COLORADO
Department of Health Care Policy & Financing

Third Party Liability and Coordination of Benefits Frequently Asked Questions

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This document is intended to provide guidance to providers serving Medicaid Members who have additional sources of insurance coverage.

Q1. What is Third Party Liability (TPL)?

A1. Under Federal regulation (*See* 42 CFR Part 433 Subpart D), "Third Party Liability" (TPL) means that payment is the responsibility of a third party other than the individual or the Medicaid Program. Medicaid is the payor of last resort. By law, virtually all other sources of health coverage must pay claims under their policies before Medicaid will pay for the care of an eligible individual.

Q2. What is Coordination of Benefits (COB) and how does it work in general?

A2. Coordination of Benefits refers to the practice of ensuring that a claim is paid by the payor that is legally responsible for paying a claim as Primary with any secondary parties paying Secondary. Coordinating benefits makes sure that the correct party pays first by, 1) cost-avoiding (aka denying) claims where a known other party should be paying and/or 2) cost-recovering a claim that Medicaid erroneously paid that should have been paid by another party.

Q3. Where can I find all of the coverages where a Medicaid Member is enrolled?

A3. Providers have multiple options for establishing a Member's coverage. A Medicaid Member has a primary responsibility for disclosing all coverages in which they are enrolled. Additionally, a provider should verify both Medicaid and other coverage in the Medicaid Provider Portal (*See* Accessing Eligibility Verification Information).

The Medicaid Provider Portal captures other coverage information from the Medicaid Management Information System (MMIS), the Department of Health Care Policy & Financing's (HCPF) system of record for TPL. TPL data is added to the MMIS from multiple sources under a hierarchy defined by HCPF and sources populate data into the system in different cadences.

Any additions of coverage or updates to existing coverage that are manually entered into the Provider Portal by providers are reviewed by HCPF's Fiscal Agent staff before changes are accepted. The Fiscal Agent, Gainwell Technologies, is responsible for enrolling providers, providing billing assistance, etc. (*See* Fiscal Agent Responsibilities). The manual review occurs weekly so providers will not immediately see changes they have made. HCPF is working on enhancements to the Provider Portal processes to increase the frequency of manual reviews and to automate additions and updates of the TPL information.

Q4. Are Children's Health Plan (CHP), MCOs and other "Medicaid" Plans treated the same as "Medicaid - Title XIX" for purposes of TPL and coordination of benefits?

A4. All programs and benefit aid types shown in the Medicaid Provider Portal are subject to coordination of benefits and remain the payor of last resort. Generally, Members with Title XIX Medicaid are able to have commercial insurance and/or Medicare.

If there is no other coverage for a Member, providers should follow standard Medicaid billing practices. Providers can find additional guidance regarding specific coverage types by viewing the Verifying Specific Coverage Types document. Providers can also reference this Verifying Eligibility Quick Guide for additional information on Member eligibility.

Q5. What can I do if I discover a Member has additional coverage after a service is provided?

A5. A provider should bill the Primary payor first under standard TPL policies. If the provider has already received payment from Gainwell or the Managed Care Entity (MCE) prior to learning of the other coverage, the provider should immediately bill the other coverage for payment as Primary. If the provider receives payment from the other carrier, they need to return their Primary payment from Gainwell or the MCE. The provider should then rebill Gainwell or the MCE as Secondary.

> *If the provider receives a denial for being out of network with the Primary payor, they should not submit the claim for full payment to Gainwell or the MCE. Please see the response to Question 9 below.

Providers contracted with an MCE should follow the applicable published timely filing guidelines for that MCE when resubmitting a claim. Providers can resubmit a Primary or Secondary fee-for-service claim to Gainwell for payment within 60 days from the date of a void or retraction. (*See* Timely Filing and Resubmissions)

Q6. Am I allowed/required to collect a deductible, coinsurance, and/or copayments for the Primary Insurance from a Member who also has Medicaid coverage?

A6. No. A provider is only allowed to collect appropriate Medicaid copays. There are no Medicaid copays for behavioral health services.

Providers cannot bill Members for the difference between commercial health insurance payments and their billed charges when Health First Colorado or an MCE does not make additional payment. The provider also cannot bill Members for copay/deductibles assessed by another payor.

Q7. Can I bill a Member for services that are not covered by Medicaid?

A7. A Medicaid Member may choose to privately pay for services that are NOT covered by Medicaid, including services determined not to be medically necessary. Failure by the provider to follow the proper process to obtain a prior authorization does not mean that a service is not covered by Medicaid or medically necessary. Additionally, if a provider chooses not to enroll with Medicaid or contract with an MCE, that does not qualify as documentation to bill a Member for services, nor does it deem a service as uncovered or not medically necessary.

A Member is responsible for payment for the items provided or services rendered only when there is a written agreement in place. This written agreement is distinct from the standard consent form included in documentation a Member completes when they establish care with a provider. This agreement should, at a minimum, be signed prior to services being rendered and include a statement of the specific services being rendered, an explanation that the services are not covered by Medicaid, and that Medicaid cannot reimburse the Member for those services directly, and the full amount the Member will be responsible for paying. *See* C.R.S. § 25.5-4-301(1)(a)(1).

Q8. What if I am contracted with an MCE but not contracted with the Primary Insurance?

A8. A provider must be contracted with a Member's Primary Insurance in order to comply with TPL standards. A provider is required to bill the Primary Insurance and cannot submit claims to Gainwell or the MCE without TPL documentation. Claims that

are submitted without TPL documentation will be denied by both Gainwell and an MCE.

Q9. Can a provider who 'Opts Out' of Medicare with CMS serve Members who are dually eligible with Medicare and Medicaid?

A9. No. A provider must be contracted with a Member's Primary Insurance in order to comply with TPL standards. A provider who 'Opts Out' of Medicare would not be able to properly bill Medicare for covered services as the Primary coverage. Additionally, this provider would not be able to bill Medicaid without the appropriate TPL documentation, and the provider would not be able to bill the Member.

Q10. What steps should I take once I have identified all of a Medicaid Member's coverages?

A10. There are three (3) steps to getting reimbursement for services provided to a Medicaid Member with multiple health insurance coverages:

1) Bill the Primary Insurance for payment.
2) Bill the Secondary for payment with the Primary Insurance TPL payment and cost sharing information.
3) Store the other coverage information within the provider's Member record and claim payment system(s) for use in future claim submissions.
   a) Add the other coverage to the Medicaid Provider Portal. (*See* the Provider Web Portal Quick Guide: Adding and Updating Third-Party Liability (TPL) Information.
   b) Update the provider records and Medicaid Provider Portal as coverages change.

Example:

Provider submits claim to Primary Insurance	$200.00
Primary Insurance pays provider	$80.00
Provider submits same claim to Gainwell or MCE - Includes TPL information with claim showing total paid to provider by Primary Insurance	$200.00 $80.00
Gainwell refers to fee schedule MCE refers to contracted rate amount	$84.00
Provider is paid the allowed rate less the TPL payment	$4.00
Provider receives total reimbursement from Gainwell/MCE	$4.00
Provider stores the other coverage for future billings	

Q11. What happens when Medicaid has issued a Directed Payment for a service?

A11. The MCE is required to reimburse a provider a minimum of the Directed Payment published rate. The Directed Payment reimbursement will still follow

general TPL guidelines where all payments from other coverage will be deducted from the amount of the Directed Payment rate.

Example:

Provider submits claim to Primary Insurance	$200.00
Primary Insurance pays provider	$80.00
Provider submits same claim to Gainwell or MCE - Includes TPL information with claim showing total paid to provider by Primary Insurance	$200.00 $80.00
Gainwell refers to fee schedule MCE refers to Directed Payment rate amount	$250.00*
Provider is paid the allowed rate less the TPL payment	$170.00
Provider receives total reimbursement from Gainwell/MCE to ensure provider receives the PPS/Directed Payment amount	$170.00
Provider stores the other coverage for future billings	

**This illustrates a provider underbilling for services but receiving the full Directed Payment amount as required.*

Q12. Are there any instances when a provider should <u>not</u> bill the Primary Insurance first?

A12. Providers should always bill a Member's Primary Insurance prior to billing Medicaid or the MCE. Covered services for Primary Insurance policies vary by plan design. Billing the Primary Insurance allows a provider the opportunity to collect a higher reimbursement for covered services and also facilitates proper coordination of benefits, especially if the service's coverage is questionable. When the Primary Insurance does not cover the service provided, a provider can submit the claim to Gainwell or the MCE.

HCPF recognizes that some behavioral health services are not routinely covered by Primary Insurance policies and may only be covered by Medicaid or the MCE. Behavioral health providers, can review services determined to be covered by Medicare, Medicaid and commercial insurances in Appendix I in the State Behavioral Health Services (SBHS) Billing Manual.

For additional questions regarding TPL and COB policies, please send your inquiries to thirdparty_liability@state.co.us.