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.

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(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.