482-000-10 Third Party Liability (TPL) Procedure Guide

Note: For purposes of this guide, the term plan is defined to mean physical health plan.

Overview

The Department has assigned to the health plan, or its subcontractors or providers, all rights to recover payments from third parties as provided by state law in its contract with the plan.

A Third Party Resource (TPR) refers to any individual, entity, or program that is, or may be, liable to pay all or part of the cost of any medical services furnished to a Medicaid client.

Under federal law, the Department is required to identify legally liable third parties and treat verified TPR as a resource of the client.

The plan, or its subcontractors or providers, shall not pursue collection from the client, but directly from the liable third party payers, except as allowed in 468 NAC, 469 NAC and 477 NAC.

Managed Care Client with Commercial Health and/or Medicare Coverage

A client enrolled in physical health managed care will not have active commercial (e.g. HMO, PPO, etc) insurance and/or Medicare. A Medicaid client may become retroactively eligible for Medicare or a non-custodial parent may acquire commercial insurance for a child after enrollment into managed care. When these situations occur, the client will be waived from managed care the first of the month after the new third party resource is discovered, given system cutoff. Until waiver of enrollment is effective, the plan is required to pursue the TPL for services in the Basic Benefits package.

Managed Care Client Involved In An Accident

When a managed care client is injured and there is possible TPL coverage for medical expenses, the plan/provider will be required to pursue reimbursement from those resources.

Both the managed care plan and the Department's TPL staff will work cooperatively on all liability cases. The plan/provider should notify the Department of any known available TPR when a client is injured.

Non-Custodial Parent Owns the Commercial Health Policy

If the TPL covering the managed care client is owned by the non-custodial parent due to Medical Support Court Orders, and a plan/provider is having difficulty obtaining information and/or payment from the insurer, the plan/provider should contact the Department's TPL Staff. In many of these cases, the Department may be able to pay the claim and the Department's TPL staff will pursue payment for the insurance and/or no-custodial parent. A non-custodial parent may include parents of a Departmental ward or child placed in foster care. The plan/provider should contact the Department's TPL staff to review these situations on a case-by-case basis.

Managed Care Client Becomes Eligible for Medicare

When the health plan becomes aware that a client has become eligible for Medicare, it is the responsibility of the health plan to notify DHHS. DHHS will notify the Medicaid eligibility staff of the Medicare status. The eligibility worker is responsible for verifying this information and making the necessary system changes. Once the eligibility worker has made the system changes, the client will be waived from physical health managed care the first of the next month given system cutoff.

If a managed care client becomes retroactively eligible for Medicare and the Department has already made payment for the services, the plan/provider will be required to reimburse the Department and submit claims to Medicare. Once Medicare has paid on the claim, the claim should "crossover" to the Department for payment of any coinsurance or deductible due. If the retroactive Medicare eligible period includes a period that is beyond the Medicare timely filing deadline for which a provider may file claims, the plan/provider would not be required to reimburse the Department and pursue Medicare payments.

Client Enrolled In Medicare Managed Care Plan

Many states have several Medicare Managed Care Plans available. To be eligible to enroll in a Medicare Managed Care Plan, a client must continue to pay his/her Medicare Part B premium. Therefore, the client will still have a Medicare card that indicates s/he has Medicare Part B. The plan/provider will need to ask the client if s/he is enrolled in a Medicare Managed Care Plan, especially if the provider is not participating in managed care in Nebraska, or the client has recently moved to Nebraska from another state.

If a Medicaid/Medicare client is enrolled in a Medicare Managed Care Plan, and the services are denied by the plan because the client fails to get prior-authorization, fails to use a network provider, or because the services are not medically necessary, neither Medicare nor Medicaid will pay the claim.

Provider Enrolls with Medicare as a Non-Participating Provider

A provider may choose to be a non-participating provider with Medicare, but this does not preclude the provider from filing a Medicare claim and accepting assignment on a case-by-case basis. When a client is Medicare/Medicaid eligible, the provider is required to file claims to Medicare and accept assignment.

Medicaid Provider Who Enters Into a Private Contract with the Client

A physician/practitioner may enter into a contract with a Medicare-eligible client to provide services with the provision that the physician/practitioner and the client would not file claims with Medicare.

If a physician/practitioner decides to "opt out" of Medicare and to enter into a contract agreement with a Medicare/Medicaid client, the Department will not process a claim for payment since Medicare, as the primary payer, has not resolved the claim. The physician/practitioner is required to inform the Medicaid/Medicare client, before the services are provided, that Medicaid will not pay, and that the client is responsible for the charges.

Medicaid Payment for Medicare Coinsurance and Deductible

The Department pays for Medicare Coinsurance and Deductible, per 471 NAC.

The plan/provider is prohibited from billing Medicaid client for any additional amount after receiving Medicare and Medicaid payment.

Medicaid Managed Care Client Enrolled In a Commercial HMO/PPO Plan

If a Medicaid managed care client is enrolled in a commercial HMO/PPO plan the health plan must notify the DHHS eligibility worker. The DHHS eligibility worker will verify the third party insurance and make the necessary system changes. Once the system changes have been made, the client will be excluded from physical health managed care. This change will become effective the first of the next month given system cut off.

It is the responsibility of the MCO to pursue the commercial payer for the payment of claims.