P-0000 THIRD PARTY LIABILITY (TPL)

P-100 GENERAL INFORMATION

Federal law and regulations require states to institute policies and procedures to assure that Medicaid enrollees use all other resources available to them to pay for all or part of their medical care prior to Medicaid paying.

Third parties are legally liable individuals, institutions, corporations (including insurers), and public or private agencies who are or who may be legally responsible for paying medical claims.

Medicaid pays only after a third party has met its legal obligation to pay. Medicaid is payer of last resort.

Exception:
Medicaid is the first payer for claims for pharmacy, EPSDT, prenatal care, and TPL furnished by an absent parent under jurisdiction of Title IV-D. Medicaid then "chases" any third party payments on these claims.

Federal regulations require:

- Reasonable measures be taken to accurately identify third parties;
- Collection and maintenance of information on health insurance, and use in processing claims;
- Verified TPL be treated as a resource of a Medicaid applicant/enrollee; and
- Assignment of rights to payments for medical support and other medical care is a condition of eligibility for Medicaid.

P-200 INDICATORS OF POTENTIAL THIRD PARTY RESOURCES

The following factors may indicate potential third party resources and should be pursued:

Age

Applicants/enrollees attaining age 65 may be eligible for Medicare. (Enrollees entitled to Medicare frequently have Medicare Advantage

plans or supplement policies.)

Minor children may be covered by insurance of the parent (custodial or absent).

Students may have insurance available through the school they attend.

Death

Death benefits received ** may cover medical expenses **.

Income

Income sources are indicators of possible third party health coverage:

- Railroad Retirement Benefits and Social Security Retirement/Disability Benefits may indicate eligibility for Medicare benefits.
- Longshore and Harbor Workers' Compensation (LHWC) and Workers' Compensation (WC) may pay benefits to Employees who suffer injuries on the job to compensate for medical expenses as well as lost income.
- Black Lung (BL) Benefits are awarded only on diagnosis of pneumoconiosis and may indicate eligibility for Medicare benefits.
- IV-D Payment child support payments may indicate potential medical support from an absent parent.
- Earned Income and Wage Earnings Record may indicate health and hospital insurance.
- Military Retirement may indicate coverage by TRICARE, TRICARE for Life and CHAMPVA.

Work History

Work history may indicate:

- Eligibility for cash and medical benefits through the previous employer (i.e., COBRA);
- Coverage through a health insurance plan if the individual is retired, or

- Coverage through the union if the individual belongs to a labor union.

Monthly Expenses

The applicant/enrollee may list health or hospitalization premiums as an expense.

Disability

A disability may indicate eligibility for other medical benefits (e.g. Casualty insurance or Medicare Parts A and/or B).

Litigation

Lawsuit settlements or pending lawsuits.

P-300 ASSIGNMENT/COOPERATION

Refer to I-200, Assignment of Rights.

P-400 LOCAL OFFICE/BHSF RESPONSIBILITIES

P-410 MEDICAID RECIPIENT INSURANCE INFORMATION UPDATE FORM

Healthy Louisiana Plans and Health Management Systems (HMS) share responsibility for maintaining TPL information. Analysts must still check for creditable health insurance at each application and renewal for applicable programs.

Coordination of Benefits (COBMatch) is a tool provided under contract by HMS used to identify insurance coverage information on applicants/enrollees and their household. Staff must check COBMatch when evaluating anyone for a program that has third-party liability as an eligibility factor such as LaCHIP, LAP or Phase IV.

Income replacement, life and accident, or indemnity insurance policies based on hospital or Nursing Facility confinement are not considered medical insurance third party liability resources.

Exception:
Some indemnity policies can be assigned to the hospital or Nursing Facility. When the hospital or Nursing Facility accepts assignment, the recipient does not receive the money. This indemnity insurance policy is considered TPL.

The Medicaid Recipient Insurance Information Update Form is used to:

- Update private insurance and Medicare Advantage coverage on an enrollee's TPL file (excluding Medicare); and
- Correct or change certain TPL information on the MMIS Third Party Resource File if it differs from the information of the provider.

The Medicaid Recipient Insurance Information Update Form for Medicare recipients is used to:

- Update traditional Medicare on an enrollee's TPL file such as removing part D plan (prescription).

The Medicaid Recipient Insurance Information Update Form will be distributed as follows:

- **Urgent** TPL updates for member enrolled with a health plan for both physical and behavioral health services are sent to the members' Healthy Louisiana Plan.
- **Urgent** TPL updates for member enrolled with a health plan for behavioral health services only or Fee-For-Service (not enrolled in a Health Plan) are sent to HMS.
- Non-urgent TPL updates are sent to HMS.
- Medicare updates are sent to the Recovery and Premium Assistance Unit.

P-411 RAILROAD RETIREMENT MEDICARE ENTITLEMENT

Railroad Retirement Medicare Parts A and B are not automatically transmitted to the MMIS Resource File because this information is not available on BENDEX. The agency representative shall send Form INS-RR to Recovery and Premium Assistance Unit with the following information on all beneficiaries who receive Railroad Retirement

Medicare Parts A and B:

- Beneficiary's name;
- Medicaid identification number;
- Social Security number;
- Railroad Retirement Medicare Parts A and B claim number;
- Effective date of entitlement; and
- The ending date of entitlement (if applicable).

When the above information is received by the Recovery and Premium Assistance Unit, it will be manually input to the MMIS Resource File.

P-420 TPL CARRIER CODE UPDATE FORM CF-1

To obtain a new carrier code for a carrier not on the current listing, complete and submit Form CF-1 to the Recovery and Premium Assistance Unit.

P-430 ACCIDENT/INJURY REPORTS

The monthly Accident/Injury Report (AIR) identifies claims with trauma-related procedure and diagnosis codes. AIR recovery cases are automatically created in the BHSF MMIS/Recovery and Premium Assistance Unit, if there is no indication of previous recovery surrounding the identified date(s) of service. An AIR notice (as well as follow-up notices after 30, 60, and 90 days) are automatically generated to the enrollee or his/her parent/guardian, requesting that contact be made directly to Recovery and Premium Assistance Unit staff, who will either close the AIR case or pursue recovery, as appropriate.

MMIS/Medicaid Recovery:

- Must be emailed information as it becomes available (include attachments).
- Responds to direct requests and/or inquiries from the enrollees, legal representatives or providers.
- Receives payments from a third party.

BHSF Eligibility Policy Unit will be notified when a Medicaid recovery case has been settled. The amount of the settlement will be given when known.

Note:
Benefits shall be terminated for an individual who refuses to cooperate. Notice and hearing requirements must be met.

P-500 BUY-IN PROGRAM

P-510 GENERAL PURPOSE

The Medicaid Program pays Medicare premiums for selected groups of eligible individuals. This is known as "Buy-In".

Purchasing Medicare coverage for certain Medicaid enrollees reduces Medicaid expenditures by shifting those expenditures to Medicare. The Medicaid program elected to "buy-in" Medicare Part B premiums beginning July 1985.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 mandated that the Medicaid Program expand Part B Buy-In coverage and extend Part A coverage to individuals meeting the Qualified Medicare Beneficiary (QMB) eligibility requirements. QMB Buy-In coverage began February 1989.

Note:
Recovery and Premium Assistance Unit is responsible for administering the Buy-In Program on the state level.

P-520 PART A BUY-IN

To qualify for Part A Buy-In the enrollee must be QMB or QDWI eligible as determined by Medicaid of Louisiana.

BHSF identifies eligible individuals on MEDS and initiates the Buy-In process. If ineligible, Recovery and Premium Assistance Unit terminates the Buy-In process.

P-530 PART B BUY-IN

To qualify for inclusion in the Part B Buy-In Program, an individual must be entitled to or enrolled in Medicare Part A and certified in MSP or an extended Medicaid program (DAC, PICKLE, SSI, and SSI Protected Status).

SSA identifies SSI enrollees and SSI/QMB enrollees eligible for Buy-In

and initiates the Buy-In process. SSI enrollees are automatically eligible for QMB. If ineligible, CMS terminates the Buy-In process.

Recovery and Premium Assistance Unit identifies Extended Medicaid, LTC, and QMB enrollees eligible for Buy-In from MEDS files and initiates the Buy-In process. If ineligible, Recovery and Premium Assistance Unit terminates the Buy-In process.