Title 23: Division of Medicaid

Part 306: Third Party Recovery

Chapter 1: Third Party Recovery

Rule 1.1: Definitions

The Division of Medicaid defines:

A. Third party as any individual, entity or program that is, or maybe, liable to pay all, or part of the expenditures for medical assistance furnished under the State Plan.

B. Cost Avoidance as a method of avoiding payment of Medicaid claims when other insurance resources are available to the Medicaid beneficiary.

C. Pay and Chase method as reimbursing the provider for a specific covered service and pursuing recovery of the payment from a third party source.

D. Casualty Cases as claims that involve the treatment of injuries arising out of vehicular collision, industrial accident, product liability, malpractice cases, etc. in which collection from the third party may be contingent upon legal action.

E. Preferred provider organization (PPO) as a medical care arrangement in which medical professionals and facilities provide services to subscribed beneficiaries at reduced rates. PPO medical and healthcare providers are called preferred providers.

Source: 42 CFR §§ 433.136, 433.137, 433.145; Miss. Code Ann. §§ 43-13-121, 43-13-125, 43-13-305, 43-13-311, 43-13-313.

History: Revised eff. 04/01/2021; Revised Miss. Admin. Code Part 306, Rule 1.1.A. eff. 06/01/2015.

Rule 1.2: Provider Requirements

A. Medicaid providers must:

    1. Identify and report any third party source to the Division of Medicaid.

    2. Cooperate with the Division of Medicaid in the recovery of payments from the third party source. Providers will be held liable, to the extent of the Division of Medicaid’s payment, for failure to cooperate with the Division of Medicaid’s staff when they have knowledge of third party coverage.

    3. Accept either the third party payment or the Division of Medicaid's payment for services provided as payment in full.

B. Providers cannot refuse to furnish Medicaid covered services to a beneficiary because of a third party's potential liability for the services.

C. The beneficiary is not liable for any more than the co-payment that has been established by the Division of Medicaid for services rendered.

D. The Division of Medicaid may reduce any payment amount otherwise due the provider by up to three (3) times the amount incorrectly received from the beneficiary if the provider is found in violation of Miss. Admin. Code Part 306, Rule 1.3.C.

E. The provider must obtain a signed statement from the beneficiary if beneficiary indicates they no longer have third party insurance. The statement must include the name of the insurance company, the policy number, and the beginning and ending date of coverage and must be submitted to the Division of Medicaid.

F. Requests for Medical Information

1. The Division of Medicaid requires that any medical information concerning a Medicaid beneficiary released by a provider must contain the following information:

    a) The person is or was a Medicaid beneficiary at the time the services were rendered,

    b) His/her Medicaid identification number, and

    c) The claim has been submitted to the Division of Medicaid or has been paid by the Division of Medicaid.

2. If a provider receives a request for medical claims or other medical information from a Medicaid beneficiary or someone acting on the beneficiary's behalf, such as an attorney, insurance company, etc., release of said information will be restricted as follows:

    a) Copies of claims or medical records requested by a beneficiary or the beneficiary’s parent, guardian or legal representative must be furnished if the provider receives a written authorization for release of the information.

    b) Information requested by an insurance carrier with whom a claim has been filed must be furnished directly to the carrier.

    c) The provider must comply promptly to a request for medical information from a Medicaid beneficiary's attorney once a signed authorization from the beneficiary has been received.

    d) Medical records or billing information requested by the Disability Determination Service (DDS) or a school system, for educational evaluation, must be sent directly to the requester. Notification to the Division of Medicaid is not necessary.

Source: 42 CFR §§ 433.136, 433.137, 433.145; Miss. Code Ann. §§ 43-13-121, 43-13-125, 43-13-305, 43-13-311, 43-13-313.

History: Revised eff. 04/01/2021.

Rule 1.3: Billing

A. Providers must file a claim with the third party prior to billing Medicaid. Documentation of payment or denial must be submitted to the Division of Medicaid with the claim including but not limited to:

    1. The explanation of benefits (EOB),

    2. Any amount paid by the third party, and

    3. If the claim is denied by the third party, the reason for the denial.

B. In the event there is no response from the third party source in sixty (60) days from the date of submittal, the provider may submit the claim to Medicaid as directed in Miss. Admin. Code Part 306, Rule 1.3.M.

C. When a Medicaid beneficiary is covered by a private insurance policy whose administrator has a preferred provider organization (PPO) in which the Medicaid provider:

    1. Does not participate, the provider must submit the claim to the Division of Medicaid with a statement indicating the provider is not a member of a particular PPO, the insurance company name and address, and specific third party filing data and follow the Division of Medicaid's instruction regarding the claim.

    2. Does participate, the Division of Medicaid does not reimburse for the difference between a third party payment and the provider's charges as the provider has agreed to accept the PPO's payment as payment in full.

D. The provider must obtain or make reasonable efforts to obtain an assignment of benefits from the beneficiary prior to billing third party insurance.

E. If a provider is unable to obtain an assignment of benefits, the provider must submit the claim to the Division of Medicaid and include the third party information.

F. The provider must file and obtain Medicare payment for the service or obtain a Medicare denial before the Division of Medicaid can pay the claim.

G. If the beneficiary has Medicare A, B, and/or C and private insurance, the provider must bill Medicare and the private insurer prior to submitting the claim to Medicaid.

H. If Medicare coverage is found after Medicaid has paid the claim, the Division of Medicaid will recoup the payments from the provider and the provider must bill Medicare.

I. The provider must attach the EOB from the third party to the claim submitted to the Division of Medicaid.

J. The provider must make every effort to acquire payment from the third party source before filing the claim with Medicaid. When a provider bills a third party insurer and does not receive a response, the provider must:

   1. Submit a written inquiry to the third party if no response has been received within thirty (30) days from the date of original claim submission,

   2. File the claim with the Division of Medicaid, attaching a completed copy of the "TPL Edit Override Attachment: No Response Form" if no response has been received in sixty (60) days from the date of original claim submission. This form must be signed and dated by the provider or an authorized provider representative. The claim is adjudicated according to the Medicaid payment policies.

K. If a provider receives payment from a third party and the Division of Medicaid for the same service, the provider must refund the full Medicaid payment and may refile the claim with Medicaid if the third party payment is less than Medicaid fee.

L. For hospitals having a PPO contract with an insurance company with payments subject to retroactive adjustments, the amount to be reported as third party liability on the claim must be as follows:

   1. If the third party insurer pays a final amount, which is not subject to change, then the third party payment should be reported as the third party liability amount.

   2. If the third party insurer makes an interim payment, which may be adjusted or settled later based on contractual agreements with the provider, the maximum third party reimbursement should be reported as the third party liability amount.

      a) If future settlements with other third party insurers result in the provider refunding amounts to the third party insurer, the Division of Medicaid makes no additional payment.

      b) If future settlements with third party insurers result in the third party insurer making an additional payment to the provider, the following should be adhered to:

         1) If third party liability amounts have been reported as benefits as required in item Miss. Admin. Code Part 306, Rule 1.3.O.2, no amounts are due the Division of Medicaid.

         2) If third party liability amounts have been reported at less than the maximum

amount payable by the third party insurer, the provider will be liable for the overpayment by the Division of Medicaid, plus interest and penalty when applicable.

Source: 42 CFR §§ 433.139, 433.145-433.148; Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2021.

Rule 1.4: Casualty Cases

A. In the event a provider has knowledge that an individual is a Medicaid beneficiary and is receiving or has received health care services which may be covered by Medicaid as a result of the accident or incident, the provider is prohibited from:

    1. Demanding any payment from the Medicaid beneficiary or his representative, or

    2. Pursuing collection of any type against the Medicaid beneficiary or his representative.

B. A provider who has filed and accepted Medicaid payment and who fails to notify the Division of Medicaid that the provider has also received payment from a third party will be referred to the Medicaid Fraud Control Unit for investigation/prosecution for any possible violation of federal or state laws.

C. A provider may be excluded from participation in the Medicaid Program if the provider:

    1. Accepts payment from a third party and fails to comply with the provisions of this policy, or

    2. Fails to refund to Medicaid a duplicate payment within thirty (30) days of receipt of the duplicate payment.

Source: Miss. Code Ann. §§ 43-13-121, 43-13-313.

History: Revised eff. 04/01/2021.

Rule 1.5: Reimbursement

A. The Division of Medicaid must be billed as the payor of last resort.

B. Providers are required to file a claim with the third party prior to filing with the Division of Medicaid except in the following circumstances:

    1. Preventive pediatric service, including EPSDT services, claims must be paid in accordance with the usual payment schedule.

    2. Covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program must be paid in accordance with the

usual payment schedule.

C. Medicaid will not pay for services denied by Medicare due to lack of medical necessity but may pay claims denied for other reasons as long as the services are covered under the Medicaid program.

Source: 42 U.S.C. § 1396(a)(25); Miss. Code Ann. § 43-13-121.

History: Revised eff. 04/01/2021.