Administrative Code

Title 23: Medicaid
Part 306
Third Party Recovery

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Part 306 Chapter 1: Third Party Recovery

Rule 1.1: General

A. 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 individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under the State Plan.

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

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

D. 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.

E. 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 the Division of Medicaid, or the difference in the third party payment and Medicaid's established reimbursement.

F. 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.

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

H. When violation of the above beneficiary liability is discovered, the Division of Medicaid may reduce any payment amount otherwise due the provider up to three (3) times the amount incorrectly received from the beneficiary.

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

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

Rule 1.2: Medicaid Cost Avoidance

A. Federal law requires that for reimbursement of covered services, other than those outlined in Rule 1.1 in this chapter, 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 the Division of Medicaid, the provider must file with the third party source before filing with Medicaid.

B. Exception to Medicaid Cost Avoidance Procedures for Practitioners

1. 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:

   a) Pregnancy related services for women (prenatal, labor and delivery, and post-partum),

   b) Preventive pediatric services (including EPSDT services), and

   c) Covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program.

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

3. 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 Title IV-D program for Mississippi is managed within the Department of Human Services (DHS).

4. 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.

C. Exception to Medicaid Cost Avoidance for Pharmacists

1. 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.

2. Neither of the these exceptions to cost avoidance relieve the provider of the responsibility of notifying Medicaid 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 Rule 1.1 and Rule 1.4 in this chapter.

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

Rule 1.3: Billing

A. 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.

B. Medicaid 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.

C. Any provider failing to cooperate with the Division of Medicaid in the protection and the recoupment of its payments from a legally liable third party or parties shall be liable to the Division of Medicaid 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. Refer to Rule 1.2 and Rule 1.4 in this chapter for exceptions to the initial filing with the third party source requirement.

D. Preferred Provider Organizations

1. When 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 must choose one of the following methods of billing:

a) Submit the claim to the Division of Medicaid 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; or

b) 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.

2. 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:

a) 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."

E. Assignment of Benefits

1. The provider must obtain assignment of benefits when billing third party insurance.

2. Providers unable to obtain assignment of benefits for circumstances beyond the beneficiary's control must submit the claim to the Division of Medicaid.

3. 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.

F. Beneficiary Denies Insurance Coverage - The provider must obtain a signed statement from the beneficiary which includes the name of the insurance company, the policy number, and the ending date of coverage and forward to Medicaid.

G. Billing Medicare - The provider must file and obtain Medicare payment for the service or obtain a Medicare denial before Medicaid payment can be made.

H. 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

1. Medicare Part A - File a claim with Medicaid after receiving third party payments or explanation of benefits of denial from Medicare Part A and the private third party source. The Medicare Part A intermediary will only crossover claims to Medicaid.

2. Medicare Part B - File a claim with Medicaid after receiving third party payments or explanation of benefits of denial from Medicare Part B and the private third party source. The Medicare Part B intermediaries will crossover all claims to the appropriate third party source.

I. 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 shall automatically recoup the payments from the provider and the provider must bill Medicare.

J. 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 on the claim. Medicaid shall pay 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.

K. Third Party Money Received - The provider must submit the EOB from the third party source to inform Medicaid of all third party money received.

L. Third Party Denial Received – The provider must submit a copy of the denial letter to Medicaid when the third party denies the claim the following:

1. The service is not covered by insurance,

2. Insurance benefits have been exhausted, or

3. Insurance coverage has expired.

M. No Response from Third Party Source - The provider must make every effort to acquire payment from the third party source before filing Medicaid. Failure of the provider to do so, by appropriate means (e.g. written response) will result in voiding of the provider's next payment for services.

N. 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 thirty (30) days from the receipt of the duplicate payment(s).

O. Hospital Retroactive Settlements - Hospitals having 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, the Division of Medicaid 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:

1) Third party liability amounts have been reported as benefits as required in item O.2 above, therefore no amounts are due the Division of Medicaid.

2) 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 the Division of Medicaid, plus interest and penalty.

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

Rule 1.4: Casualty Cases

A. A provider, who has filed and accepted Medicaid payment and who wishes to pursue the difference, shall submit written notification containing information relating to the existence or possible existence of a liable third party to Medicaid within three hundred sixty five (365) days of the accident or incident for which the third party is or may be liable. The notice shall contain the following information: Medicaid recipient's name; Medicaid recipient's Social Security number or Medicaid identification number, or both; and date of the accident or incident.

B. A provider who has filed and accepted a Medicaid payment may accept or collect the difference from a third party. Within ten (10) working days of receipt of the difference, the provider or his agent shall notify Medicaid to determine whether it has received full reimbursement for all payments made to all providers for health care services rendered to a Medicaid recipient as a result of an accident or incident. A provider shall not disburse the difference until receipt of notification from the Medicaid Third Party Recovery Bureau that it has been made "whole." Medicaid shall be made whole. The provider shall refund Medicaid within thirty (30) days from the receipt of the duplicate payment.

C. In the event Medicaid agrees to and accepts less than full reimbursement for all payments made on behalf of a Medicaid recipient, excluding any partial payment, Medicaid shall be deemed to have been made whole. Medicaid shall have ten (10) working days from receipt of notice to notify the provider whether it has been made whole.

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

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

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

E. Nothing in this policy shall prevent a provider from demanding payment from, or pursuing any type of collection efforts for the difference against any liable or potentially liable third party, directly or through the Medicaid recipient or his representative who is demanding payment from any liable or potentially liable third party.

F. 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 the Division of Medicaid or the beneficiary for the services rendered on behalf of the injured Medicaid beneficiary.

G. A provider who has filed and accepted Medicaid payment and who fails to comply with the notification requirement stated above shall be limited to the Medicaid payment received as payment in full for the health care services rendered to the Medicaid recipient.

H. A provider who has filed and accepted Medicaid payment may be referred for investigation and prosecution for any possible violation of either federal or state laws.

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

1. Pursues the difference prior to providing written notification to the Medicaid Third Party Recovery Bureau,

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

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

Source: Miss. Code Ann. § 43-13-121.

Rule 1.5: Requests for Medical Information

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

1. The person is a Medicaid beneficiary,

2. His/her Medicaid identification number, and

3. The bill has been paid by Medicaid or will be submitted to Medicaid.

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

C. 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:

1. Requests from Beneficiary or Family Member - Copies of bills or medical records requested by a beneficiary or family member must 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.

2. Requests from Insurance Companies - Information requested by an insurance carrier with whom a claim has been filed must be furnished directly to the carrier. The requested information must be clearly marked with the required three elements outlined in 1.5.A.

3. Requests from Attorneys - The provider must comply as fully and promptly as possible with the request for medical information from a Medicaid beneficiary's attorney once a signed authorization from the patient has been received.

4. 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) must be sent directly to the requester. As required by law, the data must be marked with the information listed in 1.5.A in this chapter. Notification to the Division of Medicaid is not necessary when medical records or billing information are remitted to DDS or to a school system.

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

Rule 1.6: Third Party Sources

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

A. Medicare Parts A and B,

B. Health Insurance:

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

2. Does not include policies that provide for income supplementation for lost income due to

disability (without regard to hospital confinement), or policies that make payment for disability (without regard to hospital confinement), such as weekly disability policies.

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

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

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

F. Railroad Retirement,

G. Automobile Medical Insurance,

H. Worker's Compensation,

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

J. Family Health Insurance carried by an absent parent,

K. Black Lung Benefits,

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

M. Donated Funds.

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

Rule 1.7: Coordination of Benefits

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

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

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

Rule 1.8: Estate Recovery Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

c) The relative has no other residence.

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

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

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

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

a) Reservation payments to special populations.

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

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