



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Third Party Liability

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2.0	Policies and procedures as of May 1, 2017 Published: October 3, 2017	Scheduled update: <ul style="list-style-type: none"> • Edited and reorganized text throughout the module for clarity • Changed Hewlett Packard Enterprise references to DXC Technology • Clarified Portal instructions for accident-related claims in the Liability Insurance section • In the Waiver Liability Considerations Related to Medicare section, added information about including the HCBS benefit modifier • Added a note box to the Third Party Liability Reimbursement Requirements section referring to MCEs for managed care TPL procedures and indicated FFS-specific information as needed within the subsections • Updated the Identifying Third Party Liability section, including adding information about waiver liability • Replaced references to MRN with EOMB • Removed the reference to value code A7 from the Medicare Replacement Plan Claims section 	FSSA and DXC

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Third Party Liability

Introduction

Private insurance coverage does not preclude an individual from receiving Indiana Health Coverage Programs (IHCP) benefits. Many IHCP members have other insurance in addition to the IHCP benefits. Insurance may be a commercial group plan through the member's employer, an individually purchased plan, Medicare, or insurance available because of an accident or injury. The IHCP supplements other available coverage and is primarily responsible for paying only the medical expenses that other insurance does not cover.

To ensure the IHCP does not pay expenses covered by other sources, federal regulation (*Code of Federal Regulations 42 CFR 433.139*) establishes Medicaid as the payer of last resort. In Indiana, Victim Assistance, First Steps, and Children's Special Health Care Services (CSHCS) are the only resources that are not billed prior to the IHCP. Because these programs are fully funded by the State, the IHCP, which is jointly funded by state and federal government, has primary claim-payment responsibility.

If an IHCP member has any other resource available to help pay for the cost of his or her medical care, this resource must be used prior to the IHCP. Providers access information about IHCP members' other insurance resources through the Eligibility Verification System (EVS), as described in the [Identifying Third Party Liability](#) section of this module.

IHCP Third Party Liability Program

The IHCP Third Party Liability (TPL) program ensures compliance with federal and state TPL regulations. The program has two primary responsibilities:

- Identify IHCP members who have third-party resources available.
- Help ensure those third-party resources pay prior to the IHCP.

The IHCP has full authority to fulfill these responsibilities. An individual applying for Medicaid or receiving Medicaid is considered to have automatically assigned the individual's rights, or the rights of any other person who is dependent upon the individual and eligible for Medicaid, to the State for the following:

- Medical support
- Other third-party payments for medical care for the duration of enrollment in the Medicaid program by the individual or the individual's dependent

Each member must cooperate with the IHCP to obtain payment from those resources, including authorization of providers and insurers to release necessary information to pursue third-party payment. Medicare benefits are not assigned to the IHCP.

TPL requirements are the same regardless of the type of third-party resource. The TPL program fulfills its responsibilities based on whether the other resource falls under the general category of health insurance, such as commercial policies, Medicare, and others, or under the general category of liability insurance, such as auto and homeowner.

Cost Avoidance

When a provider determines that a member has an available TPL resource, the provider is required to bill that resource prior to billing the IHCP. If the EVS indicates that a member has TPL, and the provider submits the claim to the IHCP without documentation that the third-party resource was billed, federal regulations (with a few exceptions, as described in the [Services Exempt from Third Party Liability Cost Avoidance Requirements](#) section of this document) require that the claim be denied. This process is known as *cost avoidance*.

When a claim is cost avoided, the provider must bill the appropriate third party. If that resource denies payment or pays less than the IHCP would have paid, the provider can rebill the claim to the IHCP.

Providers must be fully aware of and comply with the procedures outlined in this document to prevent claims from being erroneously cost avoided.

Health Insurance

The TPL program has five primary sources of information for identifying members who have other health insurance. Those sources are as follows:

- *Caseworkers with the Family and Social Services Administration (FSSA) Division of Family Resources (DFR)* – During the IHCP application process, applicants are asked if they have other insurance coverage. If so, all available information is obtained and updated in the member’s file in the Indiana Client Eligibility System (ICES). ICES electronically transfers the information to the IHCP.
- *Providers* – During the IHCP member’s medical appointment, providers must ask if there is another resource available for payment, such as group health insurance. In the case of an injury or illness due to an accident, there may be auto or homeowner insurance and workers’ compensation insurance. If so, providers must obtain information about the other policy and send it to the IHCP by written notice, telephone call, notification through the IHCP Provider Healthcare Portal (Portal), or inclusion on a claim form. Providers should request that the IHCP member sign an assignment of benefits authorization form. This form must state that the member authorizes the insurance carrier to reimburse the provider directly. Providers must submit a copy of this form when billing other carriers.
- *Data matches* – The IHCP uses a private vendor, HMS, to perform regular data matches between IHCP members and commercial insurance eligibility files. Data matches are performed with all major insurers, including Anthem Blue Cross and Blue Shield, Aetna, Cigna, Prudential, United Healthcare, and many others. HMS obtains full information about any identified coverage and transmits it electronically to the IHCP.
- *Managed care entities (MCEs)* – MCEs also submit information to the TPL Unit about members enrolled in the MCE’s network. Health analysts in the TPL Unit verify this information before updating the IHCP member’s file in the IHCP Core Medicaid Management Information System (CoreMMIS).
- *Medicaid Third Party Liability Questionnaire* – Providers and members use this questionnaire to update the IHCP member’s file. The completed TPL questionnaire can be uploaded as an attachment to a secure correspondence message on the Portal, or it may be emailed, faxed, or mailed to the TPL Unit. The information is verified prior to updating CoreMMIS. This form can be downloaded from the [Forms](#) page at indianamedicaid.com in the *Third Party Liability Forms* section.

Regardless of the source, all TPL health coverage information is stored in CoreMMIS and is available to providers through the EVS. Indemnity policies paying only the member, such as AFLAC, are **not** maintained in CoreMMIS.

Note: Benefits for active duty or retired military personnel and their dependents may be available through a medical plan for the uniformed services called TRICARE. Send TRICARE claims to the following address:

**TRICARE Regions 2 and 5 Claims Processing
Healthnet Federal Services
P.O. Box 870140
Surfside Beach, SC 29587
Toll-Free Telephone: 1-877-874-2273**

Liability Insurance

Unlike health insurance, liability insurance generally reimburses Medicaid for claim payments only under certain circumstances. For example:

- An auto insurance liability policy covers medical expenses only if expenses are the direct result of an automobile accident, and the individual insured under the policy is liable. However, if there is *medical payments* coverage under the automobile policy of the vehicle in which the member was injured, the member must establish only that the injuries are accident-related, **but does not have to establish liability** to pursue a medical payment claim.
- Under homeowner and other property-based liability insurance, generally, the “at fault” party’s liability must be established before an injured member is reimbursed for medical expenses related to the injury. However, if separate *medical payments* coverage is available under the policy, the member typically must establish only that the injury occurred on the property to obtain medical payment benefits.

The IHCP does not cost avoid claims based on liability insurance coverage or available medical payments coverage. If a provider is aware that a member has been in an accident, the provider can bill the IHCP or pursue payment from the liable party. If the IHCP is billed, the provider must indicate that the claim is for accident-related services by completing one of the following actions:

- For paper claim forms:
 - On the *CMS-1500* claim form, mark the appropriate boxes in field 10.
 - On the *UB-04* claim form, list the appropriate occurrence code in fields 31–36.
 - On the *ADA 2006* claim form, mark the appropriate box in field 45.
- For Portal claim submissions:
 - On the professional claim, select the appropriate option from the Accident Related and Date Type drop-down menus and complete the Date of Current field (and, for auto accidents, the Accident State and Accident Country fields) in the Claim Information section.
 - On the institutional claim, enter the appropriate occurrence code and dates in the Occurrence Code panel.
 - On the dental claim, complete the Accident Related and Accident Date fields in the Claim Information section.
- For 837 electronic transactions:
 - On the 837P (professional), 837I (institutional), or 837D (dental) transaction, enter the appropriate related causes code in data element 1362.

Providers choosing to initially pursue payment from the liable third party must remember that claims submitted to the IHCP after the one-year timely filing limit are denied. Providers are not allowed to pursue the member for the difference in the amount billed to the IHCP and the amount paid by the IHCP.

When the IHCP pays claims for accident-related services, the TPL program performs postpayment research, based on trauma-related diagnosis codes identified in the State Plan and the TPL Action Plan, to identify cases with potentially liable third parties. When third parties are identified, the IHCP presents all paid claims associated with the accident to the responsible third party for reimbursement by filing a lien against the personal injury settlement proceeds.

Providers are not normally involved in this postpayment process and are not usually aware that the IHCP has pursued recoveries. Providers may contact the TPL Casualty Unit with questions about TPL case procedures, and are encouraged to report all identified TPL cases to the TPL Casualty Unit. For example, if a provider receives a record request from an attorney regarding a TPL case, the provider is encouraged to notify the TPL Casualty Unit of the request. Providers can notify the TPL Casualty Unit by telephone at 1-800-457-4584 or by completing a *Provider TPL Referral Form*, which can be downloaded from the *Third Party Liability Forms* section of the [Forms](#) page at indianamedicaid.com. Submit the completed form to the TPL Casualty Unit by uploading it as an attachment to a secure correspondence message on the Portal, by email to INXIXTPLCasualty@hpe.com, by fax at (317) 488-5217, or by U.S. Mail to the following address:

**IHCP TPL Casualty Unit
P.O. Box 7262
Indianapolis, IN 46207-7262**

Services Exempt from Third Party Liability Cost Avoidance Requirements

To increase overall provider participation in the IHCP, the Centers for Medicare & Medicaid Services (CMS) exempts certain medical services from the cost avoidance requirement, including, but not limited to:

- Prenatal care
- Preventive pediatric care, including Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

To encourage providers to continue providing these services, federal regulations allow providers to bill some claims for these types of care to the IHCP first, even when TPL is present for the member.

To bypass the TPL edits, claims for these services must use a diagnosis code listed in *Prenatal and Preventive Pediatric Care Diagnosis Codes That Bypass Cost Avoidance* on the [Code Sets](#) page at indianamedicaid.com as follows:

- For institutional billing (*UB-04* claim form or electronic equivalent), the appropriate prenatal or preventive pediatric care diagnosis code must be principal (listed first) on the claim.
- For professional billing (*CMS-1500* claim form or electronic equivalent), the appropriate prenatal or preventive pediatric care diagnosis code must be listed at the claim level and also indicated, using the diagnosis pointer, at the detail level for relevant procedure codes.

Home and community-based services (HCBS) claims are also exempt from TPL cost avoidance requirements. The IHCP will not bill private insurance carriers through the TPL or reclamation processes for claims containing HCBS benefit modifier codes for the following 1915(c) HCBS waiver, 1915(i) HCBS, and Money Follows the Person (MFP) benefit plans:

- Community Integration and Habilitation HCBS Waiver (CIH Waiver)
- Family Supports HCBS Waiver (FSW)
- Aged and Disabled HCBS Waiver (A&D Waiver)
- Traumatic Brain Injury HCBS Waiver (TBI Waiver)
- MFP Demonstration Grant Traumatic Brain Injury (MFP TBI)
- MFP Demonstration Grant Aged and Disabled (MFP A&D)
- Adult Mental Health Habilitation (AMHH)
- Behavioral and Primary Healthcare Coordination (BPHC)
- Child Mental Health Wraparound (CMHW)

Providers that render any of these exempt services are still permitted, but are not required, to bill available third-party resources. Claims for these services bypass the normal cost-avoidance process; the IHCP pays these claims regardless of other insurance coverage or liability. In situations where the claim is for prenatal care for pregnant women or preventative services (including EPSDT) that are covered under the State Plan, the IHCP must pay the claim and then pursue recovery from the third party. However, when Medicare is the primary payer, claims with these diagnosis codes do not bypass the TPL edits unless the procedure code is identified as a code that is never paid by Medicare.

Third Party Liability Reimbursement Requirements

This section outlines provider responsibilities for supporting cost containment through timely identification and billing of primary insurers.

Note: For Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise members, contact the member's managed care entity (MCE) for specific TPL requirements and billing procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at indianamedicaid.com.

Identifying Third Party Liability

Before rendering a service, providers must use the EVS to verify that the member is eligible. See the [Provider Healthcare Portal](#), [Interactive Voice Response System](#), and [Electronic Data Interchange](#) modules for more information about these EVS options:

- [Provider Healthcare Portal](#) at indianamedicaid.com
- Interactive Voice Response (IVR) system at 1-800-457-4584
- 270/271 Eligibility Benefit Inquiry and Response electronic transactions

Additionally, the EVS should be used to verify TPL information to determine whether another insurer is liable for all or part of the bill. The EVS has the member's most current TPL information, including the health insurance carrier, coverage type, and policy numbers. The EVS lists the following TPL coverage types:

- Cancer
- Dental
- Home health
- Hospitalization
- Hospitalization, medical, and major medical
- Indemnity
- Medical
- Medicare Advantage Plan
- Medicare Part A
- Medicare Part B
- Medicare Part D
- Medicare supplemental plan
- Mental health

- Optical/vision
- Pharmacy
- Skilled care in a nursing facility

In some cases, it is not possible to determine from the coverage types stated by the EVS whether a specific service is covered. If a specific service does not appear to be covered by the stated TPL resource, providers are still required to bill this resource to receive a denial or payment. For example, some insurance carriers cover optical and vision services under a medical or major medical plan.

Services covered by a primary insurer must be billed to the primary insurer first. If no other insurer is indicated on the EVS and the member reports no additional coverage, bill the service to the IHCP as the primary payer.

For members who have **only** Qualified Medicare Beneficiary (QMB) coverage (referred to as QMB Only) or **only** Specified Low-Income Medicare Beneficiary (SLMB) coverage (referred to as SLMB Only), the IHCP pays the Medicare premiums but *does not provide medical coverage*. Providers should not bill the IHCP at any time for a QMB Only or SLMB Only member. When the EVS identifies a member as having only QMB or SLMB coverage, the provider should contact Medicare to confirm medical coverage.

Note: Providers can contact Medicare by calling 1-800-Medicare (1-800-633-4227). Failure to confirm medical coverage before billing Medicare could result in claim denial, because the Medicare benefits may have been discontinued or recently denied.

For QMB Also members (identified on the EVS as having both Qualified Medicare Beneficiary coverage **and** Full Medicaid or Package A – Standard Plan coverage) and SLMB Also members (identified on the EVS as having both Specified Low-Income Medicare Beneficiary coverage **and** Full Medicaid or Package A – Standard Plan coverage), the IHCP pays the Medicare premiums **and also** maintains the role of secondary insurance payer, or payer of last resort. QMB Also and SLMB Also members qualify for another category within the Medicaid program, including aged, blind, or disabled. For these members, if the Medicare payment amount for a claim exceeds or equals the Medicaid allowable amount for that claim, Medicaid reimbursement will be zero. If the Medicaid allowable amount for a claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement is the lesser of:

(a) The Medicaid allowable amount minus the Medicare payment amount

or

(b) The Medicare coinsurance or copayment and deductible, if any, for the claim

Note: A QMB Also or SLMB Also member can be enrolled in the IHCP with a waiver liability, meaning that the member must meet a liability amount each month before Full Medicaid or Package A – Standard Plan coverage goes into effect. For members with a waiver liability, the EVS indicates the monthly liability amount and the amount that remains due for that month. Until waiver liability is met for the month, these members are eligible for coverage as QMB Only or SLMB Only.

Providers may contact the TPL Unit with questions about other insurance available to a member; see the [Third Party Liability Inquiries](#) section of this document for details.

Prior Authorization and Third Party Liability

If a service requires prior authorization (PA) by the IHCP, this requirement must be satisfied to receive payment from the IHCP, even if a third party paid a portion of the charge. Therefore, a provider may need to obtain PA from the other health insurance entity as well as from the IHCP prior to rendering services. The only exception is when the third-party payer is Medicare Parts A or B or Medicare Replacement Plans, and Medicare or Medicare Replacement Plans allow for the service, in whole or in part.

TPL Billing and Documentation Procedures

When a provider submits a claim to the IHCP for the difference between the amount billed and the primary insurer's payment, the IHCP pays the difference, *up to the IHCP allowable charge*. If the primary insurer payment is equal to or greater than the IHCP-allowable charge, no payment is made by the IHCP. These claims will appear as paid claims on the IHCP Remittance Advice, paid at zero dollars. The provider is not required to send such claims to the IHCP for processing. Providers cannot bill members for any balance.

When submitting all claims, the total amount paid by a third party must be entered in the appropriate field on the claim form or electronic transaction, even if the payment amount is zero. Non-Medicare TPL information is also required at the *detail* level for the following claims:

- Dental
- Home health
- Outpatient
- Professional (also known as medical or physician)
- Professional crossover

Medicare information (such as Medicare paid amount, deductible, coinsurance, copayment, and blood deductible, as applicable) is required at the detail level for the following claim types:

- Professional crossover
- Outpatient crossover

Providers using paper claim forms must submit this detail-level TPL information using the [IHCP TPL/Medicare Special Attachment Form](#), available from the [Forms](#) page at indianamedicaid.com. (See the [Claim Submission and Processing](#) module for details.)

In addition, for members who have other insurance, an explanation of payment (EOP), explanation of benefits (EOB), Remittance Advice (RA), or other documentation from the third party may be required as an attachment to the claim.

When a member has other insurance, and the primary insurer denies payment for any reason or applies the payment in full to the deductible, the provider must provide proof that the service was submitted to the primary payer. This proof may be submitted in one of two ways:

- Attach a copy of the denial – such as an EOP, EOB, or RA – to the IHCP claim. The procedure code billed on the IHCP claim must be listed on the EOP, EOB, or RA submitted for documentation. If an EOP, EOB, or RA cannot be obtained, a copy of the statement or correspondence from the third-party carrier may be attached to the claim, instead.
- Use adjustment reason codes (ARCs) to report the valid claim denial reason on the claim at the time of submission, as follows:
 - In the Claim Adjustment Details panel for other insurance entered in a claim on the Portal
 - On the CAS segments of an 837 transaction
 - On the [IHCP TPL/Medicare Special Attachment Form](#) included with paper claim submission

Note that this option does not apply to zero payments made on Medicare claims. Medicare-denied claims and claims where Medicare applies the entire payment amount to the deductible require the provider to submit a copy of the denial documentation, as described in the first option.

If a third-party payer made the payment, an EOP, EOB, or RA is not always required.

Medicare or Medicare Replacement Plan Secondary Claims

If a member has Medicare or Medicare Replacement Plan, and the payment amount on the claim being submitted is greater than zero, the Explanation of Medicare Benefits (EOMB) or Medicare Replacement Plan EOB is not required.

However, if zero dollars is indicated in the Medicare paid amount field on the claim, the EOMB or Medicare Replacement Plan EOB must be attached to the IHCP claim. See the [Medicare/Medicaid-Related Reimbursement](#) section for more information about billing for dually eligible members.

Blanket Denials

When a service is repeatedly rendered and billed to the IHCP, and is not covered by the third-party insurance policy, a provider can submit photocopies of the original insurer's denial for the remainder of the year in which the denial is received. The provider should write *Blanket Denial* on the insurance denial, as well as on the top of the claim form, when submitting copies for billing purposes. The denial reason must relate to the specific services and time frames of the new claim.

For example, if an insurer denies a claim for skilled nursing care because the policy limits are exhausted for the calendar year, this same denial could be used for subsequent skilled nursing care-related claims for the duration of the calendar year.

Third-Party Payer Fails to Respond (90-Day Provision)

When the member has other insurance, an IHCP provider must submit claims to the other insurance carrier before submitting to the IHCP. The other insurance carrier will pay or deny the claim, and the provider will receive a written response on an EOB from the other insurance carrier.

If a third-party insurance carrier fails to respond within 90 days of the billing date, the provider can submit the claim to the IHCP for payment consideration. However, attempts to bill the third party must be substantiated as follows:

- When submitting the claim electronically (as an 837 transaction or Portal claim), the following information must be documented in the claim note:
 - Date of the filing attempt
 - The phrase “No response after 90 days”
 - IHCP Member ID (also known as RID)
 - Provider’s National Provider Identifier (NPI)
 - Name of primary insurance carrier billed
- When a paper claim is submitted to the IHCP, write “**90 Days No Response**” on the top of the claim form, and include the following with the claim:
 - Copies of unpaid bills or statements sent to the insurance company
 - Written notification from the provider, indicating the billing dates and explaining why the third party failed to respond within 90 days

Boldly indicate the following on the attachments:

- Date of the filing attempts
- The phrase “No response after 90 days”
- Member ID
- Provider’s NPI
- Name of primary insurance carrier billed

For more information about claim notes and attachments, see the [Claim Submission and Processing](#) module.

Insurance Carrier Reimburses IHCP Member

When a provider has proof that an IHCP member received reimbursement from an insurance carrier, follow these steps:

1. Contact the insurance carrier and advise payment was made to the member in error.
2. Request a correction and reimbursement be made to the provider.
3. If unsuccessful, document the attempts made and submit under the 90-day provision.

In future visits with the IHCP member, the provider should request the IHCP member sign an assignment of benefits authorization form. The form states that the member authorizes the insurance carrier to reimburse the provider. This process may result in reimbursement directly to the provider, if the provider submits the form when filing the claim with the third-party carrier.

Providers can also refer members to the Program Integrity staff of the FSSA Quality and Compliance Office if the provider believes the member is committing fraud. The FSSA Program Integrity staff refers the member to the Bureau of Investigations and possibly reviews the member's utilization for placement on the Right Choices Program. The Provider and Member Concern Line can be contacted at (317) 234-7598 or 1-800-457-4515. Additionally, providers may refer members to the Indiana Division of Family Resources Public Assistance Fraud Hotline toll-free at 1-800-446-1993.

Subsequent Third Party Liability Payment

TPL payments received by providers for claims paid by the IHCP cannot be used to supplement the IHCP-allowable charges. If the IHCP paid the provider for services rendered, and the provider subsequently receives payment from any other source for the same services, the IHCP payment must be refunded within 60 days. The refund is not to exceed the IHCP payment to the provider.

Fee-for-service (FFS) claims may be adjusted via the Portal (using the Void or Edit options), or an adjustment form must be completed and submitted to the Claims Adjustment Unit at the following address:

DXC Adjustment Forms
P.O. Box 7265
Indianapolis, IN 46207-7265

Adjustment procedures are outlined in the [Claim Adjustments](#) module.

DXC Technology partners with HMS to collect credit balances owed to the IHCP for FFS claims. All providers are encouraged to use the credit balance process to return overpayments. For questions about the credit balance process or requests for copies of the credit balance worksheet, providers can contact HMS Provider Relations toll-free at 1-877-264-4854. The *Indiana Office of Medicaid Policy and Planning – Credit Balance Worksheet* and the *IHCP – Credit Balance Worksheet Instructions* are also available on the [Forms](#) page at indianamedicaid.com, in the *Third Party Liability Forms* section.

Checks must be made payable to the **IHCP** and mailed to the following address:

DXC Refunds
P.O. Box 2303, Dept. 132
Indianapolis, IN 46206-2303

IHCP Remittance Advice Information

If an IHCP claim denies for TPL reasons, TPL billing information about the member is provided on the RA. RAs for FFS claims billed to DXC are available weekly on the Portal. See the [Financial Transactions and Remittance Advice](#) module for information. The electronic 835 transaction identifies this information with the adjustment reason and adjustment remark codes.

If the IHCP has a TPL resource for a member on file, and a claim is submitted for payment with no amount in the TPL field, the claim will deny for TPL. The TPL EOBs are as follows:

- EOB 2500 – *This member covered by Medicare Part A; therefore, you must first file claims with Medicare.*
- EOB 2502 – *This member covered by Medicare Part B or Medicare D; therefore, you must first file the claims with Medicare. If already submitted to Medicare, please submit your EOMB [explanation of Medicare benefits].*
- EOB 2505 – *This member covered by private insurance, which must be billed prior to Medicaid.*

If the provider has information that corrects or updates the TPL information provided on the RA or 835 electronic transaction, follow the procedures for updating TPL information as described in the [Member Third Party Liability Update Procedures](#) section of this module.

Medicare/Medicaid-Related Reimbursement

Many IHCP members are eligible for both Medicare and Medicaid. These individuals are commonly called *dually eligible* members. According to TPL regulations, Medicare is treated as any other available resource. Thus, when an IHCP member is also enrolled in Medicare, providers must bill Medicare prior to submitting a claim to the IHCP for reimbursement. (See the [Pharmacy Services](#) module for information about prescription drug billing for dually eligible members.)

The IHCP pays only when the Medicaid-allowed amount exceeds the amount paid by Medicare. If the Medicaid-allowed amount exceeds the Medicare-paid amount, the IHCP pays the lesser of the coinsurance or copayment plus deductible, or the difference between the Medicaid-allowed amount and the Medicare-paid amount.

For an IHCP provider to receive reimbursement from Medicare, the provider must be enrolled in the Medicare program. The only exception to this policy is noted as follows: Mental health providers that are not approved to bill Medicare can expedite claim payment for dually eligible members by appending modifiers HE or HO to the procedure billed and doing the following:

- For paper claims, providers must submit an attachment indicating that the provider is not eligible to bill Medicare.
- For electronic claims submitted via the Portal or 837 transaction, providers can enter “**Provider not approved to bill services to Medicare**” as a claim note instead of submitting an attachment.

This process allows the claim to suspend for review of the attachment or claim note, and the claim is adjudicated accordingly.

Providers can be enrolled in Medicare as participating or nonparticipating. Medicare participating providers, and nonparticipating providers who agree to accept assignment of benefits and to which benefits have been assigned, receive payment directly from Medicare. The provider accepts Medicare’s allowable amount (which is calculated based upon the provider’s status as participating or nonparticipating), and the patient is not responsible for the disallowed amount. The patient is responsible for only the deductible and coinsurance or copayment. For example, the charge is \$150, the allowable amount is \$100, \$50 is disallowed, the deductible is \$25, and coinsurance or copayment is \$15. Medicare pays \$60; the provider absorbs \$50.

Some nonparticipating providers may choose to accept or not accept assignment on Medicare claims, on a claim-by-claim basis. Medicare benefits not assigned are paid directly to IHCP members. If the nonparticipating provider chooses not to accept assignment, the provider may not charge the beneficiary more than the Medicare limiting charge for unassigned claims for Medicare services.

If a provider is not enrolled in Medicare, either as participating or nonparticipating, the member should be referred to a Medicare and Medicaid dually enrolled provider to receive the best benefit.

Crossover Claims

Crossover claims filed with the IHCP must comply with IHCP billing rules. Therefore, providers must bill services on the appropriate claim type. See the [Claim Submission and Processing](#) module for detailed instructions on submitting institutional and professional crossover claims. There is no filing limit for paid Medicare crossover claims.

Note: Providers should bill outpatient professional charges using the CMS-1500 claim form, the Portal professional claim, or the 837P transaction. Always submit ambulatory surgery center (ASC) charges using the UB-04 claim form, the Portal institutional claim, or the 837I transaction.

Federally qualified health centers (FQHCs), hospital-based ambulance services, and independent rural health clinics (RHCs) submit claims to the Medicare intermediary using the institutional claim type (the *UB-04* claim form or electronic equivalent), but they must submit claims to the IHCP using the professional claim type (the *CMS-1500* claim form or electronic equivalent).

Providers must use the institutional claim type to submit long-term care (LTC) facility Medicare charges for parenteral and enteral services and therapies to the IHCP.

For outpatient and professional crossover claims, the individual Medicare coinsurance or copayment and deductible must be reported for each detail on the claim. The Medicare paid amount, meaning the actual dollars received from Medicare, must also be reported as a total amount on the claim as well as for each individual detail. For crossover claims submitted on paper claim forms, these detail-level amounts must be reported in the respective locations on the *IHCP TPL/Medicare Special Attachment Form*.

Note: Providers should submit Medicare denials through the normal claim process, because the IHCP does not consider the denials as crossover claims.

Providers must include the correct NPI for a claim to cross over automatically. Atypical providers must ensure that the Medicare provider number, per service location, by individual provider and billing provider, is on file with the Provider Enrollment Unit. The [Provider Enrollment](#) module provides further information about provider enrollment.

The following information concerns crossover claims:

- Providers must be Medicare providers and accept assignment for a claim for dually eligible members to cross over.
- If a provider does not receive the IHCP payment within 60 days of the Medicare payment, claims that did not cross over should be submitted to the crossover processing address, according to the instructions found in the [Claim Submission and Processing](#) module.
- When filing claims for services paid by Medicare or a Medicare Replacement Plan, it is not necessary to include a copy of the Medicare EOMB or Medicare Replacement Plan EOB as an attachment to the claim.
- Providers must include claim filing code 16 – *Health Maintenance Organization (HMO) Medicare Risk* when submitting Medicare Replacement Plan claims electronically via 837 transaction or the Portal. Providers should use claim filing codes MA and MB for original Part A and Part B Medicare claims filed electronically.
- If the member has a Medicare supplement policy, the claim is filed with Medicare and automatically crosses over to the Medicare supplement carrier for payment of coinsurance or copayment and deductible, rather than to the IHCP. After the provider receives all EOBs, the provider may submit the claim electronically through the Portal, with the EOBs attached through the File Transfer upload process or sent separately as a paper attachment, or the claim may be submitted on paper with the corresponding paper EOBs attached.

Note: If the TPL benefit code has been entered erroneously as a hospitalization (A) or medical (B), versus Medicare Supplemental Part A (O) or Medicare Supplemental Part B (P) for the supplemental policy, the claim crosses directly to the IHCP and may be paid without proof of filing with the Medicare supplement carrier. These situations generally result in IHCP overpayments that must be refunded immediately.

To prevent an overpayment, a provider that identifies enrollees with a Medicare Supplemental policy conveyed as an A or B on the EVS can request a TPL file update by sending a copy of the enrollee's Medicare supplemental insurance card to the TPL Unit. See the [Member Third Party Liability Update Procedures](#) section of this document for update procedures.

- Providers whose claims are not crossing over automatically should contact the Customer Assistance Unit at 1-800-457-4584.
- Providers can electronically submit Medicare-processed claims that do not automatically cross over or have been denied. See the [Claim Submission and Processing](#), [Electronic Data Interchange](#), and [Provider Healthcare Portal](#) modules for additional information.
- Medicare Part D pharmacy claims do not cross over.
- Medicare and Medicare Replacement Plan noncovered charges are not considered crossover claims.
- Any Part B crossover claim that is submitted on paper **must** also include the *IHCP TPL/Medicare Special Attachment Form* that itemizes Medicare paid amounts, coinsurance or copayment, deductible, and blood deductible at the detail level. The form and instructions are available on the [Forms](#) page at indianamedicaid.com.

Medicare Replacement Plan Claims

Medicare Replacement Plan claims are processed as Medicare crossover claims. The IHCP reimburses covered services for Medicare crossover claims only when the Medicaid-allowed amount exceeds the amount paid by Medicare. If the Medicaid-allowed amount exceeds the Medicare Replacement Plan paid amount, the IHCP reimburses using the lesser of the coinsurance or copayment plus deductible or the Medicaid-allowed amount minus the Medicare Replacement Plan paid amount. This change also affects claims paid at zero because the amount allowed has been allocated to the member's deductible.

For a Medicare Replacement Plan claim to process as a crossover claim, providers must include additional information. The individual Medicare coinsurance or copayment and deductible must be reported for each detail on the claim. The Medicare Replacement Plan paid amount, meaning the actual dollars received from Medicare, must also be reported as a total amount at the header and for each individual detail. For paper claims, these amounts must be reported in the respective locations on the *IHCP TPL/Medicare Special Attachment Form*, available on the [Forms](#) page at indianamedicaid.com.

All institutional claims must identify information from the Medicare Replacement Plan EOB in the value code fields (fields 39a-41d on the *UB-04* claim form). The following value codes must be used, if applicable, along with the appropriate dollar or unit amounts for each:

- Value Code A1 – Medicare deductible amount
- Value Code A2 – Medicare coinsurance or copayment amount
- Value Code 06 – Medicare blood deductible amount

In addition, field 50A must indicate Medicare as the payer and field 54A must contain the Medicare Replacement Plan paid amount, meaning the actual dollars received from Medicare. (Do not include the Medicare-allowed amount or contractual adjustment amount in field 54A.)

See the *Medicare Crossover Claims* section of the [Claim Submission and Processing](#) module for more information about completing these fields, as well as instructions for entering corresponding information in the Portal claim.

Medicare-denied services are not crossover services. If a claim has been denied by the Medicare Replacement Plan, the EOB or RA must be attached to the claim with “**Medicare Replacement Plan**” **written on the top of the attachment**. Medicare-denied services must be filed on a separate claim from paid services, and the appropriate EOB or RA must be attached for reimbursement consideration. For Medicare-denied services billed via the Portal, the Medicare Replacement Plan EOB may be uploaded as an attachment to the claim, or sent separately by mail.

Waiver Liability Considerations Related to Medicare

For members with waiver liability who have not met their liability for the month, Medicare crossover claims credit the waiver liability with the combined sum of the amounts shown as the coinsurance or copayment, blood deductible, and deductible.

- The billed amount of a crossover claim cannot be used to credit waiver liability.
- The coinsurance or copayment and deductible amounts for Medicare Part A claims are prorated, based on the number of days billed.
- Medicare Part B claims spanning more than one month are credited to the month of the first date of service.
- Coinsurance or copayment and deductible amounts on crossover claims for members who have *only* Qualified Medicare Beneficiary coverage (QMB Only) do not credit waiver liability.

In some instances, such billing for inpatient care, claims must include span dates. The claim types and the methodology used to credit waiver liability for each type are as follows:

- **Institutional/837I/UB-04 – Inpatient:** Inpatient claims with dates of services spanning more than one month are prorated on a daily basis, not counting the discharge date. Waiver liability is credited in each month based on the number of days of service reported on the claim for each month minus the day of discharge. The reimbursement is based on the total claim allowed minus the sum of the waiver liability credits.
- **Institutional/837I/UB-04 – Outpatient:** Outpatient hospital claims spanning more than one month are credited to waiver liability based on individual dates of services, as reported on the detail lines of the claim.
- **Professional/837P/CMS-1500:** Medical claims with dates of services spanning multiple months are credited to waiver liability on the month of the first date of service.

For detailed crossover claim billing procedures, see the [Claim Submission and Processing](#) module.

Prior Authorization

PA is not required for members with Medicare Part A or Part B coverage if the services are covered (in whole or in part) by Medicare. Services not covered by Medicare or Medicare Replacement Plans are subject to normal PA requirements.

Medicare Noncovered Services

Claims for services not covered by Medicare must be submitted to the IHCP using standard claim-processing procedures and include a copy of the Medicare RA or EOMB. These claims are treated like any other TPL claim.

Certain services are excluded and never covered by Medicare; therefore, the IHCP can be billed first for these services, bypassing the requirement to bill Medicare first. This requirement applies to **Medicare supplements**, as well. Otherwise, IHCP benefits can be paid to the provider of services only after Medicare payment or denial.

Other Third Party Liability Resources

If the dually eligible member has other insurance on file covering services not covered by Medicare, the other insurance resources must be billed before the IHCP.

Covered and Noncovered Services

In some instances, provider charges include Medicare covered and noncovered services. Providers bill all Medicare services to the IHCP according to the instructions in the [Claim Submission and Processing](#) module.

Retroactive Medicare Eligibility

The IHCP performs an automated review of the member TPL coverage files to identify Medicare coverage added with a retroactive effective date. When such coverage is identified, all claims paid by the IHCP, when Medicare should have paid as primary, are reported back to the providers of service. Providers receiving these reports must refund the IHCP and bill Medicare according to instructions on the letter accompanying the reports.

HMS, on behalf of DXC, initiates the quarterly Medicare recovery project. Direct questions about the Medicare recovery project to the HMS Medicare Project Unit at 1-877-264-4854.

Coordination with Commercial Plans

Specific guidelines must be followed to receive payment from the IHCP when submitting claims for a member enrolled in any of the following plans:

- A private preferred provider organization (PPO) plan
- A preferred hospital network (PHN) plan
- A private health maintenance organization (HMO)

Third-Party Carrier Copayments and Deductibles

The IHCP reimburses providers for copayments, deductibles, and services not covered by commercial plans incurred by IHCP members under a capped arrangement.

The provider must indicate on all claims the amount paid by the PPO, PHN, or HMO in the appropriate TPL field on the claim form. The net charge billed to the IHCP is only the deductible or copayment.

Example: A member receives services from an approved network provider and incurs a \$25 copayment for a routine office visit. Assuming the provider's usual and customary rate (UCR) for the service is \$35, the provider should bill the visit to the IHCP as follows:

- The provider indicates the UCR on the professional claim and indicates TPL in the amount of \$10, resulting in a net charge to the IHCP of \$25.
- When billing for services not covered under the member's plan, the provider bills the IHCP its UCR amount and indicates zero (\$0) in the TPL amount on the professional claim. The provider must attach a copy of the statement from the capped plan indicating the service is not covered.

Services Rendered by Out-of-Network Providers

The IHCP requires a member follow the rules of his or her primary insurance carrier. The IHCP does not reimburse for services rendered out of another plan's network unless the service is court ordered. Supporting documentation must be attached to the claim when it is submitted for reimbursement. Examples of court orders are alcohol or drug rehabilitation, anger counseling, and so forth.

If the primary insurance carrier requires the member be seen by in-network providers or it will deny payment, the IHCP will not reimburse for claims denied by the primary carrier because the member received out-of-network services. A provider cannot use the *90-day provision* to circumvent this policy.

If the primary carrier pays for out-of-network services at the same rate as in-network services or at a reduced rate, the provider may submit the bill to the IHCP. If the primary insurance carrier pays for out-of-network services but does not pay a particular bill in full due to a deductible or copayment, the provider may still submit the bill to the IHCP. If the claim is allowed by the primary carrier but no payment was made due to deductible or copayment, this information must be indicated on the claim form, and documentation from the carrier noting the deductible or copayment amount must be attached to the claim.

See the [Claim Submission and Processing](#) module for additional information about submitting this information electronically.

The rules described previously apply only to fee-for-service Medicaid claims processed by DXC. For information about payment of managed care claims, contact the member's MCE.

Reporting Personal Injury Claims

Providers are asked to notify the TPL Casualty Unit if a request for medical records is received from an IHCP member's attorney about a personal injury claim, or if information is available about a personal injury claim being pursued by an IHCP member. When notifying the TPL Casualty Unit, include the following information:

- IHCP member's name
- IHCP Member ID
- Date of injury
- Brief description of injury
- Stop treatment date
- Insurance carrier information
- Attorney's name, telephone number, and address, if available

To assist providers in submitting this information, the TPL Casualty Unit has developed the *Provider TPL Referral Form*, available on the [Forms](#) page at indianamedicaid.com. However, use of this form is not required.

Providers can submit the information via the Portal using the category TPL Update or by mail, telephone, fax, or email using the following contact information:

IHCP TPL Casualty Unit
P.O. Box 7262
Indianapolis, IN 46207-7262
Toll-Free Telephone: 1-800-457-4584
Fax: (317) 488-5217
Email: INXIXTPLCasualty@hpe.com

Third Party Liability Inquiries

As described in this module, providers are required to bill all other health insurance carriers prior to billing the IHCP, except for programs for which the IHCP is primary. *Indiana Administrative Code 405 IAC 1-1-3, Claim Filing/Third Party Liability*, provides details of other insurance in relation to the IHCP.

Providers have access to the most current insurance billing information through the EVS options (Portal, IVR system, or 270/271 electronic transactions), as described in the [Identifying Third Party Liability](#) section of this module.

In addition, providers can direct TPL-related questions to the TPL Unit. The TPL Unit maintains TPL files for IHCP members and is available to assist providers with determining other insurance resources. To discuss third-party insurance issues, providers should contact the TPL Unit using the following telephone numbers:

IHCP TPL Unit
Toll-Free Telephone: 1-800-457-4584
Fax: (317) 488-5217
Hours: 8 a.m. to 6 p.m. (Eastern Time) Monday through Friday, except holidays

When calling the TPL Unit, have the Member ID available.

Examples of calls handled by the TPL Unit include the following:

- The EVS provides a significant amount of TPL information to assist with billing procedures. The EVS provides complete address information for the 100 largest insurance companies, but provides only an identification number for smaller insurers. The TPL Unit can use the identification number to research reference material and provide the smaller insurer's name and address.
- The TPL Unit can provide information about the coverage types and policy effective dates when a question about coverage dates versus the dates of service occurs.

Note: The TPL Unit cannot provide information about benefits covered under each coverage type. Providers should contact the insurance carrier for this information.

The TPL Unit can assist with Medicare-related information affecting the IHCP billing process. However, there are limitations to the TPL Unit's assistance with Medicare issues. Members' Medicare information is automatically updated through information provided by an outside source. Update information from members' Medicare database is taken from Medicare files and compared to IHCP data. *CoreMMIS* automatically makes the changes. Following these regularly scheduled updates, the IHCP information matches the Medicare file information. When errors occur, corrections are coordinated with local county offices of the FSSA Division of Family Resources (DFR). When the county office confirms the corrections, the county office updates the ICES accordingly.

Member Third Party Liability Update Procedures

The caseworker or eligibility worker enters other insurance information in the ICES when a member is enrolled in the IHCP. The information is transmitted electronically overnight to *CoreMMIS*. The next evening, eligibility information is transmitted from DXC for claim processing. The county office and the TPL health analysts update TPL information.

If a provider receives information from an insurance carrier that is different from the information the EVS lists for a member (for example, when a policy is terminated, a member was never covered, or the insurance carrier has a different billing address than on the TPL resource file), the provider can forward the information to the TPL Unit. Information about additional insurance coverage or changes in insurance coverage must be relayed to the TPL Unit as soon as possible to keep member files current and to assist in accurate provider claim processing. The provider does not need to delay filing a claim. However, notifying the TPL Unit of updated TPL data makes subsequent billing easier.

Forward copies of any documentation from another carrier that substantiates the need for changes to a member's TPL file, including the following:

- EOP
- EOB
- RA
- Member's third-party insurance card
- Letter from the carrier
- Any other correspondence to maintain the member's TPL file

Include the member's name, Member ID, and any other pertinent member or carrier data on all correspondence. Send information about other insurance coverage to the following address:

IHCP TPL Unit
Third Party Liability Update
P.O. Box 7262
Indianapolis, IN 46207-7262
Toll-Free Telephone: 1-800-457-4584
Fax: (317) 488-5217
Email: INXITPLRequests@hpe.com

Note: Do not send TPL-related claims or claim attachments to the TPL Unit for processing. TPL-related claims must be submitted using standard claim-processing procedures. The TPL Unit does not process claims. For billing instructions and claim processing, see the [Claim Submission and Processing](#) module.

Automated TPL resource update letters and questionnaires are sent to insurance carriers, members, and providers when a third-party payment is reported on a claim and there is no record of the coverage in *CoreMMIS*. These questionnaires request updated TPL information. Upon receiving a TPL questionnaire, providers have 15 days to return the completed questionnaire to the TPL Unit for verification.

Providers can access the *Medicaid Third Party Liability Questionnaire* and *Third Party Liability Accident/Injury Questionnaire*, as needed, from the [Forms](#) page at indianamedicaid.com. When a questionnaire is completed, the provider can attach the form to a secure correspondence message in the Portal or email, fax, or mail it to the TPL Unit. Providers are encouraged to use these forms to provide any and all information available for investigation, including information about additional insurance or terminated insurance. The TPL Unit investigates the information submitted and makes any changes needed to *CoreMMIS*.

The TPL Unit reviews and verifies all IHCP member insurance information provided, coordinates with the carrier if required, and makes necessary changes to the TPL file in *CoreMMIS* to accurately reflect member TPL coverage. *CoreMMIS* transmits information electronically to ICES and appropriately incorporates member TPL file updates. Providers can confirm the update with the EVS or by calling the TPL Unit. Allow 20 business days from the date of receipt for the IHCP member's file to be updated.