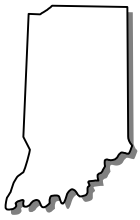
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

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To: All Providers

Subject: Important Information About Third Party Liability Procedures

Overview

This bulletin clarifies situations where many Indiana Health Coverage Programs (IHCP) members have insurance that could be available to cover medical claims in addition to the IHCP. Insurance can be in the form of a commercial group plan through the member's employer, an individually purchased plan, Medicare, or insurance available as a result of an accident or injury, such as a medical payments provision in a homeowners or automobile liability policy, or a worker's compensation policy.

Pursuant to federal regulations, the IHCP is always the payer of last resort. *Payer of last resort* means that if an IHCP member has any other resource available to pay for, or help pay for, the cost of his or her medical care, that resource must be used before the IHCP. Consequently, the IHCP supplements all other available coverage, and is primarily responsible for paying only the medical expenses that other insurance does not cover.

Assignment of Benefits Authorization

During the IHCP member's medical appointment, providers must ask if the member has other insurance coverage. If so, the provider must obtain information about the other policy and provide it to the IHCP either by written notice, phone call, inclusion on a claim form, or on a Third Party Liability (TPL) questionnaire.

Additionally, the provider must request that the IHCP member sign an *Assignment of Benefits Authorization* form. The form should state that the member authorizes the insurance carrier(s) to reimburse the provider directly.

When a provider determines that a member has an available TPL resource, the provider is required to bill that resource before billing the IHCP. The provider must include the *Assignment of Benefits Authorization* form when submitting the member's claims or should otherwise ensure the carrier is aware of the assignment of benefits. If the Eligibility Verification System (EVS) indicates TPL resource information and the provider submits a claim to the IHCP without documentation that the third party resource was billed, federal regulations require that the claim be denied. The only exemptions from this requirement are medical services provided for prenatal care, preventive pediatric care, some Medicaid Rehabilitation Option (MRO) services, and Home and Community-Based

Services Waiver. Providers rendering any of these exempted services are still permitted, but are not required to bill available third party resources.

Providers Billing Responsibilities

If after billing the appropriate third party, that source denies payment or pays less than the IHCP would have paid, the provider can bill the IHCP. If the primary insurer denies payment, a copy of the denial such as an explanation of payment (EOP), explanation of benefits (EOB) or remittance advice (RA), or a copy of the statement or correspondence from the third party carrier, must be attached to the IHCP claim or the IHCP will deny the claim.

> *Note: When billing the IHCP for the difference between the amount billed and the primary insurer's payment, the IHCP will pay the provider the difference only up to the IHCP allowable charge. If the primary insurer payment is equal to or greater than the IHCP allowable charge, no additional payment will be made. In this instance, the provider is not required to send the claim to the IHCP for processing. Providers must not bill members for any balance.*

If a provider is aware that a member has been in an accident, the provider could choose to either bill the IHCP or to pursue payment directly from the liable party or liability carrier. If the IHCP is billed claims for services that are accident related, *accident* must be noted on the claim form by marking the appropriate box for question **10b** on the Centers for Medicare & Medicaid Services (CMS)-1500 claim form or listing the appropriate occurrence code on the UB-92 claim form. Providers choosing to initially pursue payment from the liable third party should remember that claims submitted to the IHCP will deny if filed after the one-year filing limit.

In addition, 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 returned within 30 days. The refund is not to exceed the amount of the IHCP payment to the provider. An adjustment form must be completed and submitted to the Claims Adjustment Unit. Adjustment forms are available on the IHCP Web site at www.indianamedicaid.com.

Payments by Third Parties and Application of the 90-Day Rule

If a provider is notified that an IHCP member has received reimbursement from a third party source that has not been refunded to the provider, **the provider can contact the insurance carrier and advise that payment was made to the member in error and request a correction and reimbursement be made to the provider.** The provider can send the other carrier a copy of the assignment of benefits. If this is unsuccessful, the provider can submit the claim to the IHCP with documentation of the denial by the third party source as discussed above. If no response is received from the third party within 90 days of the provider's billing date, providers should follow the procedure outlined below to submit the claim to the IHCP.

In any circumstance where the third party fails to respond within 90 days of the provider's billing date, the claim can be submitted to the IHCP for payment consideration. Documentation substantiating the provider's efforts to obtain a response from the third party must be attached to the claim. As examples of documentation, the provider should attach to the claim either copies of unpaid bills or statements sent to the third party noting the date of the billing attempt and the words "no response after 90 days" at the top of the claim, or written notification from the provider giving the dates of attempts to bill and explaining the third party failed to respond within 90 days from the billing date.

Additionally, when a provider has proof that an IHCP member has received reimbursement from a third party source that has not been refunded to the provider, the provider may wish to report the IHCP member to the Medicaid Fraud Unit, and/or to the member's caseworker as receipt of the payment could affect the member's eligibility. However, remember that under federal and state law, there is no exception that would allow a provider to bill a member under these circumstances**. A provider can bill a member for copayments only**.

As part of the eligibility process, the IHCP member must sign an *Assignment of Rights* form, that provides for third party payments to be made directly to the IHCP. The IHCP member must also agree to cooperate with the IHCP to obtain payment from third party resources, including authorizing providers and insurers to release necessary information to pursue third party payment.

For additional information about third party liability, refer to *Chapter 5* of the *IHCP Provider Manual.*

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