3902.2 THIRD PARTY LIABILITY 02-90
3902.2 Third Party Liability (TPL) Action Plan-If you have an MMIS, submit to the RO an action plan for pursuing claims against third parties. Automate the activities involved in pursuing TPL to the fullest extent possible. The action plan is to describe all TPL activities and is separate and distinct from the State plan. However, the action plan may incorporate, by reference, sections of the State plan that adequately describe particular TPL activities in accordance with the action plan guidelines. This is applicable to TPL activities which are contracted out by the State agency to a fiscal agent, as well as to activities involving contingency fee contractors.

The action plan is to be integrated with the MMIS and those portions which directly relate to the MMIS will be monitored as a part of the review of the system. Only the factors included in the system performance review will be subject to reductions in Federal financial participation (FFP) for failure to meet the conditions for reapproval as set forth at 42 CFR 433.119.

Submit to the RO your action plan by June 20, 1990. Submit subsequent changes to the action plan to the RO on an ongoing basis no later than 90 days from the date of implementation. The RO will approve or disapprove your action plan. The submittal of an approvable, current action plan is a State plan requirement.

The action plan must describe the actions and methodologies taken in the following areas:

- Identifying third parties;
- Determining the liability of third parties;
- Avoiding payment of third party claims;
- Recovering reimbursement from third parties after Medicaid payment; and
- Recording and tracking such information and actions.

Use the following guidelines in developing your action plan:

I. Identification

A. Collection of Health Insurance Information (other than by the Social Security Administration (SSA)). (See 42 CFR 433.138(b)(1).)

1. What type of health insurance information is gathered from applicants/recipients (e.g., name of insurer, policy number, name of insured, services covered)?

Name of insurer, policy holder identification number, policy number, relationship of policy holder to recipient, policy type, group number, and begin date of policy.

2. Are names, SSNs, and possible third party resources of absent and custodial parents collected from applicants/recipients?

Yes, when available.

3. Who collects this information (e.g., State agency, county office, contractor)?

The Department collections the information as well as Department of Social Services and our TPL contractor.

4. When and how is the information verified?

The information is verified through the projects quasi verification; through our data match with IV-D; and through our normal weekly claims processing cycle.

5. How are the data transmitted to the Medicaid agency? What are the timeframes for transmitting the data?

The information is transferred via SFTP from HMS monthly with regard to our data matches and the IV-D agency. We can update the MMIS resource file daily when we are aware of a change.

6. Where is the verified information maintained (e.g., eligibility case file, claims processing subsystem, third party data base, third party recovery unit)?

The information is stored in the TPL subsystem which is sent over weekly to the MMIS Resource file weekly.

7. What actual information is maintained?

Data maintained on the file: Origin of information, name of issuer, relationship to recipient, policy holder name, policy holder number, group and coverage type, begin date and end dates, dependant coverage, name, address, phone number of insurance carrier.

8. How does the TPL file data interface with the claims processing subsystem or other subsystems?

The MMIS Resource file is read by the claims processing subsystem to deny a claim anytime there is a resource on-line and to prepare retro and pay and chase billings, from the MMIS resource file.

9. What are the timeframes for incorporating the information into the file or files mentioned above?

The normal process is that the information is transmitted weekly into the MMIS resource file. However, in the event of an emergency it is real time.

B. Health Insurance Information Collected by SSA (applies to States having a §1634 agreement) (See 42 CFR 433.l38(b)(2).)

1. Who receives the information from the Form SSA-8019?

Hard copies are received by a TPL program specialist, electronic files are received by TPL subsystem administrator.

2. How often is the information received?

Hard copy information is received daily and the electronic submissions are weekly.

3. When and how is the information verified?

The information is verified through the projects that our TPL contractor conducts. Through the match process the TPL contractor identifies claims associated with a recipient that was identified has having TPL. The TPL contractor sends out a project to providers that submitted claims on behalf the identified recipients with the TPL information and instructions to the provider to bill accordingly. If the provider does not submit an EOB stating denied, it is assumed that TPL exists and is added to the TPL Resource file.

4. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

MMIS Resource file

5. What actual information is maintained?

Data maintained on the file: Origin of information, name of issuer, relationship to recipient, policy holder name, policy holder number, group and coverage type, begin date and end dates, dependant coverage, name, address, phone number of insurance carrier.

6. How does the TPL file data interface with the claims processing subsystem or other subsystems?

During the weekly cycle, the claims processing system interfaces with the TPL resource file to determine if there is TPL on the file for any recipient involved in the current claims cycle. If so, the claims are segregated and processed against the TPL matrix to determine the action that should be taken 1) pay, 2) deny, 3) pend for medical review.

7. What are the timeframes for incorporating the information into the file or files mentioned above?

The MMIS Resource file updated weekly, however the ability to modify a file can be real time.

C. Data from Office of Child Support Enforcement Program (See 45 CFR 306.50.)

1. What medical support data elements are being received from the IV-D agency?

Title IV-A case number, title IV-E foster care case number, Medicaid number or the individual's social security number; Name of the noncustodial parent; Social security number of the noncustodial parent; Name and social security number of child(ren); Home address of noncustodial parent; Name and address of noncustodial parent's place of employment; and Whether the noncustodial parent has a health insurance policy and, if so, the policy name(s) and number(s) and name(s) of persons covered.

2. How often is the information received?

Monthly.

3. When and how is the information verified?

Monthly when the Medicaid recipient file is given to DSS and they match their file against it. Those that match DSS verifies the information via phone calls to the carriers and phone calls to the recipients.

4. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

MMIS Resource file.

5. What actual information is maintained?

Data maintained on the file: Origin of information, name of issuer, relationship to recipient, policy holder name, policy holder number, group and coverage type, begin date and end dates, dependant coverage, name, address, phone number of insurance carrier.

6. How does the TPL file data interface with the claims processing subsystem or other subsystems?

During the weekly cycle, the claims processing system interfaces with the TPL resource file to determine if there is TPL on the file for any recipient involved in the current claims cycle. If so, the claims are segregated and processed against the TPL matrix to determine the action that should be taken 1) pay, 2) deny, 3) pend for medical review.

7. What are the timeframes for incorporating the information into the file or files mentioned above?

Monthly.

8. Does the IV-D agency have access to your TPL data base?

No.

9. Does the IV-D agency verify the current TPL status and that the data are

correct?

Yes.

II. Data Exchanges

A. State Wage and Income Collection Agencies (SWICAs) and SSA Wage and Earnings (Beneficiary Earnings Exchange Record (BEER)) Files (See 42 CFR 433.138(d)(1).)

1. Are you conducting data matches with State wage information collection agencies and SSA wage and earnings files?

No.

2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?
3. Are the names and SSNs of absent parents being matched with SWICA and SSA files?
4. What is the process for conducting the data exchanges? (Include frequency of exchange.)
5. How do you follow up on and verify the information to determine if employer group health benefits are available directly to the Medicaid recipients or through an absent or custodial parent?
6. What are the timeframes for followup?
7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
8. What actual information is maintained?
9. How does the TPL file data interface with the claims processing subsystem or other subsystems?
10. What are the timeframes for incorporating the information into the file or files mentioned above?
11. Do you receive information from the IV-A agency that identifies Medicaid recipients who are employed and their employer(s)? If not, how do you obtain information for this population?
12. If SWICA and SSA wage and earnings data are not being utilized, does the agency have an alternative source of information? (Describe alternative method based on the above questions.) (See 42 CFR 433.138(d)(2).)

B. Workers' Compensation (See 42 CFR 433.138(d)(4)(i).)

1. Are you conducting data matches with the State's workers' compensation agency?

No

2. Do you perform this match or does a contractor? If a contractor does it, who is

the contractor?
3. What is the process for conducting the data exchange? (Include frequency of exchange.)
4. Are the names and SSNs of absent parents being matched?
5. How do you follow up on and verify the information to determine if a Medicaid recipient has an employment related injury or illness?
6. How do you follow up on and verify the information to determine if employer group health benefits are available directly to a Medicaid recipient or through an absent or custodial parent?
7. What are the timeframes for followup?
8. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
9. What actual information is maintained?
10. How does the TPL file data interface with the claims processing subsystem or other subsystems?
11. What are the timeframes for incorporating the information into the file or files mentioned above?
12. If you are not conducting data exchanges with workers' compensation, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State plan?

C. State Motor Vehicle Accident Report Files (See 42 CFR 433.138(d)(4)(ii).)

1. Are you conducting data matches with State motor vehicle accident report files?

No, we use our claims processing module produce a report of all trauma related accidents/incidents.

2. Do you perform this match or does a contractor? If a contractor does it, who is the contractor?
3. Describe the process for conducting the data exchange. (Include frequency of exchange.)
4. How do you follow up on and verify the information to identify those Medicaid recipients injured in motor vehicle accidents (pedestrians, drivers, or passengers)?
5. How do you follow up on and verify third party resources that would be available through an automobile or liability insurance policy?
6. What are the timeframes for followup?
7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)
8. What actual information is maintained?
9. How does the TPL file data interface with the claims processing subsystem or other subsystems?
10. What are the timeframes for incorporating the information into the file or files mentioned above?
11. If you are not conducting data exchanges with State motor vehicle accident report files, was a reasonable attempt made to do so? If yes, did you submit documentation with Attachment 4.22B of the State plan?

D. Other Data Exchanges

1. What other data exchanges do you conduct (e.g., private insurers, Defense Enrollment Eligibility Reporting System (DEERS), credit bureaus, fraternal organizations, unions.)?

DEERS, private insurers

For each of these data exchanges, answer the following questions:
2. Do you perform the match or does a contractor? If a contractor does it, who is the contractor?

Our contractor HMS provides the data matches for both.

3. Are the names and SSNs of absent and custodial parents being matched?

No.

4. What is the process for conducting the data exchanges? (Include frequency of exchange.)

DEERS is annually, and the private insurance is conducted monthly.

5. How do you follow up and verify the information?

The information is added to our Resource file. The information is verified through the projects that are conducted my HMS.

6. What are the timeframes for followup?

N/A

7. Where is the verified information maintained?

MMIS Resource file.

8. What actual information is maintained?

Data maintained on the file: Origin of information, name of issuer, relationship to recipient, policy holder name, policy holder number, group and coverage type, begin date and end dates, dependant coverage, name, address, phone number of insurance carrier.

9. How does the TPL file data interface with the claims processing subsystem or other subsystems?

During the weekly cycle, the claims processing system interfaces with the TPL resource file to determine if there is TPL on the file for any recipient involved in the current claims cycle. If so, the claims are segregated and processed against the TPL matrix to determine the action that should be taken 1) pay, 2) deny, 3) pend for medical review.

10. What are the timeframes for incorporating the information into the file or files mentioned?

Monthly.

III. Diagnosis and Trauma Code Edits (See 42 CFR 433.138(e).)

1. Are you conducting diagnosis and trauma code edits for codes 800 through 999, with the exception of code 994.6? If not, list codes which are not being edited.

Yes.

2. Do you conduct the diagnosis and trauma code edits or does a contractor? If a contractor does it, who is the contractor?

UNISYS conducts the code edits our fiscal intermediary.

3. What is the process? (Include frequency of conducting edits.)

The edits are in place during our weekly claims processing. Monthly the report is ran and distributed to the Medicaid parish offices.

4. How do you follow up on and verify the information to identify possible trauma related injuries?

The Medicaid parish office worker makes phone calls to the recipients.

5. How do you follow up on and verify that third party resources may be available through a liability insurance policy?

The Medicaid parish office worker asks the recipient.

6. What are the timeframes for followup?

Thirty (30) days.

7. Where is the verified information maintained? (Refer to I.A.6., if appropriate.)

This information is referred to our Trauma unit via an Accident Incident Report (AIR) lead. The Trauma unit enters the lead into the TPL system.

8. What actual information is maintained?

Recipient information, date of accident/incident, Insurance information, attorney information, and accident report if available.

9. How does the TPL file data interface with the claims processing subsystem or other subsystems?

When an AIR lead is received a case is created based on the information given. Within the TPL System the information is entered and a claims history pull is requested one month prior to the date of accident/incident. The claims history will run that night and the Specialist can view the claims and select the ones that are associated with the accident. This is used to create the initial lien amount.

10. What are the timeframes for incorporating the information into the file or files mentioned above?

Depending volume and other activities associated with TPL it is a daily operation.

IV. Claims Payment

A. Cost Avoidance (See 42 CFR 433.139(b)(1).)

l. Which claim types, recipient populations, etc. are you cost avoiding?

Louisiana cost avoids all claims except for EPSDT and prenatal.

2. What information is available through the recipient's Medicaid identification medium, if any, indicating third party resources?

Carrier name, number, address and phone number for claims processing.

3. What is your process for cost avoiding claims? (Include use of contractor.)

During the weekly cycle, the claims processing system interfaces with the TPL resource file to determine if there is TPL on the file for any recipient involved in the current claims cycle. If so, the claims are segregated and processed against the TPL matrix to determine the action that should be taken 1) pay, 2) deny, 3) pend for medical review.

4. How are electronic billers providing evidence of third party pursuit?

We only accept paper submissions.

5. How do you control and verify the partial payment of claims (hard copy and electronic) after a third party has made payment?

We only accept paper submissions. UNISYS uses the information submitted in the prior payment field of the claim and reviews the EOB for validation.

6. What method do you use for tracking cost avoided dollars (as reported on the 64.9a, Medicaid Expenditures Report)?

MARS reports M68A Quarterly Private Insurance Cost Avoidance Report is used to track the cost avoided dollars.

a. How do you account for initial claims, and reconcile the amount when the claims are resubmitted?

By requiring the provider to submit the EOMB, pharmacies are audited on the back end.

b. Do you have a method for measuring cost avoided dollars for claims that are never received by the State? (If yes, describe method.)

No.

c. Do you account for claims denied for cost avoidance purposes only up to the Medicaid payment limit?

Claims denied for TPL and the TPL paid amount.

d. Do you include Medicare or count it separately?

Medicare cost avoidance is counted separately.

e. Do you include recipient copayments?

No.

f. What do you include under "other cost avoidance"?

Nothing.

B. Pay and Chase and Recovery (See 42 CFR 433.139(b)(2)and(3).)

1. Which claim types are you paying and chasing? For which do you have a waiver? Explain those for which you do not have a waiver.

EPSDT and prenatal.

2. Are you currently paying and chasing claims in accordance with 42 CFR 433.139(b)(3)(i) and (ii)? (This section applies to claims for services for prenatal care for pregnant women, preventive pediatric services or covered services furnished in cases where the third party resource is derived from the absent parent whose obligation to pay third party medical support is enforced by the State title

IV-D agency.)

Yes.

3. Do you currently have recovery threshold amounts? If so, what are they and how were they determined? For threshold amounts greater than $100 for health insurance and greater than $250 for casualty claims, provide documentation including calculations showing that the threshold amounts are cost-effective.

The current threshold is $500 for trauma related claims. However, we would like to go to $1,000 for trauma related. A report was created in 2005 to illustrate the cost effectiveness of this increase. With a $500 threshold there were 1,333 leads for the month of May resulting in claims of $2,775,237. Same time frame with a $1,000 threshold there were 446 leads with claims amounting to $2,181,218. The net effect of this would be a reduction of AIRS by 66% and the claim amount would only be reduced by 21%.

4. Does the threshold include accumulated billing. If so, over what period of time?

The pursues potential third party for claims with diagnosis codes 800-899, except for 994.6 and accumulated payment totals of $500 or more in each regular weekly pay cycle.

5. How does the system identify when threshold levels are reached?

The code used to pull the data specifies the $500 and if the claims exceed that amount the information is pulled.

6. What is your process for seeking recovery? (Include use of contractor.)

A report is generated monthly with the trauma related claims greater than the threshold amount and is sent to each parish Medicaid office. The parish office worker contacts the recipient to determine whether or not a third party may be responsible for the accident or incident. If a third party may be responsible the parish office worker sends a Accident Injury Report to the Trauma Unit. The trauma worker reviews the information and opens a trauma case.

a. What codes, if any, are used for recovery purposes (e.g., HCPCS, diagnosis codes, other procedure codes)?

No.

b. How does the system identify individual claims for recovery?

Once a case is established the trauma worker requests a claim history on the recipient starting one month prior to the date of accident. The claim history has all claims for that recipient for the specified time frame.

c. In what order and from whom do you seek recovery?

Insurance company or attorney of the tortfeasor.

d. How do you follow up to assure collection was made? What are specific accounting and reporting procedures for recoveries?

A notice of intent is mailed to the attorney and or the Medicaid recipient. The case remains open on the system until collections are made.

e. If collection was not made, how does the system trigger follow-up?

We have the ability to have follow letters automatically generated by the system at a given interval.

f. How do you track actual dollars recovered?

When the section receives a check it is logged and the case worker is notified. The case work enters the check into the system and applies it to the case. If the check amount covers the Medicaid paid amount the case is closed. If the check amount doesn't cover the Medicaid paid amount it is applied and the case worker negotiates with the attorney.

g. How are TPL recoveries reconciled with the claims history? Specific the audit and control process.

We have developed a TPL system in house with UNISYS that allows the Trauma workers to pull a claims history for the individual involved in an accident or incident. Based on the information related to the case the Trauma worker decides which claims should be applied to the accident or incident. A notice of claim is then sent to the attorney along with claims used to determine the amount owed for their review. When a check is received, the Trauma worker will pull the electronic case that is associated with it and the check amount is applied to the claims.

h. What are the specific procedures for recovery in casualty cases involving settlement awards?

The case worker opens a case in the TPL system entering the amount of the check received from the award. The case worker requests a claim history. The case worker reviews the claims and applies the check to the claims.

i. Do you have any formal billing arrangements/agreements with private insurers? If so, describe. (Include the information shared/required, timeframes, and outstanding claim amounts are reconciled.)

No.

V. Other

1. Do you pay premiums for health insurance policies if it is determined to be cost-effective? If so, provide methodology for determining cost-effectiveness.

Yes. Louisiana incorporates a modified version of what is in the Medicaid manual. Louisiana uses the Average Annual Medicaid Cost (AAMC) by age group by gender and whether or not the person is considered disabled or normal. Louisiana uses the following eight services brackets Inpatient Hospital, Outpatient Hospital, Physician, Durable Medical Equipment, Prescription, Ambulance, Skilled Nursing Services and Home Health.

The AAMC for a particular Service Bracket in a particular demographic group is the average annual cost per Medicaid eligible in the group, for services that fall under that Service Bracket. The total average annual cost per Service Bracket comprises all eligibles of the Demographic Group, not just those who have a claim for service of that type. For example if there are 5 members in a certain demographic group, and they are all members of that group for the entire sampling period (1 year), and for a specific Service Bracket there are a total of three claims totaling $1,500.00 for all the members of that group, then the AAMC for that Service Bracket in that demographic group for the year is not $1500.00 / 3 = $500.00, but $1,500.00 / 5 = $300.00. Simplistically, the AAMC is the total annual costs for a Service Bracket for all the members in a Demographic Group, divided by the number of members in that Group. However some Eligibles may only be members of a group for part of the year. Rather than counting the number of Eligibles who were part of the group at any time during the year, we count the number of months each Eligible spent in the group, or the number of Eligible-Months for the group as a whole. For example if there were 3 members of a certain demographic group during the year, two of whom were in the group for the whole year, but the third was only in the group for 5 months, then the total number of Eligible-Months for the group is: 12 + 12 + 5 = 29 Provided that, for a specific Demographic group and Service Bracket, we have calculated the total Amount of all claims where the Recipient was in that Group on the Service Date, then we can calculate the AAMC of that Service Bracket/Demographic Group combination as follows:

Total Amount of Claims in Year for Service Bracket and Demographic Group * 12
AAMC = Total Eligible-Months of Demographic Group. When calculating the total number of Eligible-Months for each demographic group, we must take into account the fact that members can move in and out of various groups during the year because:

- The recipient is initially certified for Medicaid partway through the year.
- The recipient has a birthday, which moves them from one Age Group to another.
- The recipient's Medicaid certification changes from one Category/Type-Case to another.
- The recipient's Medicaid certification is terminated during the year.
- The recipient’s Parish of Residence changes.
- The recipient’s Medicare coverage changes.

Louisiana utilizes special conditions as well as the AAMC. If a person has a heart condition for example, a special condition "heart disease" is used in conjunction with the AAMC that encompasses the expenditures related to that specific condition.

Louisiana also uses historical costs of the Medicaid recipient in determining the cost effectiveness. For example, if claims from the prior year indicate that Medicaid spent $8,000 for the child but the AAMC is only $2,100, we will use the prior year expenditure in our determination.

Step 1 - Policy information – is gathered and enter into the system effective date, premium amount, and the covered services.

Step 2 – Medicaid cost for covering the recipient without private insurance. As described above this is determined via the AAMC and or special condition or historical costs.

Step 3 – Medicaid costs for included services. The case worker selects all of the service brackets listed above that are covered by the insurance policy.

Step 4 – Group health plan costs for included services. Louisiana uses the national factor of 1.30.

Step 5 – Adjustment for coinsurance and deductibles amounts. Louisiana uses the average employer payment rate of 75 percent.

Step 6 – Administrative costs. Louisiana uses $100 per Medicaid recipient within a single case.

Step 7 – Compare the cost under the group health plan to those costs under Medicaid.

	Total	Smith, Lauren	Smith, John	Smith, Katie
Cost of Medicaid Only Coverage				
AAMC Breakdown				
Ambulance	20.00	5.00	10.00	5.00
Inpatient Hospital	1,300.00	500.00	500.00	300.00
Outpatient Hospital	400.00	200.00	100.00	100.00
Physician	2,800.00	1,300.00	750.00	750.00
Skilled Nursing	20.00	15.00	2.50	2.50
DME				
RX	500.00	300.00	100.00	100.00
Home Health	900.00	400.00	250.00	250.00
Total AAMC	$5,940.00	$2,720.00	$1,712.50	$1,507.50
Special Condition Cost Breakdown				
Pregnancy	5,000.00	5,000.00		
Dialysis	1,500.00		1,500.00	
Total Special Condition	6,500.00			
Total Cost Medicaid-only Coverage	$11,440.00	$7,720.00	$2,212.50	$1,507.50

Medicaid to ESI Cost Adjustment Factor	1.3			
Total Billed to ESI for Included Services	$14,872.00	$10,036.00	$2,876.25	$1,959.75
Wrap Around				
Total Billed to ESI (from above)	$14,872.00	$10,036.00	$2,876.25	$1,959.75
Average ESI Payment Rate	.75			
ESI Recognized Amount	$11,154.00	$7,527.00	$2,157.19	$1,469.81
Total Wraparound –Deduct, Coins, Copay	$3,718.00	$2,509.00	$719.06	$489.94
Caps				
Annual Cap Amount				
State's Cost of ESI Participation				
Annual Premium Cost	$2,500.00			
Administrative Cost	$300.00	100.00	100.00	100.00
Total Wraparound (from above)	$3,718.00	$2,509.00	$719.06	$489.94
Total in access of Cap (from above)				
Total Cost of ESI Participation	$6,518.00			
Total Cost Medicaid-only Coverage	$11,440.00			
Annual Cost Savings (loss)	$4,922.00			

2. What other TPL practices, not covered in these sections, do you pursue? For example, do you pursue estate recoveries? Describe how you approach any "other" practices.

Estate Recovery is performed by the state. The process that we utilize is basically as follows. We receive a paper referral from the Medicaid parish office of the death of a long term care or home and community based services recipient over the age of 55. The case worker opens a case and pulls a claim history with regard to the recipient. Once the history is retrieved electronically through the TPL system the case worker applies that amount to the initial balance of the case for the deceased. A notice of intent is sent to the responsible party.

3. Do you use a contractor for any other TPL activities not covered here? If so, identify the contractor and describe the specific types of activities performed.

No.