State of Mississippi

REQUIREMENTS FOR THIRD PARTY LIABLILITY IDENTIFYING LIABLE RESOURCES

42 C.F.R. § 433.138(f)

The designated state agency, Department of Human Services (DHS), performs the required data exchanges specified in Section 433.138(d)(l) 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(d).

Data exchange agreements have been executed with Workers' Compensation Commission and the Department of Public Safety.

The Medicaid Management Information System (MMIS) identifies on a weekly basis those paid claims that contain diagnosis codes 800-999 (ICD10CM) for the purpose of identifying the legal liabilities of third parties.

42 C.F.R. §§ 433.138(e), 433.138(g)(l)(i), 433.138(g)(l)(ii) and (2)(ii)

The Division of Medicaid receives health insurance information from DHS who performs the State wage information collection agency (SWICA) and Social Security Administration (SSA) wage and earnings files data exchanges. DHS maintains a copy of the information in the eligibility file and the information to the Division of Medicaid. The Division of Medicaid completes any necessary research, enters the data into the MMIS Third Party Liability (TPL) files within forty-five (45) days.

The Division of Medicaid receives insurance information from the Department of Human Services (DHS), the SSA, and the Medicaid Regional Offices from application and redetermination procedures for Medicaid eligibility. The sources of eligibility maintain the third party information in the eligibility case file and send the information to the Division of Medicaid as part of the agreement with DHS. This information is uploaded into the MMIS TPL files.

42 C.F.R. § 433.138(q)(2)(i)

The required data exchange takes place weekly with the Mississippi Workers' Compensation Commission. In order to incorporate TPL data within sixty (60) days as specified in section 433.139(g)(2)(i), prior to producing the final report of "hits," the MMIS cross references the data received back from worker's compensation with the trauma code claims which appeared on the Trauma Code edit reports to avoid duplication of effort. Inquiries containing Medicaid's subrogation rights to insurance companies, employers or attorneys are generated by the MMIS. Upon receipt of response, a TPL recovery case is established.

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REQUIREMENTS FOR THIRD PARTY LIABLILITY IDENTIFYING LIABLE RESOURCES

42 C.F.R. § 433.138(g) (3) (i) and (iii)

A required data exchange takes place with the Department of Public Safety (DPS) annually. A questionnaire will be sent to the beneficiaries found in data match. Upon receipt of a response indicating a liable third party, a recovery case is established.

42 C.F.R. § 433.138(g)(4)(i) through (iii)

The MMIS identifies on a weekly basis those paid claims that contain diagnosis codes 800-999 (ICD-10-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 Division of Medicaid that identify a liable third party, attorney, or insurance carrier 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 third party information within 50 days, the sources of eligibility are notified to include third party information in the eligibility case record. The Division of Medicaid 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-l3-125(2)(b), Mississippi 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)(a), Mississippi Code of 1972, annotated as amended).

42 C.F.R. § 433.138(e)

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.

State of Mississippi

REQUIREMENTS FOR THIRD PARTY LIABILITY PAYMENT OF CLAIMS

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

a) Claims for preventive pediatric services (including EPSDT services), and
b) Claims 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) If a provider submits a claim to a third party and does not receive a response within thirty (30) days, the provider must submit a written inquiry to the third party. If the third party has not responded after sixty (60) days from the date of the original claim submission, the provider may submit a "Third Party Liability (TPL) Edit Override Attachment: No Response Form". The Division of Medicaid will pay the claim according to policies related to that service. The Division of Medicaid's Third Party Recovery vendor will include these claims in future recoveries.

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act to require a state to use standard coordination of benefits cost avoidance when processing claims for prenatal services which now included labor and delivery and postpartum care claims. Therefore, if DOM has determined that a third party is likely liable for a prenatal claim, the claim will be denied-and be returned to the provider noting the third party that Medicaid believes to be legally responsible for payment. If, after the provider bills the liable third party and a balance remains or the claim is denied payment for a substantive reason, the provider can submit a claim to DOM for payment of the balance, up to the maximum Medicaid payment amount established for the service in the State Plan.

Section 53102(a)(1) of the Bipartisan Budget Act of 2018 amended section 1902(a)(25)(E) of the Act, to require a state to make payments without regard to third party liability for pediatric preventive services unless DOM has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days.

Section 7 of the Medicaid Services Investment and Accountability Act of 2019 (Pub. L. 116-16) amended section 202(a)(2) of the Bipartisan Budget Act of 2013. Therefore, DOM will allow 100 days instead of 90 days to pay claims related to medical support enforcement pursuant to section 1902(a)(25)(F)(i) of the Act.

(3) 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.

REQUIREMENTS FOR THIRD PARTY LIABILITY PAYMENT OF CLAIMS

(4) 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 preventive pediatrics and Title 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.

The Medicaid provider may not refuse covered services to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability. The provider may not seek to collect from the Medicaid eligible individual (or any financially responsible relative or representative of that individual) if the total amount of the third party liability is equal to or greater than the amount payable under the State Plan (which includes, when applicable, approved cost-sharing payments.) When the total third party payment is less than the amount payable under the State Plan (which includes, when applicable, approved cost-sharing payments), the provider may collect from the individual (or any financially responsible relative or representative) an amount the lesser of any approved cost-sharing amount or the difference between the amount payable under the State Plan and the total third party payment.