INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Third-Party Liability

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of July 1, 2016 Published: October 25, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of July 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 18, 2017	*Core*MMIS update	FSSA and HPE
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3.0	Policies and procedures as of February 1, 2018 Published: April 26, 2018	Scheduled update	FSSA and DXC
4.0	Policies and procedures as of April 1, 2019 Published: September 10, 2019	Scheduled update: • Edited text as needed for clarity • Updated links to the new IHCP website • Added standard note box at beginning of module • Replaced *ADA 2006* references with *ADA 2012* • Removed statement about requirements being the same for all types of TPL from the *IHCP Third Party Liability Program* section • In the *Health Insurance* section, added a note about ICES transitioning to IEDSS, and updated contact information for TRICARE • In the *Liability Insurance* section, changed timely filing limit to 180 days and provided cross-references regarding reporting personal injury information and updating member TPL casualty information	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		• Updated the *Medicaid Coverage for Members with Medicare* section • Added hospice as an example of home health claims in the *Amount Paid: Claim- and Detail-Level Information* section; also added information urging providers to submit claims electronically • Updated fraud reporting contact information in the *Insurance Carrier Reimburses IHCP Member* section • Updated the *Retroactive Medicare Eligibility* section regarding the Medicare recovery project • Updated the information to include when reporting personal injury claim in the *Reporting Personal Injury Claims* section • Removed instruction to write on top of the paper claim in the *Third-Party Payer Fails to Respond (90-Day Provision)* section • Added a reference to exempted services in the *Third-Party Liability Inquiries* section	

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the IHCP Quick Reference Guide, available at in.gov/medicaid/providers.*
>
> *For updates to information in this module, see IHCP Banner Pages and Bulletins, available at in.gov/medicaid/providers.*

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 that 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, only four resources are not billed prior to IHCP:

- Victim Assistance
- First Steps
- Children's Special Health Care Services (CSHCS)
- Community and Home Options to Institutional Care for the Elderly and Disabled (CHOICE)

Because these four 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, that 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 or receiving Medicaid is considered to have automatically assigned his or her individual rights, and/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.

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.

  > *Note: The FSSA is in the process of transitioning from ICES to the Indiana Eligibility Determination and Services System (IEDSS). This change will not affect the appearance of the FSSA Benefits Portal for members and authorized representatives.*

- *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, homeowners' and/or 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 (*Core*MMIS).
- *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, as described in the *Third-Party Liability Update Procedures* section. The information is verified prior to updating *Core*MMIS. This form can be downloaded from the *Forms* page at in.gov/medicaid/providers in the *Third-Party Liability Forms* section.

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

> *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. For Indiana TRICARE claims, contact the east region contractor:*
>
> **TRICARE East**
> **Humana Military**
> **1-800-444-5445**
> **tricare-east.com**

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 2012* 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 cause 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 180-day 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 personal injury 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. See the *Reporting Personal Injury Claims* section for instructions.

To submit updates to the TPL casualty information on file for a member, providers and members can use the *Medicaid Third-Party Liability Accident/Injury Questionnaire*, as described in the *Third-Party Liability Update Procedures* section.

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 in.gov/medicaid/providers 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 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 Waiver (CIH Waiver)
- Family Supports Waiver (FSW)
- Aged and Disabled Waiver (A&D Waiver)
- Traumatic Brain Injury Waiver (TBI Waiver)
- Traumatic Brain Injury MFP Demonstration Grant (TBI MFP)
- Aged and Disabled MFP Demonstration Grant (A&D MFP)
- 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.

Identifying Third-Party Liability

Before rendering a service, providers must use the EVS to verify that the member is eligible. See the *Member Eligibility and Benefit Coverage*, *Interactive Voice Response System*, and *Electronic Data Interchange* modules for more information about these EVS options:

- Provider Healthcare Portal, accessible from the home page at in.gov/medicaid/providers
- 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 on file, including the health insurance carrier, policy numbers, and coverage type. 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.

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.

Coverage Types for Other Insurance

The EVS options identify the following coverage types for the member's other insurance:

- 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 type whether a *specific* service is covered. If a specific service does not appear to be covered by the identified 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 plan.

Medicaid Coverage for Members with Medicare

Members can have IHCP coverage under one or more benefit plans. For members who have **only** Qualified Medicare Beneficiary (QMB) coverage or **only** Specified Low-Income Medicare Beneficiary (SLMB) coverage, the IHCP pays the individual's Medicare premiums (and, for SLMB, Medicare deductibles and coinsurance or copayment) *but does not provide medical coverage*. These members are referred to as **QMB-Only** or **SLMB-Only**. 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 members who have QMB or SLMB coverage **and also** comprehensive Medicaid coverage (such as Full Medicaid or Package A – Standard Plan), the IHCP pays the Medicare premiums *and also maintains the role of secondary insurance payer*, or payer of last resort. These members, referred to as **QMB-Also** or **SLMB-Also**, qualify for another category within the Medicaid program, such as aged, blind, or disabled.

Figure 1 shows an example of a Portal eligibility verification for a member who is QMB-Also. If the result had shown **only** *Qualified Medicare Beneficiary* for the coverage (without **also** listing *Full Medicaid* or *Package A – Standard Plan* coverage), then the member would be considered QMB-Only.

Figure 1 – Eligibility Verification on the Portal:
Example of the Benefit Details Panel for QMB-Also Coverage

Benefit Details

Coverage	Description	Effective Date	End Date
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	11/02/2017	11/02/2017
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	11/02/2017	11/02/2017

QMB-Also and SLMB-Also members are considered *dually eligible* (having both Medicare and Medicaid coverage). 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

See the *Reimbursement for Dually Eligible (Medicare/Medicaid) Members* section for more information about billing and reimbursement for QMB-Also and SLMB-Also members.

> *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.*

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.

Amount Paid: Claim- and Detail-Level Information

When submitting all claims for services where another carrier was billed, the total amount paid by the third party must be entered in the appropriate field on the IHCP claim, even if the payment amount is zero. In addition, for certain types of claims, TPL information must also be reported for each *detail* of the claim.

TPL information is required at the detail level for the following claims:

- Dental (*ADA 2012* claim form, Portal dental claim, or 837D transaction)
- Home health and home health crossover, including hospice (*UB-04* claim form, Portal institutional claim, or 837I transaction with a corresponding type of bill)
- Outpatient and outpatient crossover (*UB-04* claim form, Portal institutional claim, or 837I transaction with an outpatient type of bill)
- Professional and professional crossover (also known as *medical* or *physician*) (*CMS-1500* claim form, Portal professional claim, or 837P transaction)

For crossover claims, this detail-level information must include Medicare paid amount, deductible, coinsurance, copayment, and blood deductible (as applicable), as well as any applicable non-Medicare TPL details.

Important:	*Providers using paper claim forms (ADA 2012, UB-04, or CMS-1500) must submit this detail-level TPL information using the IHCP TPL/Medicare Special Attachment Form, available from the Forms page at in.gov/medicaid/providers. A quick reference guide explaining in detail how to submit paper claims with detail-level TPL information, both for Medicare crossover claims and for other insurance TPL, is available on the Billing and Remittance page at in.gov/medicaid/providers.* *Providers are strongly encouraged to file claims electronically. Standard electronic data interchange (EDI) claim transactions (837P, 837I, and 837D) and Portal claim transactions (professional, institutional, and dental) allow providers to include the necessary detail-level information, and do not require the separate paper special attachment form. Electronic submissions are processed more efficiently than paper claim submissions.*

See the *Coordination of Benefits* section of the *Claim Submission and Processing* module for more information.

Proof of Zero Payment

For members who have other insurance, an explanation of payment (EOP), explanation of benefits (EOB), Remittance Advice (RA), or other documentation from the member's third-party carrier may be required along with the IHCP claim.

When the primary insurer denies payment for any reason or applies the payment in full to the deductible, the provider must include, with the IHCP claim, 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 or nonpayment – such as an EOP, EOB, or RA – to the IHCP claim. 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. The service code billed on the IHCP claim must be listed on the EOP, EOB, or RA, or other submitted documentation.
  - The Portal allows users to upload attachments electronically.
  - For paper claims and claims submitted via 837 electronic transaction, see the *Claim Submission and Processing* module for instructions on submitting attachments by mail.

- Use adjustment reason codes (ARCs) to report the valid claim denial or nonpayment reason on the IHCP claim, as follows:
  - In the *Claim Adjustment Details* panel for the 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* submitted with the paper claim

Note that the option of using ARCs to report zero payment does not apply to Medicare or Medicare Replacement Plan crossover claims. For Medicare-denied claims and claims where Medicare applied the entire payment amount to the deductible, the provider is required to submit a copy of the denial or zero-payment documentation, as described in the first option.

If a third-party payer made a payment on the claim, this documentation is generally not 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 the Medicare paid amount field on the claim indicates zero dollars, the EOMB or Medicare Replacement Plan EOB must be attached to the IHCP claim. See the *Reimbursement for Dually Eligible (Medicare/Medicaid) Members* 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 a 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, the following must be included 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 that 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.

If a provider believes a member is committing fraud, the provider can report that information to the FSSA Compliance Division. The FSSA Compliance Division will contact the Bureau of Investigations with the information and may review the member's utilization for placement in the Right Choices Program. To report fraud, providers can:

- Call IHCP Provider and Member Concerns Line at 1-800-457-4515 (option 2).
- Call Indiana FSSA fraud hotline toll-free at 1-800-446-1993 (option 5).
- Send email to ReportFraud@fssa.IN.gov.

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 Adjustment Unit at the following address:

DXC – Adjustments
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 in.gov/medicaid/providers 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. 130
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, nonpharmacy 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*.
- 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 *Third-Party Liability Update Procedures* section of this module.

Reimbursement for Dually Eligible (Medicare/Medicaid) Members

As described in the *Medicaid Coverage for Members with Medicare* section, many IHCP members are *dually eligible* – having both Medicare and Medicaid coverage. According to TPL regulations, Medicare is treated the same 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, such as the following:

- 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.
- If the Medicare paid amount exceeds the Medicaid allowed amount, the IHCP processes the claim with a paid claim status with a zero-reimbursed amount.

Medicare Enrollment Requirements for Providers

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 mental health providers. Mental health providers that are not approved to bill Medicare can expedite claim payment for dually eligible members by completing the following steps:

1. Append the appropriate midlevel-practitioner modifier to the procedure billed, as described in the *Mental Health and Addiction Services* module.
2. Indicate that the provider is not approved to bill services to Medicare as follows:
   – For electronic claims submitted via the Portal or 837 transaction, enter "**Provider not approved to bill services to Medicare**" as a claim note.
   – For paper claims, submit an attachment indicating that the provider is not eligible to bill Medicare.

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 Claim Submission

Claims for which Medicare or a Medicare Replacement Plan has previously made payment (including payments of zero due to a deductible, coinsurance, or copayment), are called *crossover claims*.

Claims that meet certain criteria cross over automatically from Medicare and are reflected on the IHCP RA statement or 835 transaction. If the Medicare or Medicare Replacement Plan crossover claim does not automatically cross over to Medicaid, the provider must submit the claim to the appropriate IHCP claim-processing address for adjudication.

Crossover claims filed with the IHCP must comply with IHCP billing rules. For detailed instructions on submitting FFS crossover claims, see the *Claim Submission and Processing* module. There is no filing limit for paid Medicare or Medicare Replacement Plan crossover claims.

> *Note: Providers should submit Medicare or Medicare Replacement Plan denials through the normal claim process, because the IHCP does not consider the denials to be crossover claims. See the Medicare Noncovered Services section.*

The following information concerns 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.
- If a provider does not receive the IHCP payment within 60 days of the Medicare payment, claims that did not cross over automatically should be submitted to the crossover processing address, according to the instructions found in the *Claim Submission and Processing* module. Providers whose FFS claims are not crossing over automatically should contact the Customer Assistance Unit at 1-800-457-4584.
- For crossover claims filed with the IHCP, providers must bill services on the appropriate claim type:
  - Submit **outpatient professional** charges using the **professional** claim (*CMS-1500* claim form or electronic equivalent).
  - Submit **federally qualified health center (FQHC), ambulatory surgery center (ASC), independent rural health clinic (RHC),** and **hospital-based ambulance** claims as follows:
    - To the *Medicare intermediary* using the **institutional** claim type (the *UB-04* claim form or electronic equivalent)
    - To the *IHCP* using the **professional** claim type (the *CMS-1500* claim form or electronic equivalent)
  - Submit **long-term care (LTC) facility** Medicare charges for **parenteral and enteral services and therapies** to the IHCP using the **institutional** claim type (the *UB-04* claim form or electronic equivalent).
- 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.
- If the member has a Medicare supplemental policy, the claim is filed with Medicare and automatically crosses over to the Medicare supplemental carrier, rather than to the IHCP, for payment of coinsurance or copayment and deductible. After the provider receives all EOBs, the provider may submit the claim to the IHCP by either of the following processes:
  - Electronically through the Portal, with the EOBs attached through the File Transfer upload process or sent separately as a paper attachment
  - By mail on a paper claim form, with the corresponding paper EOBs attached

> *Note: If the TPL coverage code for the supplemental policy has been entered erroneously as a Hospitalization or Medical, rather than Medicare Supplemental Plan, the claim crosses directly to the IHCP and may be paid without proof of filing with the Medicare supplemental carrier. These situations generally result in IHCP overpayments that must be refunded immediately.*
>
> *To prevent an overpayment, a provider that discovers a Medicare supplemental policy erroneously identified as Hospitalization or Medical on the EVS can request a TPL file update by sending a copy of the member's Medicare supplemental insurance card to the TPL Unit. See the* *Third-Party Liability Update Procedures* *section of this document for update procedures.*

- 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.
- Medicare Part D pharmacy claims do not cross over.

- For outpatient, home health, and professional crossover claims, the following must be completed:
  - The individual Medicare coinsurance or copayment and deductible must be reported for **each detail** on the claim (see the *Amount Paid: Claim- and Detail-Level Information* section).
  - The Medicare paid amount, meaning the actual dollars received from Medicare, must 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* available on the *Forms* page at in.gov/medicaid/providers.
- 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 in.gov/medicaid/providers.
- Medicare and Medicare Replacement Plan noncovered charges are not considered crossover claims.

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

- **Institutional/837I/*UB-04* – Inpatient:** Inpatient claims with dates of services spanning more than 1 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 1 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.

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

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

Medicare-Excluded Services

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 (or a Medicare supplemental plan) first. For all other services provided to dually eligible members, IHCP benefits can be paid 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.

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 to be billed to Medicare. HMS, on behalf of DXC, initiates the quarterly Medicare recovery project and will notify providers of paid IHCP claims with Medicare coverage. Providers receiving these reports must bill Medicare according to instructions in the letter accompanying the reports or notify HMS as to why the claims cannot be billed to Medicare. The providers have 60 days from receipt of the report to bill Medicare. After 60 days, the IHCP paid claims will be adjusted.

For questions about the Medicare recovery project, providers can contact 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 to 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.

The IHCP will not reimburse for claims that the primary carrier denied because the member received out-of-network services when the carrier required to services to be delivered by in-network providers. 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 the 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.

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
- Treatment dates
- Insurance carrier information
- Policy number and/or claim number
- 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 in.gov/medicaid/providers. However, use of this form is not required.

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

IHCP Third Party Liability – Casualty
P.O. Box 7262
Indianapolis, IN 46207-7262

Toll-Free Telephone: 1-800-457-4584
Toll-Free Fax: 1-866-667-6579
Email: INXIXTPLCasualty@dxc.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 (see the *Introduction* section) and exempted services (see the *Services Exempt from Third Party Liability Cost Avoidance Requirements* section). *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 coverage issues, providers should contact the TPL health analyst using the following contact information:

IHCP Third Party Liability
Toll-Free Telephone: 1-800-457-4584
Fax: 1-866-667-6579
Email: INXIXTPLRequests@dxc.com
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. *Core*MMIS 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.

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 *Core*MMIS. 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 health analyst 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 Third Party Liability – Update
P.O. Box 7262
Indianapolis, IN 46207-7262

Toll-Free Telephone: 1-800-457-4584
Fax: 1-866-667-6579
Email: INXIXTPLRequests@dxc.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 *Core*MMIS. 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 in.gov/medicaid/providers. 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 *Core*MMIS.

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 *Core*MMIS to accurately reflect member TPL coverage. *Core*MMIS 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.