Third Party Liability and Recovery Guidance

Medicaid Managed Care Organizations

MANAGED CARE REQUIREMENTS

Managed Care Contracts:

STAR: Section 8.2.8 Third Party Liability and Recovery and Coordination of Benefits
STAR+PLUS: Section 8.1.29 Third Party Liability and Recovery and Coordination of Benefits
STAR Kids: Section 8.1.31 Third Party Liability and Recovery and Coordination of Benefits

Medicaid coverage is secondary when coordinating benefits with all other insurance coverage, unless an exception applies under federal law. Medicaid coverage will pay benefits for covered services that remain unpaid after all other insurance coordination of benefits has occurred.

The following requirements apply to Medicaid managed care organizations (MCOs) when reimbursing providers for Medicaid services provided to a MCO member that **has other insurance coverage**:

1) **Medicaid MCO Network Providers** - the MCO must pay the difference between the reimbursed amount from the third party insurance up to the agreed MCO-contracted rate for Covered Services. This requirement also applies to provider reimbursement when the MCO network provider bills the third party insurance, but the third party insurance denies all or part of the payment because the MCO Network Provider is out-of-network under the third party insurance coverage.
2) **Medicaid MCO Out-of-Network Providers** - the MCO is not required to pay for Covered Services if the MCO member received services from an out-of-network Medicaid provider that is also out-of-network under the MCO member's third party insurance coverage.
   NOTE: For MCO members that **do not have other insurance**, the MCO is required to pay an out-of-network provider in accordance with HHSC's administrative rules regarding Out-of-Network payment (1 T.A.C. §353.4).

MCOs are responsible for establishing a plan and process for avoiding and recovering costs for services that should have been paid by a third party. The plan and process must be in accordance with state and federal law and regulations, including Section 1902(a)(25)(E) and (F) of the Social Security Act, which require MCOs to pay and later seek recovery from liable third parties: (1) for prenatal and preventive pediatric care, and (2) in the context of a state child support enforcement action.

NOTE: Third Party Liability (TPL) requirements for other managed care programs, such as STAR Health, Medicare-Medicaid Plan (MMP), Children's Health Insurance Program (CHIP), and Dental may vary some from the other STAR managed care programs. Please refer to TPL contract language specific to the other managed care programs not listed above.

BILLING REQUIREMENT EXAMPLES

Scenario	Response
Service is not covered by private insurance, but is covered by Medicaid.	Provider bills private insurance, receives explanation of benefits (EOB) denying coverage, then bills Medicaid MCO for the contractually agreed upon rate.
Service is covered under both private insurance and Medicaid, but deductible has not been met.	Provider bills private insurance, receives EOB showing payment has been applied to member's deductible, then bills Medicaid MCO for the contractually agreed upon rate.
Service is covered under both private insurance and Medicaid, and deductible has been met.	Provider bills private insurance, receives EOB and payment up to the agreed upon rate. The provider may bill Medicaid MCO *if* the private insurance reimbursement is lower than

	the contractually agreed upon Medicaid MCO rate; MCO pays the difference. If Medicaid MCO rate is lower, MCO is not required to reimburse.
Service is covered under both private insurance and Medicaid, private insurance denies claim because provider is out-of-network, but provider is enrolled as a network provider for Medicaid MCO.	Provider bills private insurance, receives Explanation of Benefits (EOB) denial, then bills Medicaid MCO for the contractually agreed upon rate, or any balance remaining up to the contractually agreed upon rate.

CO-PAYMENTS/DEDUCTIBLES/COINSURANCE

Providers cannot bill Medicaid-eligible individuals for co-payments, deductibles, or coinsurance for Medicaid-covered services. If an individual's private insurance does not cover a co-payment, deductible, or coinsurance, the MCO provider should bill the MCO for reimbursement of the co-payment, deductible, or coinsurance.

When billing for a deductible or coinsurance, the provider must include the EOB from the private insurance with the claim showing the payment amount was applied directly to the client's deductible or coinsurance. For billing a co-payment, the provider must include the co-payment code on the claim form in order to be eligible for reimbursement of the co-payment.

NOTE: See the next section (Other Sources) for specific rules regarding the prohibition of billing a Medicaid-eligible individual for Medicaid-covered services.

Providers should refer to the Texas Medicaid Provider Procedure Manual (TMPPM), Section 4.11, Client Eligibility, Medicare and Medicaid Dual Eligibility, when submitting claims related to dual eligibility. In most cases, Medicaid is the payer of last resort, but there are some exceptions based on services under each Medicare segment, Parts A, B, C, or D, in which an individual may be enrolled. The TMPPM, Section 4.11, provides more detailed information and billing instructions for each Medicare segment that will assist providers submitting claims for a dual eligible individual.

OTHER SOURCES

Texas Medicaid Provider Procedure Manual (TMPPM), Section 8 Third Party Liability (TPL):
Section 8.2 Verifying a Client's TPR (Third Party Resource):
Medicaid-eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered by Texas Medicaid. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to Texas Medicaid & Healthcare Partnership (TMHP) for any additional allowable amount.

Title 1, Texas Administrative Code, Chapter 354:
§354.2321 - Provider Billing and Recovery From Third Party Health Insurer:
(h) Providers are prohibited from submitting a bill, or other written demand for payment or collection of debt for any Medicaid-covered service from an individual who the provider knows or should know is a Medicaid eligible recipient or from the representative of a recipient, regardless of whether a claim for payment for the service is submitted to the Commission. This section does not prohibit a provider from submitting reasonable inquiries or requests for information to a recipient, or representative of a recipient to assist the provider in identifying a third party insurer. However, any inquiry which would lead a reasonable person to believe that the provider was making a demand for payment, or attempting to collect an unpaid debt, will bring the provider within the limitations and prohibitions as follows:
(1) If a provider attempts to recover any amount from a recipient for any Medicaid-covered service, the Commission may provide for a reduction of an amount otherwise payable to the provider in addition to referring the provider for investigation and prosecution for violations of state and/or federal Medicaid or false claims laws.
(2) The amount of the reduction may be up to three times the amount the provider sought in excess of the Medicaid payable amount.