an assignment of benefits upon admission?

C.) If beneficiary refuses to assign benefits, what procedure would you follow?

2. When you submit a claim to an insurance company and they have not responded to your claim within 30-40 days, what procedures do you follow? _____

3. A.) When you submit a claim to an insurance company and they either pay more than what Medicaid would allow or they pay the claim in full, do you still file with Medicaid? _____
B.) If yes, how do you file with Medicaid? _____

4. What do you do if you have a Medicaid beneficiary who requests a copy of their bill?

5. How do you ensure that itemized billing statements are not sent to Medicaid beneficiaries that are also covered by a commercial insurance?

Notes: _____

CASH RECEIPTS PROCEDURES

5. When you receive your Medicaid payments, do you post at the total billed amount or is the actual payment posted and the difference written off to an adjustment?

6. When you receive your Medicaid Remittance Advices, are the payments posted as of the register date or the actual date you post on the system?

7. How much of a lag is there between the register date and posting date? _____

8. If an account with Medicaid coverage has been paid out to a zero balance and an additional payment is received from either a Third Party Ins. company or Medicaid, what procedures are followed to ensure this payment is posted to this same account?

9. How long do you maintain your Medicaid payment records? _____

Notes:

THE FISCAL ACCOUNTING DIVISION

PURPOSE

This Division exists to protect the integrity of third party collections and provide historical financial data.

RESPONSIBILITY

This Division is responsible for verifying Medicaid's right to third party payments, allocating these payments to paid Medicaid claims and tracking the financial recoveries. In addition, this Division pursues reimbursements for trauma related services, tort situations, and paternity related medical support.

REPORTING REQUIREMENTS

The Fiscal Accounting Division prepares the monthly Executive Summary and Performance Measures Reports and the quarterly federal TPL Collections and Cost Avoidance Report.

BOOKKEEPING BRANCH

The TPL Bookkeeping Branch receives, researches, and disposes the third party payments resulting from subrogated claim filing, casualty-related efforts, and recoveries from estates. The fiscal agent processes third party refunds from providers. The TPL Bookkeeping Branch also maintains the MMIS TPL financial files. This Branch produces weekly status reports, monthly bureau executive summary, and the TPL section of the quarterly federal HCFA 64.9 report.

PURPOSE

The Bookkeeping Branch ensures integrity of third party collections by matching reimbursements with claims Medicaid paid. The Branch processes checks in a timely manner by collecting or refunding payments from third party insurance companies.

RESPONSIBILITIES:

The Branch is responsible for maintaining the MMIS Financial files as it relates to the Bureau of Recovery.

REPORTING REQUIREMENTS:

This Branch completes a weekly staff production report, a monthly executive summary and the monthly Bureau performance report.

BOOKKEEPING BRANCH

STANDARD OPERATING PROCEDURES

Log incoming checks

1. Compare log numbers on incoming checks to log numbers on log sheet to assure that the check was received. If there are any discrepancies, refer all checks and log sheets to supervisor.
2. Assign the check to a program (Pharmacy, Retro-Recovery, Trauma, Estate Recovery, Beneficiary Recoupment, or Paternity). Checks are researched in the *resource window*. (Medicaid Identification Number (MID) and Carrier Information are obtained in this window.)
3. If this information is not available in the *resource window*, you can also search in the *recipient detail window*.
4. Distribute checks to the appropriate auditor.

Enter checks into *Financial Receipt Window*

1. Enter TPL carrier number in the Search by field.
2. Enter the carrier number on the Search for field. (Example: 0001104410-Blue Cross Blue Shield of MS)
3. Enter the program's reason code in the Reason code field. (Pharmacy (704), Retro Recovery (713), Trauma (706), Estate Recovery (708), Paternity (701) and Beneficiary Recoupment (026))
4. Select the "new" button. Press enter. (As shown on screen print below-*financial window screenprint 1*).
5. Enter the sum of the check in the Original field.
6. Enter recipients' MID in the Beneficiary ID field.
7. Enter the check number in the check number field.
8. Enter the current date in the Log date field.
9. Enter the log number on the check in the log number field.
10. Enter employees' ID number in the TPL auditor ID field.
11. Enter the recipients' name in the receipt source field.
12. Press enter. (System will generate a Financial Control Number (FCN). (As shown on screen print below- *financial window screen print 2*) Record FCN # on the check.
13. Select the disposition tab, press *release to TPL Recovery*. (As shown on screen print below- *financial window screen print 3*)
14. *Save*

1. Process checks in the Billing Window

- a. Pharmacy (704) and Retro Recovery (713) checks are processed in the billing window.
- b. Enter recipients MID number; search.
- c. Auditors match the dates of service (DOS) found on the explanation of benefits (EOB) with DOS posted on claims in the billing window.
- d. Enter the amount paid on the check for each DOS and the FCN related to the check.
- e. The system automatically post a disposition code that relates to the reason code initially entered. (Example: 704 reason code = 754 disposition code)
- f. Once the money has been spent down there is a zero balance in the financial receipt window.
- g. Checks are filed by the date they were processed.

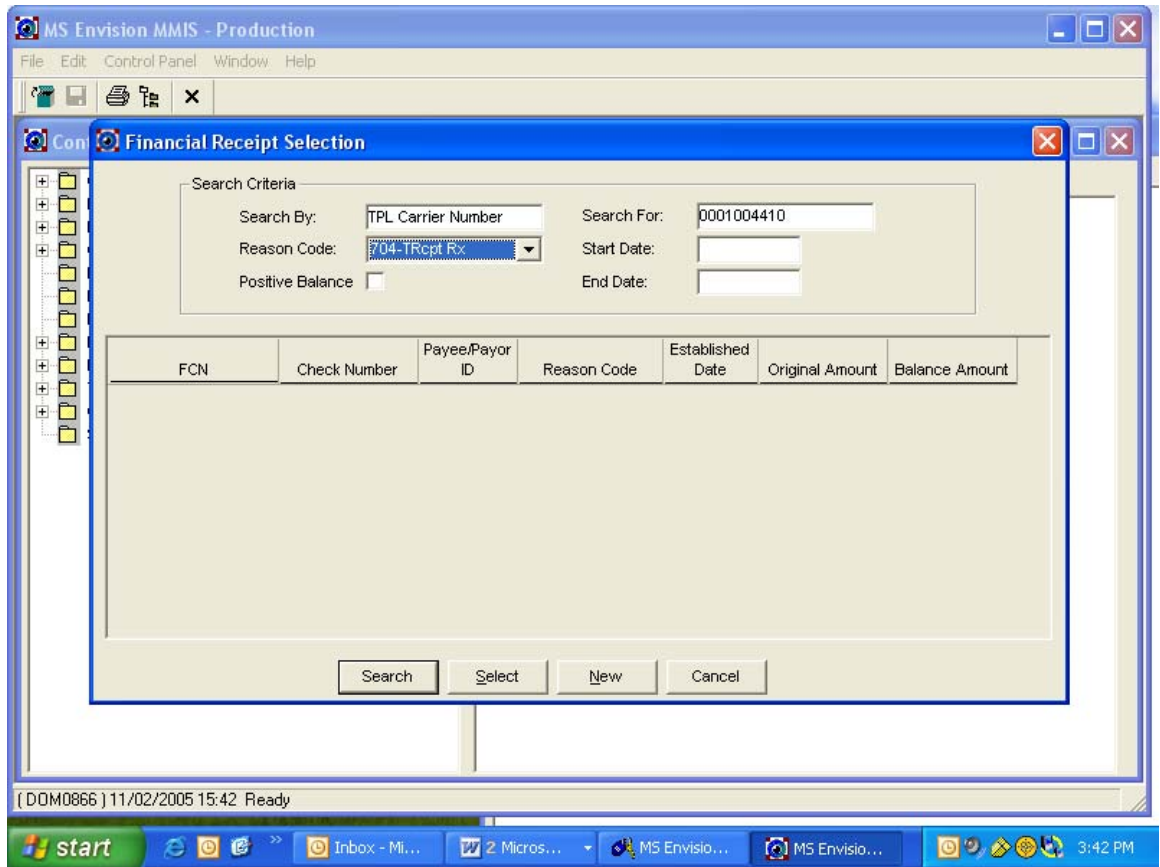
2. Process checks in the Recovery window

- a. Trauma (706), Estate Recovery (708), Beneficiary Recoupment(026) and Paternity (701) checks are processed in the recovery window.
- b. Cases have been previously established by the Trauma, Estate Recovery, and Beneficiary Branches. Bookkeeping dispositions checks received on these cases.
- c. Enter recipients MID; search
- d. Select recipient claims tab. (Click on all claims that are included in the lien)
- e. Select included claims tab. (Post the amount on the EOB for the DOS)
- f. The system automatically post a disposition code that relates to the reason code initially entered. (Example: 708 reason code = 758 disposition code)
- g. Once the money has been spent down there is a zero balance in the financial receipt window.
- h. Checks are filed in the Trauma or Estate Recovery file that was established by the Trauma and Estate Recover Branchs.
- i. Estate Recovery and Beneficiary Recoupment letters are mailed out to payees informing them of the status of their claim.

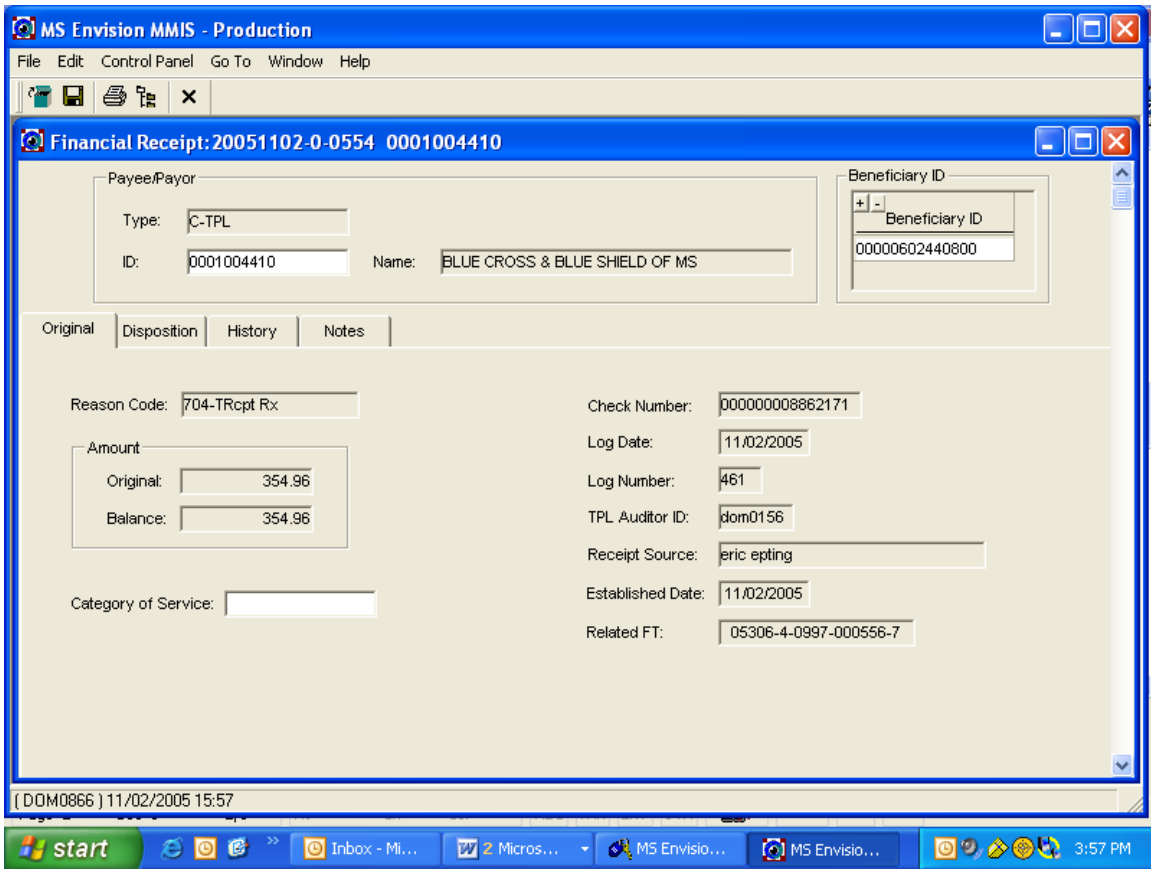
3. Process Refunds

- a. Pull file and verify refund. (Usually the request for refund is written on the check)
- b. Process the amount of the check that is due Medicaid.
- c. Release the remaining balance for a refund.
- d. A refund letter is sent to fiscal agent (ACS) requesting that a refund is prepared along with a letter to the receiver of the refund.
- e. Refunds are submitted to supervisor for review.

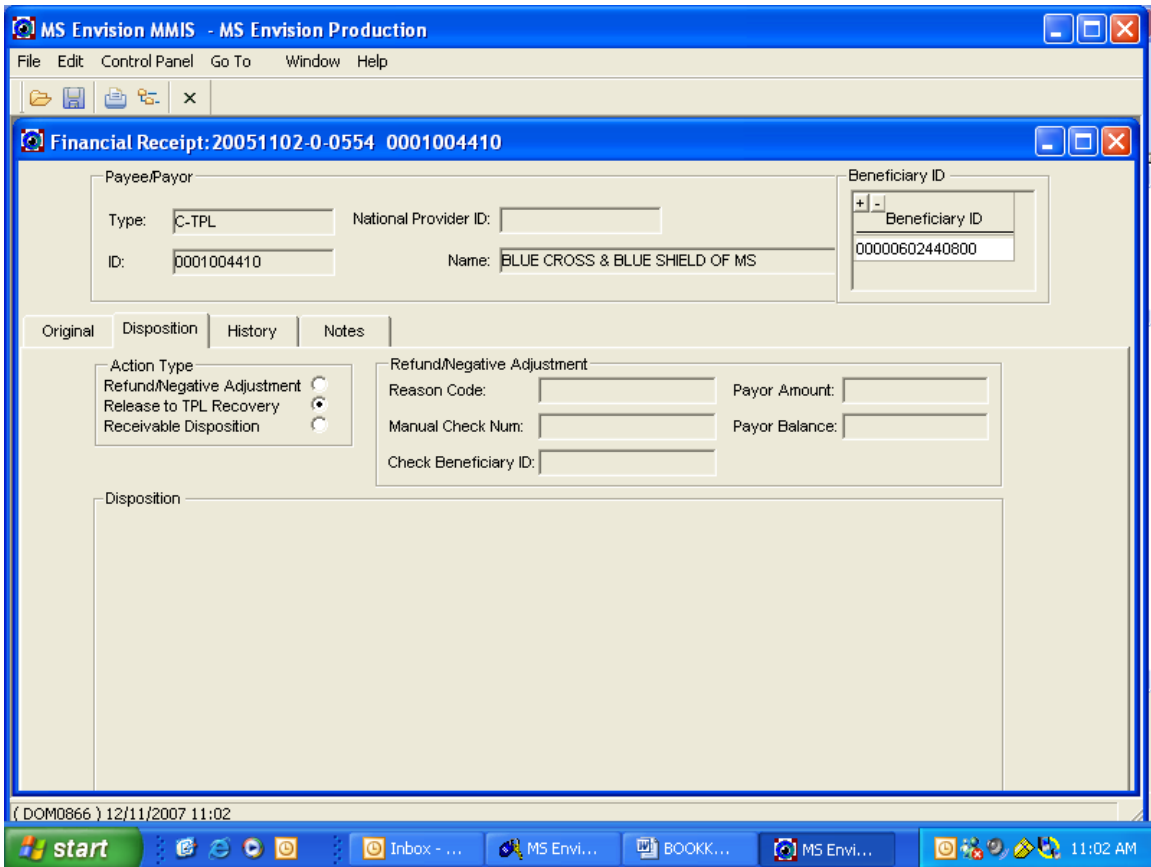
- f. If the refund is over \$500 it is forwarded to Deputy Director for approval. If the refund is less than \$500 it is approved by the Bureau Director.
- g. After receiving appropriate signatures, three copies are made of refund package. One copy is sent to Lillian Loggins, one is sent to Dave Mattalah, the third copy is filed in the case.
- h. The original is forwarded to fiscal agent (ACS).
- i. Fiscal Agent (ACS) sends copy of refund check to TPR. Check copy is filed in the file folder.



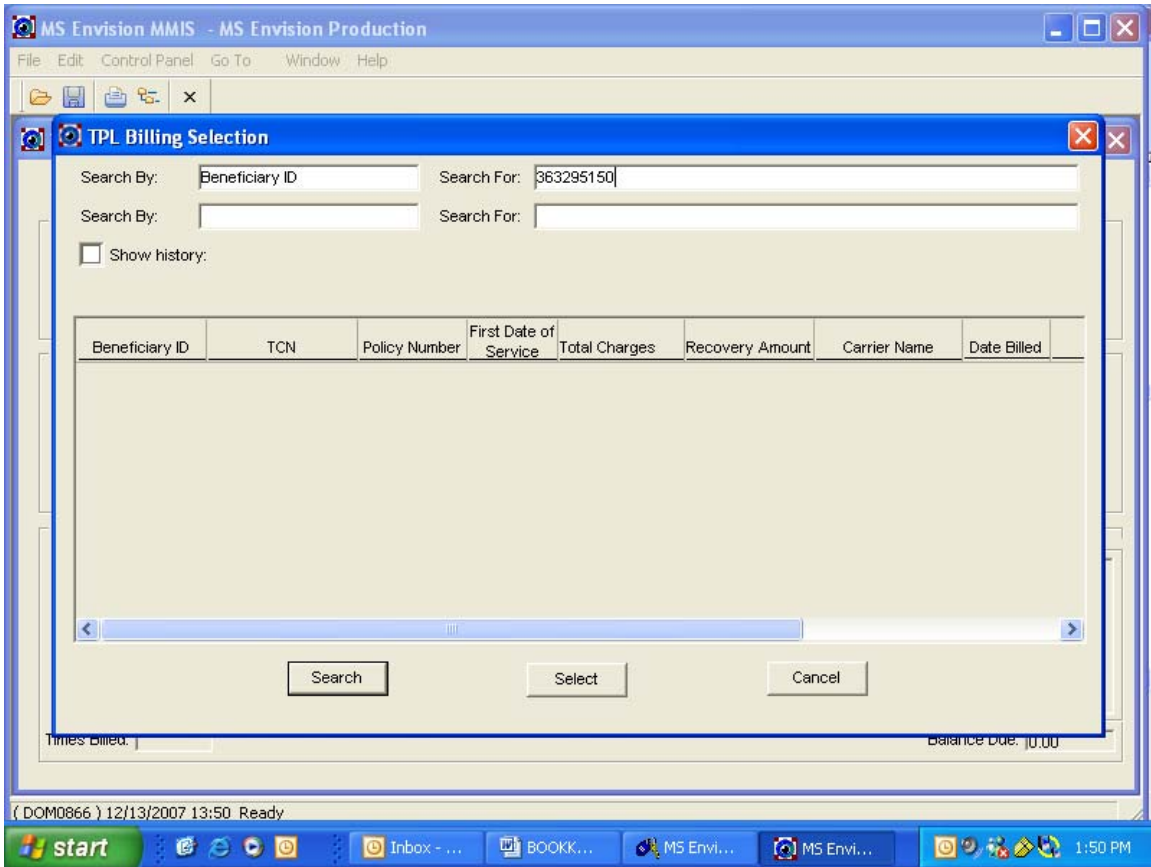
Financial receipt Screen 1.



Financial Receipt Screen 2



Financial Receipt screen 3



Billing Screen 1

MS Envision MMIS - Production

File Edit Control Panel Go To Window Help

TPL Billing: 0012009901 FISERV 11/11/2004

Beneficiary ID: 00000363295150 Beneficiary Name: TYCELYN R JACKSON

Policy Information
 Policy Number: 428470734 Policyholder Name: TYCELYN R JACKSON
 Policy Sequence: 1
 Carrier: 0012009901 Carrier Name: FISERV

Claim Information
 TCN: 432738500004427 Total Charges: 215.00 Billing Provider ID: 00220392
 Claim Type: O-Outpatient Allowed Amount: 0 Provider Type: 001-HospNPGen
 First Date of Service: 11/11/2004 TPL Recovered Amount: 0
 Last Date of Service: 11/11/2004 Payment Amount: 79.53

Billing and Response Information

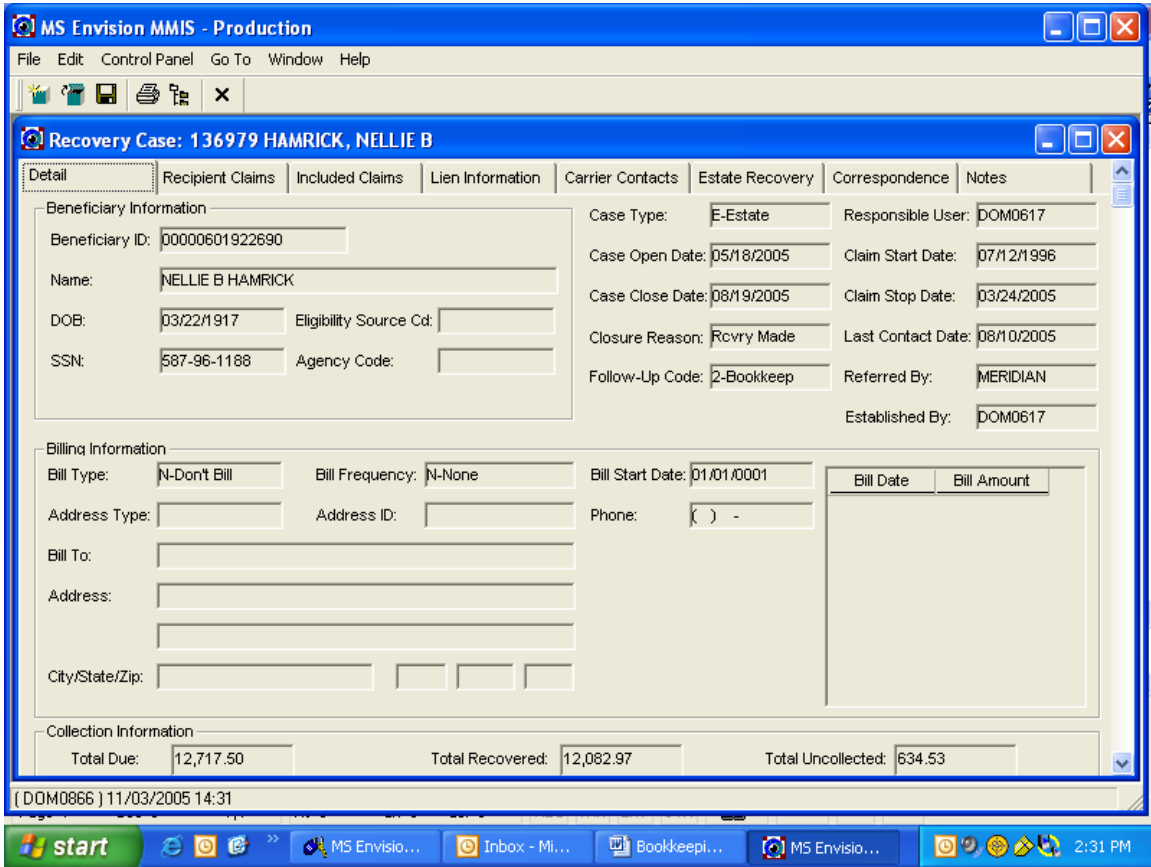
Bills		Response					
Date Billed	Amount Billed	+ -	Date	Amount	Reason	FCN	Overage Amt

Times Billed: 0 Reprint Bill: Closure Reason: C03-close-repl Follow-Up Code: Balance Due: 79.53

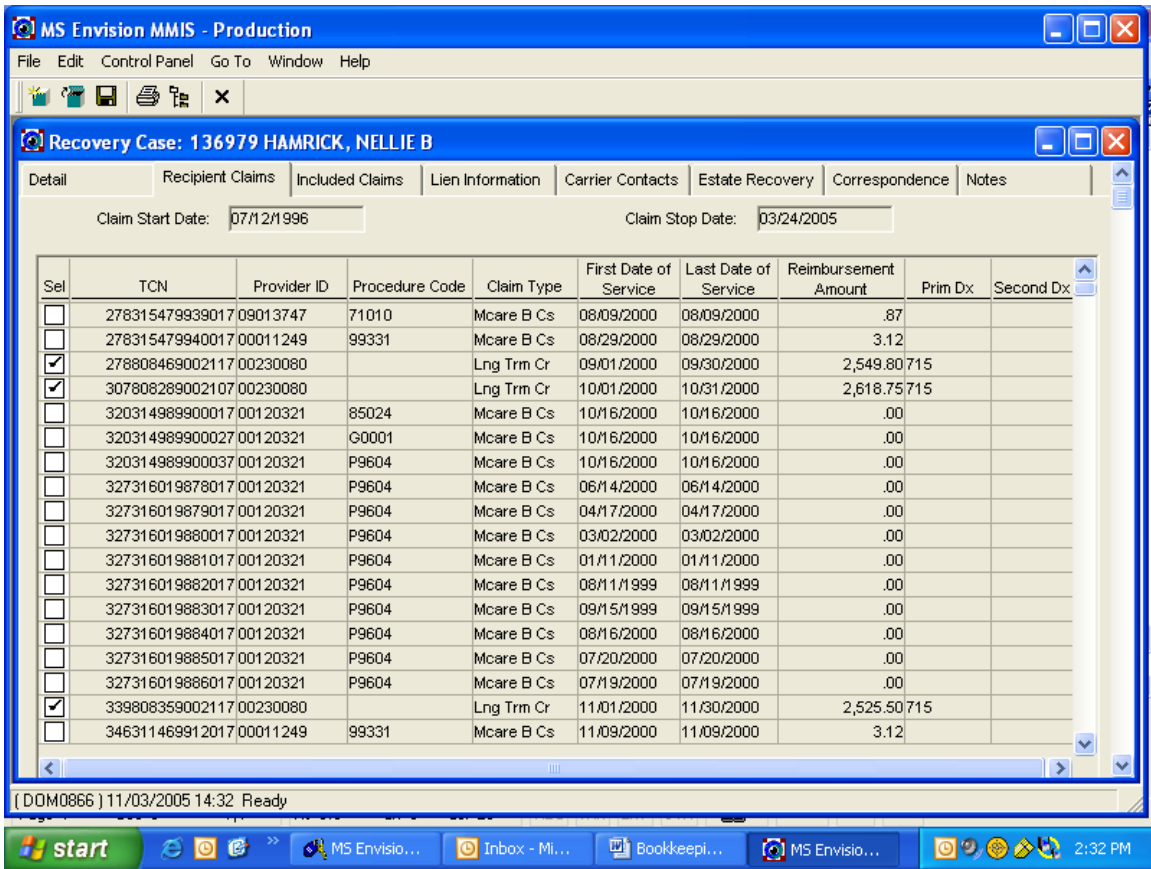
[DOM0866] 11/03/2005 14:23

start MS Envisio... Inbox - Mi... Bookkeepi... MS Envisio... 2:24 PM

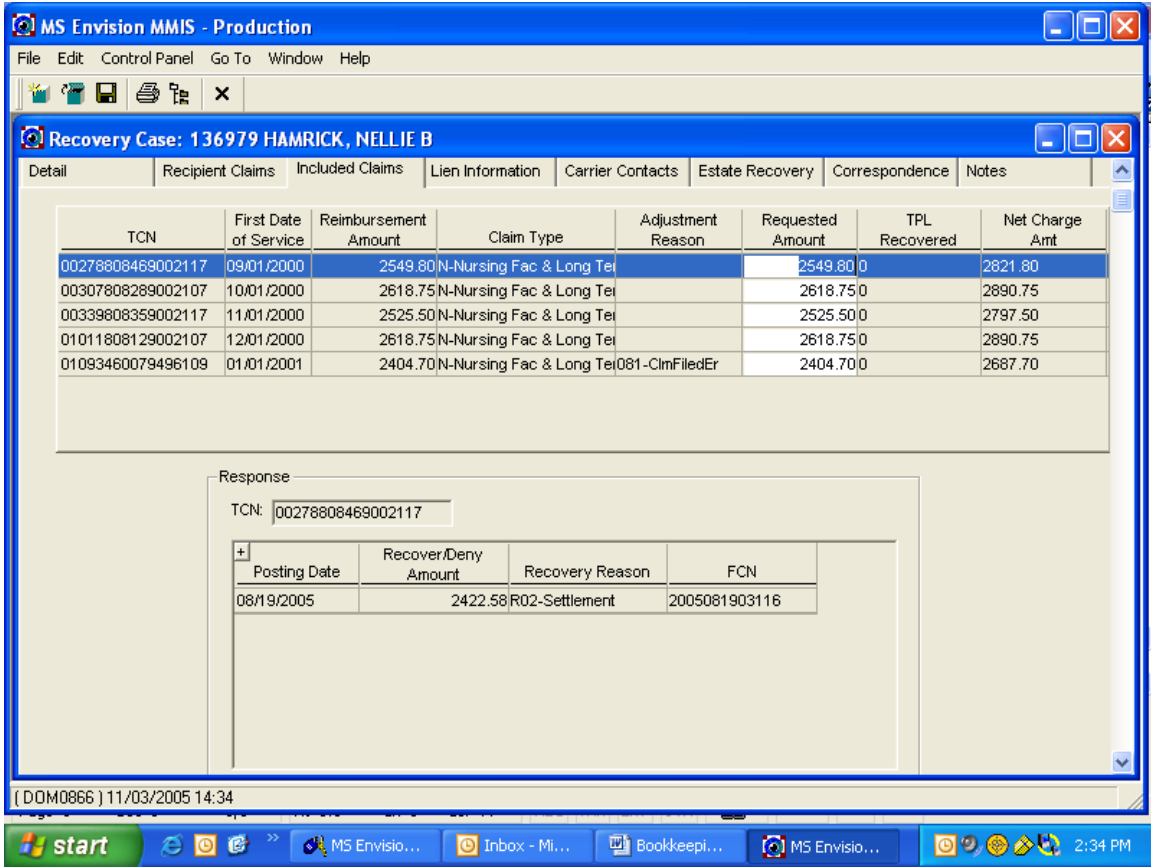
Billing Screen 2



Recovery window screen 1



Recovery window screen 2 (Recipient claims)



Recovery window screen 3 (Included claims)

SAMPLE LETTERS USED BY THE BOOKKEEPING BRANCH

TO: Tiffany Fairley
ACS

FROM: Shirlean Smith

DATE: November 29, 2004

RE: Third Party Refund

Medicaid Recipient:
Medicaid Number:
Date of Service(s):
Log Number:
FCN Number:
Check Number:
Transaction Amount:
Document Control Number:
Category of Service: 06

Please prepare a refund in the amount of \$(**amount of refund**) made payable to (**medicaid recipient or insurance carrier**) and forward with the attached correspondence. This refund is being requested because Medicaid has recovered all funds paid out for this procedure.

Thank you.

Date

Authorized Signature

Title

--	--	--	--

Refund package (page 1)

Third Party Overpayment
Medicaid Recipient:
Medicaid Number:

Dear (Recipients Name):

Please find enclosed Medicaid's check in the amount of \$ (amount of refund) made payable to you.

Medicaid has recovered its payment and is refunding the amount you are due from the insurance payment made for medical services rendered on (dates of service).

We appreciate your cooperation with Medicaid in this matter.

Sincerely,

Medicaid Auditor I
Third Party Liability Branch
Division of Medicaid

:\Deputy2\Prw\Data\Health\Hlth08.let

Enclosure

Refund package (page 2)

Recipient Payment Letter

STATE OF MISSISSIPPI
DIVISION OF MEDICAID
DR. ROBERT L. ROBINSON
EXECUTIVE DIRECTOR

Representative Name

C/O

Representative Address

Representative City, Representative State, Representative Zip Code

RE: Beneficiary Name

Medicaid #: 000-000-000

Recovery Case #: 12345

Dear Representative Name,

Your payment in the amount of \$Payment Amount was received in our office on Payment date (ex: January 2007). This leaves you the balance of \$Balance amount.

For your convenience, enclosed please find a self addressed postage paid envelope for your next payment. To ensure proper credit to the account, please put the name and case number in which the account is listed on the check or money order.

Thank you for your cooperation.

Sincerely,

Auditor Name

Bureau of Recovery

Division of Medicaid

Recipient Closure Letter

Date

Representative Name

Representative Address

Representative City, Representative State, Representative Zip Code

Medicaid Recipient: Recipient's Name

Medicaid Number: Recipient's MID

Dear Representative Name:

The Division of Medicaid has received your payment in the amount of \$(Payment Amount). Medicaid's claim in this matter is now satisfied.

Thank you for your cooperation in the repayment of this loan.

Sincerely,

Auditor Name

Bureau of Recovery

Division of Medicaid

TPL CASUALTY BRANCH

Federal law mandates that the state agency takes necessary measures to recover Medicaid payments made as a result of trauma diagnosis claims. The TPL Casualty Branch has the responsibility of recovering Medicaid trauma-related claims' payments. This Branch receives and investigates leads as a result of MMIS generated beneficiary questionnaires concerning trauma diagnosis on paid claims. The injuries may be caused as a result of product liability, malpractice, and any tort situation. The Branch also receives inquiries from the legal community, the Medicaid beneficiaries, and the medical providers. The staff supplies accurate accounts of Medicaid paid claims associated with any trauma-related case, and appear as a fact witness in court, if necessary. State law requires the legal community to protect Medicaid as payer of last resort when representing an individual who has had medical services paid by Medicaid.

Federal law requires data matches to be affected with specific state agencies in order to learn of third party responsibility for accident-related claims. The Bureau of Recovery directs and monitors annual data matches with Workers Compensation Commission and the Department of Public Safety. The TPL Casualty Branch also has the responsibility of pursuing recovery on any leads received as a result of the data matches. The Division of Medicaid has a claim to any settlement proceeds received for services paid for by this agency. Our authority to recoup those funds is found in Section 43-13-125 and 43-13-315 of the Mississippi Code of 1972, as amended.

In providing protected health information (PHI) to third parties as we pursue recovery, the Trauma/Casualty Branch works diligently to protect the beneficiary. We comply with the guidelines for protecting privacy as set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). No PHI is released without a written request from the third party, and an accompanying HIPAA compliant medical authorization.

PURPOSE

The purpose of the Casualty Branch is to recover Medicaid's payments as a result of claims for services with trauma diagnosis.

RESPONSIBILITIES

The Trauma/Casualty Branch (1) recovers Medicaid payment for services related to accidents, injuries, malpractice, tort, and paternity, (2) prepares itemizations of payments for court documentation, (3) monitors progress of court action, and (4) educates the legal community.

REPORTING REQUIREMENTS

A production report is submitted to the Division Director Monthly. COGNOS has the capability to generate status reports as needed.

CASUALTY BRANCH

STANDARD OPERATING PROCEDURES

Processing Lien Requests from Third Party Sources

Requests Requiring DOM to appear in Court

The TPL source document of highest importance to the Trauma staff is one that requires the Division of Medicaid to be present in court or to submit records to court. Subpoena, Subpoena Duces Tecum, or any other correspondence that indicates the Division is to appear or is to provide records should be handled in the following manner:

Immediately, notify the Branch Supervisor and the staff attorney via E-mail of the receipt of such correspondence. Be sure that the correspondence has been accurately date stamped. A current and accurate itemization and claims history print out must be prepared. These should be done on the laser printer. These items must be completely clean in order to be presented in court. That is, no pen or pencil markings, no staples, no hole-punches, etc. Also, make file copies of both of these items for our records. Submit the case with the itemization and claims print out to the Trauma Supervisor within 48 hours of receipt of the correspondence.

When a problem arises and an Investigator needs to work quickly to get some information for an attorney for court, this last minute request will be honored, if at all possible. The Investigator, with supervisory help and review, will handle these requests. The supervisory will review affected by the Trauma Supervisor the TPL supervisor or both.

Standard Requests

Lien requests received by phone or mail should be prioritized according to the following suggestions:

1. Cases requiring legal action by the Division
2. Cases with an eminent court or hearing date set, to which the plaintiff's or defense attorney must respond
3. Cases in which the attorney or insurance adjuster needs to disburse funds immediately
4. Cases for which you have received more than one request
5. All other cases should be handled chronologically

Always be sure that the third party is notified of the State statute protecting Medicaid's interest and outlining the third party's responsibilities. This may be done at the time of lien notification. Response to requests for lien amounts should be made within 5 working days of receipt.

Release of Information

When the attorney representing the Medicaid beneficiary initially requests information regarding the lien, he must submit a written request accompanied by a signed HIPAA compliant authorization. This may be faxed or mailed. When the case file contains this written request and the signed authorization, the plaintiff's attorney can then receive information over the phone, by mail or by fax without further written requests or signed authorizations.

When the defense attorney, an insurance agent, etc., requests information regarding the Medicaid beneficiary and the lien amount, he must be referred to the plaintiff's attorney. This allows the defense attorney or insurance company to receive the lien information from the beneficiary's attorney in a spirit of settlement. If the defense attorney or insurance agent calls the Investigator back and insists that the beneficiary's attorney will not furnish the information and he wishes to pay the Division, the Investigator will refer the case file to the staff attorney.

If an attorney is not representing the beneficiary, we may release information to the third party or its representative with written authorization from the beneficiary. If the third party is unable to obtain authorization from the beneficiary, the TPL Investigator may attempt to obtain authorization. The Investigator should first attempt to get written authorization from the beneficiary. If this is not possible, the Investigator may obtain verbal authorization over the phone.

If the beneficiary refuses to cooperate in the recovery of third party funds, because the beneficiary has already assigned his third party rights to the Division of Medicaid as a condition of eligibility, the Investigator may release the information to the third party. Then, the Investigator provides written notice to the beneficiary that the information was communicated.

Preparing Liens Using COGNOS

Opening and Saving a File

To calculate a casualty lien, log into COGNOS. At the prompt, enter your COGNOS log-in ID and password, click "OK."

Save your work in your personalized directory in M:\USERS\PRRW\DATA\. The file name should consist of the Medicaid ID.

Retrieving Data

In the Public Folders, Select the “Ad-Hoc Reports” folder at the top of the screen. Choose SIO5003389: Casualty Lien (All Dates) v.3.1.

On the Format page in the drop-down box, choose Excel 2002. Click “Run.” At the Selection page, enter the Medicaid ID, with five (5) leading zeros – “00000XXXXXXXXX”. Click “Finish.”

An Excel dialog box pops-up. Choose “Open.” The Excel spreadsheet opens, online on the Internet. Select “File,” “Save As,” and save your work in your personalized directory in M:\USERS\PRRW\DATA\.

Close the online Excel spreadsheet, open your desktop Excel application, open the saved file, edit the file as required and save.

Preparing Claims Printouts

Notice the tabs at the bottom of the screen, labeled “Index”, “All Paid Claims-2,” “All Claims-(Paid & Denied) -3,” “Procedures, NDCs and Diagnoses (Paid)-4,” “Procedures, NDCs and DX1(Paid and Denied)-5,” “All Claims-6”, “All Medications-7,” and “Denials-8.” These represent worksheets designed to review claims data. To access the various worksheets, simply click on the appropriate tab at the bottom of the screen. You should make a complete print out of the claims for each case record. You may either print out the sheet labeled “All Claims-(Paid and Denied),” or the one labeled “Procedures, NDCs and Diagnoses (Paid).”

Reviewing Claims Data

After producing the printout for the case record, review the data to determine which claims are related to the accident. In most cases, you will begin with the “Diagnosis Codes” tab. This worksheet displays the date of service, provider, and the verbal descriptions of the primary and secondary diagnosis codes. You may also want to view the “Procedure Code” worksheet.

NOTE: Claims that crossover from Medicare, other than the hospital crossovers, do not have diagnosis codes. These claims are very difficult to make a determination on, since the only data you have is the date of service and provider. In these cases, you will have to work with the third party to determine which claims to include in the lien.

Waiver Requests

Trauma Investigators are authorized to offer a 25% procurement fee to the attorney. If the attorney requests a waiver or reduction of our lien, offer him the standard 25% reduction. If this is not acceptable to the attorney, he should submit justification for his request to us in writing with a proposed disbursement sheet.

This request will be forwarded to our staff attorney for negotiations.

Generally, this is only to the plaintiff's attorney. If the defense attorney or insurance company requests a waiver, this should be forwarded to the staff attorney as specified above.

Verifying Checks

The most common reason checks are referred to Investigators for verifications is that MMIS does not contain the most recent lien information. Also, there are sometimes two records for the same beneficiary. Review the case and update MMIS if necessary.

When the Case is in Legal

If the case is in the Legal Bureau, request via E-mail that the case be sent to TPL for check processing. The staff attorney may have agreed to an amount other than 75% of our lien. We will not have any record of such agreement until we have the case.

DO NOT approve a check for deposit based on the copied documentation attached by the payor. Without case review, you have not verified that this was the final statement of our lien.

If an Investigator verifies that a check received is for the wrong amount, the Investigator is to call the attorney and request that a new check for the correct amount be written. If the Investigator's request for a new check is denied by the attorney, the Investigator will submit the case to the Trauma Supervisor for referral to the staff attorney, following the guidelines for *Transfer of Case Files between the TPL and Legal Bureaus*.

Use prudent judgment in discussing cases with attorneys and third party sources. It may be necessary to correct our lien based on new information received from the third party at this point.

Transfer of Case Files between TPL and Legal Bureaus

E-mail will be used for Legal to request an itemization update and/or a case file from the TPL Investigator and for the TPL Investigator to request a case file from Legal. On the E-mail transmissions to the staff attorney and to the Investigators, the Division Director, the Trauma Supervisor and the legal secretary will be copied.

When an E-mail request is made to TPL, the Investigator will complete the request, update the lien amount, document the Record of Contact Form, update MMIS, and place the file in the Trauma Supervisor's office. Notations on the Record of Contact will include an explanation of the request from Legal and the date and time the case is placed in the Supervisor's office. Updates to MMIS include the following:

Detail Tab:

Follow-up Status - 4 (Stops all computer-generated correspondence while staff attorney is in negotiations)

Lien Information Tab:

Lien Amount - This should be updated each time the case goes to Legal.

Lien Date - Update the Lien Date even if the Lien Amount did not change to indicate the most recent update

Legal Status – The options are: **Referred to Legal, or Returned to TPL**

Reference Number – **Manually input current date**

In order to maintain records accurately, no one will go into Legal's files except the Legal staff. In the same vein, no one will go into the Recovery files except the Recovery staff.

Processing Mail Daily

It is the Investigator's responsibility to assure that all correspondence is dated and/or date stamped. Mail should be reviewed daily in order to ensure that urgent matters are handled. **SUGGESTION: If mail is not handled by the close of the day, it should be bound together and the bundle marked as to the date received.**

6-month Follow-up Questionnaires

MMIS generates follow-up letters every 6-months. Post the date the response was received in the last contact field. The questionnaires should be thoroughly reviewed and any necessary action taken. Many of these questionnaires require no action on our part and must simply be filed.

If the attorney indicates that they will not protect our lien, forward the case immediately to the Trauma Supervisor. It will be necessary in this case for the Bureau's attorney to intervene.

If we receive notification from an attorney that they no longer represent the Medicaid recipient, **DO NOT** blank out the attorney information or the firm ID field.

Send a CASU9 form letter to the recipient. Update the last contact field and follow-up status. Enter comments in the comments field to alert you to get new attorney info from the recipient. Complete the appropriate follow-up when you receive your questionnaire back or when you get a tickler indicating that no response was received.

Establishing a Recovery Trauma Case

When a Third Party Source is identified, obtain all information necessary to pursue the third party funds, that is, beneficiary name and Medicaid ID#, date of accident, name of third party source, policy number, claim number, name of plaintiff's attorney.

The beneficiary detail screen print should be included in all Trauma cases files.

Determine if Medicaid has paid for services for which the third party source is liable.

Computer generated follow-up occurs every 6 months, based on correct entry in MMIS. Therefore, it is imperative that MMIS reflects accurate, updated information.

Initial and Follow-up questionnaires and any miscellaneous correspondence with recipients, should be acted upon by Investigators every 30 days.

Putting the Third Party Source on Notice

The investigator is responsible for putting the third party source on notice. The system does not generate a notice letter.

Maintenance of Case Files

Pronged letter-size folders will be used for setting up new cases. The case file must be maintained with the TPL documents on the right hand side in chronological order as received, the oldest receipt date being on the bottom. The oldest item in every case should be the MMIS beneficiary detail screen and eligibility screen. If these printouts are not in the case file, print them and add them to the bottom right side.

Legal documents will be placed on the left hand side with the Record of Contact form always on top of the legal documents. The Investigator must use this Record of contact form to document each and every transaction, phone call, transfer of file, etc.

All activity, especially phone calls should be properly documented on the Activity Form. Documentation should include organization and person to whom you spoke, details of information given or received, the date and your initials. Refrain from writing on correspondence; use the activity form for notations.

Duplicate letters are unnecessary unless they are accompanying forwarded correspondence, in which case they should be attached. Only one copy of any document is necessary. **There will not be any grammatical errors in outgoing correspondence. Grammatical errors will not be tolerated.**

Recipient reference date should be gathered and filed when a case is initially established. This should be filed on the bottom right side of folder.

When the case is established, the following steps should be completed.

1. Run MMIS screens: from recipient detail, print the summary and eligibility screens.
2. Complete Activity Sheet.
3. Forward notification to TP source.
4. Pull claims history as appropriate.
5. Calculate subrogation lien and itemization, if requested.

Updating MMIS-TPL Recovery Case

Prior to transferring the case to the attorney, the Investigator must update the lien amount; record the details of the contact in the Record of Contact form maintained on the left side of the case file, and update the MMIS System. The updates to MMIS include coding the Follow-up Status, the Legal Status, the Lien Amount, and the Lien Date.

When the lien amount is initially determined and each time it is updated, enter the amount into the MMIS with the effective date. The MMIS contains the fields Lien Amount and Lien Date for this purpose.

Casualty Threshold

The Recovery Casualty threshold is \$250.00. Therefore, **the Casualty Branch will not pursue recovery of cumulative claims of less than \$250.00.** This policy applies to recipients, insurers, providers, etc. However, lien itemizations and claim copies will be provided regardless of the lien amount. Computer Follow-up will continue on these cases. **Reimbursement will be received and collected on cases regardless of the lien amount.**

This threshold simply means that, if we discover after the fact, that reimbursement was made to the provider or beneficiary, we will make an effort to collect our money, but if our attempts are not successful, we will close our case. No further recovery action will be taken.

Pursuit of Funds Paid Directly to the Beneficiary

The beneficiary/payee will be contacted by mail twice in an effort to reconcile the matter.

A third effort will be completed in the form of a certified letter informing the payee that unless a response is received within 10 days the source of eligibility will be contacted to begin termination procedures of the adult's eligibility.

Closure procedures will be initiated in accordance with Transmittal Notice #433.09139018 dated September 13, 1990.

NOTE: Termination of Medicaid Eligibility will not be initiated on cases involving less than \$250.00.

If during the 10-day notice period a negotiated agreement is met, the beneficiary will be required to sign a legal agreement to repay Medicaid, in order to maintain Medicaid eligibility.

The beneficiary will be required to sign an agreement to repay Medicaid in accordance with the TPL Repayment Schedule. This agreement will further indicate that failure to pay Medicaid may result in terminating Medicaid coverage.

NOTE: Good Cause Waiver may affect eligibility reinstatement.

Requesting Approval for Closure

The Investigator must have exhausted all efforts to recover Medicaid monies prior to submitting a case for closure.

Reasons for submitting a case for closure include:

A statement by the insurance company or attorney that no liability exists

The Court ruled against the recipient

The beneficiary dropped or is not pursuing the case and the statute of limitations has expired. The statute of limitations is the deadline for filing suit. It is three years for a personal injury case and two years for a medical malpractice case.

Medicaid has not made any payments nor has no lien.

The Investigator must request written documentation of this negative action. When written documentation is received, complete a Closure Request Form and attach it to the front of the case record. Submit the case record to the Casualty Supervisor. Notate in the comments field that the case was submitted for closure.

If the attorney states that he no longer represents the beneficiary, the Investigator will send a questionnaire to the beneficiary requesting new attorney information. Do not delete the old attorney data from MMIS. Set a tickler to follow-up on the questionnaire. Make an entry in the comments field that a questionnaire has been sent.

When new attorney information is received, the Investigator will notify the new attorney in writing of DOM's subrogated interest and follow the previously outlined SOP. If three years have passed since the date of the accident, contact the attorney by phone to determine the status of the case. (Two years for medical malpractice cases). Request written documentation of any negative action.

If contact cannot be made with the attorney, contact the beneficiary by phone. If this attempt is unsuccessful, send a questionnaire followed by a second request. As a final effort the Investigator will send a certified letter to the beneficiary. If there is no representation or no response, submit the case for closure.

Reports of Possible Abuse

If you receive a report from beneficiary(s) of possible abuse by the provider due to the beneficiary having a third party resource, get the provider's name and address, provider #, beneficiary Medicaid ID, a copy of the billing if applicable, details of alleged abuse, and any other necessary information. Forward this information to the Trauma Supervisor. This information will be referred to Program Integrity.

Accepting Total Charges vs. Medicaid Paid Amounts

When preparing an itemization always include the actual amount that Medicaid paid in the Medicaid Paid column, even when Medicaid paid more than the charged amount. The Agency's lien will be the lesser of the total charges or the total Medicaid paid. Whichever total figure is smaller is the amount that we will enter into MMIS and quote in our letter to the attorney or insurance adjuster.

BENEFICIARY RECOUPMENT

STANDARD OPERATING PROCEDURES

Improper payment referrals are initiated by the Department of Human Services and the Division of Medicaid Eligibility, and the Medicaid Eligibility Quality Control Branch. All referrals are reviewed by the staff member upon receipt for understanding of the Improper Payment as it exists and for appropriate documentation. This document provides the reason for the Improper Payment and the period of ineligibility. If during this review, developments are encountered that potentially could lead to a different outcome for this Improper Payment, it should be referred to the Beneficiary Recoupment Supervisor for review. The Improper Payment reports may be received as often as daily and report periods of Medicaid ineligibility caused by client error, agency error, or suspected fraud.

Relevant information from the improper payment referral is entered into the Third Party Recovery system for tracking purposes. A COGNOS report is produced to calculate applicable Medicaid claims paid in error during the ineligible period. A case file is created and includes the improper payment report to document the cause of ineligibility and the ineligible period, the COGNOS report and/or documentation of the amount of repayment if the Improper Payment is due to Medicaid Income error or premium repayment.

Staff members are each assigned the same number of letters of the alphabet. When the total Beneficiary Recoupment population was housed in Access, the case would be placed in Personal Field Investigation (PFI) status until the issuance of the demand letter. As of May 2007 the cases are entered into the Third Party Recovery Sub-system. Each staff member drafts and mails the initial demand letter to the beneficiary of their respective caseloads. This letter includes the reason for Improper Payment, the period of ineligibility and the repayment amount. If no response is received within 30 days, the Beneficiary Recoupment subsystem, using the unique case information entered upon receipt of the improper payment referral, automatically generates a beneficiary Past Due Notice letter every 30 days. For Access and Third Party Recovery cases, staff members conduct a 30, 60 and 90 day review of their cases.

An in-person interview may be attempted if the beneficiary lives within a reasonable driving distance; however, the primary recovery effort is by telephone and correspondence. The case may also be referred to the Agency's Legal Bureau for further recovery efforts. If no response is received from the beneficiary after the initial demand letter and 3 system generated letters are sent, the case is reviewed and the decision to continue to pursue recovery is made. If no response is achieved after these efforts or the beneficiary cannot be located, or if it is

otherwise determined that further recovery efforts are considered useless, the case may be recommended for closure.

The recommendation to close the case is submitted by the staff member along with sufficient documentation to substantiate the closure. The Branch Director makes the final decision to close the case with the exception of cases with balances above \$250. The Division Director approves closures with a balance from \$251 to \$500 and the Bureau Director approve closures with balances above \$500.

Beneficiary Recoupment system generated Past Due Notices are produced monthly for all cases that do not have the PFI designation in Access. This will be true until the cases are moved from Access to Third Party Recovery. Past Due Notices are mailed on or about the 5th of each month. A Past Due Notice is mailed to every beneficiary who has not made a payment in over 30 days, and includes 3 repayment options: lump-sum, installment, or monthly payments. A pre-addressed, stamped envelope is included with the demand letter to facilitate payment. A copy of the Past Due Notice is filed in the case for documentation purposes.

Payments received from beneficiaries in the Third Party Recovery system are processed by Third Party's Bookkeeping Branch. The staff member mails a Beneficiary Payment Receipt letter to the Beneficiary acknowledging receipt of the payment, the amount received and the balance due. A copy is retained for the beneficiary's case file.

Payments received from beneficiaries remaining in Access are processed by the Division's Accounting Bureau, and a photocopy of the payment and a check log are hand-mailed to the Beneficiary Recoupment Branch. All payments received from beneficiaries in Access are posted in the subsystem and a payment report is produced to verify total payments. Two copies of the Beneficiary Payment Receipt letters are created; one letter is mailed to the Beneficiary acknowledging receipt of the payment, the amount received, and the balance due. A pre-addressed, stamped envelope is included with the receipt letter to facilitate the following month's payment.

The second copy of the payment receipt letter is filed in the Beneficiary Recoupment case along with the copy of the payment for documentation purposes. When the improper payment recovery is satisfied and the file is verified to ensure all payments have been received, the case is then documented to show the payment verification process has been completed. If the staff member determines that the claim has been fully satisfied, the case is documented and a letter is mailed to the beneficiary acknowledging satisfaction of the claim and the case is closed. A copy of the letter is filed in the case record. The case is then

closed in the Beneficiary Recoupment subsystem and the case is filed in the closed files.

Process Improper Payment Reports

1. Improper Payment Referrals are date stamped upon receipt. Print and sum total a claim history for each improper payment report's period of ineligibility.
 - a. Medical benefit claim due to the reason for the period of ineligibility: Reports are prepared in COGNOS to determine the amount of the medical benefit claim due to excess income, resources or other ineligibility cause.
 - b. Medicaid income liability claim: Use the forms established in Excel.
 - (1) an increase in beneficiary income
 - (2) loss of insurance premium deduction due to cancellation of health insurance. After entering data, print completed claim form.
2. Enter case information into the Third Party Recovery system. Cases currently remaining in Access will be moved to the Third Party Recovery system.
3. Prepare a case folder. Place each improper payment report, a claim history printout, all correspondence and a record of contact form in each file folder.

Recovery of Overpayments

Draft and mail an initial demand letter to the beneficiary.

1. Ineligible Cases - An overpayment claim notice along with a demand letter and a voluntary repayment agreement is mailed in an attempt to collect reimbursement from each beneficiary who receives a benefit paid in error.
2. Incorrect Liability –A Medicaid Income adjustment notice along with a demand letter and a voluntary repayment agreement is mailed in an attempt to collect additional liability from each beneficiary who underpaid Medicaid Income.

Posting Payments

Payments received from beneficiaries in Access are processed by the Division's Accounting Bureau. A photocopy of the payment and a check log are hand-mailed to the Beneficiary Recoupment Branch. All payments received from beneficiaries are posted in the subsystem by the staff member according to caseload and a payment report is

produced to verify total payments. Two copies of the Beneficiary Payment Receipt letters are created; one letter is mailed to the Beneficiary acknowledging receipt of the payment, the amount received, and the balance due. A pre-addressed, stamped envelope is included with the receipt letter to facilitate the following month's payment. The second copy of the payment receipt letter is filed in the Beneficiary Recoupment case along with the copy of the payment for documentation purposes. When the improper payment recovery is satisfied and subsystem indicates the balance due and owing is zero, the file is verified to ensure all payments have been received. The case is then documented to show the payment verification process has been completed. If the claim has been fully satisfied, the case is so documented and a letter is mailed to the beneficiary acknowledging satisfaction of the claim and to state that the Beneficiary Recoupment case is closed. A copy of the letter is filed in the record. The case is then closed in the Beneficiary Recoupment subsystem and the case is filed in the closed files.

Processing Accounts Receivable for Beneficiaries Remaining in Access

1. Date stamp the Incoming Check Log when received.
2. Open Beneficiary Recoupment Subsystem (RecipRecoup Icon on desktop)
3. Post each payment in Beneficiary Recoupment System:
 - a. Select [FIND] to search by case number, last name, first name or address
 - b. Verify address against envelope
 - c. Post payment by selecting [Select Here to Enter Payment] then select [Add]
 - d. Enter payment date of Incoming Check Log
 - e. Enter payment amount, select [Save]
 - f. Exit payment screen
 - g. Keep envelope and check copy (and any other documentation with Payment)
 - h. Search for next case

4. After completion of payment posting, print Payment Report:
 - a. Select [Reports] tab in subsystem
 - b. Select [Beneficiaries Making a Payment]
 - c. Enter log date (for beginning and end date), Print Report
 - d. Verify that balance on this report matches Recipient payment total on Incoming Check Log.

5. If in balance:

1. Staple Report: "Recipients Making a Payment" on top of Incoming Check Log
2. File in file drawer for Report: "Recipients Making Payments".
3. Run Payment Receipts:
 - a. Select [Reports]
 - b. Select Report #10 [Recipient Payment Letters by date]
 - c. Use date of Payment Log - run 2 sets
 - d. Set #1 - match to check copies for files
 - e. Set #2 - mail to recipients (pull any zero balance copies and throw away)
6. Paid Out Cases
 - a. Pull case folder
 - b. Type Paid Up Letter. Print 2 copies.
 - c. Mail one to Recipient
 - d. Place 2nd copy with check copy in case file.
 - e. In Recoupment Recoupment subsystem - search for case, select [Edit], select the [Closed] box, make sure date is in the [Closed] box, enter description (Paid in Full) and your initials in the [Comments] box, select [Save].
 - f. Place in Closed files

7. If out of balance:

Refer to Exhibit A to reconcile balance.

- a. Make adjustments using Exhibit A format.
- b. Notify Accounting of any discrepancies and return any payments not for Beneficiary Recoupment. Print a copy of adjustment and include with the Incoming Payment Log and with Report "Beneficiaries Making a Payment".

(Reconciliation Sample)

Incoming Check Log Adjustments				Date:
01/09/2008				
Log	No		Log	Date
Amount				
	01/04/2008	Incoming	Check	Log
\$3,000.00				Balance
01/05/2008	01/04/2008	Not for BR subsystem		\$
100.00				
		Total Adjustments		\$
(100.00)				
		Beneficiary	Recoupment	Balance
\$2,900.00				

Monthly Past Due Notices

If no payment is received within 30 days from the mailing date of the initial letter, the Beneficiary Recoupment subsystem, using the unique case information entered upon receipt of the improper payment referral, identifies and generates a beneficiary Past Due Notice every 30 days until a payment is received.

Beneficiary Recoupment system generated Past Due Notices are produced monthly for all cases that do not have the PFI designation in Access. Past Due Notices are mailed on or about the 5th of each month. A Past due Notice is mailed to every beneficiary who has not made a payment in over 30 days, and includes 3 repayment options: lump-sum, installment, or monthly payments. A pre-addressed, stamped envelope is included with the demand letter to facilitate payment. A copy of the Past Due Notice is filed in the case for documentation purposes.

Printing Past Due Notices:

- 1 .Open Beneficiary Recoupment subsystem (RecipRecoup Icon on desktop)
2. Run [Reports]
3. Select Report #12[Recipient Overdue Letters (NO PAYMENT)]
4. Enter prior month (Ex: 07/01/07 for August 1, 2007) – Use the 1st day of the month.
5. Select [Print]
6. Select Report #13 [Recipient Overdue Letters (PAYMENT)]
7. Enter prior month (Ex 07/01/07 for August 1, 2007) – Use the 1st day of the month
8. Select [Print]
9. File Copy – Repeat the [Print] process for both batches again so you will have a file copy. Mail one set with return envelopes and file the second set in the case file.

Past Due Follow Up

If no payment is received after 3 past due notices are mailed, the beneficiary is contacted by telephone. An in-person interview may also be attempted if the beneficiary lives within a reasonable driving distance. If no response is achieved after these efforts or the beneficiary cannot be located, or if it is otherwise determined that further recovery efforts are considered useless, the case may be recommended for closure. The recommendation to close the case is submitted by the staff member along with sufficient documentation to substantiate the closure recommendation. The Branch Director makes the final decision to close the case or to continue recovery efforts with the exception of certain balance ranges which are decided by the Division Director for certain balance ranges or the Bureau Director for certain balance ranges.

1. Using FoxPro Recipient Recoupment subsystem Report Menu, the following steps are taken to identify cases 180 days past due.

a) Click on Report #25 – General Report

b) List information in each category as follows:

Field:	Operator:	Value:
LAST PAID	LESS THAN	(DATE REQUIRED)
<u>AND</u>		
CLOSED	EQUALS	FALSE

2. This report will display: Date Last Paid, Recipient Name and Balance Due.

3. Using this report, a telephone call will be made to each beneficiary. Telephone numbers will be retrieved from MMIS.

4. After each contact attempt, dates, times of contact and results will be recorded in the Record of Contact section of each case file.

5. If there is no response, additional attempts will be made. If additional attempts are unsuccessful, the following special letter will be mailed to the last known address.

Follow-up Letter

Name
Address
City, State, Zip

Medicaid has attempted to contact you several times regarding the Division's \$_____ overpayment.

You are individually liable, regardless of cause, for the value of overpayments made by Medicaid on your behalf and in accordance with Section 43-13-121 (j), Mississippi Code (1972), Medicaid is entitled to recover any and all payments incorrectly made by the division.

The balance due Medicaid is \$_____.

You should reimburse the full amount within 30 days. If you can not make the full repayment, you may select the monthly repayment option. After you decide how to make payments, you must sign the Repayment Agreement and return it in the enclosed postage-free envelope.

~~Do not change your repayment agreement. Make your check or money order payable to Division of Medicaid. If you have questions about repayment, call 1-800-880-5920. Medicaid Auditor: Jim Ladner~~

MEDICAID ASSISTANCE REPAYMENT AGREEMENT

Case Name _____

Case Number: _____

I agree to pay by the following method checked below.

Full amount now. \$_____

Make monthly payments of \$_____ Starting date_____.

Partial payment of \$_____ Balance in monthly payments of \$_____ thereafter.

I understand that the monthly payment or partial payment now plus the monthly payments may not be less than the total balance due divided by 60 (\$10 minimum). Therefore, the balance due must be paid within a five-year period.

Signature

Date

Updating Data in Physical file and Computer File

When a notice of bankruptcy is received, place case file in bankruptcy file and immediately cease further collection attempt. If the Medicaid legal department request case file, send case file to legal department and notate in Beneficiary Recoupment sub-system in comment section that the case file was sent to legal along with date sent. Place a copy of the file in the Bankruptcy section of the Beneficiary Recoupment file. When a bankruptcy case is returned from the legal department, notate in Beneficiary Recoupment sub-system that case was returned with date returned and remove the copy of the record from the Beneficiary Recoupment Bankruptcy section.

When there is a notification of a change in circumstances, enter correct or current circumstances in each data field affected by change in circumstances. For example: name change, change of address, change in payment mode, etc.

Beneficiary Recoupment Reports

DHS Report

At the end of each three (3) month period, send a quarterly report detailing \$0 claims to the Department of Human Services Economic Assistance Division Claims Management office. To print this report, use the Beneficiary Recoupment sub-system report module, report #17, DHS and totals.

Improper Payment Log

At the end of each month an Improper Payment Log is printed listing all new cases received during each month. To print this report, use the Beneficiary Recoupment sub-system report module, report #7.

Monthly Beneficiary Recoupment Report

This report is provided in the first week of each month to show prior month Beneficiary Recoupment activity. This report shows number of payments and amount received vs. same month prior and year to date totals for both years; total current balance due for all open/active cases; total current number of open/active cases; the number of past due / delinquent notices mailed; the number of improper payment referrals by source and year to date.

Improper Payment Referral Report

Maintains statistics and produces quarterly report to show the number of improper payment referrals received monthly from each Medicaid Regional Office and total; the number of referrals received monthly from DHS and totals; and the number or referrals received monthly from MEQC and totals.

Beneficiary Recoupment Overpayment

This section contains a brief explanation of the overall process. Details are addressed in the sections that follow. The improper payment case is received and reviewed for understanding of the Improper Payment as it exists and for appropriate documentation. If during this review, developments are encountered that could potentially lead to a different outcome for this Improper Payment, it is returned to the Beneficiary Recoupment Supervisor for review. If it is determined that the Improper Payment should continue for recovery as it exists, the initial demand letter is drafted and mailed to the beneficiary. This letter explains the cause of the improper payment and specifies the

repayment amount. The Personal Field Investigation (PFI) code would have been removed for cases entered in Access and non-payment cases will begin to receive system generated Past Due Notices every 30 days. A field investigation and in-person interview with the beneficiary may also be conducted; however, the primary recovery effort is by telephone and correspondence. The case may also be referred to the Agency's Legal Branch for further recovery efforts. If no response is received from the beneficiary after the initial demand letter and 3 systems generated Past Due Notices are sent, the case is reviewed and the decision to continue to pursue recovery is made. If it is determined that the beneficiary has no resources to repay the claim, or other circumstances prohibit recovery, or if it is otherwise determined that further recovery efforts are considered futile, the case may be recommended for closure. The recommendation to close the case is submitted by the staff member along with sufficient documentation to support the closure recommendation. The Branch Director makes the final decision to close the case or to continue recovery efforts with the exception that the Division Director would decide regarding cases with certain balance ranges and the Bureau Director would decide for certain remaining balance ranges.

Initial Beneficiary Recoupment Demand Letter

The initial demand letter should always contain a specific reason for ineligibility and the period of ineligibility. It should also include basic information about how to repay Medicaid, repayment options that may be available, a contact name and telephone number, a postage-paid envelope, and a repayment agreement form.

As a general rule, the beneficiary is offered three (3) repayment options in the initial demand for repayment. The options are:

1. Lump-sum payment
2. Monthly installments of a reasonable amount depending on amount of overpayment
3. Partial payment now followed by smaller monthly installments

Once the initial demand letter has been sent, the PFI date is removed for beneficiaries in Access and a due date is entered in BR/Access. The letter includes the reason for the improper payment, the period of ineligibility and the amount of the repayment. The due date is always the first day of the following month, regardless of the date of the initial demand letter. This is done to facilitate follow-up procedures for cases that fail to repay Medicaid. Follow up procedures are outlined later in this manual.

Attachments: Refer to sample initial demand letters at the end of this section.

Beneficiary Recoupment Field Investigations

The staff member sets up appointments with beneficiaries for whom a field investigation becomes necessary. The interviews are conducted at either the DOM Regional Office depending on the origination of the improper payment report. Use the following procedures.

1. Identify all cases in an area of the State that require field investigation so that trips can be scheduled efficiently.
2. Call the DOM office to let them know what your intended schedule is, make sure you have a place to conduct interviews, and work out any other details.
3. Send a letter to the beneficiary notifying him or her of the date, time, and place of the interview. The schedule must be finalized and notices sent to the beneficiaries the week prior to the field investigations.

If the beneficiary or representative fails to show up for the interview, attempts are made to contact the beneficiary by telephone. If telephone contact is unsuccessful, a home visit is attempted. A repayment agreement is made with the beneficiary if at all possible. If the beneficiary provides evidence that he or she is unable to pay due to poor financial conditions, they are advised that they will be notified at a later date of a decision regarding collection of the overpayment.

Upon returning to the office, a field investigation report is completed. The report will contain relevant findings and any appropriate recommendations and is submitted to the supervisor. The report is then given to the Medicaid Auditor to enter a decision into the BR system. The possible decisions are:

1. Repayment agreement with due date

2. Set up tickler for a letter to be sent on a specified date
3. Mail a series of three demand letters
4. Close the case (reason must be fully documented and approved by supervisor)
5. An initial demand is issued followed by three (3) demand letters (Investigator sends the initial demand letter)
6. A copy of the field investigation report is maintained in the Beneficiary Recoupment file.

Beneficiary Recoupment – Special Follow Up

PROCEDURE: The staff member conducts special follow-up on cases that are past due more than sixty days. Running and printing a report from the BR Access system using the General Report menu identify the cases. The selection parameters are Due date equals mm/01/yyyy, where mm=month and yyyy equals year

Once printed, the report for any given month can be used monthly to follow-up on cases for that month until final disposition.

Allow adequate time for all payments from the prior month to be posted to BR before special follow-up activities are initiated. Use BR to check status as of the date follow-up activity is being done on each case. Check the Last Date Paid and Closed fields. If closed note this on the list. No follow-up is needed. If Last Date Paid is within sixty days, note the date paid on the list. No follow-up is needed since the case is not sixty days past due.

If neither situation in the preceding paragraph apply, pull the file to determine what follow up action is appropriate for the case. If file will be kept for an extended period of time and no routine Past Due Notice should go out in the meantime, put case in PFI status. After reviewing the case, determine what follow up actions will be taken. Such actions will generally include one or more of the following:

1. Telephone calls and/or special demand letters
2. Referral to DOM's Legal department or the Attorney General; s office
3. Continue sending routine follow up letters
4. Close the case (require approval from supervisor)

If the case is sixty days past due, make a call and/or send a special follow up letter. If the case is ninety days past due, send a final notice letter and consider referring it to Legal. If the case is six months past due, closure should be considered. Follow the procedures for closing cases.

Depending on the circumstances surrounding the case, simply allowing the routine system generated past due notices is appropriate for specified periods of time. For

example, the overpayment was due to agency error, the beneficiary is of advanced age and has limited resources to repay.

Document any follow up activity on the case by making a note on the listing. This note serves as a reference when the list is worked in subsequent months.

Date

Name

Address

Address

Re: Name

ID Number

Dear Mx *XXXXXXXX*:

During a recent review of your Medicaid case, the Division of Medicaid discovered that members of your household received Medicaid benefits from May 1, 2003 through June 30, 2003 that you were not eligible for.

The reason for ineligibility was that your household income during the above period exceeded the limit to be eligible for Medicaid. Your total income, specifically your spouse's income, was not fully disclosed. For the period May 1, 2003 through June 30, 2003, Medicaid improperly paid claims on your behalf. A detailed list is enclosed. Since you were not eligible for these payments, you are responsible for repaying Medicaid the \$553.47 improperly paid on your behalf. Public Law requires the Division of Medicaid to collect this overpayment from you.

Please complete the enclosed form indicating your method of payment and return it within fifteen days of the date of this letter. A postage-paid envelope is enclosed for your convenience.

If you have questions, or would like to discuss other repayment options, please call me at 1-800-880-5920 or 601-987-4890.

Sincerely,

Medicaid Investigator
Bureau of Recovery

PLEASE FILL OUT THIS FORM AND RETURN IT IN THE ENCLOSED ENVELOPE

Recipient Name:

Case Number:

Total Amount Due: \$

I agree to pay by the method checked below.

Full amount on or before _____ .
(Date)

Make monthly payments of \$_____ starting _____ .
(Date)

Partial payment now of \$_____ and balance in monthly payments of \$_____.

(Signature)

(Date)

**MAKE MONEY ORDER OR
CASHIER'S CHECK PAYABLE: DIVISION OF MEDICAID**

**MAIL TO: DIVISION OF MEDICAID
 BENEFICIARY RECOUPMENT
 SUITE 1000, WALTER SILLERS BLDG.
 550 HIGH STREET
 JACKSON, MS 39201-1399**

**ALWAYS INCLUDE YOUR NAME AND CASE NUMBER
ON MONEY ORDER OR CASHIER'S CHECK.
DO NOT SEND CASH.**

Date

Name

Address

City, State, Zip

Re: Name

ID Number

Dear Mx xxxxxxxx:

The Division of Medicaid State Office has been notified by the Jackson Regional Office that you have received Medicaid benefits during a period that you were not eligible. The period of ineligibility was January 1, 2003 through June 30, 2003.

Your ineligibility was due to resources in excess of the limit to qualify for services under Medicaid. The lump-sum payment of \$30,726.00 that you received from the Veterans Administration December 2002 resulted in your resources being above the limit. This lump-sum payment was not reported to Medicaid in a time manner as required. During the period that you were not eligible, Medicaid made improper payments totaling \$780.04 on your behalf. A list of the improperly paid claims is enclosed. Please note that if additional claims are paid in the future, then the payments will be added to the list.

Since these payments were made on your behalf during a period that you were not eligible, you are required to repay Medicaid the \$780.04 improperly paid on your behalf.

To repay this improper payment, please make your check or money order payable to the Division of Medicaid and send it to us in the enclosed postage-paid envelope within 30 days of the date of this letter. To ensure proper credit, show your name and the above case number on your payment.

If you have questions or would like to discuss other repayment options, please call me at 1-800-880-5920 or 601-987-4890.

Sincerely,

Medicaid Investigator
Bureau of Recovery

Recovery of State Income Tax Refunds

The Beneficiary Recoupment Division recovers from Beneficiaries money paid for services received during an established period of Medicaid ineligibility or incorrect liability.

The division shall report to the State Tax commission the name of any current or former Medicaid recipient who has received medical services rendered during a period of established Medicaid ineligibility and who has not reimbursed the division for the related medical service payment (s). The Tax commission shall withhold from the state tax refund of the individual, and pay to the division, the amount of the payment (s) for medical services rendered to the ineligible individual that have not been reimbursed to the division for the related medical service payment (s).

The Beneficiary Recoupment subsystem includes Social Security numbers for all known Beneficiaries. State income tax refunds are recovered from all beneficiaries who are delinquent in payment; who have received at least three demand letters; who have not entered into a repayment agreement and have not repaid any portion of the debt in three or more months. A listing of Beneficiaries subject to State Income tax refund recovery will be submitted to the State Tax Commission in the proper format, and by the required submittal date.

Medicare Buy-In

Standard Operating Procedures

Monitoring the Outgoing and Incoming Transmissions of the Buy-In Part A and Part B file

The Buy in files must be monitored for timeliness. The Outgoing Part A and Part B files must be available to CMS by the 25th of the month or the last business day prior to the 25th if the 25th falls on a non-business day.

Incoming Part A and Part B file: The fiscal agent prepares certain reports that are usually available around the 10th of a given month. If not, this serves as an alert to contact our representative Business System Analyst to determine the current status of the Part A and Part B Incoming file.

Preparation and Maintenance of the Buy-In Part A and Part B Matrix

Preparation and maintenance involves associated documents for communication between DOM and the fiscal agent staff in their establishment and maintenance of the Buy-In Part A and Part B computer program

Certain documents are provided to the fiscal agent for the purpose of communication between the state and the fiscal agent in regard to the criteria for the Buy-In Part A and Part B computer program in the identification of the eligible or ineligible beneficiary and the appropriate transaction code and date to be used for communicating the state's accretion, deletion or change request to CMS, Baltimore. These documents include the following:

1. A matrix for the Part A and Part B Buy-In Outgoing program that is prepared by the state to be used by the fiscal agent to assist in establishing the Buy-In Part A and Part B Buy-In Outgoing computer program.
2. A Customer Service Request (CSR) is utilized by DOM to communicate changes in the program to the fiscal agent or to request corrective action to bring the program into compliance with state and federal guidelines.
3. A Research CSR is utilized by DOM to communicate to the fiscal agent a request to research for determination of cause of a specific occurrence. The outcome may result in a CSR.
4. The State Buy-In Manual is prepared by the federal government for the states and provides a communication tool that is common to all states and the federal government.

Finally, the fiscal agent is operating under a contract with the state which provides the parameters for business decisions regarding a given program.

Monitoring the Buy-In Part A and Part B Computer Program

Monitoring the Buy-In files assure that the MMIS transactions comply with state and federal guidelines via monthly reports prepared by the fiscal agent from the Buy-In Part A and Part B Outgoing and Incoming file.

Reports prepared by the fiscal agent from the Buy-In Part A and Part B Outgoing file are available in DOM's "Reports Online" on the day or usually no later than the day following the preparation of the files. The reports addressing the accretion and deletion requests are randomly reviewed each for accretions and deletions for compliance with state and federal guidelines. If not in compliance, the reason is established or a Research CSR or a CSR regarding the occurrence is submitted to our representative Business System Analyst for submission to the fiscal agent. The specific reports are as follows:

Outgoing Part A:

RB021A: "Outgoing Buy-In Part A Batch Transactions"

For this report, the following transaction codes would be reviewed:

Transaction Code 61 identifies the accretions

Transaction Code 51 identifies the deletions due to closure of Medicaid eligibility or Medicare entitlement

Transaction Code 53 identifies the deletions due to death

The number included in each transaction code is located at the bottom left of the report. Beneficiaries are randomly selected in a given transaction code.

Accretion Request Errors:

"M" unless beneficiary has QWDI coverage.

*Beneficiary is other than an SSI/related Medicaid eligible and is above the income limit for this program. This income limit is identified as the current QMB income limit. For MEDS and MEDSX beneficiaries, the income of the beneficiary can be verified by viewing the financial section of the MEDS or MEDSX file. An SSI beneficiary is considered to be within the QMB income limit.

*Transaction date is other than the month following identification of the beneficiary's meeting the criteria for accretion.

*Beneficiary being submitted has only Medicare, Part B entitlement and is not open on the Part B Buy-In program.

Deletion Request due to Medicaid or Medicare Closure Errors:

”M” unless beneficiary has QWDI coverage

*Transaction date must be no earlier than the month of the Outgoing file preparation.

Example: 1) If the beneficiary’s Medicaid eligibility ended 12/31/2007 and the beneficiary is identified when the Outgoing file is being prepared in 12/2007, the transaction date would be 12/2007. 2) If this same beneficiary is not identified until the Outgoing file is being prepared in 01/2008, the earliest transaction date would be 01/2008. In this instance, the reason for the delay in identification of this occurrence must be determined. An acceptable reason would be that the Medicaid closure or the Medicare entitlement closure updated to MMIS after the run date of the Buy-In Outgoing program.

Deletion due to Death Errors:

”M” unless beneficiary has QWDI coverage

Transaction Date is other than month and year of death of beneficiary

Outgoing Part B

RB021B: “Outgoing Buy-In Part B Batch Transactions”

For this report, the following transaction codes would be reviewed:

Transaction Code 61 identifies accretion request for the MEDS and MEDSX population

Transaction Code 64 identifies accretion request for the SSI population

Transaction Code 51 identifies deletion request due to loss of Medicaid or Medicare for the entire population

Transaction Code 53 identifies deletion request due to death for the entire population

Accretion Request Errors:

Transaction Code 61

HIC# must be valid. Examples of invalid HIC#’s:

* HIC# with a BIC of “C01”

* HIC# with spaces between the number and the BIC.

Transaction Date is set in the computer program to be the most recent of the following dates: date must be no earlier than the 1st month of eligibility in a given Medicaid program provided that the beneficiary also has Medicare entitlement for this date and is not already open on the Part B Buy-In program.

Monitoring of the Buy-In Part A and Part B Incoming file for Corrective Action

Reports prepared by the fiscal agent from the Buy-In Part A and Part B Incoming file are usually available in DOM's "Reports Online" around the 10th of the month.

Part B Buy-In: All of the data from this Incoming file is available in each of three sorts for the Buy-In Part B Incoming file. The three reports are each under a different sort:

1. Alpha: This report lists the beneficiaries in alphabetical order based on the name from the Incoming file
2. Transaction code: this reports lists the transaction codes in numerical order and the beneficiaries listed alphabetically within the transaction code sort and
3. HIC# (Medicare Claim Number): this report lists the Medicare Claim Number from the Incoming file in numerical order.

The separation of this report into the three sorts is beneficial in identification of the beneficiary's Medicaid file because the beneficiary may be being billed to Medicaid under a different name or Medicare Claim Number than that established for the beneficiary's Medicaid file.

Part A Buy-In: All of the data from the Buy-In Part A Incoming file is available only in transaction code sort and the beneficiaries are listed alphabetically within the transaction code sort.

To identify the sections from which to retrieve the working reports, the transaction code report is utilized for Buy-In Part A and Part B. Each of the transaction codes is identified in the State Buy-In Manual for Buy-In Part A and Part B and includes the action to be taken by the state. (See State Buy-In Manual under "Transactions Codes for Part A" and "Transaction Code for Part B").

All beneficiaries who are being rejected for the first time have their Medicare Claim Number, entitlement and personal characteristics of name, date of birth and gender verified with the Social Security Administration via a special FAX form utilized for this purpose unless a Bendex or SVES record can be located for them. This verification is then compared to the data as displayed on the MMIS file and the following action is taken.

*For MEDS and MEDSX beneficiaries, the Branch Director and Assistants at the controlling Medicaid Regional Office are notified of the differences and given three days in which to correct the data. If not, a second e-mail includes the Medicaid Regional Office's Division Director for correction of the data. If not, a third e-mail is directed to Alex Denny.

*For SSI beneficiaries, the controlling SSA District Office is asked if the beneficiary's data can be matched between their SSI and Medicare record at SSA. NOTE: If the verification is occurring via telephone and the data is identified as unmatched, the SSA Office is asked at this time whether the data can be matched. If the data cannot be matched, DOM cannot accomplish the addition of the beneficiary to the Buy-In program without continuing problems within the various computer programs such as not being able to reaccrete after a federal deletion or delete as appropriate.

It is noted that beneficiaries may change their Medicare Claim Number, name or provide documentation for correction of a date of birth at any given time. This means that although a beneficiary may have been open on the Buy-In program and then deleted, a requested reaccretion using the same data may not be accepted.

Receiving and Resolving Beneficiary Inquiries

Inquiries may be received via letter, telephone, e-mail or via the "Buy-In Problem Memo" form from in state or out of state. For in state inquiries regarding a given beneficiary, the file is reviewed to determine whether the Medicare entitlement is on file correctly, Part A and/or Part B Buy-In is currently open and whether the beneficiary is eligible for reimbursement for any period. If no corrective action is necessary, contact the beneficiary's local SSA office to determine whether the premium continues to be deducted from their check. If so, SSA has a procedure in place for corrective action.

For out of state inquiries regarding a given beneficiary, review the file to determine whether the file remains open in this state and whether beneficiary remains open on the Buy-In A or B program.

For SSI beneficiaries, contact the beneficiary's local SSA Office to determine whether the address and state and county code indicates a move to the identified state. If not, advise that the beneficiary would need to contact their local SSA office in their state to request the appropriate corrections to their file. In the meantime, the beneficiary remains open on MS Medicaid and the Part A and/or Part B Buy-In program. If so, the Enrollment Bureau would be advised and the file would be monitored for closure. After the closure, a Buy-In Part A and/or Part B deletion would be submitted via the Online Outgoing Part A or Part B Holding file.

For MEDS and MEDSX beneficiaries, the appropriate Medicaid Regional Office is contacted to advise of the report concerning the beneficiary's residence and request closure of the Medicaid eligibility if they verify that the beneficiary has moved out of state. If not, advise that the beneficiary remains a resident of this state. If so, the beneficiary's file would be monitored for Medicaid eligibility closure. After the closure, a deletion would be submitted via the Online Outgoing Buy-In Part A or Part B Holding file.

The goal is to respond to the inquiries within three business days of receipt of the inquiry although this is not always possible.

Medicare File Maintenance

Standard Operating Procedures

Monitoring the BENDEX File

Monitoring the updating of the beneficiary's Medicare History file with Medicare data from the BENDEX and SVES file by the fiscal agent is accomplished by review of the reports prepared by the fiscal agent following the BENDEX update process. These reports are available in DOM's "Reports Online" and are as follows.

Beneficiary & Earnings Data Exchange System (BENDEX) Reports

For the BENDEX file, the fiscal agent prepares a report of all BENDEX updates to the beneficiary's file in alpha sort within a County sort and includes the BENDEX and Medicaid data for a given beneficiary. This report is RB214 and is titled "BENDEX Transactions Applied". A report is also prepared for all transactions that were not updated to a given beneficiary's MMIS file. This report is RB213 and is titled "BENDEX Transactions Not Applied". This report will include the BENDEX data and may or may not include the Medicaid data. These reports are available in DOM's "Reports Online" usually the day following the BENDEX update.

At the time of the BENDEX update run, the SVES file is to be reviewed to determine which data is more current and accurate. This is the data that will be updated to the beneficiary's file. If from BENDEX, the record will be written to the "BENDEX Applied Report". If the SVES data is accepted, the record should be written to a "BENDEX/SVES Applied Report".

If the same data that is incoming on the BENDEX and/or the SVES file is currently displayed on the given beneficiary's file from whatever source, there will be no update to the beneficiary's file. This record would be written to the "BENDEX Transactions Not Applied" Report RB213.

The reports "BENDEX Transactions Applied" and "BENDEX Transactions Not Applied" are to be reviewed 100%. This is for the purpose of locating records incorrectly applied so that corrective action can be taken. Example: A parent's Medicare entitlement is sometimes applied to a child's Medicaid record. On the "BENDEX Transactions Not Applied" report, records may be located that should have been applied. In both instances, the corrections can be accomplished via online updates to the given beneficiary's Medicare, Part A and/or Part B Medicare entitlement.

The staff also utilizes COGNOS for specialized reports in resolving certain identified problems.

Manually Updating the MMIS Medicare Eligibility Segment

Manual updating of the beneficiary's Medicare History file may occur not only from reviewing the above mentioned reports. Updates may be due to telephone calls, e-mails, correspondence or contacts from providers, beneficiaries or their representatives. In addition, DOM maintains a form, "Buy-In Problem Memo" that is used by SSA Field Offices and Medicaid Regional Offices to report Buy-In problems to Buy-In/Medicare staff for corrective action. This form includes space for beneficiary's Medicare entitlement information. DOM also maintains a FAX form for SSA Field Offices for use in reporting Medicare and Buy-In data from their files for a given beneficiary to DOM Buy-In/Medicare staff for corrective action.

If a beneficiary has active Part A and no Part B or active Part B and no Part A coverage, Medicaid can pay the inactive part. Conditions allowing Medicaid to pay include an inactive part due to initial refusal of the benefit, accepting the benefit and later withdrawing from the benefit or accepting the benefit and later being terminated due to failure to pay premiums. Medicaid can offer to pay this premium if the beneficiary meets all qualifications. Currently, Medicaid does not update the remaining Medicare Part to the given beneficiary's Medicare file at the time of the billing of the premium to Medicaid. Instead, the update occurs when it is known that the beneficiary's Master Beneficiary Record (MBR) at SSA has been updated so that the Common Work File (CWF) for provider claims has the opportunity to be updated. This may change to an update to the beneficiary's Medicare data when CMS bills Medicaid for the premium for the remaining Medicare Part.

CMS APPROVED STATE PLAN FOR THIRD PARTY
RECOVERY PROCESSES

Revision: HCFA-PM-94-1 (MB) FEBRUARY 1994
State/Territory: Mississippi
Citation

4.22 Third Party Liability

42 CFR 433.137

(a) The Medicaid agency meets all requirements of:

- (1) 42 CFR 433.138 and 433.139.
- (2) 42 CFR 433.145 through 433.148.
- (3) 42 CFR 433.151 through 433.154.

1902(a)(25)(H) and (I)

(4) Sections 1902(a)(25)(H) and (I) of the Act

42 CFR 433.138(f)
52 FR 5967

(b) ATTACHMENT 4.22-A

(1) Specifies the frequency with which the data exchanges required in S433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in S433.138(e) are conducted;

42 CFR 433.138(g)(1)(ii)

(2) Describes the methods the agency uses for meeting the follow-up requirements contained in S433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138(g)(3)(i) (3) Describes the methods the agency uses for following upon information obtained through the State motor vehicle accident into report file data exchange required under S433.138(d)(4)(ii) and specifies the time frames for incorporation the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and 42 CFR 433.138 (g) (4) (i) through (iii) (4) Describes the methods the agency uses for on paid claims identified under S433.138(e) (methods include a procedure for periodically identifying third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

69a

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994
State/Territory: Mississippi

Citation

42 CFR 433.139(b)(3) -(C) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. (d) ATTACHMENT 4.22-B specifies the following:

42 CFR 433.139(b)(3)(ii)(c)

- (1) The method used in determining a provider's compliance with the third party billing at requirements S433.139(b)(3)(ii)(c).
- (2) The threshold amount or other 42 CFR 433.139(f)(3)(2) guideline used in determining seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

42 CFR 433.139(f)(3)

(3) The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the seek decision to recovery of reimbursement.

42 CFR 447.20

The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

TN No. 94-09 Supersedes Approval Date 8-15-94 Effective Date 7-1-94
TN No. 90-11 Date

Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994
State/ Territory: Mississippi

Citation 4.22 (continued)

42 CFR 433.151(a) (f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility or medical assistance with at least one of the following (Check as appropriate.)

-X State title IVD agency. The requirements of 43 CFR 433.152(b) are met.

-Other appropriate State agency(s) -

-Other appropriate agency(s) of another State-

-Courts and law enforcement officials. 1902(a) (60) of the Act (g) The Medicaid agency assures that the State has in effect the laws to relating medical child support under section 1908 of the Act.

1906 of the Act (h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of selecting one of the following.

-The Secretary' s method as provided in the State Medicaid Manual, Section 3910.

-X The State provides methods for determining cost effectiveness on Attachment 4.22-C.

TN No. 94-09 . . . Supersedes Approval Date 8-15-94 Effective Date 7-1-94
TN No. 92-16 Date Received 7-11-94

Revision: **HCFA-PM-** 90-2 (BERC)

January, 1990

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OME NO.: 0938-0193

STATE **PLAN** UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Requirements for Third Party Liability

Identifying Liable Resources

citation (1)

433.138(f)

52 FR 5967

The designated state agency, Department of Human Services (**DHS**), performs the requested data exchanges specified in Section 433.138(d)(I) during application period and at least on a quarterly basis. The exception **to** this time frame is the institutionalized individuals for which exchanges of data are conducted as specified in Sec. 435,948 (**d1**). Data exchange agreements have been **executed** with Workers' Compensation Commission and the Department of Public Safety with specific fed exchange time frame on each of annually. (Section 433.138td) (4))

The **MMIS** identifies on a monthly basis **those** paid claims that contain diagnosis **codes 800-999** (IC139CM) for the purpose of identifying the legal liabilities of third parties, (Section 433.138ie))

433,138(g)(1)(ii) The TPL unit receives health insurance and **(2)(ii)** information from DHS who **performs** the 52 **FR** 5967 **SWFCA** and SSA wage and earnings files **data** exchanges. **DHS** maintains a copy of the TP information in the eligibility file and sends a copy to the DOM TPL Unit. The **TPL** Unit completes any necessary research, **enters** the data into the MMIS TPL files within **45** days, and files the hard copy information.

(Section 433.138(g)(1)(i))

TN No, 93-01 Approval Date 4-6-93 Effective Date 1-1-93

supersedes Date Received 3-2-93

TN No. 91-02

Revision: HCFA-PM- 90-2 (BERG) Attachment: 4 22 -A
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OMB NO* : 0938-0193

STATE PLAN UNDER TITLE XIX OF THE **SOCIAL SECURITY ACT**
State/Territory: Mississippi

Requirements for Third Party Liability
Identifying Liable Resources

The TPL Unit receives insurance information **from** DHS, the **SSA**, and the Medicaid Regional Offices from application and redetermination procedures for Medicaid **eligibility**. The sources of eligibility maintain **a** copy of the third party information in the eligibility case file and send a copy to the DOH TPL Unit. Within **60** days, **the** TPL Unit completes the necessary research, enters the data into the **MMIS** TPL Support System, and files the hard copy document.

(section **433.138(g162)** (1))

The required data exchange takes place annually with the **Mississippi Workers ' Compensation Commission**. In order to incorporate TPL data within 60 days as specified in Section **433.139(g)** (2) (**11**, prior to producing the final report of "hits," the **MMIS** cross references **the** matched tape received back from WC with **the** trauma code claims which appeared on the Trauma Code edit reports to avoid duplication of

effort. Upon receipt of the final report, the WC **case** files are examined by **the** DOM **TPL** Unit **as** warranted. Inquiries containing Medicaid's subrogation rights to insurance companies, employers or attorneys are generated. Upon receipt of response, the source of eligibility is sent detailed information on the liable third party to include in the eligibility **case** file.

TN No. 93-01 Approval Date 4-6-93 Effective Date 1-1-93
supersedes Date Received 3-2-93

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TN No. 91-02

Revision: **HCFA-PM-90-2** (BERC)

January, 1990

Attachment: 4.22 - A

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OMB NO. : 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Requirements for Third Party Liability

Identifying Liable Resources

The TPL Unit maintains related case files.

433.138(g) f3)(i)

(3) **A** required data exchange takes place and (iii) with the Department of Public Safety 52 FR 5967 (DPS) annually. The potential for a useful data exchange is slight since the DPS file is keyed by driver license number. This is not always the social security number which will be used to execute the exchange. Furthermore, **the** data maintained on the **DPS** file relates only to the driver or the owner of the vehicle ;no passenger information. Also, State law prohibits access to the accident reports or supplemental reports. In order to incorporate TPL data within 60 days, follow-up includes **the MMIS** automatically generating inquiries to recipients listed on final data exchange report. Upon receipt of response indicating a liable third party, the source of eligibility will be sent TP information to include in the eligibility case file. The TPL Unit will maintain related case files.

TN No, 93-01 Approval Date 4-6-93 Effective Date 1-1-93

supersedes Date Received 3-2-93

TN No. 91-02

Revision: HGFA-PM- 90-2 (BERC)

January, 1990

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OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XI% OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Requirements for Third Party Liability-
Identifying Liable Resources

433.138(g) (4)(i) through (iii)

The MMIS identifies on a monthly basis those paid claims that contain diagnosis codes 52 FR 5967 800-999 (ICD-9-CM.) An accident questionnaire is system generated and mailed to each recipient whose accumulated monthly paid amount; equals or exceeds \$250. Responses received by the TPL Unit that identify a liable third party, attorney, or insurance carriers require a notice and inquiry to that party advising of Medicaid's subrogation statute [section 43-13-125 of the Mississippi Code of 1972, annotated as amended) within 30 days, In order to incorporate TP information within 60 days, the sources of eligibility are notified to include TP information in the eligibility case record. The TPL Unit will make any necessary updates to the MMIS files and maintain related hard copy files, a detailed amount of the state's subrogation claim is provided to the third party upon request and updated immediately prior to settlement. Should Medicaid's potential recovery be less than the total subrogation interest, the case is referred to the staff attorney for a comprise determination (Section 43-13-i25(2)(b), Mississfpipi Code of 1972, annotated amended,)Additionally, the right of subrogation by the state to the recipient's right to recovery shall be subject to ordinary and reasonable attorney fees (Section 43-13-125(2){aj, Mississippi Code of 1972, annotated as amended,)

TN N093-01 Approval Date 4-6-93 Effective Date
supersedes Date Received 3-2-93 TTY NO. 91-31

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January, 1990

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OMB NO, : 0938-0193

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Mississippi**

**Requirements for Third Party Liability-
Identifying Liable Resources**

Priority for follow-up will be given to the trauma codes which yield the highest recovery as evidenced by the quarterly report produced by the DOM TPL Unit in-house computer program.

**TN NO. 93-01 Approval Date 4-6-33 Effective Date 1-1-93
supersedes Date Received 3-2-33**

TN NO. 91-31

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Requirements for Third Party Liability payment of Claims

Citation 433.139(b)(3)
(ii)(c)
55 FR 1423

- (1) The provider is not required to file with the third party prior to filing Medicaid in a situation where the TP is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D Agency.

433.139(f)(2)(2)
50 FR 46652

- (2) A threshold amount of \$100 is used to determine whether to seek recovery from a liable third party except for trauma-related claims in which case a threshold amount of 250 is used.

433.139(0)(3) (3)
50 FR 46652

- (3) Third party recovery will be pursued when the accumulated monthly trauma code paid claims amount for each beneficiary equals or exceeds a \$250 threshold.

The MMIS will generate monthly invoices of prenatal, preventive pediatrics, and IV-D related claims when the accumulated paid claims for each beneficiary with a third party indicator in the claims payment system and no third party amount listed on the claim, equals or exceeds a \$100 threshold.

TN No. 2005-001
Supersedes
TN No. 2001-15

Date Received: 01/05/2005
Date Approved: 01/03/2005
Date Effective: 01/01/2005

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Mississippi

Citation _____ Condition or Requirement _____

1906 of the Act _____ State Method on Cost Effectiveness of Employer-Based Group Health Plans

I. The State of Mississippi will use two (2) methods to determine the likely cost effectiveness of a group health plan:

(1) Cost Effectiveness Based on Average Expenditure Projection

The likely cost effectiveness of a health insurance policy to Medicaid may be determined by comparing the annualized premium, deductible, and copayments, plus the administrative cost of analysis and processing by the State against the average Medicaid expenditure for a recipient in the recipient's eligibility classification for types of service(s) covered under the policy. The premium shall be paid even if the policy covers other non-Medicaid person(s).

(2) Cost Effectiveness Based on Actual Expenditures

The likely cost effectiveness of health insurance may be established by documentation of actual expenditure (Explanation of Benefits) from the insurer which, based on a recipient's existing condition, are likely to continue and that exceed the annualized cost of the policy as described in item (1) above.

II. Policies with Coverage Limitations

Health insurance policies which are not considered to be cost effective, based upon the limited nature of their coverage, are accident, indemnity, Medicare supplemental and surgical policies. These policies, therefore, will not be evaluated. Dread disease and cancer policies may be cost effective if documented by insurance benefits which can be expected to be ongoing and when determined to be cost effective as described in item I.

TN No. 92-16 Approval Date 11-3-93 Effective Date 7-1-92
Supersedes _____ Date Received 9-30-92 HCFA ID: 7985E
TN No. New

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/ Territory: Mississippi
LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State Division of Medicaid uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home: Mississippi does not have a lien law; therefore a determination of when an individual can reasonably be expected to be discharged is not applicable to this state.
2. The following criteria are used for establishing that a permanently care institutionalized individual's son or daughter provided as specified under regulations at 42 CFR § 433.36(f) : The statement of primary care giver, collateral contacts, and/ or documentation of recipient's medical history may be used to establish that a specified person rendered care enabling the recipient to stay at home rather than in an institution.
3. below 3 . The State Division of Medicaid defines the terms as follows:

0 estate -any real or personal property owned by the individual in its entirety or by shared ownership.

0 individual's home -the recipient's residence prior to institutionalization in which he has an ownership interest.

0 equity interest in the home the money value -of property or of an interest in that property in excess of any claims or liens against it.

0 residing in the home for at least one or two years on a continuous basis -having possessions in that home, receiving mail at that address, sharing or paying all of the expenses, having no extended periods of absence, having no other place of residence.

0 lawfully residing - being able to use dwelling principal place of residence.

4. The State Division of Medicaid defines undue hardship as follows:

a. the property is the sole income-producing asset of the survivors and such income is limited;

b. an adult relative who is a recognized heir has lived in of the decedent, depended upon that home for his principal place of residence for at least one (1) year prior to the recipient entering the nursing facility, has remained in the house continually, either has or has not an equity interest in the property, and has given so that the person care was kept from entering the nursing facility during the year;

\$ 5,000 or less and there C. the asset in the estate totals is no prepaid burial contract or other money set aside for burial; d. the estate of modest value as defined by the Secretary.

TN	NO.	95-13	Supersedes	7-1-95	Effective
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5. The following standards and procedures are used by the State Division of Medicaid for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective: The State Division of Medicaid receives notification of death from the Medicaid Regional Offices and MMIS. Research is completed through use of the eligibility case file documentation and pertinent legal documents, tax receipts, etc. If there is evidence of undue hardship as defined in state/ federal guidelines, no pursuit is affected. While the state will attempt to recover all amounts that are not waived for undue hardship, recovery is not deemed cost effective if the amount to be recovered is less than \$ 2,000 or the value of the estate is less than **25** percent of the recovery amount if attempted recovery will require protracted litigation. The findings and conclusions are documented in physical and computer files.

6. The State Division of Medicaid defines cost-effective as follows: While the State Division of Medicaid will attempt to recover all amounts that are not waived for undue hardship, recovery is not deemed cost effective if the amount to be recovered is less \$ **2,000** and protracted litigation is required to recover, or the value of the estate is less than 25 percent of the recovery amount making Medicaid's potential recovery less than 25 percent of the recovery amount and protracted litigation will be required to recover. These thresholds are based on the legal time and expense involved in pursuing recoveries through the courts.

7 . The State Division of Medicaid uses the following collection procedures:

If an estate exists, within 30 days of death date, a letter is mailed to survivor indicating the basic law, value of estate, Medicaid's recovery amount, dates of service, and explanation of fair hearing. The letter can be used by the survivor as a formal request to the Division of Medicaid for a fair hearing or to write an undue hardship explanation. If no response is received from the survivor within **15** days of the date of the notice, the court case is referred to the Legal Unit which files in the proper **as** a creditor of the estate or notifies the survivor in writing of Medicaid's recovery amount. If a request for a fair hearing is timely received, the hearing date is set within **10** days of receipt of request. The survivor is notified of hearing date at least 10 days prior to the date. The time for hearing may be extended if survivor has good cause; i. e. , illness, failure to receive notice timely, being out of the state, or any other reasonable explanation. If good cause for filing a timely request is shown, a hearing request will be accepted. After the hearing occurs, the hearing officer forwards a transcript with recommended action to the Executive Director for a final decision. The Executive Director renders a decision which is sent to the survivor in writing. The survivor is entitled to seek judicial review in the court **of** Medicaid must of proper jurisdiction. The Division take final administrative action on a hearing within **90** days from the date **of** the hearing request. Hearing procedures have been promulgated and are available to the survivor upon request for **a** hearing.

FEDERAL LAW MANDATING
THIRD PARTY RECOVERY PROCESSES

[Code of Federal Regulations]
[Title 42, Volume 3]
[Revised as of October 1, 2002]

From the U.S. Government Printing Office via GPO Access
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TITLE 42--PUBLIC HEALTH

CHAPTER IV--CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF
HEALTH AND HUMAN SERVICES--(Continued)

PART 433--STATE FISCAL ADMINISTRATION--Table of Contents

Subpart D--Third Party Liability

Source: 45 FR 8984, Feb. 11, 1980, unless otherwise noted.

Sec. 433.135 Basis and purpose.

This subpart implements sections 1902(a)(25), 1902(a)(45),
1903(d)(2), 1903(o), 1903(p), and 1912 of the Act by setting

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forth State plan requirements concerning--

- (a) The legal liability of third parties to pay for services provided under the plan;
- (b) Assignment to the State of an individual's rights to third party payments; and
- (c) Cooperative agreements between the Medicaid agency and other entities for obtaining third party payments.

[50 FR 46664, Nov. 12, 1985]

Sec. 433.136 Definitions.

For purposes of this subpart--

Private insurer means:

- (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 services included in the State plan; and
- (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.

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

Title IV-D agency means the organizational unit in the State that has the responsibility for administering or supervising the

administration of a State plan for child support enforcement under title IV-D of the Act.

[49 FR 8984, Feb. 11, 1980, as amended at 50 FR 46664, Nov. 12, 1985;
50 FR 49389, Dec. 2, 1985]

Sec. 433.137 State plan requirements.

(a) A State plan must provide that the requirements of Secs. 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that--

(1) The requirements of Secs. 433.145 through 433.148 are met for assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

(2) The requirements of Secs. 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.

[50 FR 46665, Nov. 12, 1985, as amended at 55 FR 48606, Nov. 21, 1990; 55 FR 52130, Dec. 19, 1990; 60 FR 35502, July 10, 1995]

Sec. 433.138 Identifying liable third parties.

(a) Basic provisions. The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility. (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or recipient such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in Sec. 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or recipient, the social security number (SSN) of the policy holder,

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and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for--

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in

accordance with a written agreement, the Medicaid agency must modify the agreement to provide for--

(i) Collection, from the applicant or recipient during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in Sec. 433.139 (b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) Obtaining other information. Except as provided in paragraph (1) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid recipients to the extent such information is available.

(d) Exchange of data. Except as provided in paragraph (1) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in Sec. 433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under Sec. 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in Sec. 435.4 of this chapter and from the SSA wage and earnings files data as specified in Sec. 435.948(a)(2) of this chapter, the agency must--

(i) Use the information that identifies Medicaid recipients that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of recipients and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under Sec. 435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies those Medicaid recipients that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining--

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid recipients and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid recipients with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

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(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional

office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) Diagnosis and trauma code edits. (1) Except as specified under paragraph (e)(2) or (1) of this section, or both, the agency must take action to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in Sec. 433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) Data exchanges and trauma code edits: Frequency. Except as provided in paragraph (1) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in Sec. 435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) Follow-up procedures for identifying legally liable third party resources. Except as provided in paragraph (1) of this section, the State must meet the requirements of this paragraph.

(1) SWICA, SSA wage and earnings files, and title IV-A data exchanges. With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section--

(i) Except as specified in Sec. 435.952(d) of this chapter, within 45 days, the agency must followup (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in Sec. 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) Health insurance information and workers' compensation data exchanges. With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section--

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in Sec. 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) State motor vehicle accident report file data exchanges. With respect to information obtained under paragraph (d)(4)(ii) of this section--

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in Sec. 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) Diagnosis and trauma code edits. With respect to the paid claims identified under paragraph (e) of this section--

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under

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the third party liability payment procedures specified in Sec. 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the timeframes for incorporation of the information.

(h) Obtaining other information and data exchanges: Safeguarding information. (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in part 431, subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify--

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) Reimbursement. The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) Reports. The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under Sec. 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under paragraph (1) of this section, it is not required to provide the reports required in this paragraph.

(k) Integration with the State mechanized claims processing and information retrieval system. Basic requirement--Development of an action plan. (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to--

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in

Sec. 433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in Sec. 433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in Sec. 433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in Sec. 433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from

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the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(1) Waiver of requirements. (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (1)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

[52 FR 5975, Feb. 27, 1987, as amended at 54 FR 8741, Mar. 2, 1989; 55 FR 1432, Jan. 16, 1990; 55 FR 5118, Feb. 13, 1990; 60 FR 35502, July 10, 1995]

Sec. 433.139 Payment of claims.

(a) Basic provisions. (1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must

use the procedures specified in paragraphs (b) through (f) of this section.

(2) The agency must submit documentation of the methods (e.g., cost avoidance, pay and recover later) it uses for payment of claims involving third party liability to the CMS Regional Office.

(b) Probable liability is established at the time claim is filed. Except as provided in paragraph (e) of this section--

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment.

(2) The agency may pay the full amount allowed under the agency's payment schedule for the claim and then seek reimbursement from any liable third party to the limit of legal liability if the claim is for labor and delivery and postpartum care. (Costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost-avoided.)

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV-D agency), consistent with paragraph (f) of this section if--

(i) The claim is prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B of this chapter), that is covered under the State plan; or

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(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV-D agency. The agency prior to making any payment under this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) The provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited 30 days from the date of the service and has not received payment from the third party.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

(c) Probable liability is not established or benefits are not available at the time claim is filed. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency must pay the full amount allowed under the agency's payment schedule.

(d) Recovery of reimbursement. (1) If the agency has an approved waiver under paragraph (e) of this section to pay a claim in which the probable existence of third party liability has been established and then seek reimbursement, the agency must seek recovery of reimbursement from the third party to the limit of legal liability within 60 days after the end of the month in which payment is made unless the agency

has a waiver of the 60-day requirement under paragraph (e) of this section.

(2) Except as provided in paragraph (e) of this section, if the agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the agency must seek recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

(3) Reimbursement must be sought unless the agency determines that recovery would not be cost effective in accordance with paragraph (f) of this section.

(e) Waiver of requirements. (1) The agency may request initial and continuing waiver of the requirements in paragraphs (b)(1), (d)(1), and (d)(2) of this section, if it determines that the requirement is not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are costs associated with billing, claims recovery data, and a State analysis documenting a cost-effective alternative that accomplishes the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (e)(1) of this section waived and will request

additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind the waiver at any time that it determines that the State no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

(4) An agency requesting a waiver of the requirements specifically concerning either the 60-day limit in paragraph (d)(1) or (d)(2) of this section must submit documentation of written agreement between the agency and the third party, including Medicare fiscal

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intermediaries and carriers, that extension of the billing requirement is agreeable to all parties.

(f) Suspension or termination of recovery of reimbursement. (1) An agency must seek reimbursement from a liable third party on all claims for which it determines that the amount it reasonably expects to recover will be greater than the cost of recovery. Recovery efforts may be suspended or terminated only if they are not cost effective.

(2) The State plan must specify the threshold amount or other guideline that the agency uses in determining whether to seek recovery of reimbursement from a liable third party, or describe the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

(3) The State plan must also specify the dollar amount or period of time for which it will accumulate billings with respect to a particular liable third party in making the decision whether to seek recovery of

reimbursement.

[50 FR 46665, Nov. 12, 1985, as amended at 51 FR 16319, May 2, 1986; 60 FR 35503, July 10, 1995; 62 FR 23140, Apr. 29, 1997]

Sec. 433.140 FFP and repayment of Federal share.

(a) FFP is not available in Medicaid payments if--

(1) The agency failed to fulfill the requirements of Secs. 433.138 and 433.139 with regard to establishing liability and seeking reimbursement from a third party;

(2) The agency received reimbursement from a liable third party; or

(3) A private insurer would have been obligated to pay for the service except that its insurance contract limits or excludes payments if the individual is eligible for Medicaid.

(b) FFP is available at the 50 percent rate for the agency's expenditures in carrying out the requirements of this subpart.

(c) If the State receives FFP in Medicaid payments for which it receives third party reimbursement, the State must pay the Federal government a portion of the reimbursement determined in accordance with the FMAP for the State. This payment may be reduced by the total amount needed to meet the incentive payment in Sec. 433.153.

Assignment of Rights to Benefits

Sec. 433.145 Assignment of rights to benefits--State plan requirements.

(a) A State plan must provide that, as a condition of eligibility, each legally able applicant or recipient is required to:

(1) Assign to the Medicaid agency his or her rights, or the rights of any other individual eligible under the plan for whom he or she can legally make an assignment, to medical support and to payment for medical care from any third party;

(2) Cooperate with the agency in establishing paternity and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating, and except for individuals described in section 1902(1)(1)(A) of the Act (poverty level pregnant women), who are exempt from cooperating in establishing paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(3) Cooperate in identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan, unless the individual establishes good cause for not cooperating.

(b) A State plan must provide that the requirements for assignments, cooperation in establishing paternity and obtaining support, and cooperation in identifying and providing information to assist the State in pursuing any liable third party under Secs. 433.146 through 433.148 are met.

(c) A State plan must provide that the assignment of rights to benefits obtained from an applicant or recipient is effective only for services that are reimbursed by Medicaid.

[55 FR 48606, Nov. 21, 1990, as amended at 58 FR 4907, Jan. 19, 1993]

Sec. 433.146 Rights assigned; assignment method.

(a) Except as specified in paragraph (b) of this section, the agency must require the individual to assign to the State--

(1) His own rights to any medical care support available under an order of a court or an administrative agency, and any third party payments for medical care; and

(2) The rights of any other individual eligible under the plan, for whom he can legally make an assignment.

(b) Assignment of rights to benefits may not include assignment of rights to Medicare benefits.

(c) If assignment of rights to benefits is automatic because of State law, the agency may substitute such an assignment for an individual executed assignment, as long as the agency informs the individual of the terms and consequences of the State law.

Sec. 433.147 Cooperation in establishing paternity and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.

(a) Scope of requirement. The agency must require the individual who assigns his or her rights to cooperate in--

(1) Establishing paternity of a child born out of wedlock and obtaining medical support and payments for himself or herself and any other person for whom the individual can legally assign rights, except that individuals described in section 1902(1)(1)(A) of the Act (poverty level pregnant women) are exempt from these requirements involving paternity and obtaining medical support and payments from, or derived from, the father of the child born out of wedlock; and

(2) Identifying and providing information to assist the Medicaid agency in pursuing third parties who may be liable to pay for care and services under the plan.

(b) Essentials of cooperation. As part of a cooperation, the agency may require an individual to--

(1) Appear at a State or local office designated by the agency to provide information or evidence relevant to the case;

(2) Appear as a witness at a court or other proceeding;

(3) Provide information, or attest to lack of information, under penalty of perjury;

(4) Pay to the agency any support or medical care funds received that are covered by the assignment of rights; and

(5) Take any other reasonable steps to assist in establishing paternity and securing medical support and payments, and in identifying and providing information to assist the State in pursuing any liable third party.

(c) Waiver of cooperation for good cause. The agency must waive the requirements in paragraphs (a) and (b) of this section if it determines that the individual has good cause for refusing to cooperate.

(1) With respect to establishing paternity of a child born out of wedlock or obtaining medical care support and payments, or identifying or providing information to assist the State in pursuing any liable third party for a child for whom the individual can legally assign rights, the agency must find the cooperation is against the best interests of the child, in accordance with factors specified for the Child Support Enforcement Program at 45 CFR part 232. If the State title IV-A agency has made a finding that good cause for refusal to cooperate does or does not exist, the Medicaid agency must adopt that finding as its own for this purpose.

(2) With respect to obtaining medical care support and payments for an individual and identifying and providing information to assist in pursuing liable third parties in any case not covered by paragraph

(c)(1) of this section, the agency must find that cooperation is against the best interests of the individual or the person to whom Medicaid is being furnished because it is anticipated that cooperation will result in reprisal against, and cause physical or emotional harm to, the individual or other person.

(d) Procedures for waiving cooperation. With respect to establishing paternity, obtaining medical care support and payments, or identifying and providing information to assist the State in pursuing liable third parties for a child for whom the individual can legally assign rights, the agency must use the procedures specified for the Child Support Enforcement Program at 45 CFR part 232. With respect to obtaining medical care support and payments or to identifying and providing information to assist the State in pursuing liable third

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parties for any other individual, the agency must adopt procedures similar to those specified in 45 CFR part 232, excluding those procedures applicable only to children.

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[45 FR 8984, Feb. 11, 1980, as amended at 55 FR 48606, Nov. 21, 1990; 58 FR 4907, Jan. 19, 1993]

Sec. 433.148 Denial or termination of eligibility.

In administering the assignment of rights provision, the agency must:

(a) Deny or terminate eligibility for any applicant or recipient who--

(1) Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment; or

(2) Refuses to cooperate as required under Sec. 433.147(a) unless cooperation has been waived;

(b) Provide Medicaid to any individual who--

(1) Cannot legally assign his own rights; and

(2) Would otherwise be eligible for Medicaid but for the refusal, by a person legally able to assign his rights, to assign his rights or to cooperate as required by this subpart; and

(c) In denying or terminating eligibility, comply with the notice and hearing requirements of part 431, subpart E of this subchapter.

Cooperative Agreements and Incentive Payments

Sec. 433.151 Cooperative agreements and incentive payments--State plan requirements.

For medical assistance furnished on or after October 1, 1984--

(a) A State plan must provide for entering into written cooperative agreements for enforcement of rights to and collection of third party benefits with at least one of the following entities: The State title IV-D agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. The agreements must be in accordance with the provisions of Sec. 433.152.

(b) A State plan must provide that the requirements for making incentive payments and for distributing third party collections specified in Secs. 433.153 and 433.154 are met.

[50 FR 46665, Nov. 12, 1985; 50 FR 49389, Dec. 2, 1985]

Sec. 433.152 Requirements for cooperative agreements for third party

collections.

(a) Except as specified in paragraph (b) of this section, the State agency may develop the specific terms of cooperative agreements with other agencies as it determines appropriate for individual circumstances.

(b) Agreements with title IV-D agencies must specify that the Medicaid agency will--

(1) Meet the requirements of the Office of Child Support Enforcement for cooperative agreements under 45 CFR Part 306; and

(2) Provide reimbursement to the IV-D agency only for those child support services performed that are not reimbursable by the Office of Child Support Enforcement under title IV-D of the Act and that are necessary for the collection of amounts for the Medicaid program.

[50 FR 46666, Nov. 12, 1985]

Sec. 433.153 Incentive payments to States and political subdivisions.

(a) When payments are required. The agency must make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or a friend of the court, or another State that enforces and collects medical support and payments for the agency.

(b) Amount and source of payment. The incentive payment must equal 15 percent of the amount collected, and must be made from the Federal share of that amount.

(c) Payment to two or more jurisdictions. If more than one State or political subdivision is involved in enforcing and collecting support and payments:

(1) The agency must pay all of the incentive payment to the political subdivision, legal entity of the subdivision, or another State that collected medical support and payments at the request of the agency.

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(2) The political subdivision, legal entity or other State that receives the incentive payment must then divide the incentive payment equally with any other political subdivisions, legal entities, or other States that assisted in the collection, unless an alternative allocation is agreed upon by all jurisdictions involved.

Sec. 433.154 Distribution of collections.

The agency must distribute collections as follows--

(a) To itself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based.

(b) To the Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment made in accordance with Sec. 433.153.

(c) To the recipient, any remaining amount. This amount must be treated as income or resources under part 435 or part 436 of this subchapter, as appropriate. Subpart E [Reserved]

**STATE LAW MANDATING
THIRD PARTY RECOVERY PROCESSES**

MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-13-125. Recovery of medical assistance payments from third parties; compromise or settlement of claims; plaintiff's recovery of medical expenses as special damages; disposition of funds received.

(1) If medical assistance is provided to a recipient under this article for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm or corporation, then the division shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery which the recipient may have against any such person, firm or corporation to the extent of the actual amount of the medical assistance payments made by the Division of Medicaid on behalf of the recipient. The recipient shall execute and deliver instruments and papers to do whatever is necessary to secure such rights and shall do nothing after said medical assistance is provided to prejudice the subrogation rights of the division. Court orders or agreements for reimbursement of Medicaid payments shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all checks, drafts, money orders, or other negotiable instruments representing Medicaid payment recoveries that are received.

The division, with the approval of the Governor, may compromise or settle any such claim and execute a release of any claim it has by virtue of this section.

(2) The acceptance of medical assistance under this article or the making of a claim thereunder shall not affect the right of a recipient or his legal representative to recover the medical assistance payments made by the division as an element of special damages in any action at law; provided, however, that a copy of the pleadings shall be certified to the division at the time of the institution of suit, and proof of such notice shall be filed of record in such action. The division may, at any time before the trial on the facts, join in such action or may intervene therein. Any amount recovered by a recipient or his legal representative shall be applied as follows:

(a) The reasonable costs of the collection, including attorney's fees, as approved and allowed by the court in which such action is pending, or in case of settlement without suit, by the legal representative of the division;

(b) The actual amount of the medical assistance payments made by the division on behalf of the recipient; or such pro rata amount as may be arrived at by the legal representative of the division and the recipient's attorney, or as set by the court having jurisdiction; and

(c) Any excess shall be awarded to the recipient.

(3) No compromise of any claim by the recipient or his legal representative shall be binding upon or affect the rights of the division against the third party unless the division, with the approval of the Governor, has entered into the compromise. Any compromise effected by the recipient or his legal representative with the third party in the absence of advance notification to and approved by the division shall constitute conclusive evidence

of the liability of the third party, and the division, in litigating its claim against said third party, shall be required only to prove the amount and correctness of its claim relating to such injury, disease or sickness. It is further provided that should the recipient or his legal representative fail to notify the division of the institution of legal proceedings against a third party for which the division has a cause of action, the facts relating to negligence and the liability of the third party, if judgment is rendered for the recipient, shall constitute conclusive evidence of liability in a subsequent action maintained by the division and only the amount and correctness of the division's claim relating to injuries, disease or sickness shall be tried before the court. The division shall be authorized in bringing such action against the third party and his insurer jointly or against the insurer alone.

(4) Nothing herein shall be construed to diminish or otherwise restrict the subrogation rights of the Division of Medicaid against a third party for medical assistance paid by the Division of Medicaid or the Medicaid Commission in behalf of the recipient as a result of injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against such a third party.

(5) Any amounts recovered by the division under this section shall, by the division, be placed to the credit of the funds appropriated for benefits under this article proportionate to the amounts provided by the state and federal governments respectively.

SOURCES: Codes, 1942, Sec. 7290-43; Laws, 1969, Ex Sess, ch. 37, Sec. 13; 1979, ch. 326; 1984, ch. 488, Sec. 52; 1993, ch. 609, Sec. 6; Laws, 2000, ch. 301, § 11, eff from and after July 1, 1999.

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§ 43-13-126. Health insurers required to provide certain information to Division of Medicaid, accept Division's right of recovery and not deny claims submitted by Division on the basis of certain errors as condition of doing business in Mississippi.

As a condition of doing business in the state, health insurers, including self-insured plans, group health plans (as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974), 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, are required to:

(a) Provide, with respect to individuals who are eligible for, or are provided, medical assistance under the state plan, upon the request of the Division of Medicaid, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address and identifying number of the plan) in a manner prescribed by the Secretary of the Department of Health and Human Services; (b) Accept the Division of Medicaid's right of recovery and the assignment to the division of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the state plan; (c) Respond to any inquiry by the Division of Medicaid regarding a claim for payment for any health care item or service that is submitted not later than three (3) years after the date of the provision of that health care item or service; and (d) Agree not to deny a claim submitted by the Division of Medicaid solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if: (i) The claim is submitted by the division within the three-year period beginning on the date on which the item or service was furnished; and (ii) Any action by the division to enforce its rights with respect to the claim is begun within six (6) years of the division's submission of the claim.

Sources: Laws, 2007, ch. 553, § 3, eff from and after July 1, 2007.

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MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-13-127. Reports and recommendations required of Division of Medicaid.

(1) Within sixty (60) days after the end of each fiscal year and at each regular session of the Legislature, the division shall make and publish a report to the Governor and to the Legislature, showing for the period of time covered the following:

- (a) The total number of recipients;
- (b) The total amount paid for medical assistance and care under this article;
- (c) The total number of applications;
- (d) The number of applications approved;
- (e) The number of applications denied;
- (f) The amount expended for administration of the provisions of this article;
- (g) The amount of money received from the federal government, if any;
- (h) The amount of money recovered by reason of collections from third persons by reason of assignment or subrogation, and the disposition of the same;
- (i) The actions and activities of the division in detecting and investigating suspected or alleged fraudulent practices, violations and abuses of the program; and
- (j) Any recommendations it may have as to expanding, enlarging, limiting or restricting the eligibility of persons covered by this article or services provided by this article, to make more effective the basic purposes of this article; to eliminate or curtail fraudulent practices and inequities in the plan or administration thereof; and to continue to participate in receiving federal funds for the furnishing of medical assistance under Title XIX of the Social Security Act or other federal law.

(2) In addition to the reports required by subsection (1) of this section, the division shall submit a report each month to the Chairmen of the Public Health and Welfare Committees of the Senate and the House of Representatives and to the Joint Legislative Budget Committee that contains the information specified in each paragraph of subsection (1) for the preceding month.

SOURCES: Codes, 1942, Sec. 7290-44; Laws, 1969, Ex Sess, ch. 37, Sec. 14; 1972, ch. 306, Sec. 1; 1984, ch. 488, Sec. 53; 1990, ch. 548, Sec. 4; Laws, 2002, ch. 636B, § 4, SB 2189, eff from and after passage (approved Apr. 12, 2002.). **PREVIOUS VERSIONS:** [Pre-2002](#).

MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-13-301. Identification of cases involving third-party liability.

The State Department of Public Welfare shall assist the Division of Medicaid in the Office of the Governor in identifying cases involving third-party liability, including without limitation, third-party insurance benefits, health insurance or other health coverage maintained by the recipient or absent parent through intake, initial determinations, and redeterminations of eligibility, and shall promptly transmit such information to the Division of Medicaid or the fiscal agent of the Division of Medicaid.

SOURCES: Laws, 1985, ch. 497, Sec. 1, eff from and after July 1, 1985.

MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-13-303. Inclusion of medical support in child support enforcement orders; duties of health insurers and employers; withholding of reimbursement amounts from parent's state tax refund.

(1) The Department of Human Services, in administering its child support enforcement program, or any other attorney representing a Medicaid recipient, shall include a prayer for medical support in complaints and other pleadings in obtaining a child support order whenever health care coverage is available to the absent parent at a reasonable cost.

(2) Health insurers, including but not limited to ERISA plans, preferred provider organizations, and HMOs, shall not have contracts that limit or exclude payments if the individual is eligible for Medicaid, is not claimed as a dependent on the Federal income tax return, or does not reside with the parent or in the insurer's service area.

Health insurers and employers shall honor court or administrative orders by permitting enrollment of a child or children at any time and by allowing enrollment by the custodial parent, the Division of Medicaid, or the Child Support Enforcement Agency if the absent parent fails to enroll the child(ren).

The health insurer and the employer shall not dis-enroll a child unless written documentation substantiates that the court order is no longer in effect, the child will be enrolled through another insurer, or the employer has eliminated family health coverage for all of its employees.

The employer shall allow payroll deduction for the insurance premium from the absent parent's wages and pay the insurer. The health insurer and the employer shall not impose requirements on the Medicaid recipient that are different from those applicable to any other individual. The health insurer shall provide pertinent information to the custodial parent to allow the child to obtain benefits and shall permit custodial parents to submit claims to the insurer.

The health insurer and employer shall notify the Division of Medicaid and the Department of Human Services when lapses in coverage occur in court-ordered insurance. The health insurer and employer shall allow payments to the provider of medical services, shall honor the assignment of rights to third party sources by the Medicaid recipient and the subrogation rights of the Division of Medicaid as set forth in Section [43-13-305](#), Mississippi Code of 1972, and shall permit payment to the custodial parent.

The employer shall allow the Division of Medicaid to garnish wages of the absent parent when such parent has received payment from the third party for medical services rendered to the insured child and such parent has failed to reimburse the Division of Medicaid to the extent of the medical service payment.

Any insurer or the employer who fails to comply with the provisions of this subsection shall be liable to the Division of Medicaid to the extent of payments made to the provider

of medical services rendered to a recipient to which the third party or parties, is, are, or may be liable.

(3) The Division of Medicaid shall report to the Mississippi State Tax Commission an absent parent who has received third party payment(s) for medical services rendered to the insured child and who has not reimbursed the Division of Medicaid for the related medical service payment(s). The Mississippi State Tax Commission shall withhold from the absent parent's State tax refund, and pay to the Division of Medicaid, the amount of the third party payment(s) for medical services rendered to the insured child and not reimbursed to the Division of Medicaid for the related medical service payment(s).

SOURCES: Laws, 1985, ch. 497, Sec. 2, eff from and after July 1, 1985. Laws, 1994, ch. 649, Sec. 7, eff from and after July 1, 1994

1997 Amendment:

SECTION 139. Section 43-13-303, Mississippi Code of 1972, is amended as follows:

43-13-303. (1) The Department of Human Services, in administering its child support enforcement program on behalf of Medicaid and non-Medicaid recipients, or any other attorney representing a Medicaid recipient, shall include a prayer for medical support in complaints and other pleadings in obtaining a child support order whenever health care coverage is available to the absent parent at a reasonable cost.

(2) Health insurers, including, but not limited to, ERISA plans, preferred provider organizations, and HMOs, shall not have contracts that limit or exclude payments if the individual is eligible for Medicaid, is not claimed as a dependent on the federal income tax return, or does not reside with the parent or in the insurer's service area.

Health insurers and employers shall honor court or administrative orders by permitting enrollment of a child or children at any time and by allowing enrollment by the custodial parent, the Division of Medicaid, or the Child Support Enforcement Agency if the absent parent fails to enroll the child(ren).

The health insurer and the employer shall not dis-enroll a child unless written documentation substantiates that the court order is no longer in effect, the child will be enrolled through another insurer, or the employer has eliminated family health coverage for all of its employees.

The employer shall allow payroll deduction for the insurance premium from the absent parent's wages and pay the insurer. The health insurer and the employer shall not impose requirements on the Medicaid recipient that are different from those applicable to any other individual. The health insurer shall provide pertinent information to the custodial parent to allow the child to obtain benefits and shall permit custodial parents to submit claims to the insurer.

The health insurer and employer shall notify the Division of Medicaid and the Department of Human Services when lapses in coverage occur in court-ordered insurance. If the non-custodial parent has provided such coverage and has changed employment, and the new employer provides health care coverage, the Department of

Human Services shall transfer notice of the provision to the employer, which notice shall operate to enroll the child in the noncustodial parent's health plan, unless the noncustodial parent contests the notice. The health insurer and employer shall allow payments to the provider of medical services, shall honor the assignment of rights to third-party sources by the Medicaid recipient and the subrogation rights of the Division of Medicaid as set forth in Section 43-13-305, Mississippi Code of 1972, and shall permit payment to the custodial parent.

The employer shall allow the Division of Medicaid to garnish wages of the absent parent when such parent has received payment from the third party for medical services rendered to the insured child and such parent has failed to reimburse the Division of Medicaid to the extent of the medical service payment.

Any insurer or the employer who fails to comply with the provisions of this subsection shall be liable to the Division of Medicaid to the extent of payments made to the provider of medical services rendered to a recipient to which the third party or parties, is, are, or may be liable.

(3) The Division of Medicaid shall report to the Mississippi State Tax Commission an absent parent who has received third-party payment(s) for medical services rendered to the insured child and who has not reimbursed the Division of Medicaid for the related medical service payment(s). The Mississippi State Tax Commission shall withhold from the absent parent's state tax refund, and pay to the Division of Medicaid, the amount of the third-party payment(s) for medical services rendered to the insured child and not reimbursed to the Division of Medicaid for the related medical service payment(s).

SOURCE: 1997 Laws, Chapter 588, Sec. 139, SB2164, Effective July 1, 1997.

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MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-13-305. Assignment of rights against third-parties; appointment of Division as attorney-in-fact; direction of payments to Division.

(1) By accepting Medicaid from the Division of Medicaid in the Office of the Governor, the recipient shall, to the extent of the payment of medical expenses by the Division of Medicaid, be deemed to have made an assignment to the Division of Medicaid of any and all rights and interests in any third-party benefits, hospitalization or indemnity contract or any cause of action, past, present or future, against any person, firm or corporation for Medicaid benefits provided to the recipient by the Division of Medicaid for injuries, disease or sickness caused or suffered under circumstances creating a cause of action in favor of the recipient against any such person, firm or corporation as set out in Section [43-13-125](#). The recipient shall be deemed, without the necessity of signing any document, to have appointed the Division of Medicaid as his or her true and lawful attorney-in-fact in his or her name, place and stead in collecting any and all amounts due and owing for medical expenses paid by the Division of Medicaid against such person, firm or corporation.

(2) Whenever a provider of medical services or the Division of Medicaid submits claims to an insurer on behalf of a Medicaid recipient for whom an assignment of rights has been received, or whose rights have been assigned by the operation of law, the insurer must respond within sixty (60) days of receipt of a claim by forwarding payment or issuing a notice of denial directly to the submitter of the claim. The failure of the insuring entity to comply with the provisions of this section shall subject the insuring entity to recourse by the Division of Medicaid in accordance with the provision of Section [43-13-315](#).

(3) Court orders or agreements for medical support shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all checks, drafts, money orders or other negotiable instruments representing medical support payments which are received. Any designated medical support funds received by the State Department of Human Services or through its local county departments shall be paid over to the Division of Medicaid. When medical support for a Medicaid recipient is available through an absent parent or custodial parent, the insuring entity shall direct the medical support payment(s) to the provider of medical services or to the Division of Medicaid.

SOURCES: Laws, 1985, ch. 497, Sec. 3; 1991, ch. 579, Sec. 3; 1993, ch. 609, Sec. 7, eff from and after passage (approved April 20, 1993).

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§ 43-13-307. Loss of eligibility upon refusal to cooperate with Division or local agency.

Any applicant or recipient, inclusive of the grantee relative of a dependent child who refuses to cooperate with or to provide reasonable assistance to the Division of Medicaid against a liable third party in accordance with [Section 43-13-125](#), Mississippi Code of 1972, or fails to pay over to the Division of Medicaid third-party payments as provided in this article, or fails or refuses to cooperate with the local county department of public welfare shall not be eligible for Medicaid benefits under the Mississippi Medicaid Law.

Sources: Laws, 1985, ch. 497, § 4, eff from and after July 1, 1985 <http://michie.lexisnexis.com/mississippi/lpext.dll/mscode/ce6e/d1df/d2f4/d304?fn=document-frame.htm&f=templates&2.01/15/2008 4:19:23 PM>

SEC. 43-13-313. Denotation on medical information furnished by provider; provider to direct copy of medical information and authorization to Division of Medicaid; effect of failure to comply.

(1) In furnishing medical information to the recipient, his attorney or any other party upon written authorization, a provider participating in the Medicaid program shall denote in writing on such medical information that the patient is a Medicaid recipient and his Medicaid identification number, and if the medical charges have been paid by the Division of Medicaid, the provider shall, in addition, write or cause to be stamped or printed thereon "paid by the Division of Medicaid." If the provider has not been paid by the Division of Medicaid but seeks to bill the Division of Medicaid for medical services rendered the recipient, the provider shall denote in writing on such medical information the same information as herein provided and shall advise the recipient, his attorney, or any other party upon written authorization that it intends to bill the Division of Medicaid for medical services rendered the recipient.

(2) At the time the requested medical information is furnished to the recipient, his attorney, or other party, including medical information produced under court order, subpoena, interrogatory or deposition, the participating provider shall immediately direct a copy of the medical information so furnished or produced to the Division of Medicaid along with the authorization for the production of such information. The failure of the provider of medical services to comply with the provisions of this section shall subject the provider to recourse by the Division of Medicaid in accordance with the provisions of Section [43-13-311](#).

SOURCES: Laws, 1985, ch. 497, Sec. 7; 1989, ch. 408, Sec. 2, eff from and after July 1, 1989.

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MISSISSIPPI CODE OF 1972

As Amended

SEC. 43-13-315. Liability for failure or refusal to honor subrogation rights of Division.

Any person, firm, or corporation who fails or refuses to honor the subrogation rights of the Division of Medicaid and, specifically, without limitation, hospital insurance and indemnity benefits accruing to a recipient, after advanced written notice and a reasonable opportunity of responding, shall be liable to the division, should suit become necessary by the division and liability be established, for double the amount of Medicaid benefits paid by the Division of Medicaid or double the amount of the insurance policy limits, whichever is the lesser, inclusive of the assessment of a reasonable attorney's fee and all costs of court.

SOURCES: Laws, 1985, ch. 497, Sec. 8, eff from and after July 1, 1985. Laws, 1995, ch. 614, Sec. 5, eff from and after July 1, 1995

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MISSISSIPPI CODE OF 1972

*As
Amended*

SEC. 43-13-317. Recovery of Medicaid payments from estate of deceased recipient; waiver of claim.

(1) In accordance with applicable federal law and rules and regulations, including those under Title XIX of the Social Security Act, the division may seek recovery of payments for nursing facility services, home- and community-based services, and related hospital and prescription drug services from the estate of a deceased Medicaid recipient who was fifty-five (55) years of age or older when he received the assistance. The division shall be noticed as an identified creditor against the estate of the deceased Medicaid recipient pursuant to Section [91-7-145](#), Mississippi Code of 1972.

(2) The claim shall be waived by the division (a) if there is a surviving spouse; or (b) if there is a surviving dependent who is under the age of twenty-one (21) years or who is blind or disabled; or (c) as provided by federal law and regulation, if it is determined by the division or by court order that there is undue hardship.

SOURCES: Laws, 1994, ch. 649, Sec. 8, eff from and after July 1, 1994

§ 43-13-311. Requirement of cooperation by providers.

Providers of medical services participating in the Medicaid program shall, in committing claims for the payment of services, identify, if known to the provider, the third party or parties who are or may be liable for the injuries, disease, or sickness of the recipient and shall cooperate with the Division of Medicaid in the recoupment of the payments from such third party or parties. Any provider submitting claims for the payment of medical services by the Division of Medicaid, who, having knowledge of the liability or potential liability of a third party for the injuries, disease, or sickness of the recipient, fails to identify such third party or parties to the Division of Medicaid or who fails to cooperate with the Division of Medicaid in the recoupment of its payments from such third party or parties shall be liable to the Division of Medicaid to the extent of the payments made to the provider for medical assistance or services rendered to a recipient to which the third party or parties is, are, or may be liable.

Sources: Laws, 1985, ch. 497, § 6, eff from and after July 1, 1985.

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**CENTER FOR MEDICARE AND MEDICAID SERVICES
(CMS) STATE MEDICAID MANUAL**

3900. THIRD PARTY LIABILITY (TPL)

3900.1. General Purpose--The purpose of establishing and maintaining effective TPL programs is to reduce Medicaid expenditures. Third parties are entities or individuals who are legally responsible for paying the medical claims of Medicaid recipients. Federal law and regulations require States to assure that Medicaid recipients utilize all other resources available to them to pay for all or part of their medical care needs before turning to Medicaid. This may involve health insurance, casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more recipients. Medicaid pays only after the third party has met its legal obligation to pay; i.e., Medicaid is payer of last resort.

HCFA and a State workgroup developed and published A Guide to Successful State Agency Practices which contains various State TPL practices that were selected based on the cost effectiveness of implementation and ongoing operation as well as long range TPL savings and recoveries to the State. The guide has been distributed to all State Medicaid agencies to be used as a management tool to assist you in upgrading and improving TPL programs. Refer to the guide in considering changes to your current TPL programs.

3900.2 Statutory Basis--The following sections of the Social Security Act (the Act) set forth the requirements for TPL:

1902(a)(25) Requires that States or local agencies take all reasonable measures to identify legally liable third parties and treat verified TPL as a resource of the Medicaid applicant or recipient. Provides for the collection of health insurance information.

1902(a)(45) Provides for mandatory assignment of rights to payments for medical support and other medical care owed to recipients.

1903(d)(2) Allows reducing payments to States by the amount of TPL reimbursement.

1903(o) Provides that Federal financial participation (FFP) is not available to a State if an insurer would have paid except for a Medicaid exclusionary clause.

1903(p) Allows incentive payments for collecting and enforcing rights of support or payment assigned under §1912.

1912(a)(1) Requires as a condition of eligibility:

- o Assignment to the State of rights to medical support and to payment for medical care from any third party;

- o Cooperation, in the absence of “good cause”, in establishing paternity and obtaining medical support and payments; and

- o Cooperation, in the absence of “good cause”, in providing information to assist the State in pursuing any third party liable for payment.

1912(a)(2) Requires that State plans provide for entering into cooperative agreements for the enforcement of rights and collection of third party benefits. These agreements may be with the State title IV-D agency, any appropriate agency of any State, and appropriate court and law enforcement officials.

3901. DEFINITIONS

Estate - Property (real or personal) in which one has a right or interest.

Decedent - A deceased individual whose estate is being probated.

Testator - A person who has died leaving a valid will.

Intestate - Not having made a will.

Administrator (Administratrix) - A representative appointed by the probate court to administer an estate, pay bills, and disburse assets of a decedent.

Executor (Executrix) - Person nominated by a decedent in his will to carry out its provisions.

Probate - The act or process of proving the authenticity or validity of a will; the settlement of a decedent's estate.

Subrogation - Right of the State to stand in place of the client in the collection of third party resources.

Third party - Any individual, entity, or program that is, or may be, liable to pay all or part of the medical cost of any medical assistance furnished to a recipient under the approved State plan. Third parties include, but are not limited to:

- o Private health insurance;
- o Employment-related health insurance;
- o Medical support from absent parents;
- o Automobile insurance (including no-fault insurance);
- o Court judgments or settlements from a liability insurer;
- o State workers' compensation;
- o First party probate-estate recoveries; and
- o Other Federal programs (unless excluded by statute; i.e., Indian Health, Community Health, and Migrant Health programs).

Private insurer:

- o Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated and indemnity contracts);

- o Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for the diagnosis and treatment of an injury, disease, or disability; or

o 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 for services, including self-insured and self-funded plans.

Indemnity Policy--Insurance which provides payment directly to the policyholder under certain conditions. Indemnity policies are a potential third party resource which are subject to the assignment of rights provisions if the benefits payable are designated for medical care or can be used for this purpose. There are many variations in this type of policy. Each policy must be examined to determine the type of benefit it provides and the purposes for which it can be used. If not a third party resource, the proceeds from this type of policy are usually considered income.

Cost Avoidance--A method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid recipient. Whenever the Medicaid agency is billed first, claims are denied and returned to the provider who is required to bill and collect from liable third parties. Cost avoidance also includes payment avoided when the provider bills the third party first.

Pay and Chase--A method used where Medicaid pays the recipients medical bills and then attempts to recover from liable third parties.

Title IV-D Agency--The organizational unit in the State responsible for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

Medical Support - Payment of the costs of medical care ordered by a court or administrative process established under State law.

3902. GENERAL TPL REQUIREMENTS

Take reasonable measures to determine the legal liability of third parties to pay for services furnished under the Medicaid State plan (herein referred to as the State plan). At a minimum:

- o Collect health insurance information during the initial eligibility interview process and the redetermination process. (See §3903.1.)
- o Conduct diagnosis and trauma code edits to identify specific codes which could denote trauma related injury. (See §3903.2.)
- o Conduct data exchanges with: (See §3903.3.)
 - State wage information collection agencies,
 - SSA wage and earnings files,
 - State title IV-A agencies,
 - State motor vehicle accident report files, and
 - State workers' compensation or Industrial Accident Commission files.

Follow up on the information derived from these activities for the purpose of identifying third parties resources. Incorporate this third party information into the eligibility case file, the third party data base, and third party recovery unit. (See §3903.4.) If a third party resource is identified for an individual, use the information to seek recovery if you have paid claims for which a third party is liable and cost avoid future claims.

Use the cost avoidance method where the probable existence of TPL is established at the time a claim is filed unless you have an approved waiver as specified in §3904.2, or specific conditions exist as follows:

- o The third party is derived from a parent whose obligation to pay medical support is being enforced by the State title IV-D agency and the provider has not received payment from the third party within 30 days after the date of services. (See §3904.4.A.); or

- o Claims are for prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services (EPSDT)) that are covered under the State plan. (See §3904.4.B.) Seek recovery from the third party whenever you have paid a claim or claims for which a third party is liable. (See §3904.3.)

Determine and utilize cost effective thresholds on recovery actions. (See §3904.5.)

As a condition of eligibility, require that each applicant and recipient (see §3905):

- o Assign his/her rights (and the rights of any other eligible individuals on whose behalf he/she has legal authority under State law to assign such rights) to medical support and to payment for medical care from any third party;

- o Except for poverty level pregnant women (see §3311 ff), cooperate, in the absence of good cause, in establishing paternity and obtaining medical support and payments; and

- o Cooperate, in the absence of good cause, in providing information to assist the State in pursuing any liable third party.

State title IV-D agencies are required to petition the court or administrative authority to include medical support in court orders. The IV-D agencies are also required to obtain basic medical support information and provide this information to you. (See §3905.6.)

The State plan must provide for entering into cooperative agreements for the enforcement of rights and collection of third party benefits. The agreement(s) may be with the State title IV-D agency, any appropriate agency of any State, and appropriate courts and law enforcement officials. (See §3906.)

Submit a plan (herein referred to as the action plan) to the RO for pursuing claims against third parties, and integrate this action plan into the State's Medicaid Management Information System (MMIS). (See §3902.2.)

3902.1. State Plan Requirements--A State plan must:

o Provide that all the requirements of 42 CFR 433.138 and 433.139 are met for determining the legal liability of third parties to pay for services under the State plan and for payments of claims involving third parties. (See §§3903 and 3904.)

o Provide that the requirements of 42 CFR 433.145 through 433.148 are met for assignment of rights to benefits and cooperation with the agency in obtaining medical support or payments. (See §3905.)

o Provide that the requirements of 42 CFR 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collection. (See §3906.)

o Describe the methods the agency uses to follow up on health insurance information provided by SSA and State agencies other than the Medicaid agency. (See §3903.1.)

o Specify the frequency with which diagnosis and trauma code edits and data exchanges (i.e., SWICA, SSA wage and earnings files, State title IV-A agency, State worker's compensation or Industrial Accident Commission files, and State motor vehicle report files) are conducted (Attachment 4.22-A). (See §§3903.2 and 3903.3.)

o Describe the methods the agency uses to follow up on paid claims identified through conducting diagnosis and trauma code edits (Attachment 4.22-A). (See §3903.2.)

o Describe the methods the agency uses to follow up on data exchanges (Attachment 4.22-A). (See 3903.3.)

o Specify the timeframes for incorporation into the third party data base and third party recovery unit of all information that identifies legally liable third party resources (Attachment 4.22-A).

o Specify whether or not providers are required to bill the third party in situations where the third party liability is derived from a parent whose obligation to pay support is being enforced by the State title IV-D agency (Attachment 4.22-A). (See §3904.4.A.)

o Specify the method used in determining the provider's compliance with the billing requirement in situations involving medical support enforcement by the State title IV-D agency (Attachment 4.22-B). Providers are required to wait 30 days from the date of service to bill the State if they have billed the third party. (See §3904.4.A.)

o Specify the threshold amount or other guidelines used in determining whether to seek reimbursement from a liable third party; or describe the process by which the agency determines that seeking reimbursement would not be cost effective. It must also specify the dollar amount or time period the State uses to accumulate billings with respect to a particular liable third party (Attachment 4.22-B). (See §3904.5.)

3902.2 Third Party Liability (TPL) Action Plan-If you have an MMIS, submit to the RO an action plan for pursuing claims against third parties. Automate the activities involved in pursuing TPL to the fullest extent possible. The action plan is to describe all TPL activities and is separate and distinct from the State plan. However, the action plan may incorporate, by reference, sections of the State plan that adequately describe particular TPL activities in accordance with the action plan guidelines. This is applicable to TPL activities which are contracted out by the State agency to a fiscal agent, as well as to activities involving contingency fee contractors.

The action plan is to be integrated with the MMIS and those portions which directly relate to the MMIS will be monitored as a part of the review of the system. Only the factors included in the system performance review will be subject to reductions in Federal financial participation (FFP) for failure to meet the conditions for reapproval as set forth at 42 CFR 433.119.

Submit to the RO your action plan by June 20, 1990. Submit subsequent changes to the action plan to the RO on an ongoing basis no later than 90 days from the date of implementation. The RO will approve or disapprove your action plan. The submittal of an approvable, current action plan is a State plan requirement.

The action plan must describe the actions and methodologies taken in the following areas:

- o Identifying third parties;
- o Determining the liability of third parties;
- o Avoiding payment of third party claims;
- o Recovering reimbursement from third parties after Medicaid payment; and
- o Recording and tracking such information and actions.

Use the following guidelines in developing your action plan:

I. Identification

A. Collection of Health Insurance Information (other than by the Social Security Administration (SSA)). (See 42 CFR 433.138(b)(1).)

1. What type of health insurance information is gathered from applicants/recipients (e.g., name of insurer, policy number, name of insured, services covered)?
2. Are names, SSNs, and possible third party resources of absent and custodial parents collected from applicants/recipients?
3. Who collects this information (e.g., State agency, county office, contractor)?

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4. When and how is the information verified?
 5. How are the data transmitted to the Medicaid agency? What are the timeframes for transmitting the data?
 6. Where is the verified information maintained (e.g., eligibility case file, claims processing subsystem, third party data base, third party recovery unit)?
 7. What actual information is maintained?
 8. How does the TPL file data interface with the claims processing subsystem or other subsystems?
 9. What are the timeframes for incorporating the information into the file or files mentioned above?
- B. Health Insurance Information Collected by SSA (applies to States having a §1634 agreement) (See 42 CFR 433.138(b)(2).)
1. Who receives the information from the Form SSA-8019?
 2. How often is the information received?
 3. When and how is the information verified?
 4. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
 5. What actual information is maintained?
 6. How does the TPL file data interface with the claims processing subsystem or other subsystems?
 7. What are the timeframes for incorporating the information into the file or files mentioned above?
- C. Data from Office of Child Support Enforcement Program (See 45 CFR 306.50.)
1. What medical support data elements are being received from the IV-D agency?
 2. How often is the information received?
 3. When and how is the information verified?
 4. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
 5. What actual information is maintained?

6. How does the TPL file data interface with the claims processing subsystem or other subsystems?
7. What are the timeframes for incorporating the information into the file or files mentioned above?
8. Does the IV-D agency have access to your TPL data base?
9. Does the IV-D agency verify the current TPL status and that the data are correct?

II. Data Exchanges

A. State Wage and Income Collection Agencies (SWICAs) and SSA Wage and Earnings (Beneficiary Earnings Exchange Record (BEER)) Files (See 42 CFR 433.138(d)(1).)

1. Are you conducting data matches with State wage information collection agencies and SSA wage and earnings files?
2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?
3. Are the names and SSNs of absent parents being matched with SWICA and SSA files?
4. What is the process for conducting the data exchanges? (Include frequency of exchange.)
5. How do you follow up on and verify the information to determine if employer group health benefits are available directly to the Medicaid recipients or through an absent or custodial parent?
6. What are the timeframes for followup?
7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
8. What actual information is maintained?
9. How does the TPL file data interface with the claims processing subsystem or other subsystems?
10. What are the timeframes for incorporating the information into the file or files mentioned above?
11. Do you receive information from the IV-A agency that identifies Medicaid recipients who are employed and their employer(s)? If not, how do you obtain information for this population?

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12. If SWICA and SSA wage and earnings data are not being utilized, does the agency have an alternative source of information? (Describe alternative method based on the above questions.) (See 42 CFR 433.138(d)(2).)

B. Workers' Compensation (See 42 CFR 433.138(d)(4)(i).)

1. Are you conducting data matches with the State's workers' compensation agency?
2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?
3. What is the process for conducting the data exchange? (Include frequency of exchange.)
4. Are the names and SSNs of absent parents being matched?
5. How do you follow up on and verify the information to determine if a Medicaid recipient has an employment related injury or illness?
6. How do you follow up on and verify the information to determine if employer group health benefits are available directly to a Medicaid recipient or through an absent or custodial parent?
7. What are the timeframes for followup?
8. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
9. What actual information is maintained?
10. How does the TPL file data interface with the claims processing subsystem or other subsystems?
11. What are the timeframes for incorporating the information into the file or files mentioned above?
12. If you are not conducting data exchanges with workers' compensation, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State plan?

C. State Motor Vehicle Accident Report Files (See 42 CFR 433.138(d)(4)(ii).)

1. Are you conducting data matches with State motor vehicle accident report files?
2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?

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3. Describe the process for conducting the data exchange. (Include frequency of exchange.)
4. How do you follow up on and verify the information to identify those Medicaid recipients injured in motor vehicle accidents (pedestrians, drivers, or passengers)?
5. How do you follow up on and verify third party resources that would be available through an automobile or liability insurance policy?

6. What are the timeframes for followup?
7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
8. What actual information is maintained?
9. How does the TPL file data interface with the claims processing subsystem or other subsystems?
10. What are the timeframes for incorporating the information into the file or files mentioned above?
11. If you are not conducting data exchanges with State motor vehicle accident report files, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State plan?

D. Other Data Exchanges

1. What other data exchanges do you conduct (e.g., private insurers, Defense Enrollment Eligibility Reporting System (DEERS), credit bureaus, fraternal organizations, unions.)?

For each of these data exchanges, answer the following questions:

2. Do you perform the match or does a contractor? If a contractor does it, who is the contractor?
3. Are the names and SSNs of absent and custodial parents being matched?
4. What is the process for conducting the data exchanges? (Include frequency of exchange.)
5. How do you follow up and verify the information?
6. What are the timeframes for followup?
7. Where is the verified information maintained?

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8. What actual information is maintained?
9. How does the TPL file data interface with the claims processing subsystem or other subsystems?
10. What are the timeframes for incorporating the information into the file or files mentioned?

III. Diagnosis and Trauma Code Edits (See 42 CFR 433.138(e).)

1. Are you conducting diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6? If not, list codes which are not being edited.
2. Do you conduct the diagnosis and trauma code edits or does a contractor? If a contractor does it, who is the contractor?
3. What is the process? (Include frequency of conducting edits.)
4. How do you follow up on and verify the information to identify possible trauma related injuries?
5. How do you follow up on and verify that third party resources may be available through a liability insurance policy?
6. What are the timeframes for followup?
7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
8. What actual information is maintained?
9. How does the TPL file data interface with the claims processing subsystem or other subsystems?
10. What are the timeframes for incorporating the information into the file or files mentioned above?

IV. Claims Payment

A. Cost Avoidance (See 42 CFR 433.139(b)(1).)

1. Which claim types, recipient populations, etc. are you cost avoiding?
2. What information is available through the recipient's Medicaid identification medium, if any, indicating third party resources?
3. What is your process for cost avoiding claims? (Include use of contractor.)
4. How are electronic billers providing evidence of third party pursuit?

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5. How do you control and verify the partial payment of claims (hard copy and electronic) after a third party has made payment?
6. What method do you use for tracking cost avoided dollars (as reported on the 64.9a, Medicaid Expenditures Report)?
 - a. How do you account for initial claims, and reconcile the amount when the claims are resubmitted?

- b. Do you have a method for measuring cost avoided dollars for claims that are never received by the State? (If yes, describe method.)
- c. Do you account for claims denied for cost avoidance purposes only up to the Medicaid payment limit?
- d. Do you include Medicare or count it separately?
- e. Do you include recipient copayments?
- f. What do you include under "other cost avoidance"?

B. Pay and Chase and Recovery (See 42 CFR 433.139(b)(2)and(3).)

- 1. Which claim types are you paying and chasing? For which do you have a waiver? Explain those for which you do not have a waiver.
- 2. Are you currently paying and chasing claims in accordance with 42 CFR 433.139(b)(3)(i) and (ii)? (This section applies to claims for services for prenatal care for pregnant women, preventive pediatric services or covered services furnished in cases where the third party resource is derived from the absent parent whose obligation to pay third party medical support is enforced by the State title IV-D agency.)
- 3. Do you currently have recovery threshold amounts? If so, what are they and how were they determined? For threshold amounts greater than \$100 for health insurance and greater than \$250 for casualty claims, provide documentation including calculations showing that the threshold amounts are cost-effective.
- 4. Does the threshold include accumulated billing. If so, over what period of time?
- 5. How does the system identify when threshold levels are reached?
- 6. What is your process for seeking recovery? (Include use of contractor.)
 - a. What codes, if any, are used for recovery purposes (e.g., HCPCS, diagnosis codes, other procedure codes)?
 - b. How does the system identify individual claims for recovery?

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- c. In what order and from whom do you seek recovery?
- d. How do you follow up to assure that collection was made? What are specific accounting and reporting procedures for recoveries?
- e. If collection was not made, how does the system trigger followup?
- f. How do you track actual dollars recovered?
- g. How are TPL recoveries reconciled with the claims history? Specify the audit and control procedures followed.

- h. What are the specific procedures for recovery in casualty cases involving settlement awards?
- i. Do you have any formal billing arrangements/agreements with private insurers? If so, describe. (Include the information shared/required, timeframes, and how outstanding claim amounts are reconciled.)

V. Other

1. Do you pay premiums for health insurance policies if it is determined to be cost-effective? If so, provide methodology for determining cost-effectiveness?
2. What other TPL practices, not covered in these sections, do you pursue? For example, do you pursue estate recoveries? Describe how you approach any of these "other" practices.
3. Do you use a contractor for any other TPL activities not covered here? If so, identify the contractor and describe the specific types of activities performed.

3902.3 System Capabilities--Automate the activities involved in pursuing TPL to the fullest extent possible. All systems (MMIS or otherwise) should have certain features in order for States to comply with Federal regulations and run an effective TPL program. The more specific the information fed into the system the better the TPL program will function. Following are TPL system capability requirements. The first column lists requirements which are effective June 20, 1990. The second column under A. and B. includes requirements that are effective at the time of the next scheduled reprocurement or replacement of your MMIS. If you do not have a reprocurement or replacement scheduled, the requirements are effective no later than September 30, 1992.

A. TPL MMIS System Requirements--

<p><u>Reprocurement Effective June 20, 1990</u></p> <p>Store and retrieve TPL information including name and address of insurance company, policy number and group number (if applicable).</p>	<p>Effective September 30, 1992, or at Time of Next Scheduled</p> <p><u>or Replacement of MMIS</u></p> <p>Store and retrieve TPL information on services covered, policy period, and multiple resources under one receiptent.</p>
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Edit claims based on the existence of any form of Matrix by which claims are screened to form of insurance which may cover the particular claim determine if claim is for an individual particular claim in question and cost avoid the claim with TPL, if the service is covered by the claim whenever it is appropriate.(If the system does policy, and if the date of service is system does not not discriminate by type of within the coverage period.service, every claim flagged by the edit must be subject to manual review that matches the billed procedure with known insurance coverage.)

Override TPL cost avoidance edit(s) for claims that were billed to and denied by the TPL resource.

Account for TPL payment to the provider in determining the Medicaid payment.

Identify claims with trauma diagnosis codes.

Screen any verified TPL resource against a paid claims history going back at least one year to identify recoverable funds. (A shorter period of time may be considered if you can show it is not cost-effective to go back one full year.)

Accumulate claims up to a specified threshold amount.

Track and report cost avoidance dollars.

Associate recoveries back to individual claims (or functional equivalent). (It is important that you know which claims have been recovered, not only for internal accounting purposes, but to know which claims to pursue under estate recovery programs after the recipient's death. This function may be performed outside of the MMIS.)

B. TPL Automated Requirements (Non-MMIS).--

at	Effective September 30, 1992, or
Reprocurement	Time of Next Scheduled
<u>Effective June 20, 1990</u>	<u>or Replacement of MMIS</u>

Medicaid identification medium which TPL identifies the existence of TPL coverage, a direct data link which	Medium must include all relevant data (i.e., insurer, type of start date, etc.) or
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gives providers access to the State's payment system to ascertain the availability of third party resources and billing information.

Verify collection efforts made and "tickle" for followup.

C. TPL Recommended System Capabilities.--

- o Store and retrieve information on deductibles and copayments, if feasible.
- o Track deductibles and deny claims when deductibles have been met, if feasible.
- o Associate family members together even if they are separate cases in the State system.
- o Associate resubmitted claims with the original denied claim.

- o Automate recovery activities - Electronic submission of claims to insurers.
- o Automate data matches.

3903. IDENTIFICATION OF RESOURCES (42 CFR 433.138)

TPL depends to a large extent on the accurate and thorough identification of resources available to recipients. Nothing can be cost avoided or collected if the resource is not known.

3903.1 Intake Process.--All State agencies that determine eligibility for Medicaid must, during the initial application and each redetermination process, obtain from the applicant or recipient health insurance information useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f). Many States have a 1634 agreement with SSA in which SSA determines Medicaid eligibility for individuals who apply for Supplemental Security Income (SSI) benefits. The SSA field offices collect health insurance data from the SSI applicants and recipients during the initial application and redetermination processes and transmit the information to the State Medicaid agencies.

Health insurance information may include, but need not be limited to, the name of the policyholder, his/her SSN, relationship to the applicant or recipient, name and address of the insurance company, and the policy number or group number, if applicable.

Sometimes applicants or recipients are not aware of potential health insurance coverage that may be available to them. In some cases it is not sufficient to simply ask during the initial application or redetermination process if health insurance is available. There are

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other ways of detecting the existence of a third party during an interview. Be aware of what to look for. These indicators may also represent potential third party resources:

A. Age.--Applicants who are 65 or older are usually eligible for Medicare. Frequently, Medicare beneficiaries have insurance in the form of a Medigap policy which covers Medicare coinsurance and deductible amounts. Students may have insurance available through the school they attend. Minor children may be covered through an absent parent. (See subsection C.4.)

B. Death.--Question applicants on behalf of deceased persons about "last illness" coverage through any life insurance policies.

C. Income.--Certain income sources are indicators of possible third party health coverage.

1. Railroad Retirement Benefits and Social Security Retirement/Disability Benefits.--Indicate eligibility for Medicare benefits.

2. Longshore and Harbor Workers' Compensation (LHWC) and Workers' Compensation (WC).--Employees who suffer injury on the job may file for benefits to

compensate for medical expenses as well as lost income. Payment for medical expenses may be made either as medical bills are incurred or as a lump sum award.

3. Black Lung (BL) Benefits--Payments under the Coal Mine Workers' Compensation Program, administered by the Department of Labor (DOL), are similar to those described in subsection C.2, except that benefits are only awarded on a diagnosis of pneumoconiosis. The beneficiary may be reimbursed only if services are rendered by specific providers authorized by the DOL. BL payments are made monthly and medical expenses are paid as incurred.

4. IV-D Payment--Financial support payments from an absent parent strongly indicate potential medical support as well. An absent parent may be required by court order to provide medical insurance in addition to support payments; he/she may be responsible for a portion of medical bills, or, if employed, may be required to include dependent children in the medical insurance made available by the employer. Federal regulations require the IV-D agency to develop medical support in addition to monthly child support payments for certain cases, and to provide this information to the Medicaid agency.

5. Earned Income--Usually indicates medical and health insurance made available by an employer.

D. Work History--May indicate eligibility for cash and medical benefits through previous employers. Retired individuals may be covered under a retiree's health insurance plan. Individuals belonging to a labor union may have coverage through the union. Previous military service suggests the potential for Department of Veterans Affairs or Department of Defense (DOD) provided health care. (See §3903.5 for more details concerning DOD.)

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E. Monthly Expense--Information may show that the recipient pays premiums for private health insurance or HMO enrollment.

F. Disability Information--May indicate eligibility for other medical benefits. If disability resulted from an accident, casualty insurance may be available. Medicare is available to disabled persons who have received social security monthly disability benefits for two years and to certain persons suffering with end-stage renal disease who are receiving renal dialysis treatments or who have had a kidney transplant.

Follow up on the information gathered during the intake process to identify legally liable third party resources and incorporate such information into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4 within 60 days.

The 60 days begin on the date processing of the application is initiated (the date the agency learns of the potential third party resource) or the date the eligibility determination is made, whichever is later. For SSI recipients only, the 60 days begin upon receipt of the SSA-8019. In some cases followup may not be required since the applicant or recipient may supply complete identifying information during the eligibility determination or redetermination process. Use this information to seek recovery if you have paid claims for which a third party is liable. Create an edit in the claims processing system and cost avoid future claims in accordance with §3904.1.

3903.2 Claims Processing Edits--Identify paid claims that contain specific diagnosis or trauma codes and follow up on information for purposes of identifying potentially liable third parties. Identify the paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 (International Classification of Disease, 9th Revision, Clinical Modification, Volume 1) with the exception of code 994.6, Motion Sickness, for the purpose of determining the legal liability of third parties.

Based on experience, you may find that the identification and followup of specific codes has not been productive in detecting possible third party liability. You may receive authorization from CMS to discontinue this activity for certain diagnosis and trauma codes. If you wish to exclude specific codes from being edited, request approval from the RO by submitting documentation which proves that pursuit of the specific code(s) has not been cost-effective.

The purpose of reviewing trauma codes is to detect potential casualty and liability claims and determine if another party is at fault. For example, if you determine that an injury resulted from a job-related accident, claims that have been submitted, as well as future claims for that accident, may be covered by workers' compensation.

Conduct these edits on a routine and timely basis and develop and specify in your State plan the frequency of the edits performed and the methods used for followup. Followup may involve contacting the recipient by phone or questionnaire to determine the nature of the trauma and then follow up with insurance companies, attorneys, witnesses, etc., to establish liability. After followup, incorporate all information that identifies legally liable third party resources into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4. Use this information to seek recovery from the liable third party. In addition, create an edit in the claims processing system and cost avoid future claims related to the injury, if appropriate, in accordance with §3904.1.

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In addition to producing significant recoveries, the use of trauma edits to identify cases with recovery potential heightens the awareness of Medicaid's rules and regulations among the medical and legal communities. This produces the added benefit of increased numbers of voluntary referrals from providers, recipients, and attorneys.

3903.3 Data Exchanges--Conduct the following data exchanges in an automated fashion if possible:

A. State Wage Income Collection Agency (SWICA), SSA Wage and Earnings File, and State Title IV-A Agencies--You are required to have an income and eligibility verification system (IEVS). Under IEVS, certain wage and other relevant information from various agencies must be utilized for purposes of verifying Medicaid eligibility and the correct amount of medical assistance payments for applicants and recipients. In part, you are required to obtain State wage information from the SWICA, and self-employment, wage, and payment of retirement benefits information from the SSA wage and earnings file. For purposes of verifying income and eligibility, you are not required to follow up on all cases identified through the data exchange. You may target, for each data source, those items that are likely to be productive in identifying and preventing ineligibility and incorrect payment. (See Part 15, §15800.) For purposes of identifying third party resources, targeting does not apply.

The State IV-A agency is also required to conduct similar data exchanges for verifying income and eligibility for the Aid to Families with Dependent Children (AFDC)

population. The IV-A agency is also permitted to target for purposes of verifying income and IV-A eligibility. The IV-A information may not be targeted for purposes of identifying third party resources.

For TPL purposes, IEVS data matches must include the names and SSNs of absent or custodial parents of recipients to the extent available. The match will identify Medicaid recipients, as well as absent or custodial parents of recipients, that are employed and their employer(s).

You must follow up on all information for the purpose of identifying legally liable third parties and incorporate such information into the eligibility case file, the third party data base and the third party recovery unit as specified in §3903.4 within 45 days from the date the data exchange was received, or as otherwise specified in 42 CFR 435.952(d). Every employment lead, no matter how small, could potentially be a lead for health insurance.

In most cases, followup would include contact with the identified individual's employer to obtain information regarding the availability of health insurance for the Medicaid recipient. This information should be gathered when the case worker is following up with an employer to verify income and eligibility requirements under IEVS regulations to avoid two employer contacts for the same individual. If the eligibility case file already contains information regarding health insurance available or not available through the individual's employer(s), additional followup is not necessary. Also, if you know that a particular employer does not provide health insurance at all or for particular categories of employees (e.g., employees who work less than 15 hours per week), you need not contact the employer each time. However, follow up periodically (once a year) with the employer to determine if they have changed their policy for providing health insurance.

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Request from the State title IV-A agency information obtained from its SWICA and SSA wage and earnings file data exchanges which identifies AFDC/Medicaid recipients that are employed and their employer(s). If the IV-A agency has not followed up on the data to determine if the individuals have health insurance, you must conduct the followup. For TPL purposes, targeting does not apply to the IV-A agency data exchanges.

Use information identifying third parties to seek recovery if you have paid claims for which a third party is liable. In addition, create an edit in the claims processing system and cost avoid future claims in accordance with §3904.1.

If you can demonstrate to the RO that you have an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of this section are deemed to be met. However, you must follow up on all leads from these alternate matches in the same fashion as described above.

B. State Workers' Compensation or Industrial Accident Commission Files--Match identifying information; e.g., name, SSN for Medicaid recipients and (assuming names and SSNs have been obtained) absent or custodial parents of Medicaid recipients with Workers' Compensation or Industrial Accident files to identify those individuals with employment-related injuries or illness. A match with a Medicaid recipient may indicate that the individual was involved in a job-related injury and that worker's compensation or the Industrial Accident Commission may be liable for the cost for care and services furnished to the recipient. A match involving an absent parent or custodial parent could

indicate that the parent is or was employed and that third party resources may be available through health insurance provided by the employer.

Follow up on the information for purposes of identifying legally liable third parties and incorporate such information into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4 within 60 days from the date the data exchange was received. Followup based on a match involving a Medicaid recipient may involve contacting the workers' compensation agency.

Followup based on a match with an absent parent may involve contacting the employed individual's employer. Use information identifying third parties to seek recovery if you have paid claims for which a third party is liable. In addition, create an edit in the claims processing system and cost avoid future claims, if appropriate, in accordance with §3904.1.

Secure an agreement (to the extent permitted by State law) with the State workers' compensation agency or the Industrial Accident Commission or submit documentation to the RO that demonstrates that you made a reasonable attempt to do so.

C. State Motor Vehicle Accident Report Files--Match identifying information for Medicaid recipients with State motor vehicle accident report files to identify those recipients injured in motor vehicle accidents, whether injured as pedestrians, drivers, or passengers in motor vehicles, or as bicyclists. A match may indicate that third party resources would be available through an automobile or liability insurance policy.

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Describe, as part of the State plan, your methods for following up on the information. Followup may include, but is not limited to, obtaining and reviewing police reports and interviewing witnesses to establish legal liability. After followup, incorporate all information that identifies legally liable third party resources into the eligibility case file, the third party data base and third party recovery unit as specified in §3903.4. Use information identifying third parties to seek recovery if you have paid claims for which a third party is liable. In addition, create an edit in the claims processing system and cost avoid future claims related to the accident, if appropriate, in accordance with §3904.1.

Secure an agreement (to the extent permitted by State law) with the State Motor Vehicle Department, or submit documentation to the RO that demonstrates that you made a reasonable attempt to do so.

3903.4 Incorporation of TPL Information into the Eligibility Case File, Third Party Data Base, and Third Party Recovery Unit--

A. Eligibility Case File--Incorporate into the eligibility case file health insurance information. The case file is the official audit trail for all TPL identification activity on a case, and should include all relevant information.

B. Third Party Data Base--Incorporate into the third party data base all health insurance information necessary to appropriately cost avoid claims. You must incorporate casualty and workers' compensation information into the third party data

base after liability has been determined in order to cost avoid claims, unless you have evidence that there will be no future claims related to the injury.

C. Third Party Recovery Unit--Maintain in the third party recovery unit all information which is necessary to appropriately seek recovery of reimbursement. This includes casualty information and health insurance information if there are paid claims for which a third party is liable.

3903.5 Other Methods of Identification--Some States utilize various methods to identify third party resources in addition to the methods required by Federal regulations. There are numerous practices described in the Successful Practices Guide referred to in §3900.1. Examples of some State practices are:

A. Release of Information by Providers--Casualty-related third party resources not known to the State may be identified through requests for medical reports and bills received by providers from attorneys, insurance companies, and other parties. Some States require providers to contact the State agency before responding to such requests. This practice improves communications between providers and State agencies. What begins as a restriction on release of information evolves into a two-way inquiry/response process that improves relationships and claims processing efficiency.

B. Accident Related Third Party Resources Through Coordination with Ambulance Services--Ambulance services may provide to the State accident reports involving Medicaid recipients. When such reports are submitted timely, it can ensure the filing of claims and liens against third parties before damages are sought or payments made to the recipient.

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C. Data Matches with Defense Eligibility and Enrollment Reporting System (DEERS)--DEERS is a centralized computer based system for confirming who is entitled to benefit programs administered by the DOD. The data base includes active duty personnel, retirees, surviving spouses and dependents. Data matches against DEERS will identify Medicaid recipients who are eligible for medical benefits under the military health care system which includes Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). HCFA coordinates all activities concerning the data matches. If you are interested in participating or would like information, write to:

Health Care Financing Administration
Office of Medicaid Management, BQC
Attention: Third Party Liability Branch, DPS
Room 273 East High Rise Bldg.
6325 Security Blvd.
Baltimore, MD 21207

3903.6 Agreement Between SSA, HCFA and State Medicaid Agencies is required in 1634 States (States in which SSA makes the SSI/Medicaid eligibility determination) that provides, in writing, for the collection from the applicant or recipient during the initial application and each redetermination process of health insurance information in the form and manner specified by the Secretary and for the transmittal of the information to the Medicaid agency. (See 42 CFR 433.138(b)(2).)

3903.7 Agreement Between the Medicaid Agency and Other State Agencies that Determine Medicaid Eligibility is required to provide for the collection from the applicant or recipient during the initial application and each redetermination process of such health insurance information as would be useful in identifying legally liable third

party resources, and for transmittal of such information to you, so that you may process claims under the TPL payment procedure specified in 42 CFR 433.139(b) through (f). (See 42 CFR 433.138(b)(3).)

3903.8 SSNs of Absent or Custodial Parents, to the extent available, are required to be incorporated into the Medicaid eligibility case file and the third party data base by the State agency for the purpose of conducting data matches with SWICAs, the SSA earnings files, workers' compensation agency, and other sources. While you must, in connection with obtaining health insurance data, request the SSN of any person with legal responsibility (other than the applicant/recipient) for any member of the unit applying for or receiving benefits, you may not require that the applicant/recipient disclose SSNs other than his/her own as a condition of eligibility. When you request voluntary disclosure of SSNs, you must do so in accordance with section 7 of the Privacy Act, Public Law 93-579.

3903.9 Safeguarding of Information--Your State plan must provide safeguards that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan. Regulations located at 42 CFR Part 431, Subpart F implement this requirement by specifying State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information. Specifically, you must have criteria that govern the safeguards of information received and released in connection with the identification of legally liable third party resources. (See 42 CFR 431.305(b)(7).)

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3904. PAYMENT OF CLAIMS (42 CFR 433.139)

3904.1 Cost Avoidance--Use the cost avoidance method unless you have a waiver, as described in §3904.2, or in specific situations described in §3904.4. Under the cost avoidance method, if you have established the probable existence of third party liability at the time the claim is filed, reject the claim and return it to the provider for determination of the amount of liability. The establishment of third party liability takes place when you receive confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, pay the claim to the extent that payment allowed under your payment schedule exceeds the amount of third party payment. (See 42 CFR 433.139(b).)

Program experience has indicated that, when third party resources are known or there is a reasonable expectation that they exist, it is usually more cost-effective for a State to use the cost avoidance method of claims payment than it is to use the pay and chase method. Areas of potential savings include:

- o Administrative savings from using fewer personnel and other resources to administer the filing of claims with third party payers and the resulting accounts receivable system;

- o Program savings from saved interest loss because Medicaid program dollars are not outstanding with the providers before the third party payment is received;

- o Administrative savings of claim processing costs for those claims that providers submit directly to the third party instead of to Medicaid;

o Program savings from small dollar claims that are never submitted to a third party under "pay and chase," but which can be avoided altogether if a third party pays up front.

3904.2 Cost Avoidance Waivers--Federal regulations set forth at 42 CFR 433.139(e) provide the opportunity for States to seek a waiver of the required use of the cost avoidance method where it can be demonstrated that the pay and chase method is as cost-effective as the cost avoidance method. Usually, a separate waiver request should be submitted for each specific service or claim type for which a waiver is being sought; however, you may submit a single waiver package representing several services or claim types if the purpose, background, and rationale are the same for all services or claim types included in the package.

Cost avoidance waiver guidelines are provided for the purpose of assisting you in developing documentation to justify cost-effectiveness as specified in the regulations. Update and resubmit documentation every three years to substantiate that the pay and chase method continues to be as cost-effective as the cost avoidance method.

Use the following guidelines in submitting waivers.

A. Purpose.--Describe the specific type of claim or service to be waived.

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B. Background.--Provide a historical analysis of this claim or service type which may include, but is not limited to, a description of the previous claims payment methodology, statistical data, or any other information that may provide background which would be helpful in making a determination.

C. Rationale.--Provide documentation which substantiates that the postpayment recovery method (i.e., pay and chase) is at least as cost-effective as the cost avoidance method. Base documentation on actual experience where applicable; otherwise, develop estimates. Fully explain the basis for the estimates. Base your determination of cost-effectiveness on the use of the best technology and practices reasonably and practicably available to the State.

Whether the waiver meets the conditions of cost-effectiveness is determined by, but not limited to:

- o Time, effort, and capital outlay required to perform cost avoidance versus pay and chase.

- o Examples of factors to be considered:

- Volume
- Average cost per claim
- Denial rate
- Benefit limitation parameters
- Administrative costs
- Contractor costs
- Salaries
- Overhead
- Equipment/computer costs

- o Startup costs will generally not be considered.

3904.3 Recovery--Seek reimbursement from third parties whenever you have paid claims for which there are third parties that are liable for payment of the claims. This is referred to as the "pay and chase" method. Reimbursement must be sought unless it is determined that recovery of reimbursement would not be cost effective in accordance with threshold amounts that have been established. (See §3904.5.)

If the probable existence of TPL cannot be established or third party benefits are not available to pay the recipients medical expenses at the time the claim is filed, pay the full amount allowed under your payment schedule. If you learn of the existence of a third party after you have paid the claim, or benefits become available from the third party after the claim is paid, seek recovery of reimbursement from the third party to the limit of legal liability within 60 days from the end of the month in which you learn of the existence of the third party or benefits become available, whichever is later.

Take whatever action is necessary to meet the 60 day requirement for seeking recovery of reimbursement. If you have established threshold amounts in accordance with §3904.5, initiate recovery action for all claims within 60 days from the end of the month after reaching the accumulated threshold amount. In situations where periodic interim payments are made to providers, make an entry in your accounting system within 60 days of learning that benefits have been paid to the provider by the third party after Medicaid payment was made for the same services. Include these recovery amounts due the State in your end-of-year adjustments.

After you have billed a third party, track the status of payments targeted for recovery and follow up with the third party if you do not receive a response within a reasonable amount of time. One method is to generate a letter to the third party every 90-120 days if you have not received an appropriate response.

There are specific situations in which you are required to use the pay and chase method of payment, even though there is a known third party at the time a claim is filed. These situations involve claims for Medicaid recipients who have been provided medical support as a result of a court order, and claims involving pregnancy-related and preventive pediatric services. (See §3904.4.)

Use the pay and chase method if you have an approved waiver as specified in §3904.2. If you have an approved waiver and you pay the claim, you must seek recovery from the third party within 60 days after the end of the month in which payment is made. Such a waiver does not preclude you from using the cost avoidance method, however.

When you adopt an aggressive recovery stance, all other parties involved in the process (i.e., providers, attorneys, casualty firms, private health insurers, and recipients) tend, over time, to cooperate voluntarily with State procedures and policies.

3904.4 Mandatory Use of Pay and Chase--There are specific circumstances where cost avoidance must not be used. Use the pay and chase method in accordance with established thresholds whenever these conditions exist:

A. **Medical Support Enforcement**--Pay and chase claims in situations where the TPL is derived from a parent whose obligation to pay support is being enforced by the State title IV-D agency and the provider has not received payment from the third party within 30 days after the date of service. The intent of this requirement is to protect the custodial parent and his/her dependent children from having to pursue the absent spouse, and his/her employer or insurer, for TPL.

Choose whether or not providers will be required to bill a third party in this situation. Ensure that when a provider does bill Medicaid, the provider indicates whether a third party has been billed. If you require providers to bill the third party first, and you receive a bill from a provider who has not billed the third party, return the claim to the provider or wait until 30 days have elapsed from the date of service to process the claim for payment in accordance with your normal payment schedule. If you do not require a provider to bill the third party, pay the full amount allowed under your payment schedule and seek reimbursement from the third party.

For situations when the provider does bill a third party first, have a method in place to monitor that the provider did not receive payment from the third party prior or subsequent to billing Medicaid. You may require hard copy documentation that identifies the third party, and certifies that the third party has been billed and payment has not been received.

In some cases, such as when electronic billing is used, it may not be cost effective to require hard copy certification. Pay the claim and follow up to assure that providers have complied with billing requirements. When you contact a third party to seek recovery, you can verify whether or not the provider received payment from the third party and failed to report it to you.

B. Prenatal and Preventive Pediatric Care--You must pay and chase in situations where the claim is for prenatal care for pregnant women or preventive pediatric services (including EPSDT services) that are covered under the State plan.

The intent of this requirement is to alleviate the administrative burden associated with TPL efforts so as not to discourage participation in the Medicaid program by physicians and other providers of these types of services, since beneficiaries in need of such services already have difficulty finding providers in many communities.

In order to carry out the intent, it may be necessary to pay and chase claims for pregnancy-related services other than prenatal care (i.e., labor and delivery and post-partum care). The pay and chase method may be used for pregnancy-related services other than prenatal care whenever it is determined that using the cost avoidance method would discourage provider participation.

For instance, the same practitioner that provides the prenatal care often handles the labor and delivery and post-partum care. Generally, the practitioner bills for the entire range of obstetrical services in a lump sum amount; prenatal is not broken out from the labor and delivery and post-partum care. The administrative burden placed on providers of changing their billing practices and requiring them to bill a third party for the labor and delivery and post-partum care only could adversely affect access to prenatal care. You have the option to pay and chase for the entire range of pregnancy-related services. However, you must continue to cost avoid claims associated with the inpatient hospital stay for labor and delivery and post-partum care.

The following exhibits are provided as guidelines for determining certain claims for which you must use the pay and chase method. The first exhibit includes diagnosis codes related to prenatal care. The second exhibit includes diagnosis codes related to preventive pediatric care. These diagnosis codes were selected since it would be impractical to identify every procedure code which could relate to prenatal and preventive pediatric care. In order to identify prenatal claims which must be paid and chased, use the appropriate procedure codes related to these diagnoses. These guidelines define the terms prenatal and preventive pediatric care narrowly. You have the option of defining these terms more broadly. For example, the definition of prenatal care may be expanded to include preexisting conditions which are likely to affect the pregnancy.

Prenatal Care Services

ICD-9-CM Diagnosis Codes (Volumes 1 and 2)

Prenatal care is defined as services provided to pregnant women if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy. The types of claims involved would be claims for routine prenatal care, prenatal screening of mother or fetus, and care provided in the prenatal period to the mother for complications of pregnancy.

Code	Description (applies to services provided to mother)	Routine Prenatal Care	Prenatal Screening of		Complications of Pregnancy
			Mother	or Fetus	
V22.0, V22.1	Supervision of normal pregnancy	x			
V23	Supervision of high risk pregnancy				
V28	Antenatal screening			x	
640-648	Complications related to pregnancy				
*651-658 671, 673, 675-676	Other conditions requiring care in pregnancy		x	x	

* Claims must be paid and chased unless the fifth digit is a 2 or 4.

Preventive Pediatric Care Services

ICD-9-CM Diagnosis Codes (Volumes 1 and 2)

Preventive pediatric care is defined as screening and diagnostic services to identify congenital physical or mental disorders, routine examinations performed in the absence of complaints, and screening or treatment designed to avert various infectious and communicable diseases from ever occurring in children under age 21. This includes immunizations, screening tests for congenital disorders, well child visits, preventive medicine visits, preventive dental care, and screening and preventive treatment for infectious and communicable diseases.

Code	Description	Immunizations	Screening Tests for Congenital	Well Child or Preventive Disorders	Preventive Dental Medicine Visits
VO1	Contact with or exposure to communicable disease				
VO2	Carrier or suspected carrier of infectious disease				
VO3-VO6	Need for prophylactic vaccination against bacterial, viral, and other communicable diseases			x	
VO7	Need for isolation & other prophylactic measures	x			
V20	Health supervision of infant or child			x	
V70.0	Routine general medical examination			x	
V72.0-.3	Routine examination of specific organ system			x	
V73-V75	Special screening exams/tests for infectious & communicable diseases or congenital defects		x		
V77.0-.7					
V78.1-.3					
V79.2-.3					
V79.8					
V82.3-.4					

3904.5 Threshold Amounts--Suspend or terminate efforts to seek reimbursement from a liable third party if you determine the activity would not be cost effective. Also, the State plan must:

- o Specify the threshold amount or other guideline to use in determining whether to seek reimbursement from a liable third party; or describe the process by which you determine that seeking reimbursement would not be cost effective. Documentation of a cost-effective measurement must be provided for States with thresholds greater than \$100 for health insurance and greater than \$250 for casualty claims.

- o Specify a dollar amount or period of time for which you will accumulate billings with respect to a Medicaid recipient or particular liable third party in making the decision whether to seek recovery. An example would be to accumulate pharmacy claims for a 60-day period, or until a set threshold is achieved before billing the third party.

Low thresholds may result in pursuing claims which cost more to process than will be recouped. Conversely, if thresholds are too high, you lose money. Most States utilize thresholds under \$50 for health insurance and \$100 for casualty claims. Accumulate claims that fall under the threshold; when the total meets the threshold, send claims to the third party for recovery.

3904.6 Federal Financial Participation (FFP) and Repayment of Federal Share (42 CFR 433.140)--FFP is not available if:

- o You fail to take the reasonable measures to determine the legal liability of third parties. (See §3903.)

- o You fail to seek reimbursement from liable third parties. (See §3904.)

- o A private insurer would have been obligated to pay for the services except that its insurance contract limits or excludes payments for Medicaid eligible individuals.

- o You received reimbursement from a liable third party. Whenever this occurs, repay the Federal government the amount of FFP received as payment for claims which were subsequently reimbursed by a third party. The payment may be reduced by the amount of incentive payments discussed in §3906.

3904.7 Medicaid Payment to Providers Who Offer Discounts to Third Party Payers--Some providers enter into agreements with third party payers to accept payment for less than the amount of charges. These arrangements are often referred to as "preferred provider agreements" or "preferred patient care agreements."

Whenever you are billed for the difference between the payment received from the third party based on such an agreement and the charges, do not make Medicaid payment. The provider's agreement to accept payment of less than its charges constitutes receipt of a full payment for its services, and the insured has no further responsibility. Medicaid is intended to make payment only where there is a recipient legal obligation to pay.

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3905. ASSIGNMENT OF RIGHTS TO BENEFITS - (42 CFR 433.145)

The requirement for mandatory assignment of rights must be included in the Medicaid State plan as provided by §1902(a)(45) of the Act. A plan must provide that, as a condition of eligibility, each legally able applicant and recipient:

- o Assigns his/her rights and the rights of any other eligible individuals for whom the individual has the legal authority under State law to assign such rights, to medical support or other third party payments to the agency;

- o Except for poverty level pregnant women (see §3311 ff), cooperates with you, in the absence of good cause, in establishing paternity and obtaining medical support or payments; and

- o Cooperates, in the absence of good cause, in identifying and providing information to assist you in pursuing liable third parties.

3905.1 Rights Assigned (42 CFR 433.146).--The applicant or recipient must make a written assignment assigning his/her rights to any medical support available under an order of a court or an administrative agency. He/she must also assign to you any third party payments for medical care and payments for any other individual eligible under the plan for whom he/she has the legal authority under State law to make an assignment.

The rights to Medicare benefits may not be assigned. The individual may assign Medicare payments to the provider. This results in the provider being paid directly by Medicare rather than the individual receiving and forwarding the payment.

In some instances, Federal law restricts assignment of insurance. 31 U.S.C. 3727 prohibits the assignment of claims against the United States.

The only exception to that rule is the assignment before two witnesses of a claim that has been approved, for which a warrant for payment has been issued, and the assignment of which is approved by an officer having authority to acknowledge deeds. That exception does not authorize the kind of blanket assignment of rights to medical support contemplated under §1912 of the Act. Therefore, assignment of benefits covered by §1912 of the Act cannot be required.

If an applicant refuses to make an assignment of benefits as a condition of Medicaid eligibility, Medicaid does not pay for any services for that individual.

3905.2 Method of Assignment (42 CFR 433.146(c)).--If assignment of rights to benefits is automatic because of State law, you may substitute such an assignment for an individually executed one if you inform the individual of the terms and consequences of State law.

A State subrogation law must meet the requirement mandating assignment of rights as a condition of eligibility upon an applicant filing for Medicaid. States utilizing a subrogation law are required to notify applicants of the terms and consequences of the statute. As a means of efficient administration of the program, you may choose to utilize a single assignment form for both child support and medical support purposes for applicable recipients. If you choose this option, clearly explain to the recipient the dual purpose of the form.

SSA continues to determine Medicaid eligibility of applicants and recipients for Supplemental Security Income (SSI) in States which have entered into agreements under §1634 of the Act.

SSA gives an oral explanation to all applicants of the assignment of rights requirements and advises that it is a condition of eligibility for Medicaid. The explanation also advises that the applicant must cooperate with the Medicaid agency in establishing paternity and obtaining medical support payments from third party payers, and cooperate in identifying and providing information to assist the State in pursuing any liable third party.

For initial determinations, SSA annotates an SSI application and provides the Medicaid agency with a code and date indicator via the State Data Exchange (SDX) for purposes of showing whether the individual has assigned his/her rights and whether the individual has cooperated in identifying and providing third party information in States which have a §1634 agreement. During the redetermination process, SSA determines if the recipient continues to meet the conditions of eligibility for Medicaid. SSA annotates the SSI redetermination form and provides the Medicaid agency with a code and date indicator via the SDX. The specific codes for assignment of rights and cooperation are:

- A = Refused to assign rights
- R = Refused to provide third party information
- Y = Assigned rights and provided third party information
- N = Assigned rights and does not have third party coverage

In States where assignment of rights is not automatic under State law upon an applicant's filing for Medicaid, SSA has each applicant sign a form showing an explanation of the assignment of rights, and that he/she assigns such rights. In States where assignment of rights is automatic under State law, SSA provides applicants an oral explanation of the assignment of rights and cooperation provision, without requiring written execution of assignments, if requested by a State.

3905.3 Cooperation in Establishing Paternity and Obtaining Support and Cooperation in Identifying and Providing Third Party Information (42 CFR 433.147).

A. Establishing Paternity and Obtaining Support.--Except for poverty level pregnant women (see §3311 ff), require the individual to cooperate in establishing the paternity of a child born out of wedlock for whom the individual can legally assign rights and in obtaining medical care support and medical care payments for himself/herself, as well as for any other person for whom the individual can legally assign rights.

B. Identifying and Providing Third Party Information.--Require the individual to cooperate in identifying and providing information to assist you in pursuing any third party which may be liable to pay for care and services available under the plan. Individuals are not required to pursue collections themselves. Pursuit is the responsibility of the provider or the State.

C. Good Cause for Non-cooperation--The conditions of paragraphs A. and B. must be met unless such individual has good cause for not cooperating as determined by you in accordance with the standards prescribed in paragraph E.

D. Cooperation may Require the Individual to:

o Appear at a State or local office designated by you to provide information or evidence relevant to the case;

o Appear as a witness at a court or other proceeding;

o Identify liable third parties and provide information, or attest to lack of information, under penalty of perjury;

o Pay to you any support or medical care funds received covered by the assignment of rights; and

o Take any other reasonable steps to assist in establishing paternity and securing medical support and payments.

E. Waiver of Cooperation for Good Cause--You may waive the requirements for cooperation if you determine that the individual has good cause for refusing to cooperate. To do so, you must find that cooperation is against the best interests of the individual, child, or other person as specified in current regulations at 42 CFR 433.147(c)(2). Determine whether good cause for noncooperation exists, based on the factors established by the AFDC child support enforcement program at 45 CFR 232.40-232.49. The criteria to use in situations involving children (including establishment of paternity) are listed in the Child Support Enforcement Program at 45 CFR, Part 232 and §302.31. You are not required to submit your findings to the State IV-A agency director for review and approval. However, some form of communication is required in order to discover whether the IV-A agency has made a good cause finding. (See 42 CFR 433.147(c)(1).)

Circumstances which constitute "good cause" for noncooperation exist if:

o The person for whom support is sought was conceived as a result of incest or rape;

o Legal proceedings for adoption are pending;

o The question of whether to place the child for adoption is under active consideration; or

o Cooperation is reasonably anticipated to result in:

-- Physical or emotional harm (an emotional impairment that substantially affects the individual's functioning) to the Medicaid recipient or other person for whom the Medicaid recipient has authority to assign rights for TPL; or

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-- Physical or emotional harm to the person who has responsibility for cooperating.

Furnish Medicaid services to an otherwise eligible recipient pending resolution of whether a waiver should be granted, if the applicant or recipient meets all other eligibility requirements and has submitted the requested evidence to determine good cause.

Make good cause determinations for SSI and noncash recipients. When the State title IV-A agency makes a good cause finding for a AFDC/Medicaid recipient, adopt that finding as your own.

Pursuant to 45 CFR 232.40(b), prior to requiring cooperation, notify the applicant or recipient of the right to claim good cause as an exception. The notice must include advising the applicant or recipient that good cause may be claimed and that corroborative evidence must be furnished. Specify that the applicant or recipient may be requested to provide sufficient information to permit an investigation to determine the validity of the good cause claim.

Several separate determinations of good cause may be required in the same case (e.g. cases involving several children with different parents, or where the spouse and parent are different individuals).

With regard to obtaining medical care support and payments for an individual other than a child, adopt procedures similar to those specified in 45 CFR, Part 232, excluding those applicable only to children. Consider as minimum requirements: (See 45 CFR 232.40-232.46.)

- o Inform the individual that a claim for good cause may be made for refusing to cooperate;

- o Advise the individual of the grounds for claiming good cause and the evidence needed to support such a finding;

- o Review the evidence submitted, conduct any additional investigation warranted, and reach a determination as promptly as possible;

- o Make payments for Medicaid furnished to an otherwise eligible individual pending a determination whether good cause exists if the individual has submitted the evidence requested; and

- o Make a determination that good cause exists only if the evidence establishes that the required cooperation is not in the best interests of the individual or other person who has the legal authority to assign rights.

3905.4 Denial or Termination of Eligibility (42 CFR 433.148).--Individuals who fail to meet the assignment provisions including assignment of rights to benefits and cooperation must be denied Medicaid eligibility. Deny eligibility, or terminate if already certified, any applicant or recipient who:

- o Refuses to assign his own rights or those of any other individual for whom he can legally make an assignment;

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- o Except for poverty level pregnant women (see §3311 ff), refuses to cooperate in establishing paternity and obtaining medical support and payments; or

- o Refuses to cooperate in identifying and providing third party information (unless cooperation has been waived for good cause).

Provide Medicaid to any individual who cannot legally assign his/her own rights and is otherwise eligible for Medicaid but for a refusal to assign the individual's rights or refusal to cooperate by a person who has the legal authority under State law to assign his/her rights. For example, if a mother refuses to assign benefits for herself and her children (for whom she can legally make an assignment) or refuses to cooperate, only the mother becomes ineligible for Medicaid. The children remain eligible. However, if a mother with a newborn refuses to assign rights or to cooperate, both the mother and the newborn are ineligible, since the newborn's eligibility is dependent upon the mother's eligibility. A new application must be filed on behalf of the newborn to establish eligibility on his/her own behalf as a child. (See §3305.)

In denying or terminating eligibility, comply with the notice and hearing requirements in 42 CFR Part 431, Subpart E.

3905.5 Handling Situations Where SSI/Medicaid Applicants and Recipients Refuse to Assign Rights or Refuse to Cooperate.--When an individual has refused to assign his/her rights or to cooperate, the Social Security district office (DO):

- o Advises the individual that SSA cannot complete the determination or redetermination for medical assistance;
- o Refers the individual to the State Medicaid agency; and
- o Annotates the SSI application or redetermination form indicating refusal to assign rights and/or refusal to cooperate.

If the individual contacts the State Medicaid agency, ascertain the reason for refusal to assign rights and/or cooperate. If you determine that the individual has good cause for refusing to cooperate (see §3905.3.E.) or if the individual changes his/her mind and agrees to assign his/her rights and to cooperate, he/she is eligible for Medicaid benefits provided he/she is also eligible for SSI benefits.

Inform the SSA DO of any changes which affect the code indicator shown in the SDX. If SSA has not completed the SSI application process, refer the individual back to the SSA DO. The DO executes the assignment and/or collects the health insurance information.

If SSA has completed the SSI application process:

- o Execute the assignment and/or collect the health insurance information.
- o Advise the DO to make the necessary changes to the code and date indicators on the SDX.

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If the individual does not contact you and you become aware of a refusal code via the SDX, notify the individual that eligibility is being denied. In denying or terminating eligibility, comply with the notice and hearing requirements in 42 CFR Part 431, Subpart E.

3905.6 Recommendations for Referring Medicaid Recipients to Child Support Enforcement (CSE) Agencies.--CSE agencies are required to provide all CSE services

(without an application or fee) to all families with an absent parent who receive Medicaid and have assigned to the State their rights to medical support. The CSE agencies are required by 45 CFR 303.31 to petition for medical support when health insurance is available to the absent parent at a reasonable cost. For these agencies to provide the required services, they must know who these individuals are. Therefore:

- o Coordinate with the CSE agency to ascertain the needed information. The type of information collected and the method of transmitting the data may vary from State to State.

- o Solicit specific information from Medicaid recipients to determine if they are eligible for CSE services and for transmission to the title IV-D agency unless:

- The recipient already has satisfactory health insurance other than Medicaid;

- The recipient is receiving adequate medical support from the absent parent;

or

- The Medicaid agency has a cooperative agreement for the enforcement of rights to medical support with an entity other than the title IV-D agency.

- o Refer cases to the CSE agency once you have determined that individuals may be eligible for their services. Do not refer pregnant women until after the child is born.

Refer to the SDX to identify SSI/Medicaid recipients who may qualify for CSE services. Use the recipient type code field to identify recipients who are blind or disabled children. (For a listing of the specific codes, refer to the Program Operations Manual System, §02601.305, issued by SSA). Upon identifying a blind or disabled child, follow up with the recipient or the recipient's representative to determine if an absent parent situation exists. If so, collect the necessary information and refer the case to the CSE agency.

AFDC regulations (see 45 CFR, Parts 232 and 235.70) set forth their program requirements for collecting and referring information to the CSE agencies. Use these regulations as guidelines for referring Medicaid only cases to the CSE agencies.

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3905.7 Requirements of Title IV-D Agency in Obtaining Medical Support. (See 45 CFR 306.50 and 306.51 (to be redesignated as Subpart A of Part 306 effective October 1, 1990).)--Title IV-D agencies are required to:

- o Obtain basic medical support information, if available, and provide this information to the State Medicaid agency (if it is not already being provided by the title IV-A or title IV-E agency) for use in TPL activities. If the individual requesting services is a Medicaid applicant or recipient, the title IV-D agency is required to secure the:

- Name, address and SSN of the absent parent;

- Name and address of the absent parent's place of employment;
- Name and SSN of child(ren);
- AFDC or title IV-E foster care case number, Medicaid number, or custodial parent's SSN; and
- Policy name(s) and number(s) and names of persons covered if the absent parent has any health insurance policies.
 - o Petition the court or administrative authority, in new and amended court orders, to require the absent parent to provide health insurance for dependent children whenever it is available to the absent parent at reasonable cost. (Health insurance is defined to be reasonable in cost if it is employment-related or other group health insurance.) This includes petitioning for medical support whether or not it is actually available to the absent parent at the time the order is entered or modified;
 - o Identify existing child support cases which have a high potential for obtaining medical support and petition the court or administrative authority to modify support orders to include medical support for targeted cases even if no other modification is anticipated;
 - o Inform you of any new or modified support orders that include a medical support obligation;
 - o Take steps to enforce the health insurance coverage required by a court or administrative order;
 - o Provide you with health insurance policy information whenever it becomes available (i.e., at the time services are being requested, at the time the order is entered or modified, or when the absent parent secures health insurance coverage under the order);
 - o Communicate with the Medicaid agency to determine if there have been lapses in health insurance coverage for Medicaid applicants and recipients; and
 - o Request employers and other groups offering health insurance coverage that is being enforced by the title IV-D agency to notify the title IV-D agency when the absent parent's health insurance coverage lapses.

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3905.8 Responsibility of Medicaid State Agency in Obtaining Medical Support Information from Title IV-D Agency.--Contact the title IV-D agency immediately if you have not already done so to arrange for the timely and efficient exchange of the information identified in §3905.7. Maintain contact with the title IV-D agency on an ongoing basis to ensure the timely flow of required information.

3906. COOPERATIVE AGREEMENTS AND INCENTIVE PAYMENTS

A. Cooperative Agreement. (See 42 CFR 433.152.)--A State plan must provide for entering into written cooperative agreements for enforcement of rights to and collection of third party benefits with at least one of the following entities: the State title IV-D

agency, any appropriate agency of any State, and appropriate courts and law enforcement officials.

- o The terms are left to your discretion.
- o Agreements with title IV-D agencies must specify that the title IV-D agency's reimbursement from the Medicaid agency is limited to services beyond the requirements specified in 45 CFR Part 306 Subpart B.
- o The removal of the detailed requirements from the cooperative agreements does not change the specific requirements of the Office of Child Support Enforcement (OCSE) under 45 CFR Part 306 governing cooperative agreements between State child support enforcement agencies and State Medicaid agencies.
- o Retain final responsibility for TPL collection functions that are not covered by cooperative agreements.

Failure to obtain an agreement does not relieve you of medical enforcement responsibility.

B. Incentive Payments. (See 42 CFR 433.153.)--Make an incentive payment to a political subdivision, a legal entity of the subdivision such as a prosecuting or district attorney or friends of the court, or another State that enforces and collects medical support and payments for you under a cooperative agreement.

Enforcement may be defined as a pursuit of medical support against someone other than the Medicaid recipient, or against some source, such as an insurance company, which is responsible for medical services provided to a recipient by virtue of its responsibility to an absent responsible relative. It includes actions taken against responsible relatives to insure provision of health insurance coverage for Medicaid recipients, as well as pursuit of benefits from third parties which are based on insurance policies held by legally responsible relatives. Enforcement does not include pursuit of third parties based on insurance policies held by Medicaid recipients themselves. Collections is defined as amounts collected from sources who are responsible for medical services provided Medicaid recipients, including benefits received as the result of premiums paid by an absent responsible relative. Collections do not include amounts collected for premiums.

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Enforcement and collection activity must be controlled by a cooperative agreement if FFP to the extent of the incentive payment is allowed. If a locality or another State performs only enforcement or collection activities, but not both, no incentive payment under 42 CFR 433.153 is allowed. States may make incentive payments from State only funds.

Incentive payments cannot be made under 42 CFR 433.153 when a State makes a collection itself. The purpose of the incentive payment is to encourage local participation and to encourage cooperation between States. Thus, when a State makes a collection itself, an incentive payment is not appropriate, since there is no involvement of a locality of the State. A State which makes a collection itself shares in the benefits of the collection through the reimbursement it receives for the State share of payment.

The incentive payment must equal 15 percent of the amount collected. It is made from the Federal share of that amount.

If more than one State or political subdivision is involved in enforcing and collecting support and payments:

- o Pay the incentive payment to the political subdivision, or another State that collected medical support and payments at your request; and

- o The political subdivision, legal entity or other State that receives the incentive payment divides the incentive payment equally with any other political subdivisions, legal entities, or other States that assisted in the collection unless an alternative allocation is agreed upon by all jurisdictions involved.

3906.1 Requirements of State CSE Agency and Cooperative Agreements.--Title IV-D regulations in 45 CFR Part 306 contain the requirements applicable to the State CSE agency with respect to medical support enforcement and the requirements applicable to cooperative agreements between you and the State CSE agency.

3906.2 Funding.--You are responsible for reimbursement to the State CSE agency for any activities performed under the agreement that are necessary for the collection of amounts for the Medicaid program. This includes activities the CSE agency is required to perform under its regulations.

The Medicaid FFP rate for activities contained in a cooperative agreement with the State CSE agency is 50 percent. Therefore, claim your full reimbursement to the State CSE agency as an administrative expense on the quarterly statement of expenditures.

Activities performed by a CSE agency that are not under a cooperative agreement with the Medicaid agency are reimbursed under title IV-D.

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3907. DISTRIBUTION OF COLLECTIONS

Distribute collections to:

- o Yourself, an amount equal to State Medicaid expenditures for the individual on whose right the collection was based;

- o The Federal Government, the Federal share of the State Medicaid expenditures, minus any incentive payment; and

- o The recipient, any remaining amount. SSI policy states that refunds of medical insurance payments made by a Medicaid agency are not income to recipients. Therefore,

this refund is not considered income for aged, blind or disabled Medicaid recipients in States which use SSI criteria. However, the refund is considered a resource in the month after it is received.

AFDC program policy states that a refund of medical insurance payments made to a recipient is considered income. Therefore, the refund is considered income to AFDC-related Medicaid recipients. States may permit providers to collect directly from third party resources.

In liability situations, the Medicaid program must be fully reimbursed before the recipient can receive any money from the settlement or award. This is based on §1912(b) of the Act and 42 CFR 433.154. Legitimate costs of obtaining the settlement or award, such as attorney fees, may be deducted prior to reimbursement to the Medicaid program.

3908. CONFLICTING CLAIMS BY MEDICARE AND MEDICAID

Under §1862(b) of the Act (see 42 U.S.C. 1395y(b)), Medicare payments may not be made, to the extent that payment has been made, or can reasonably be expected to be made, for Medicare covered items or services under:

- o A workers' compensation law or plan of the United States or a State;
- o An automobile, no-fault, or any liability insurance policy or plan (including a self-insured plan); or
- o An employer group health plan for employed beneficiaries age 65 or over and the spouses aged 65 and over of employed individuals of any age.

Also, with regard to beneficiaries entitled to Medicare solely on the basis of end stage renal disease (ESRD), payment may not be made for Medicare covered items or services during a period of up to 12 months to the extent that payment for these items or services has been, or will be, made by an employer group health plan as promptly as would otherwise be the case if payment were made by Medicare.

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Any Medicare payment for items or services under §1862(b) of the Act is conditioned on reimbursement to the appropriate Trust Fund when notice or other information is received that payment for those items and services is made under such a law, policy, plan or insurance. Under the law, Medicare has the right to recover its benefits from employers and workers' compensation carriers, liability insurers, automobile or no fault insurer, and employer group health plans before any other entity, including a State Medicaid agency. Also Medicare has the right to recover its benefits from any entity, including a State Medicaid agency, that has been paid by any of these third parties. In other words, Medicare's recovery rights where any of these third parties is primary payer, are higher than and take precedence over the rights of any other entity.

The superiority of Medicare's recovery right over those of other entities, including Medicaid, derives from §1862(b) of the Act, which provides that where Medicare is secondary to another insurer:

- o HCFA may recover Medicare benefits from the responsible insurer;

o HCFA may recover its payments from any entity that has been paid by the responsible insurer; and

o HCFA is subrogated to the right of the Medicare beneficiary and the right of any other entity to payment by the responsible insurer.

Subrogation literally means the substitution of one person or entity for another. Under the Medicare subrogation provision, the program is a claimant against the responsible insurer, to the extent that Medicare has made payments to or on behalf of the beneficiary for services covered by the insurer. Medicare can be a party to and participate in any claim by a beneficiary or other entity against the insurer, can participate in negotiations concerning the total insurance payment and the amount to be repaid to Medicare, and may seek recovery of conditional payments directly from the responsible insurer.

If Medicare and Medicaid both have claims against any of these third parties, Medicare's right to recover its benefits from the third party or from a beneficiary/recipient that has been paid by the third party is higher than Medicaid's, notwithstanding the fact that Medicaid is the payer of last resort, and therefore, does not pay its benefits until after Medicare has paid. Medicare's priority right of recovery does not violate the concept of Medicaid's being payer of last resort. Under §1862(b) of the Act, Medicare's ultimate statutory authority is not to pay at all (with a concomitant right to recover any conditional benefits paid) where payment can reasonably be expected by any of these third parties. Where the third party pays right away, Medicare makes no payment to the extent of the third party payment. Delay of third party payment does not change Medicare's ultimate obligation to pay the correct amount regardless of any Medicare payments conditionally made. Thus, where the third party pays less than the charges, Medicare may be responsible to pay secondary benefits. And where the third party pays the charges, Medicare may not pay at all. Pro-rata or other sharing of recoveries with Medicaid has the effect of creating a Medicare payment where none is authorized under the law, or improperly increasing the amount of the Medicare secondary payment.

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The right of Medicaid agencies to recover their benefits derives from an assignment by Medicaid recipients to the States of their rights to third party payments. Since the recipient can assign to the State a right no higher than his own, and since Medicare's statutory right is higher than the recipient's, Medicare's right is higher than that assigned to the State.

Thus, where Medicare and Medicaid have paid for services, and the amount available from the third party is not sufficient to satisfy the claims of both programs for reimbursement, the third party must reimburse Medicare the full amount of its claim before any other entity, including a State Medicaid agency, may be paid.

Also, where a beneficiary/recipient, attorney, provider or supplier receives payment from the third party for services which have already been paid for by Medicare and by Medicaid, and the amount paid by the third party is less than the combined amounts paid by Medicare and Medicaid, the payee is obligated to refund the Medicare payment up to the full amount of the third party's payment, despite a conflicting claim by a State Medicaid agency. Only after Medicare has recovered the full amount of its claim does the beneficiary/recipient, attorney, provider or supplier have the right to reimburse Medicaid or any other entity.

If the third party has reimbursed a State Medicaid agency, or if a beneficiary/recipient, after receiving a payment from the third party, has reimbursed a State Medicaid agency, the State agency must reimburse Medicare up to the full amount the agency received if Medicare is unable to recover its payment from the remainder of the third party payment. If the State refuses to reimburse Medicare in full, Medicare carriers and intermediaries are instructed to refer the case to the RO for resolution. If payment is not made by the State, recovery of Medicare benefits is achieved by offset of Medicare's claim against any Federal financial participation funds otherwise due the State.

3909. MEDICARE/MEDICAID CROSSOVER CLAIMS

Medicare/Medicaid crossover claims are claims for services in which both the Medicare and Medicaid programs are involved because an individual is entitled to Medicare and eligible for Medicaid. Crossover claims may involve Part A Medicare services, Part B Medicare services purchased under a buy-in agreement, or Part B Medicare services outside the context of a buy-in agreement, which are also covered under a Medicaid State plan. Crossover claims may also involve Medicare services which are not covered under Medicaid. These instructions apply to crossover claims where the Medicare beneficiary is also eligible for Medicaid, but does not qualify as a Qualified Medicare Beneficiary (QMB). (See §3490 for QMB crossover claims.)

Participation in the Medicaid program is limited by 42 CFR 447.15 to providers who accept, as payment in full, the amounts paid by the Medicaid agency, plus any cost sharing amount (recipient liability) authorized under the State Medicaid plan. You are not responsible for paying more than the applicable payment rate established in your State plan. A Medicaid recipient's liability, if any, for services covered under the Medicaid program is limited by §1916 of the Act to "nominal" amounts. In addition, §1902(a)(25)(C) of the Act further limits a recipient's liability for services where a third party, such as Medicare, is liable for payment, and prohibits a provider from seeking to collect from the recipient any amount in excess of the recipient's liability.

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Effective for physicians' services furnished on or after April 1, 1990 to a Medicare beneficiary who is also eligible for medical assistance, Medicare payment may only be made on a Medicare assignment-related basis. Thus, the provider must accept Medicare assignment for physicians' services if the Medicare beneficiary is Medicaid eligible. In addition, Medicare sanctions may be applicable if a person knowingly and willfully bills for physicians' services in violation of this restriction.

Medicaid is the payer of last resort; therefore, when an individual is entitled to Medicare and eligible for Medicaid, Medicare, like other third parties, is the primary payer. After the amount of Medicare's liability is determined, pay the claim up to the amount of the Medicaid rate, only to the extent that the Medicaid rate exceeds the amount of Medicare's liability and that an obligation remains on the part of the Medicaid eligible, but only up to the upper limits specified in the regulations. For example, as specified in 42 CFR 447.304, payments made under the plan for deductibles and coinsurance payable on an assigned Medicare claim for noninstitutional services may be made only up to the reasonable charge under Medicare, even if the payment amount in the State plan is higher. An exception to the upper payment limits in 42 CFR 447.272(c) allows States to make Medicaid payments in excess of the Medicare cost principles to hospitals designated as those serving a disproportionate share of low-income patients with special needs.

In establishing the applicable payment schedule amount for payment of Medicare Part A and Part B deductibles and coinsurance for Medicare/Medicaid crossover claims, you

have the option of setting the applicable payment amount at the rate paid when the recipient is not also a Medicare beneficiary, or you can choose to set a higher amount up to the Medicare allowable rate. This means that, after deducting Medicare's liability for the service, you are paying part or all of the amount of the Medicare deductible and coinsurance. Your payment amount for Medicare/Medicaid crossover claims must be reflected in the State plan.

Following are examples of several situations showing your responsibility and the recipient's responsibility for payment of Medicare cost sharing amounts for services which are covered under Medicare and also covered under the Medicaid State plan. In each of the example, the Medicare deductible is met unless otherwise indicated.

Example 1

Medicare rate for service (amount allowed without regard to deductible and coinsurance)	=	\$
100		
Medicare pays (80 % of rate for service) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service	=	\$
100		
(No recipient copayment imposed by Medicaid)		
Medicaid pays	=	\$ 20
Medicaid recipient liability	=	0

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Example 2

Medicare rate for service	=	\$
100		
Medicare pays (80%) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service	=	\$ 80
(No recipient copayment imposed by Medicaid)		
Medicaid pays	=	0
Medicaid recipient liability	=	0

Example 2 assumes that the State has not set a separate rate for the service for Medicare beneficiaries eligible for Medicaid. If the State wishes to pay some or all of the Medicare cost sharing amounts, it could set a separate rate for the service for these individuals at the Medicare allowed charge or between the Medicare allowed charge and the normal Medicaid rate. If the State paid the full cost sharing amount, the result is as described in Example 1.

Example 3

Medicare rate for service	=	\$
100		

Medicare pays (80 %) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service (\$95 + \$5) 100	=	\$
Medicaid copayment for service	=	5
Medicaid pays	=	\$ 15
Medicaid recipient liability	=	5

Example 4

Medicare rate for service 100	=	\$
Medicare pays (80%) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service (\$65 + \$5)	=	\$ 70
Medicaid copayment for service	=	5
Medicaid pays	=	0
Medicaid recipient liability	=	0

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Example 5

Medicare rate for service	=	\$ 100
Unmet Medicare deductible	=	65
Medicare pays (80 % of \$35 (\$100-\$65=\$35)) (TPL)	=	28
Medicare coinsurance (amount not paid by Medicare)	=	7
Medicaid rate for service (\$95 + \$5)	=	\$ 100
Medicaid copayment for service	=	5
Medicaid pays	=	\$ 67
Medicaid recipient liability	=	5

Example 6

Medicare rate for service	=	\$ 100
Unmet Medicare deductible	=	65
Medicare pays (80 % of \$35 (\$100-\$65=\$35)) (TPL)	=	28
Medicare coinsurance (amount not paid by Medicare)	=	7
Medicaid rate for service (\$75 + \$5)	=	80
Medicaid copayment for service	=	5
Medicaid pays	=	\$ 47
Medicaid recipient liability	=	5

Example 7

Medicare rate for service	=	\$ 100
Medicare pays (80 %) (TPL)	=	80
Medicare coinsurance (amount not paid by Medicare)	=	20
Medicaid rate for service (\$78 + \$5)	=	\$ 83
Medicaid copayment for service	=	5
Medicaid pays	=	0
Medicaid recipient liability	=	3

3909.1 State Buy-In of Part B Benefits (See 42 CFR 431.625).-- If you have a buy-in agreement to enroll certain Medicare-eligible recipients under Medicare Part B, you are required to pay their premiums. This entitles the recipient to the entire range of Medicare Part B benefits. However, your payment of the premiums under a buy-in agreement does not obligate you to cover, or to pay deductibles and coinsurance for, the entire range of Medicare Part B benefits. With respect to deductibles and coinsurance, you have the following options:

A. Option 1.--You may elect to pay Medicare cost sharing amounts only for those Medicare Part B services which are covered in your Medicaid plan even if the total amount paid for these services (composed of the Medicare and the Medicaid payments) exceeds the Medicaid rate employed for this service for Medicaid only eligibles. You obtain this result by establishing a separate higher rate for the service for Medicare beneficiaries eligible for Medicaid. (This rate may not be limited only to individuals who receive Medicare under a buy-in agreement.)

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B. Option 2.--You may elect to pay Medicare cost sharing amounts for the entire range of Medicare Part B benefits, whether or not they are covered under your State plan. With respect to covered services, you are subject to conditions contained in the last two sentences of Option 1.

C. Option 3.--You may elect to pay Medicare cost sharing amounts for all those Medicare Part B services which are covered under your plan as well as some Part B services which are not covered under your plan, but for which you specify that you pay the Medicare cost sharing. With respect to covered services, you are subject to the conditions contained in the last two sentences of Option 1.

For those Part B benefits covered under your plan, your payment of deductible and coinsurance amounts is subject to the applicable payment schedule amounts in your plan for Medicare (Part B)/Medicaid crossover claims, as indicated in §3909.

If you elect not to pay toward deductibles and coinsurance for Part B benefits not covered in your plan, the recipient is still eligible for the Part B benefits from Medicare, but, is considered only a Medicare beneficiary with respect to these benefits and is liable for the Medicare deductibles and coinsurance for services not covered under Medicaid. However, you may elect to pay any amount toward deductibles and coinsurance for part or all of the Part B benefits not covered in your plan.

3910 MEDICAID PAYMENTS FOR RECIPIENTS UNDER GROUP HEALTH PLANS

3910.1 General.--Section 4402 of OBRA 1990 added §1906 to the Act to provide for the mandatory enrollment of Medicaid eligibles in cost effective group health plans as a condition of Medicaid eligibility. Section 4741 of the Balanced Budget Act (BBA) of

1997 amended § 1902(a) (25) and 1906(a)(1) of the Act making this provision optional, effective August 5, 1997.

3910.2 Affected States.--This requirement applies to the 50 States and the District of Columbia.

3910.3 Definitions.--

Group Health Plan--This is a plan which meets §5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to title XXII of the Public Health Service Act, §4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of such employees or former employees.

Cost Effectiveness--The amount you pay for premiums, coinsurance, deductibles, other cost sharing obligations under a group health plan, and additional administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

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3910.4 State Plan Requirements.--If elected a State plan must:

- o Provide a methodology for determining the likely cost effectiveness of an individual's enrollment in a group health plan;
- o Provide for payment of all premiums, deductibles, coinsurance and other cost sharing obligations under the group health plan for Medicaid recipients enrolled in the group health plan for items and services under the State plan;
- o Provide for payment of items and services provided to Medicaid recipients under the State plan that are not covered in the group health plan;
- o Provide for payment of premiums for non-eligible family members only if it is necessary in order to enroll a Medicaid eligible family member in the group health plan and it is likely to be cost effective to do so; and
- o Treat the group health plan as a third party resource in accordance with third party liability requirements in §§3900-3909 except Federal financial participation (FFP) is available as provided in §3910.6.

A State may require, as a condition of eligibility, enrollment in a group health plan where the enrollment is likely to be cost effective (except for an individual who is unable to enroll on his/her own behalf.)

3910.5 Condition of Eligibility.--If a State elects to pay for cost effective group health plans, the State may require individuals, who are eligible to enroll in a group health plan the State determines to be cost effective, to enroll in that group health plan to obtain or maintain their Medicaid eligibility. The State must make an exception to this

requirement where an individual who is otherwise eligible for Medicaid, is unable to enroll in the group health plan on his/her own behalf. For example, if a parent refuses to enroll the child, or a spouse is unable to enroll freely on his/her own behalf, such failure does not affect the child's or spouse's eligibility to Medicaid benefits.

The fact that an individual is enrolled in a group health plan does not change the individual's eligibility for benefits under the State plan. If Medicaid services covered under the State plan are not part of the services covered by an eligible individual's group health plan, the individual may obtain those services from participating Medicaid providers. These services are reimbursed at the State Medicaid rate.

3910.6 Availability of FFP.--FFP is available for the payment of premiums for Medicaid eligible enrollees in a cost effective group health plan. FFP is also available for all deductibles, coinsurance and other cost sharing obligations under the group health plan that are for services covered under the State plan, except for the nominal cost sharing amounts otherwise permitted under §1916 of the Act which are the recipient's responsibility.

If a non-Medicaid eligible family member must be enrolled in the group health plan in order to obtain coverage for the Medicaid eligible member, FFP is available for premiums only (no other cost sharing expenses) for the non-Medicaid eligible family member(s). A family member may reside in a separate household.

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If an individual's group health plan offers more services than covered under the State plan, no FFP is available for the deductibles, coinsurance and other cost sharing obligations for non-covered services.

If a Medicaid recipient is also eligible for Medicare Part B and is not enrolled in Part B, no FFP is available for the payment of premiums or other cost sharing obligations to the group health plan.

If a Medicaid recipient is currently enrolled in a non-employer based group health plan and is also eligible to enroll in a cost effective group health plan as described in this section, the State may require the recipient to enroll in the cost effective group health plan to maintain his/her Medicaid eligibility. If enrollment in both health plans remains cost effective, then FFP is available for the cost sharing obligations of the non-employer based plan per §1903(a) of the Act.

3910.7 Guidelines for Enrollment.--Group health plans usually limit an individual's enrollment period. If an individual, who is already enrolled in a group health plan, becomes Medicaid eligible, the State may buy into the plan as of the effective date of Medicaid eligibility. Eligibility for Medicaid may be effective no later than the third month before the month of application as described in 42 CFR 435.914.

If a Medicaid recipient is not eligible for coverage under a group health plan for a specified waiting period, the State may buy into the plan as of the effective date of eligibility. Until the recipient is eligible to enroll, or entitled to receive services under the group health plan, all covered services are paid under applicable Medicaid procedures for group health coverage.

If the State elects to pay for cost effective group health plans, §1906(a)(3) of the Act requires you to pay the premiums that an enrollee is required to pay. This type of payment is most often obtained through payroll deductions and some employers may refuse to provide health insurance unless it is paid for through that means. Therefore, where enrollees make payment through payroll deductions, reimburse the enrollee for the payment. An individual is only required to enroll in a group health plan if the plan is cost

effective. Whenever a periodic Medicaid redetermination is done, the cost effectiveness of the group health plan must be reevaluated.

3910.8 Guidelines for Disenrollment.--If a State elects to require enrollment in a cost effective group health plan as a condition of eligibility, an affected individual may disenroll in that group health plan only when the employer offers more than one cost effective group health plan and the employee applies for enrollment in a different cost effective group health plan. Where only one group health plan is available, and you determine that it is cost effective, disenrollment from the plan results in the termination of Medicaid eligibility. This ineligibility remains effective until the next open season for group health plan enrollment.

If the availability for enrollment in the group health plan and eligibility to Medicaid benefits do not coincide, have the applicant apply (by completing necessary forms) for enrollment in the group health plan at the time of Medicaid application. Hold the enrollment application for the group health plan until open season, then submit the form. The applicant is not eligible for Medicaid benefits if he/she refuses to apply for enrollment in a group health plan during the Medicaid application process. This ineligibility remains effective until the next open season for group health plan enrollment.

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3910.9 Non-Medicaid Providers.--Some providers that participate in group health plans may not be Medicaid participating providers. Although §1902(a)(25)(C) does not appear to limit providers to Medicaid participating providers, encourage all providers to become Medicaid participating providers. Provider participation may be initiated solely through the submission of a bill for services as is currently permitted for Qualified Medicare Beneficiaries (QMBs). If providers refuse to bill Medicaid, consider the option of direct payment to recipients.

3910.10 Optional Minimum 6-Month Eligibility.--You may deem a minimum enrollment period of up to 6 months in cost effective group health plans for Medicaid eligibles. If recipients lose their eligibility to Medicaid benefits before the end of the 6 month period, you may continue entitlement to the plan from the effective date of the individual's enrollment to the end of the deemed period. During this period, FFP is limited to premiums, deductibles, coinsurance and other cost sharing obligations for benefits provided under the group health plan. The individual is not entitled to any Medicaid benefits provided outside of the group health plan. Specify the minimum enrollment period in your State plan.

3910.11 Cost Effectiveness.--An individual's enrollment in a group health plan is considered cost effective when the amount you pay for premiums, coinsurance, deductibles, other cost sharing obligations, and additional administrative costs is likely to be less than the Medicaid expenditures for an equivalent set of services. The methodology for determining cost effectiveness must be included in the State plan and approved by HCFA. Submit documentation demonstrating a reasonable approach to any suggested methodology. Your methodology may include factors not presented in our guidelines, e.g. considering a recipient's diagnosis. The following guidelines are one way to determine cost effectiveness.

Step 1-Policy Information.--Obtain information on the group health plan available to the recipient. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy and premiums paid by the employee.

Step 2-Average Medicaid Costs.--Using the Medicaid Management Information System (MMIS), obtain the average total annual Medicaid costs of persons like the applicant (age, sex, category and geographic data).

Step 3-Medicaid Costs for Included Services.--Determine the amount of the total yearly Medicaid expenditures that are spent on the services covered by the individual policy. For example, assume that 10 services are covered under the State plan and 6 of those 10 are covered by the group health plan, but those 6 are the most frequently used services under both the group health plan and the Medicaid State plan. Compute the percentage of expenditures for group health plan services to the expenditures for Medicaid services. In this example, assume that the services comprise 82 percent of the Medicaid expenditures which are covered by this group health plan. Then adjust the average total annual Medicaid costs specified in step 2 by this percentage.

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Step 4-Group Health Plan Costs for Included Services.--Adjust the Medicaid average covered expense amount (amount from step 3) for the higher prices employer plans typically pay. You may use a single State specific factor that is derived from your experience with TPL or use group health plan specific information. Alternatively, a national average factor may be used. This factor is supplied and updated by HCFA periodically. Once this factor is determined, the Medicaid covered expense is multiplied by this factor to produce an estimated covered expense as recognized by the employer plan.

Step 5-Adjustment for Coinsurance and Deductible Amounts.--The health plan cost (amount from step 4) is multiplied by an average employer health insurance payment rate to obtain the employer recognized covered expense amount. Derive the average employer health insurance payment rate from State specific tables, if available, or group health plan specific information. Alternatively, for your use, national tables are supplied and updated by HCFA periodically. This average payment rate number varies by how large the average employer recognized covered expense is.

Step 6-Administrative Costs.--Account for additional administrative costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.

Step 7-Cost Effectiveness Calculation.--Compare the costs under the group health plan to those costs under Medicaid.

Group Health Plan

- o Subtract the employer recognized covered expense (step 5) from the costs of services under the group plan (step 4);
- o Add the employee's share of premiums paid (step 1); and
- o Add the additional administrative costs (step 6).

Medicaid Expenditures.--Use the average Medicaid cost for the services covered under the group health plan (step 3).

Cost effectiveness is likely if your cost under the group health plan is lower than your cost for the same services under Medicaid. (See example on determining cost effectiveness.)

NOTE: When non-Medicaid eligible family members are enrolled in group health plans in order to enroll the Medicaid eligible member, do not include the deductibles, coinsurance and other cost sharing obligations for the non-Medicaid eligible family members in your calculations.

3910.12 Effective Date.--The enrollment date of a Medicaid eligible individual in a group health plan is the effective date for benefits made by these amendments. However, in no case are benefits effective prior to January 1, 1991. The optional provision at §4741 of the BBA of 1997 is effective August 5, 1997.

3910.13 Comparability of Services.--Section 1902(a)(10) of the Act has been amended to allow Medicaid coverage for the costs of premiums, deductibles, coinsurance and other cost sharing obligations for individuals in cost effective group health plans without requiring the availability of comparable services of the same amount, duration, and scope to other Medicaid eligibles.

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3910.15

3910.14 Determination and Redeterminations of Eligibility.--Determination and redeterminations of eligibility are subject to the rules in 42 CFR 435.911 and 916.

3910.15 Erroneous Excess Payments.--You are not charged errors with respect to payments made in violation of §1906 of the Act.

Example of Cost Effectiveness Guidelines

Step 1-Policy Information.--Obtain information on the group health plan available to the Medicaid recipient. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy and premiums paid by the employee.

Individual: Ms. Smith, aged 25, AFDC, county X
Daughter, aged 6, AFDC, county X

Group Health plan: Effective date 1/1/91
No exclusions
6 Covered Services - Hospital Inpatient, Hospital Outpatient, Physician Services, Clinic, Laboratory and X-ray, and Prescription Drugs

Premiums: \$840.00 yearly

Step 2-Average Medicaid Costs.--Using the Medicaid Management Information System (MMIS), obtain the average total costs per person per year for Medicaid services to persons like the applicant (age, sex, category and geographic data).

MMIS Data: 25 year old female, AFDC, county X =	\$1,550.00
6 year old female, AFDC, county X =	<u>1,250.00</u>
Total Medicaid Expenses	\$2,800.00

Step 3-Medicaid Costs for Included Services.--Determine the amount of the total yearly Medicaid expenditures that are spent on the services covered by the individual policy.

10 Services offered under the State plan:

Inpatient Hospital Clinic	Outpatient Hospital Laboratory and X-ray
SNF and Home Health	EPSDT
Physician Services	Family Planning services
Physical Therapy	Prescription Drugs

6 Services offered under the group health plan:

Inpatient Hospital Clinic	Outpatient Hospital Laboratory and X-ray
Physician services	Prescription Drugs

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3910.15 (Cont.)

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The services covered by the health plan are the most frequently used services. These 6 services happen to comprise 82 percent of the Medicaid costs in the example State. On an average annual basis, the costs to Medicaid of providing the 6 services offered under the group health plan are:

Ms. Smith's expenses at 82%	\$1,271.00
Daughter's expenses at 82%	<u>1,025.00</u>
Medicaid average covered expense amt.	\$2,296.00

Step 4-Group Health Plan Costs for Included Services.--Adjust the Medicaid average covered expense amount (amount from step 3) for the higher prices employer plans pay. Use a single State specific factor that is derived from your experience with TPL, or use group health plan specific information. For the purpose of this example, the national factor of 1.3 was used. Once this factor is determined, the Medicaid covered expense is multiplied by this factor to produce an estimated covered expense as recognized by the employer plan.

Medicaid average covered expense amount	\$2,296.00
National average factor	<u>X 1.30</u>
Actuarial value of group health plan services if there were no cost sharing or service limitations	\$2,984.80

Step 5-Adjustment for Coinsurance and Deductible Amounts.--The health plan cost (amount from step 4) is multiplied by an average employer health insurance payment rate to obtain the employer recognized covered expense amount. Derive the average employer health insurance payment rate from State specific tables, national tables, or group health plan specific information. Assume the number is 75 percent for the purposes of this example. This average payment rate number varies by how large the average employer recognized covered expense is.

Cost to health plan for services	\$2,984.80
Average employer payment rate (75%)	<u>X .75</u>
Employer recognized amount	\$2,238.60

Step 6-Administrative Costs.--Account for additional administrative costs to Medicaid for processing the group health information by determining the average increase in cost per recipient.

Increased cost to process info.	\$ 50.00
Number of recipients	<u>x 2.00</u>
Additional admin. costs	\$100.00

Step 7-Cost Effectiveness Calculation.--Compare the costs under the group health plan to those costs under Medicaid.

Cost to group health plan (step 4)	\$2,984.80
Employer recognized amt. (step 5)	<u>-2,238.60</u>
Proxy for deductibles, coinsurance and limitations within types of service covered under the group health plan	\$ 746.20

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Employee's premiums (step 1)	+ 840.00
Additional admin. costs (step 6)	<u>+ 100.00</u>

Total costs to State under group health plan	\$1,686.20
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Costs to State from Medicaid for these services	\$2,296.00
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Cost effectiveness is likely if the costs to the State under the group health plan is lower than the cost to the State for these services under Medicaid.

Costs to State from Medicaid for these services	\$2,296.00
Costs to State under group health plan	<u>-1,686.20</u>

Savings from group health plan	\$ 609.80
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THIRD PARTY LIABILITY (TPL) ACTION PLAN

MISSISSIPPI THIRD PARTY LIABILITY (TPL) ACTION PLAN

I. Identification of Resources

A. Collection of Health Insurance Information (Other than SSA and IV-D)

Health Insurance information is secured on Medicaid applicants and recipients during the initial application and at each re-determination by the Department of Human Services (DHS) and the Medicaid Regional Offices responsible for eligibility determinations. The Eligibility Worker (EW) or Medicaid Specialist determines health insurance availability during the interview process and obtains required verification, a copy of the policy or the identification card. Health insurance information is collected via form DHS-EA-346 and DOM-TPL406. Collected information includes name and address of the insurance company, name of the policy holder, policy number, employer name and address, group number and social security numbers of applicable case members. The name, address, and social security number of the absent parent and custodial parent are also gathered. This information is reported to the Division of Medicaid (DOM) Third Party Liability (TPL) Bureau via DHS-EA-346 and DOM-TPL 406. A copy of these forms is retained in the physical case record within the DHS and the DOM Regional Offices. The Medicaid Eligibility Determination System (MEDS) within the MMIS is updated with the applicable TPL code.

Further, when a Medicaid claim is submitted to the fiscal agent with indication of third party money received and the MMIS shows no third party source, a recipient inquiry is automatically generated and mailed. The return address is the DOM TPL Bureau. This claim is reported on the MMIS TPL report, RT050, generated to the TPL Unit with each payment cycle.

The MMIS TPL report, RT050, also lists all claims with a third party indication and no record in the MMIS TPL files as well as claims with TPL attachments. The report along with the copies of related claim documents and attachments are forwarded to the DOM TPL Unit weekly.

The DOM TPL Unit receives the eligibility TPL source documents named in the above paragraph and the recipient inquiries that were system generated, completes any needed verification by contact with the recipient and/or source of third party, and within 60 days enters the information into the MMIS TPL files.

The MMIS TPL Support System consists of the Resource Sub-System and the Carrier Sub-System. The resource has the capability of holding up to seven (7) different third party sources and contains the following data elements:

- Medicaid Recipient Name and Medicaid Identification Number
- Insurance Company State Assigned Number
- Start and End Dates of Coverage
- Employer or Group Name and Address
- Subscriber's Name and Number
- Relationship of policy holder to recipient - Policy and/or Group Number
- Scope of Benefits
- Absent Parent Name, Address, Social Security Number - IV-D Status
- Cash Medical Support Information

The CIM contains the identifying information on each third party source contained in the resource; for example, the state assigned number, the name, and the address for mailing claims.

B. Collection of Health Insurance Information by SSA

TPL information collected by SSA in the application process is electronically transmitted to the state. The Medicaid fiscal agent receives this TPL electronic data and places it in an on-line work file for the DOM TPL Unit to research and perform the necessary MMIS TPL file transactions. Health insurance information is collected by the SSA in the re-determination process via form SSA8019 which is received in the DOM TPL Unit on a daily basis. Through contact with the recipient and/or the third party source, any incomplete verification is obtained. The information for the individual already on the MMIS recipient file is entered into the MMIS TPL Support System files within sixty (60) days. When no record exists on the MMIS recipient file, the SSA information is held and rechecked periodically for 90 days. Refer to item I.A. above for explanation of the data elements contained in the TPL Support System files.

C. Data From the Office of Child Support Enforcement Program (IV-D)

The DHS Child Support Enforcement Agency is responsible for petitioning the court for medical support, either in the form of insurance coverage or money for medical services received, for Medicaid recipients who have been referred for IV-D services. The DOM TPL Unit is notified of medical support via Mississippi Enforcement and Tracking of Support System (METSS) electronic data transmission. The METSS electronic transmission provides the following information:

- Custodial Parent's Name, Case Number, Social Security Number, Medicaid ID Number (if applicable)

- Non-custodial Parent's Name/Address, Social Security Number, Employer Name/Address
- Children's Names, Social Security Numbers
- Medical Coverage Information: Insurance Company Name/Address, Policy Number, Names of Persons Covered

The DHS Child Support Enforcement Agency also utilizes the METSS to notify the DOM TPL Unit of any changes to the medical support. Changes in the status of eligibility or third party coverage are exchanged by the discovering agency. The MMIS and the Eligibility case files are updated within sixty (60) days of receipt of notification.

The DOM TPL Unit will use all available resources; i.e., insurance claims, employer, recipient, etc. to verify any incomplete information on the METSS on-line work file. Within sixty (60) days of receipt, the DOM TPL Unit will enter the appropriate data into the MMIS TPL Support System. Refer to item IA. above for the data elements contained in the MMIS TPL files.

The IV-D status in the resource, as referenced in item I.A. above, contains the following values:

- B blank- No Legal Action Ordered by the Court
- C- Insurance and Expense Combined, not IV-D D- Insurance, not IV-D
- X- Expense, not IV-D
- M- Insurance and Expense Combined, IV-D I- Insurance, IV-D
- E- Expense, IV-D

II. DATA EXCHANGES

A. State Wage and Income Collection (S WICA) and SSA Wage and Earnings [Beneficiary Earnings Exchange Record (BEER)] Files

The responsibilities of the State Wage Information Collection Agency (SWICA) as defined in 42 CFR 435.4 are administered by the Mississippi Employment Security Commission (MESC). The state Medicaid eligibility data base is matched against the MESC wage files at application and on a quarterly basis. It is also matched against MESC unemployment pay files at application, monthly on non-institutionalized recipients and yearly on institutionalized recipients. The MESC matches provide information on Medicaid recipients that are employed and their employer. SSA Wage and Earnings Record (BEER) files are matched with Medicaid eligible monthly in conjunction with IRS matches. Appendix I outlines the procedures.

Including the names and SSN's of absent parents with the SWICA and BEER files will be initiated upon the approval of the Medicaid Agency's Executive Director.

The DHS Title IV-A program determines Title XIX eligibility and secures information on AFDC and AFDC-related Medicaid recipients that are employed and their employers on a continuous basis. Follow-up on data match hits includes contact with the individual's employer to obtain information regarding the availability of health insurance for the Medicaid recipient. This information is gathered when the DHS eligibility worker (EW) is following up with an employer to verify income and eligibility requirements under IEVS regulation, which require follow-up within 45 days of the hit. If the eligibility case file already contains information regarding health insurance availability through the individual's employer(s), additional follow-ups are not performed. A monitoring system is used to track the completion of referrals sent to EWs from the required IEVS tape matches. Hits requiring additional TP follow-up are forwarded to the DOM TPL Unit via DHS-346.

Within sixty (60) days of receipt of an updated form, DHS-346, from the IV-A Agency, the DOM TPL Unit completes any verification needed, updates the MMIS TPL Support System files.

Verified information coming from data matches is integrated with the DOM TPL Unit files and the eligibility files. Health insurance information collected includes the name/address of the insurance company, name of policy holder, policy number, employer name/address, group number, and inclusive period of coverage. The original data is continuously refined as additional and/or new information is collected. DHS-346s are maintained in the DOM TPL Unit and eligibility case file in order to build TPL history files and avoid duplicity.

Refer to item I.A. above for data elements contained in the MMIS TPL Support System files.

B. Workers' Compensation

Pursuant to 42 CFR 433.138(d)(4)(1), the DOM has an agreement with the Mississippi State Workers' Compensation Commission (MWCC) to conduct annual data matches with the MWCC files. The Medicaid fiscal agent furnishes the MWCC a tape of current Medicaid eligibles as well as absent and custodial parents. This tape is processed against the MWCC files with social security numbers being the element of identification in the match. All persons appearing as hits on the match have had a work-related injury.

Once the match is processed, the Medicaid fiscal agent cross-references the "bits" with the related trauma code reports to alleviate duplication. The fiscal agent cross references the MW CC tape with trauma code claims that appeared on the BUREAU OF RECOVERY PROCEDURAL MANUAL

trauma code edit reports in order to avoid duplication. A report in recipient alpha-order is generated by the fiscal agent and forwarded to the DOM TPL Unit for follow-up within forty-five (45) days from the receipt of the report. The report provides identifying information such as name, Medicaid ID number (if applicable), date of work-related injury, nature of injury, MW CC attorney number, MW CC carrier number, status of the MWCC file, and MWCC diagnosis codes.

A MW CC coding legend is provided for all MWCC codes and numbers. Based on the highest dollar trauma code report, MWCC diagnosis codes are cross-referenced and a diagnosis code hierarchy is established to target potentially high dollar recoveries.

Hits for which there are no established casualty cases are ranked and pursued based on the highest recovery trauma code report. Within 60 days, the DOM TPL Unit follows up on MWCC data exchange information, as appropriate, in order to identify legally liable third party resources available to the Medicaid recipient either through his own employment or through the employment of an absent or custodial parent. Follow-up entails examination of MWCC case files as warranted. When the match report indicates an absent or custodial parent, inquiries are mailed to the absent or custodial parent, the employer, and/or the insurance company, as appropriate, to determine if medical coverage is available directly to the Medicaid recipient or through the absent or custodial parent. The insurance carrier, employer, and/or the representing attorney are notified of the Medicaid Agency's subrogation rights pursuant to Mississippi State legislation.

Third party information obtained throughout this process is maintained in the TPL case file. Notification is sent to the source of eligibility to be maintained in the eligibility case record. For cases in which recovery is appropriate, in order to track the process, data is also entered into the DOM in-house computer program within fifteen (15) working days of receipt.

The in-house computer program contains the following data fields: - Medicaid recipient's name and ID number.

-Liable Party name/address, phone number - Attorney name/address, phone number

- Date added to file

The DOM TPL staff will enter into the in-house TPI, files any changes to the TPI, information within fifteen (15) workdays of receipt of data. Upon the establishment of liability, recovery procedures are implemented within 15 workdays and follow-up is maintained on cases at appropriate intervals to ensure prompt reimbursement by the third party source.

C. State Motor Vehicle Accident Report Files

The DOM has an agreement in place with the Mississippi Department of Public Safety (DPS) to perform annual data matches with State Motor Vehicle Accident Report files. The fiscal agent will supply the DPS a tape of Medicaid eligible who are fifteen years of age or older. This tape will be matched with the Motor Vehicle Accident Report files using social security numbers as the element of identification. The accident report files only reflect driver's name and driver's license number. The driver's license number in Mississippi is the same as the social security number on most licenses issued since 1969. The fiscal agent will receive the tape of hits from DPS and produce a report of all hits not listed on the related Trauma Code Reports. This eliminates some duplicity in recovery effort. The MMIS will generate and mail accident inquiries to all recipients listed on the report with return address to the DOM TPL Unit. No further information is available through the DPS since accident reports are, by Mississippi State Statute, not public records.

All verified third party information will be maintained in the DOM TPL Unit case record and incorporated in the DOM TEL computer files within 15 working days. (Refer to Item H.B. above for the data elements contained in the DOM TPL computer files.) The source of eligibility will be informed of any third party recovery upon settlement in order for resource information to be maintained in the eligibility case file and for any required eligibility determinations to be made.

The DOM TPL computer files are updated within fifteen (15) working days of any notification of change in TPL information. Upon the establishment of liability, recovery procedures are implemented within 15 days and follow-up is maintained on cases at appropriate intervals to ensure prompt reimbursement by the third party source.

D. Other Data Exchanges

*On an annual basis, Mississippi Medicaid conducts a data match with the Defense Enrollment Eligibility Reporting System (DEERS). Per required time frames, the Medicaid fiscal agent furnishes the DEERS representative with a tape of Medicaid eligibles. This tape is matched against the DEERS files and any resulting information is returned to the fiscal agent. Upon receipt of the DEERS matched tape and after approval from DOM, the fiscal agent automatically accomplishes any necessary adds or updates to the MMIS TPL files.

III. DIAGNOSIS AND TRAUMA CODE EDITS

The Division of Medicaid in connection with the fiscal agent takes action to identify paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 with the exception of 900-919.5, 921.3, 930, 931-939.9, 942.22, 944.20, 945, 946.2, E950-958.8, 958.3, 960-979.9, 980.9, 981, 986, 989.5, 990-995.89, 996-998.9, and 999.8. As specified in 42 CFR 433.139(b) through (f), routine checks are done to determine the legal liability of third parties.

The fiscal agent, as directed by the State Medicaid Agency, follows up monthly on all accumulated trauma related paid claims totalling \$250.00 or more by mailing the recipient or guardian an accident questionnaire. The MMIS lists these trauma related paid claims in recipient order in the TPL History File. The TPL History File contains the following data elements:

- Medicaid recipient's name and ID number
- Listing of all Medicaid paid claims associated with the accident -Liable Party name/address, social security number, phone number -Attorney name/address, phone number
- Date added to file

The Trauma Code Report, an alphabetical listing of all recipients to whom questionnaires were mailed, is system-generated and maintained in the DOM TPL Unit.

Upon receipt of returned questionnaires, research and follow-up is initiated as warranted within 30 days of receipt.

Upon establishing a probable existence of third party liability, payment data is compiled. Notice of Medicaid's subrogation rights is issued to the appropriate attorney or insurance company within thirty (30) days. A casualty case is initiated and follow-up is scheduled at appropriate intervals. All verified data is maintained in the casualty case record.

Any change to the recipient's third party information will be entered into the DOM TPL computer files and the MMIS TPL Support System files as appropriate within fifteen (15) days of the receipt of the notification of change. See Items I.A. and II.B. for explanation of the data elements in these files.

IV. CLAIMS PAYMENT

A. Cost Avoidance

Mississippi Division of Medicaid cost avoids all claim types with the exception of the federally mandated pay and chase services, prenatal, preventive pediatrics, and IV-D related claims.

When the medical provider swipes the Mississippi Medicaid card, a print out is received with the private third party source and/or Medicare coverage. If a

private third party source exists, the Medicaid card lists the name of the source, its address, and the policy number.

Mississippi requires the provider to file with the third party source prior to filing with Medicaid except in the three (3) situations named above. The provider, by State Statute, is required to protect Medicaid as the payor of the last resort by verifying third party sources and by recovering third party monies.

If a third party source is indicated in the MMIS whose effective dates cover the dates of service and whose scope of benefits cover the category of service, the Medicaid claim must either have attached an Explanation of Benefits from the third party source indicating payment denied, benefits exhausted, or policy no longer in effect or have listed a third party dollar amount. If the claim has none of these, then the claim is denied with instructions on the Provider's Remittance Advice (RA) to bill the third party source. Also, the RA lists the name, address, and policy number of the third party source to be billed. In the MMIS, the denied claim is written to the aging file and held for 120 days. If within 120 days, that claim is resubmitted with either the valid attachment or a third party amount, the resubmitted claim is processed for payment and the original denied claim is removed from the aging file. The aging file is read monthly. Cost avoidance is calculated on the claims which are 120 days old.

When a third party amount is listed on a claim, Mississippi pays only up to the Medicaid fee schedule and considers the cost avoided amount the difference in the Medicaid fee schedule and the Medicaid payment. When the third party payment listed on the claim is larger than the Medicaid fee schedule, Medicaid makes no payment and counts the cost avoidance as the Medicaid fee schedule amount. Mississippi considers the third party payment for the entire claim rather than by line item. The control and verification of the partial payment of claims after a third party payment has been made is handled through the hospital/physician third party audit process. Further, the MMIS contains a third party edit that denies the claim and requires hard copy evidence of the third party payment amount when the third party payment listed on the claim is less than 20 percent of the billed amount. The MMIS, as of January 1, 1992, captures the Medicare approved amount as the Medicare savings. Mississippi also includes VA Aid and Attendance as cost avoidance. Co-payments are not included as cost avoided amounts.

B. Pay and Chase

The prenatal, preventive pediatrics, and IV-D related claims are being paid according to 42 CFR 433.139(b)(3)(i) and (ii).

Mississippi also identifies newly added resources to the MMIS TPL Support System files with retroactive policy effective dates and attempts recovery of Medicaid dollars expended during the period of time the State was unaware of the TPL coverage.

Mississippi employs an approved \$100 threshold for TPL Health recovery and \$250 for TPL Casualty related recovery. The threshold includes accumulated billing either on a quarterly or a monthly basis as explained below in the four (4) pay and chase categories. The MMIS identifies threshold levels in the following manner. As claims are processed in the daily claims processing cycle they are identified and assigned TPL status codes related to TPL pay and chase (Prenatal, Preventive Pediatrics, and IV-D) using the principles outline in the matrix shown in Appendix 111. In the weekly claims processing cycle, the claims are paid and collected in a "Month to Date Pay and Bill" file. At month's end, these records are sorted and totalled for each of the pay and chase programs. When the accumulated total of claims for each recipient is greater than \$99.99, the resource file is read to ensure that the dates of service for all claims accumulated are within the policy effective dates.

PRENATAL

Monthly, the MMIS generates and mails to the applicable Third Party Source, prenatal invoices for all recipient's whose cumulative monthly prenatal claim payments equal or exceed \$100 and whose MMIS TPL Support System file indicates a third party resource with prenatal coverage. These claims are identified by HCPCS codes W9350 thru W9352, W9355 thru W9357, and W9361 thru W9363 (perinatal high risk). The MMIS generates and sends to the DOM TPL Unit a listing of claims mailed to the third party resource as well as a copy of the actual invoices. These media are used to track and follow-up TPL recoveries.

PREVENTIVE PEDIATRICS

Monthly, the MMIS generates and mails to the applicable Third Party Source, preventive pediatric invoices for all recipients whose cumulative monthly preventive pediatric claim payments equal or exceed \$100 and whose MMIS TPL Support System file indicates a third party resource with preventive pediatric coverage- These claims are identified by the following Categories of Service: 10 (Periodic Screening Services), 16 (Dental Screening), 17 (Eyeglass Screening Services), and 18 (hearing Screening Services). The MMIS generates and sends to the DOM TPL Unit a listing of claims mailed to the third party resource as well as a copy of the actual invoices. These media are used to track and follow-up TPL recoveries.

IV-D

Monthly the MMIS generates and mails to the applicable Third Party Source, IV-D invoices for all recipients whose cumulative monthly IV-D claim payments equal or exceed \$100 and whose MMIS TPL Support System file indicates a third party resource with applicable coverage. All claims processed by the MMIS for recipients whose resource record indicates a Court Action (IV-D status) status code of M (Insurance and Expense Combined, IV-D), I (Insurance, IV-D), and E (Expense, IVD) are identified for this category of mandatory pay and chase. The MMIS generates and sends to the DOM TPL Unit a listing of claims mailed to the third party resource as well as a copy of the actual invoices. These media are used to track and follow-up TPL recoveries.

When a recipient's resource record reflects more than one TPL resource, invoices are generated and mailed to each carrier for which coverage is available for the service paid by the Medicaid agency. Receipts in excess of the Medicaid payment are refunded to the recipient in accordance with federal and state law.

The MMIS generates a listing of the claims that are filed with the third party carriers. The listings are downloaded from the MMIS files into a DOM TPL Unit in-house computer tracking system.

As TPL recovery checks are received by the DOM Accounting Division, they are logged and check copies are forwarded by Accounting to the DOM TPL Unit for research and disposition. The DOM TPL Unit assigns a Financial Control Number (RCN) to each check and in-puts this data to the MMIS Add/Pay file for tracking and disposition.

TPL recoveries are recorded in the DOM TPL Unit computer tracking system as they are processed via the Refund, Receipt, and Cash Disposition form. Denials received from the third party sources are also recorded in the DOM TPL Unit tracking file and used to update the MMIS TPL files.

Upon receipt of the checks from the Accounting Division, the DOM TPL Unit enters the receipts into the In-House Bookkeeping System and disperses them to the appropriate Auditor. The Auditor researches and prepares the check for disposition via the Refund, Receipts, and Cash Disposition Form using the assigned FCN. The financial transaction is recorded in the In-House Bookkeeping System. *The transaction is also in-put by the DOM TPL Unit into the MMIS financial files for claims processing and financial reporting, primarily for the HCFA 64 report, which is system generated.

Each entry into the MMIS Financial system is coded to relate the collected dollars to a particular program area (Health, Drugs, Casualty, Preventive Pediatrics, Prenatal, IV-D, and Others). Weekly, monthly, and quarterly reports are generated reflecting collections from each program area.

This information is used to assist in the management of TPL operations.

Recoveries are gross levelled adjusted based on recipient Medicaid ID#, FCN, and dates of service. Each recovery is maintained in the MMIS financial files and can be accessed and retrieved by recipient ID.

Casualty cases involving settlement awards are handled in the following manner. A detailed amount of the state's subrogation claim is provided to the third party source (insurance company or attorney) upon request and updated immediately prior to settlement. Should Medicaid's potential recovery be less than the total subrogation interest, the case is referred to the Medicaid Agency's attorney for a compromise determination [Section 43-13-125(2)(b), Mississippi Code of 1972, annotated as amended]. Additionally, the right of subrogation by the State to the recipient's right to recovery shall be subject to ordinary and reasonable attorney fees [Section 43-13-125(2)(a), Mississippi Code of 1972, annotated as amended]. Upon receipt of Medicaid's settlement amount, the funds are processed via the Refund, Receipt and Cash Disposition Form which is used to update the MMIS financial files. The source of eligibility (DHS, SSA, or Regional Medicaid Office) is notified of potential income and/or resources received by the recipient which may affect the Medicaid eligibility determination.

Priority for follow-up will be given to the trauma codes which yield the highest recovery as evidenced by the quarterly report produced by the DOM TPL computer program.

V. OTHER

ESTATE RECOVERY

The Mississippi Legislature enacted an Estate Recovery law effective July 1, 1994 enabling the state Medicaid agency to begin to seek recovery of payments for nursing facility services and related hospital and prescription drug services from the estate of a deceased Medicaid recipient who was 55 years of age or older when Medicaid benefits were received. An estate is defined as 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 previously been transferred into a trust is not subject to estate recovery. Estate recovery rules do not apply to a deceased recipient if at the time of death the recipient has a legal surviving spouse, a surviving dependent child under the age of 21, or a dependent blind or disabled child of any age.

The DOM TPL Unit and the staff attorney will determine hardship on a case by case basis. For instance, if an adult relative has had the home place as a principal place of residence for of least 1 year prior to the recipient entering the nursing facility and the adult relative has supplied care for the recipient so that he/she did not have to enter the nursing facility during that year, this would be considered a hardship case.

The Application and Redetermination forms will include a statement of Estate Recovery and DOM's rights to recovery.

The source of eligibility will notify the DOM TPL Unit via form DOM-TPL 411 of any nursing facility recipient who dies and meets the criteria specified above. Included with the notification form will be the latest Application or Redetermination form and any case record verification of the property ownership.

The DOM TPL Unit will research the ownership, develop the lien amount, and submit the case record to the staff attorney to handle the legal requirements. It should be noted that no contact will be made with the family or representative of the deceased recipient until 30 days following the death date. The DOM TPL Unit will receive any Estate Recovery funds and disposition the funds as explained in Section IV above.

Appendix I.

PROCESSING OF IRS AND BEERS INTERFACE FILES AND STATE MEDICAID OFFICE PROCEDURES IN HANDLING OF IRS DATA

1. The State Department of Human Services (DHS) is the single state agency responsible for tape submissions to IRS and receipt of the returned tapes from IRS containing match information on Medicaid recipients whose eligibility is determined by the Division of Medicaid, Office of the Governor.
2. When tapes are returned by IRS to DHS, the tapes are secured in the Data Services Department until needed for processing.
3. When ready for processing, the DHS-IEVS analyst or designee removes the tapes and personally takes the tapes to the State Central Data processing Authority to be processed. The analyst is required to wait until the tape has been processed and brings the tape back to the Data Services Department of DHS and returns the tape to the locked tape cabinet.
4. DHS will prepare one copy per match of the "hits" identified for MAO recipients. This group belongs to the Division of Medicaid and must be forwarded to the Medicaid agency in an envelope marked "Confidential" to the attention of the Director of Medicaid Eligibility. After processing the tapes of MAO recipients, the tapes are returned to locked storage.
5. The "Confidential" envelope containing the IRS match data will be forwarded to the Director of Medicaid Eligibility for opening. The match data will be stored in a locked file cabinet marked "Confidential" until ready to be distributed.
6. When the match data is ready to be distributed, the Medicaid Eligibility Director will give the match data to the Program Administrator for distribution. Only the Director, the Program Administrator, and the Hearing Officer assigned to handle IRS matches will have access to the IRS match data during the distribution of the forms.
7. Forms are distributed by first hatching the forms according to Regional Office and attaching a cover transmittal that will identify the number of "hits" attached for each Regional Office. Before mailing, a photocopy will be made of each match form and cover transmittal. These photocopies will be maintained in locked storage until the "originals" are returned by the Regional office. When the "original" match data and cover transmittals are returned, the photocopies kept in storage are destroyed and the originals are kept in locked storage.

TPL RECOVERY PROCEDURES

At the end of each month, the MMIS will read the Resource Information Module (resource) file in the TPL Support System. For all additions made that month to the file with retroactive policy effective dates, the system will extract claims from history. The \$100 accumulated threshold will be applied to each recipient's claims. The system will generate and mail the subrogated claims to the respective third party sources with the Division of Medicaid's return address. The billings are tracked and refilled if no response code is posted within 45 days of the last filing date.

Follow up in the DOM TPL Unit is monitored based on the below listed schedule:

Type of Transaction	Days Allowed
Claim filed with Insurance Company	60
Second Request of Same Recipient Questionnaires	60
Second Request of Same Endorsement of Check	30
Miscellaneous Correspondence with Recipient	15
Miscellaneous Correspondence with Insurance Company	30
Data Request, if Necessary	30
Claim Request, if Necessary	15
	20

If contact is initially made by phone and a return call is pending, follow-up is due in one week. Within 30 days of receipt of copy of the third party payment with the DOM assigned FCN, the TPL Auditor will recover the amount due Medicaid and, if necessary, request that the fiscal agent refund any overage to the recipient.

The TPL recovery is recorded on the Refund, Receipts, and Cash Disposition form by the TPL Auditor and *is in-put by DOM into the MMIS financial files. The MMIS history files are thus updated and the information is maintained in order to be reported on the federally required HCFA 64.9 report.

BUREAU REPORTS

Federal Reporting

The HCFA 64.9 is a quarterly report of TPL collections and savings that goes to the CMS Atlanta Regional Office by the 5th of the month after the quarter ends. The TPL Collections and Cost Avoidance form is completed showing a breakdown of TPL Health collections, TPL Casualty collections, and cost avoided figures. It is completed using figures from the CP-0-75-1, MR-0-65, TP-0-20A, and the TP-0-20B.

Agency Reporting

Program data is collected in accordance with SB 2995 on performance indicators and measures. Reports are submitted to the Deputy Administrator monthly and semi-annually.

Monthly Performance Measure Report

This report measures the Bureau's performance in reaching its established goals for the fiscal year. The deadline for getting this report to the Deputy Administrator is the 15th of the month. Third party collections and dollars cost avoided for the current month are measured against the same period the prior year for results.

Monthly Executive Summary

This report compares Bureau recoveries for the current month from health plans, accidents and injuries, and cost avoidance of drugs and total cost avoidance to the same period in the previous fiscal year. This report goes to the Deputy Administrator by the 4th of the month.

Semi -Annual Governor/Legislature Report

Pursuant to Section 43-13-127, Mississippi Code of 1972, as Annotated, performance reports are due at each regular session of the Legislature as well as within sixty days of the end of the fiscal year.

The report of activities of the Third Party Liability Unit of the Bureau of Third Party Recovery includes both recovery, cost avoidance, and the cost per investigation. Recovery activities involve recoupment of Medicaid payments for medical services by the amount of third party liability for those services. Cost avoidance activities result in the reduction of Medicaid payments for medical services by the amount of third party liability for those services.

DATA MATCHES

Mississippi State Workers' Compensation Commission

Pursuant to 42 CFR 433.138(d)(4)(1), the DOM has an agreement with the Mississippi State Workers' Compensation Commission (MWCC) to conduct annual data matches with the MWCC files. In December the Bureau Director submits a request to the fiscal agent to submit eligibility files for data matching.

Mississippi Department of Transportation

The DOM has an agreement in place with the Mississippi Department of Transportation (MDOT) to perform annual data matches with State Motor Vehicle Accident Report files. In December the Bureau Director submits a request to the fiscal agent to submit eligibility files for data matching.

Defense Enrollment Eligibility Reporting System

On an annual basis, Mississippi Medicaid conducts a data match with the Defense Enrollment Eligibility Reporting System (DEERS). The Department of Defense notifies the state each year of the schedule for submitting files with Medicaid eligibles. The Bureau Director sends a request to the fiscal agent and a copy of the notification upon receipt.

State Tax Commission Offsets

In December DOM sends a diskette of names and social security number of absent parents with delinquent medical support accounts and beneficiaries delinquent in repaying debts due to ineligibility to the State Tax Commission to offset tax refunds.