

## **Section 7. Third-Party Insurance**

### **Third Party Liability – Commercial Health Insurance and Medicare – Medicaid Payment Guidelines for Third Party Coverage**

Federal regulations require Medicaid to be the “payer of last resort.” This means that all third-party insurance carriers, including Medicare and private health insurance carriers, must process the claim before Medicaid processes the claim. Additionally, providers must report any such payments from third parties on claims filed for Medicaid payment.

If the Medicaid-allowed amount is more than the third-party payment, Medicaid will pay the difference up to the Medicaid-allowed amount. If the insurance payment is more than the Medicaid-allowed amount, Medicaid will not pay any additional amount.

Certain Medicaid programs are not considered “primary payers” regarding the payer-of-last-resort provision. When a Medicaid recipient is entitled to one or more of the following programs or services, Medicaid pays first:

- Vocational Rehabilitation Services
- Division of Services for the Blind
- Division of Public Health “Purchase of Care” Programs:
  - Cancer program
  - Prenatal program
  - Sickle cell program
  - Children’s Special Health Services
  - Kidney program
  - School health fund
  - Tuberculosis program
  - Maternal and Child Health Delivery funds

DMA contracts with various vendors that perform multiple audits and recoveries to ensure that Medicaid is the “payer of last resort”.

### **Services Provided to Medicare-Eligible Medicaid**

Medicaid denies claims for recipients aged 65 and older who are entitled to Medicare benefits but do not apply for Medicare. The provider may bill the recipient for Medicare-covered services under these circumstances.

### **Contracted Fee-for-Service Payments – Commercial Health Insurance**

The Medicaid program makes payments to providers on behalf of recipients for medical services rendered, but Medicaid is not an “insurer.” Medicaid is not responsible for any amount for which the recipient is not responsible. If the recipient is not responsible for payment, then Medicaid is not responsible for payment.

### **Noncompliance Denials – Commercial Health Insurance and Medicare**

Medicaid does not pay for services denied by private health plans due to noncompliance with the private health plan’s requirements. If the provider’s service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid will not pay for the service.

The provider and the recipient both have equal responsibility for complying with private plan requirements. If the provider asked the recipient if there is coverage with a private plan, the recipient did not inform the provider of the existence of the recipient's private plan, and the plan's requirements were not met because the provider was unaware of them, then the provider may bill the recipient for those services if both the private plan and Medicaid deny payment due to noncompliance. It is the recipient's responsibility to inform the County Department of Social Services of any third-party insurance as well as any changes in insurance coverage.

Similarly, if the recipient fails to cooperate in any way in meeting any private plan requirement, the provider may bill the recipient for the services. However if the recipient presents the private payer information to the provider, and the provider knows that the provider is not a participating provider in the plan or cannot meet any of the private plan's other requirements, then before rendering any service the provider must so inform the recipient and also tell the recipient that 1) the provider is a nonparticipant in the plan or otherwise cannot meet one or more of its requirements and 2) the recipient will be responsible for payment.

Medicaid will deny payment due to noncompliance. Common noncompliance denials are:

- failure to get a referral from a participating primary care provider (PCP),
- failure to go to a participating provider or outside your employers plan network,
- failure to obtain a second opinion,
- failure to obtain prior approval

Common noncompliance denials include failure to get a referral from a participating primary care provider (PCP), failure to go to a participating provider, failure to obtain a second opinion, and failure to obtain prior approval.

### **Determining Third-Party Liability – Commercial Health Insurance and Medicare**

The following information helps providers to determine if a Medicaid recipient has third-party liability (TPL):

1. Check the recipient's eligibility for third-party insurance information. (Refer to **Appendix F**, Verifying Recipient Eligibility, for additional information on verifying eligibility and checking for third-party insurance.)
2. Before rendering service, providers should ask the recipient if s/he has any additional health insurance coverage or other TPL, including Medicare. If health insurance is indicated, the provider must bill the carrier before billing Medicaid. Before filing a claim with Medicaid, the provider must receive either payment or a written denial from the insurance company.
3. Check the Remittance and Status Report (RA). When a claim is denied for other insurance coverage (EOB 94), the provider's RA will indicate the other insurance company (by code), the policy holder name, and the certificate or policy number.

If the insurance company or other third-party payer terminates coverage, providers must complete a **Health Insurance Information Referral Form** (DMA-2057) and attach a copy of the written denial. Send the form, denial, and the claim to DMA's Third Party Recovery (TPR) section at the address shown on the form. A copy of the form is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

As a provider, your role in the TPL process begins as soon as you agree to treat a Medicaid eligible patient. You should ask every patient and /or the patients' responsible party about other insurance coverage. It is the patient's responsibility as well as the provider to update Medicaid with any changes.

Medicaid providers have the option of submitting requests for updates to a recipient's commercial insurance information electronically via a secured Internet connection. To submit a request, go to <http://ncprovider.hms.com>.

Health Management Systems (HMS), Medicaid's TPL contractor, researches third party insurance verification information. It can take up to 48 hours to process a request for updates to recipient's commercial insurance information.

### **Time Limit Override on Third-Party Insurance – Commercial Health Insurance**

All requests for time limit overrides due to a third-party insurance carrier that does not respond within its time limit must be submitted to the TPR section and include documentation verifying that the claim was timely filed to the third-party insurance carrier.

If the third-party insurance carrier does not respond within the Medicaid time limit, time limit overrides may be granted if the claim is filed within 180 days of the third-party denial or payment. Submit the claim with a completed **Medicaid Resolution Inquiry Form** (<http://www.ncdhhs.gov/dma/provider/forms.htm>) and the third-party voucher attached to the claim.

### **Refunds to Medicaid – Commercial Health Insurance and Medicare**

When a provider does not learn of other health insurance coverage or Medicare entitlement for a recipient until after receipt of Medicaid payment, the provider must submit a refund to Medicaid following the guidelines listed below.

For commercial health insurance:

1. File a claim with the health insurance company.
2. Upon receipt of payment from the insurance carrier, recoup the Medicaid payment by voiding the original claim. Then file a corrected secondary claim reporting the third party payment. If time limit override is required, submit a paper claim using a Medicaid Resolution Inquiry Form and attach a copy of the primary insurance carrier's EOB.

For Medicare:

1. Recoup the Medicaid payment, by voiding the initial claim.
2. File a claim with Medicare intermediary or carrier.
3. File a claim for the coinsurance or deductible; or the intermediary or carrier will cross this over to the fiscal agent for payment.

Unless DMA requests in writing those refunds should be sent to another address, providers send refunds to HP Enterprise Services.

HP Enterprise Services  
P.O. Box 300011  
Raleigh, NC 27622-3011

Refer to **Provider Refunds** in **Section 11, Resolving Denied Claims**, for additional information on refunds to Medicaid.

## Personal Injury Cases

### Tort (Personal Injury Liability)

Medicaid recipients may qualify for other third-party reimbursement because of an accident, illness, or disability. A third party, or other than those already cited, may be legally liable. Frequently, these injuries and illnesses result from automobile accidents or on-the-job injuries or illnesses not covered by Workers' Compensation.

N.C. General Statute §108A-57 gives the State subrogation rights; that is, the State has the right to recover any accident-related Medicaid payments from personal injury settlement awards as an offset to the cost of Medicaid.

### Provider's Rights in a Personal Injury Case

When a provider learns that a Medicaid recipient has been involved in an accident, the provider **must** notify the TPR Section. If the provider has knowledge of the liable third party at the time of filing the claim, a completed **Third Party Recovery Accident Information Report** (DMA-2043) must be submitted with the claim to DMA's TPR Section at the address shown on the form. A completed DMA-2043 must also be submitted with a copy of the bill when anyone requests a copy of a bill. A copy of the form is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>.

The following information is required by the TPR Section, and will also assist the provider when filing a claim with the liability insurer:

- Name of liability insurer
- Name of the "at-fault" insured person
- Insurance policy number of the "at fault" insured person
- Name and address of the attorney, if any

**Note:** A copy of a letter sent by an attorney or liability insurer to the provider requesting information will suffice in lieu of the DMA-2043.

### Billing for Personal Injury Cases

The provider must choose between billing Medicaid and submitting the bill of charges to the liability insurer. Providers cannot initially file a casualty claim with Medicaid, receive payment, and then submit the bill of charges to the liability insurer (or the recipient) for the same service, even if the provider refunds Medicaid.

The provider cannot bill the recipient, Medicaid, or the liability insurer for the difference between the amount Medicaid paid and the provider's full charges. (See *Evanston Hospital v. Hauck*, 1 F.3d 540 [7<sup>th</sup> Cir. 1993]). Providers who withhold billing Medicaid have six months from the date of a denial letter or receipt of payment from the insurance company to file with Medicaid, even if the end of the six months is after the end of the usual 365-day filing deadline.

In order for the provider to obtain a time limit override, however, the following requirements must be met:

- The provider must have filed the claim with the liability insurer or attorney within 365 days from the date of service.
- The provider must have made bona fide and timely efforts to recover reimbursement from the third party.
- The provider must submit documentation of partial payment or denial with a claim to Medicaid within six months of such payment or denial.

## Payment for Personal Injury Cases

When Medicaid payment is received, the provider is paid in full and there is no outstanding balance on that claim. Once Medicaid makes a payment for a service, only Medicaid has the right to seek reimbursement for payment of service.

If the provider withholds billing Medicaid and receives payment from a liability insurer, the provider may bill Medicaid with the liability payment indicated on the claim. Medicaid may pay the difference if the Medicaid allowable amount is greater than the liability payment.

Pursuant to federal regulations and the Evanston case, there is a distinction between private health insurance payments and other liable third-party payments.

## Refunds and Recoupments for Personal Injury Cases

If Medicaid discovers that a provider received Medicaid payment and communicated with a third-party payer or attorney in an attempt to receive payment of any balance, Medicaid will recoup its payment to that provider immediately, regardless of whether the provider ultimately receives payment from that third party.

The following is an example of how a liability payment should be treated:

Amount billed by provider to Medicaid	\$100.00
Amount paid by Medicaid	\$50.00
Amount paid by attorney/liability carrier	\$100.00
Amount to be refunded to Medicaid	\$50.00
Amount to be refunded to attorney/liability	\$50.00

## Third-Party Liability – Frequently Asked Questions

### 1. What is TPL and how does it affect claim processing?

TPL is another individual or company who is responsible for the payment of medical services. Most commonly, these third parties are private health insurance, auto, or other liability carriers. There are state and federal laws, rules, and regulations setting out TPL requirements, which require these responsible third parties to pay for medical services before Medicaid is billed. The TPR Section is charged with implementing and enforcing these TPL laws through both cost avoidance and recovery methods. Therefore, providers who know of the existence of private health insurance are required to seek payment from these third parties prior to seeking payment from Medicaid. At this time, providers have the option to either file with Medicaid or file with the liability insurer.

### 2. Why was my claim denied for EOB 094, “Resubmit claim indicating private insurance payment or applicable occurrence code. If documented insurance denial required submit with claim on provider inquiry form.”?

The TPL database indicates the recipient had third-party insurance on the date of service for which you are requesting reimbursement and that this type of insurance should cover the diagnosis submitted for payment. If the service could be covered by the type of insurance indicated, the provider must file a claim with that insurance company prior to billing the Medicaid program. If the provider receives a denial that does not indicate noncompliance with the insurance plan, or if the provider is paid for less than your charges, bill the Medicaid program and, if appropriate, the claim will be processed. If the Medicaid-allowable amount is greater than the insurance payment you received, Medicaid will pay the difference up to the recipient’s liability as disclosed on the private insurance plan’s explanation of benefits (EOB). It is the

provider's responsibility to secure any additional information needed from the Medicaid recipient to file the claim.

If the insurance plan denied payment due to noncompliance with the plan's requirements, Medicaid will not make any payment on the claim.

Third-party insurance information can be determined by checking the recipient's eligibility (see **Appendix F, Verifying Recipient Eligibility**). You may also find the recipient's insurance information in the denial section of your RA.

**Note:** This denial code does not refer to Medicare.

**3. How do providers determine the name and the address of the third-party insurance company that is indicated for the recipient file?**

A description of the Third-Party Insurance Codes is available upon request from the TPR Section or on DMA's website at <http://www.ncdhhs.gov/dma/provider/tpr.htm>. This code list provides the name and billing address for each code that is listed for the recipient.

**4. What can the provider do when the claim is denied for EOB 094?**

Refer to the RA that showed the claim denying for EOB 094. The insurance information—including the policy holder's name, certificate number, and a three-digit insurance code—are listed below the recipient's name.

A list of Third-Party Insurance Codes is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/tpr.htm>.

**5. What is considered an acceptable denial from an insurance company?**

An acceptable denial is a letter or an EOB from the insurance company or group/employers on company letterhead that complies with the policy reflected in question #7. Blue E print-outs are acceptable for only North Carolina Based plans, provided that the claims on the denial match the claims being submitted. Forward claims for questionable denials to the TPR section:

Division of Medical Assistance  
Third Party Recovery  
2508 Mail Service Center  
Raleigh NC 27699-2508

If the provider has an acceptable denial or EOB, attach the denial to the claim and forward to HP Enterprise Services, Provider Services Department:

HP Enterprise Services  
Provider Services  
P.O. Box 300009  
Raleigh, NC 27622

**6. Why was the claim denied for TPL after the provider included an insurance denial as referred to in question #5?**

Medicaid denies payment for any service that could have been paid for by a private plan had the recipient or provider complied with the private plan's requirements.

Examples of common private plan noncompliance denials include

- Failure to get an authorization referral from a PCP
- Nonparticipating provider
- Failure to obtain a second opinion

- Failure to obtain prior approval

In these circumstances, the provider may bill the recipient for these services, provided the noncompliance was not due to provider error, or the provider may appeal to the private plan.

It may be the provider's responsibility to fulfill requirements of the private plans such as prior approval and referral authorization from the PCP.

**7. What are the uses of the Health Insurance Information Referral Form (DMA-2057) and where can copies be obtained?**

Complete the DMA-2057 Form in the following instances:

- To delete insurance information (that is, the recipient no longer has third-party insurance, but the recipient's eligibility information indicates other insurance)
- To add insurance information (that is, a recipient has third-party insurance that is not indicated in the recipient's eligibility information)
- To change existing information (that is, a recipient never had the third-party coverage that is indicated in the recipient's eligibility information; the effective dates are incorrect, etc.)

A copy of the form is available on DMA's website at

<http://www.ncdhhs.gov/dma/provider/forms.htm>. Or providers may submit requests electronically via a secured Internet connection at <http://ncproviders.hms.com>.

**8. If the Medicaid recipient's private health insurance company pays the recipient directly, can the provider bill the recipient?**

If the amount of the insurance payment is known, the provider may bill the recipient for that amount only. The provider may also file the claim to Medicaid indicating the third-party payment amount in the appropriate block on the claim form, and Medicaid will pay the Medicaid allowable amount, less the insurance payment. If the insurance payment is unknown, the provider may bill the patient the total charges if the provider is unable to obtain the amount paid from either the insurance carrier or the recipient.

**9. May providers have an office policy that stating the provider will not accept Medicaid in conjunction with a private insurance policy?**

Yes. A provider can refuse to accept Medicaid for recipients who also have third-party coverage, even though the provider accepts Medicaid for recipients who do not have third-party coverage. However, providers must advise the recipient of the responsibility for payment before the services are rendered. The provider must obtain proper consent from the recipient for this arrangement prior to any services being rendered. The signed form must be in the recipient's record.

**10. What may providers do when a recipient or authorized recipient's representative requests a copy of a bill that was submitted to Medicaid?**

Providers may provide a copy of the bill to the recipient or authorized recipient's representative even if the provider has already submitted the claim to Medicaid and received payment if the provider has the proper patient authorization. However, the provider can do so **only** if in compliance with the following requirement. All copies of any bill that have been submitted to Medicaid **must** state "MEDICAID RECIPIENT, BENEFITS ASSIGNED" in large, bold print on the bill. If the provider provides a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment.

**11. When do providers file a claim with HP Enterprise Services and when do providers file a claim with the DMA TPR section?**

Send the claim directly to HP Enterprise Services when

- The recipient has no private health insurance
- The insurance EOB reflects an insurance payment
- There is an insurance denial with the following reasons:
  - Applied to the deductible
  - Benefits exhausted
  - Noncovered services (meaning the service was not and will never be covered under this policy)
  - Pre-existing condition
  - Medicare/Medicaid dually eligible with no private health insurance

File the claim with the DMA TPR section if the claim includes either a **Health Insurance Information Referral Form** (DMA-2057) or an insurance EOB indicating any other type of denial not mentioned in the question above and not denied for reasons listed in #6.

**12. If the Medicaid recipient is required by their private insurance to pay a copayment amount, can this amount be collected up front at the time the services are rendered?**

No. The provider cannot bill the Medicaid recipient for the private insurance copayment amount unless the Medicaid payment is denied because the service was a non-covered service, and then only if the provider has advised the recipient in advance that the services are not covered. The provider must keep documentation in the recipient's record that the recipient was made aware of this fact before services were rendered.

**13. What can providers do when a recipient or another authorized person requests a copy of a bill that was submitted to Medicaid? (Casualty or liability cases)**

Providers may provide a copy of the bill to the recipient, a liability insurer, an attorney or other authorized person even if the claim was submitted to Medicaid and the provider received payment if the provider has the proper patient authorization. However, providers can do so **only** if in compliance with the following requirement. All copies of any bill that have been submitted to Medicaid **must** state "MEDICAID RECIPIENT, BENEFITS ASSIGNED" in large, bold print on the bill. If providers provide a copy of a bill that was filed with Medicaid without this language, Medicaid may recoup this payment. What a provider cannot do is receive payment from another entity after you have received payment from Medicaid.

**14. How do providers determine the amount of refund due to Medicaid when Medicaid pays my claim and subsequently receive payment from a liability insurer? (Casualty or liability cases)**

Once a provider filed a claim with Medicaid and received payment, the claim has been paid in full. Upon receipt of any payment from the liability insurer or attorney, the provider must return or refund the payment to the payer. By billing Medicaid and receiving payment, the provider relinquishes any right to Medicaid's payment for that service through assignment and subrogation. This includes the prohibition on the provider's billing for or receiving a recovery for the difference between the amount Medicaid paid and the provider's full charges. This practice violates both state and federal laws.

In liability cases, the provider has the option to defer billing Medicaid and pursuing a claim for full charges with the liability insurer. In the event that the recipient does not recover payment from the liability insurer, as long as the provider has filed a claim with the liability insurer or attorney within one year from the date of service, and is **diligently** pursuing reimbursement from that liability insurer or attorney, the provider may file a claim with Medicaid within 180 days of a denial or payment from that insurer, even though the 180 days may end after the usual 12-month time limit for filing with Medicaid.

## **Health Insurance Premium Payments**

### **Payment of Health Insurance Premiums**

The Health Insurance Premium Payment (HIPP) program is a cost-effective premium payment program for Medicaid recipients with catastrophic illnesses such as end-stage renal disease, chronic heart problems, congenital birth defects, cancer, etc. These recipients are often at risk of losing private health insurance coverage due to nonpayment of premiums. DMA will consider the benefit of paying health insurance premiums for Medicaid recipients when the cost of the premium, deductible, and co-insurance is less than the anticipated Medicaid expenditure.

### **Eligibility Determination**

To be eligible for Medicaid payment of premiums, the recipient must be authorized for Medicaid and have access to private health insurance through an employer. DMA will pay the premiums only on existing employer-based policies, including COBRA, or those known to be available to the recipient. Family members who are not eligible for Medicaid cannot receive Medicaid payment for deductible, co-insurance, or cost-sharing obligations.

### **Qualifying Process**

Medicaid reviews the case of each recipient who meets any of the conditions cited above for possible premium payment. DMA verifies the insurance information, obtains premium amounts, makes the cost-effectiveness determination, and notifies the recipient and the appropriate referral source.

When DMA determines that a group health insurance plan available to the recipient through an employer is cost effective, and the recipient is approved for participation in the HIPP program, the recipient is required to participate in the health insurance plan as a condition of Medicaid eligibility. If the recipient voluntarily drops the insurance coverage or fails to provide the information necessary to determine cost effectiveness, Medicaid eligibility may be terminated. The recipient is not required to enroll in a plan that is not a group health insurance plan through an employer.

### **Where to Obtain Information**

Information about HIPP and the HIPP application are available online at <http://www.MyNCHIPP.com> and through the county department of social services (DSS) office, hospitals, and rural health clinics. A copy of the HIPP Application (DMA-2069) is available on DMA's website at <http://www.ncdhhs.gov/dma/provider/forms.htm>. You may also request information by e-mail at [CustomerService@MyNCHIPP.com](mailto:CustomerService@MyNCHIPP.com) or by calling the toll-free number, 1-855-696-2447, Monday through Friday between 9:00 a.m. through 6:00 p.m.

## Medicaid Credit Balance Reporting

Providers are required to submit a quarterly **Medicaid Credit Balance Report** reporting all outstanding Medicaid credit balances reflected in the accounting records as of the last day of each calendar quarter.

The report is used to monitor and recover “credit balances” due to Medicaid. A credit balance is defined as an improper or excess payment made to a provider as the result of recipient billing or claims processing errors. Credit balances include all money that is due to Medicaid, regardless of its classification in a provider’s accounting records.

For example, if a provider maintains a credit balance account for a stipulated period (such as 90 days) and then transfers the account or writes it off to a holding account, this does not relieve the provider of its liability to Medicaid. In these instances, the provider is responsible for identifying and repaying all of the money due to Medicaid.

DMA has contracted Health Management Systems (HMS) to conduct post-payment recoveries after review of financial records and credit balances of hospitals nursing homes, dialysis centers, physician clinics, and other providers as requested. Providers may be randomly selected by HMS or selected at the discretion of DMA.

## Completing and Submitting the Medicaid Credit Balance Report

The **Medicaid Credit Balance Report** requires specific information for each credit balance on a claim-by-claim basis. The Medicaid Credit Balance Report is available on the DMA’s Provider form web page. The form provides space for 15 claims, but it may be reproduced as many times as necessary to report all the required credit balances. Specific instructions for completing the report are on the reverse side of the form.

Send the report to the TPR section at the address listed on the form no later than 30 days following the end of the calendar quarter. (Calendar quarters end March 31, June 30, September 30, and December 31.)

- **A report is required from hospital providers and long-term-care facilities even if a zero (\$0.00) credit balance exists.**
- **Failure to submit a Medicaid Credit Balance Report in a timely manner could result in withholding of Medicaid payments until the report is received.**

Electronic adjustment are the preferred method of satisfying the credit balance and can be performed through the North Carolina Electronic claims submission/Recipient Eligibility Verification Web Tool. Refer to the February 2010 Medicaid Bulletin article, titled Adjusting North Carolina Medicaid Claims Electronically for specific instructions.

**Only** the completed form should be sent to the TPR section. The information on the form should be accurate and legible. Refund or recoupment requests should be sent to HP Enterprise Services along with all the necessary documentation to process the refund or recoupment. **Do not** send refunds or recoupment requests to the TPR section.

It is DMA’s intent that every provider will assign a high priority to the reconciliation of its outstanding Medicaid credit balances and to identify overpayments for return to Medicaid.