
THIRD PARTY LIABILITY

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THIRD PARTY LIABILITY (TPL)

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P-100 GENERAL INFORMATION

Federal law and regulations require states to institute policies and procedures to assure that Medicaid recipients use all other resources available to them to pay for all or part of their medical care prior to Medicaid paying.

Third parties are legally liable individuals, institutions, corporations (including insurers), and public or private agencies who are or who may be legally responsible for paying medical claims.

Medicaid pays only after a third party has met its legal obligation to pay. Medicaid is payer of last resort.

Exception:

Medicaid is the first payer for claims for pharmacy, Kid-Med, prenatal care, and TPL furnished by an absent parent under jurisdiction of Title IV-D. Medicaid then ~~chases~~ any third party payments on these claims.

Federal regulations require:

- reasonable measures be taken to accurately identify third parties;
- collection and maintenance of information on health insurance, and use in processing claims;
- verified TPL be treated as a resource of a Medicaid applicant/recipient; and
- assignment of rights to payments for medical support and other medical care is a condition of eligibility for Medicaid.

P-200 INDICATORS OF POTENTIAL THIRD PARTY RESOURCES

The following factors may indicate potential third party resources and should be pursued:

Age

Applicants/recipients attaining age 65 may be eligible for Medicare. (Recipients entitled to Medicare frequently have Medicare supplement policies.)

Minor children may be covered by insurance of the parent (custodial or absent).

Students may have insurance available through the school they attend.

Death

Question applicants on behalf of deceased persons about death benefits received which may cover expenses of last illness.

Income

Income sources are indicators of possible third party health coverage:

- Railroad Retirement Benefits and Social Security Retirement/Disability Benefits may indicate eligibility for Medicare benefits.
- Longshore and Harbor Workers' Compensation (LHWC) and Workers' Compensation (WC) may pay benefits to Employees who suffer injuries on the job to compensate for medical expenses as well as lost income.
- Black Lung (BL) Benefits are awarded only on diagnosis of pneumoconiosis and may indicate eligibility for Medicare benefits.
- IV-D Payment child support payments may indicate potential medical support from an absent parent.
- Earned Income and Wage Earnings Record may indicate health and hospital insurance.
- Military Retirement may indicate coverage by CHAMPUS.

P-200 Continued**Work History**

Work history may indicate:

- eligibility for cash and medical benefits through the previous employer;
- coverage through a health insurance plan if the individual is retired, or
- coverage through the union if the individual belongs to a labor union.

Monthly Expenses

The recipient may list health or hospitalization premiums as an expense.

Disability

A disability may indicate eligibility for other medical benefits (e.g., casualty insurance or Medicare Parts A and/or B.)

P-300 ASSIGNMENT/COOPERATION

Refer to I-200, Assignment of Rights.

P-400 LOCAL OFFICE/BHSF RESPONSIBILITIES**P-410 HEALTH INSURANCE RESOURCE FORM**

Each policy must be examined to determine the type of benefit provided and the purposes for which it can be used (i.e., whether benefits can be assigned to the medical provider). If the policy provides health insurance coverage, complete the Health Insurance Resource Form.

Income replacement, life and accident, or indemnity insurance policies based on hospital confinement are not considered medical insurance third party liability resources.

Exception:

Some indemnity policies can be assigned to the hospital. When the hospital accepts assignment, the recipient does not receive the money. This indemnity insurance policy is considered TPL.

The Health Insurance Resource Form is used to:

- record and input private health insurance information (excluding Medicare), and
- correct or change certain TPL information on the MMIS Third Party Resource File for all items except case ID number, policy number or scope of coverage.

Send a memo to BHSF/TPL Unit:

- for correction of case ID number, policy number, or scope of coverage on the resource file, and
- to delete an insurance record or make corrections that are not accomplished by the Health Insurance Resource Form.

P-411 RAILROAD RETIREMENT MEDICARE ENTITLEMENT

Railroad Retirement Medicare Parts A and B are not automatically transmitted to the MMIS Resource File because this information is not available on BENDEX. The agency representative shall send Form 117-RR to BHSF/TPL unit with the following information on all beneficiaries who receive Railroad Retirement Medicare Parts A and B:

- Beneficiary's name,
- Medicaid identification number,
- Social Security number,
- Railroad Retirement Medicare Parts A and B claim number,
- effective date of entitlement, and
- if applicable, the ending date of entitlement.

When the above information is received by BHSF/TPL Unit, it will be manually input to the MMIS Resource File.

P-420 TPL CARRIER *CODE* UPDATE FORM CF-1

To obtain a new carrier code for a carrier not on the current listing, complete and submit Form CF-1 to the BHSF/TPL Unit.

P-430 ACCIDENT/INJURY REPORTS

The local office shall initiate and complete the Accident/Injury Report when:

- an applicant/recipient has been injured or in an accident, or
- an applicant is eligible because of incapacity which resulted from injuries received in an accident.

The local office can become aware of the accident or injury:

- from the applicant/recipient, or
- from BHSF Medicaid Recovery Unit.

A monthly listing of the Accident/Injury Report request is generated to the local office/BHSF for detailed information on these claims. A response is due within 30 days to the inquiry. Return the information to the Third Party/Medicaid Recovery Unit.

Certification/renewal shall not be delayed in order to obtain the necessary information.

Include information concerning other parties involved if available.

Review with the applicant/recipient his responsibility under assignment of rights and advise him that he may be contacted by BHSF if additional information is needed. Advise the applicant/recipient that he will be responsible for reimbursing Medicaid if he receives a settlement.

Forward the Accident/Injury Report with all available information to the BHSF Third Party/Medicaid Recovery Unit. If additional information becomes available, the local office/BHSF shall promptly advise Third Party/Medicaid Recovery Unit by memo and include attachments.

Direct requests and/or inquiries from the applicant/recipient, his legal representative or providers to the BHSF Third Party/Medicaid Recovery Unit.

If the applicant/recipient or his legal representative brings in any payment received from a third party, forward the payment to the BHSF Third Party/Medicaid Recovery Unit, return receipt requested.

The local office/BHSF will be notified when a Medicaid recovery case has been settled. The amount of the settlement will be given when known.

P-440 REQUEST FOR ACCIDENT/INJURY REPORT FORM DISPOSITION

This form is used:

- when the request for the Accident/Injury Report was not appropriate according to the applicant's/recipient's situation;
- when enough information is not available to submit the Accident/Injury Report, or
- as a cover memo when the Accident/Injury Report was previously submitted on the same accident or injury.

Give an account of attempts to make contact in "Other Comments" section of the request from Third Party/Medicaid Recovery Unit when a recipient fails to respond to inquiries needed to complete the Accident/Injury Report. Flag the case record to alert the agency representative to complete the Accident/Injury Report when contact is again made, such as at the next renewal.

Note:

Benefits shall be terminated for an individual who refuses to cooperate. Notice and hearing requirements must be met.

P-510 GENERAL PURPOSE

The Medicaid Program pays Medicare premiums for selected groups of Medicaid eligibles. This is known as "Buy-In".

The purpose of "Buy-In" is to reduce Medicaid expenditures by purchasing Medicare coverage for certain Medicaid recipients. Medicaid expenditures are then shifted to Medicare. The Medicaid program elected to "buy-in" Medicare Part B premiums beginning July, 1985.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 mandated that the Medicaid Program expand Part B Buy-In coverage and extend Part A coverage to individuals meeting the Qualified Medicare Beneficiary (QMB) eligibility requirements. QMB Buy-In coverage began February, 1989.

Note:

BHSF/TPL Buy-In Unit is responsible for administering the Buy-In Program on the state level. Contact this Unit by memorandum for individual case questions or problems related to the payment of either Part A or Part B premiums. Send a copy of the memorandum to the Program Specialist.

P-520 PART A BUY-IN

To qualify for Part A Buy-In the recipient must be QMB or QDWI eligible as determined by Medicaid of Louisiana.

BHSF identifies eligibles on WIS and initiates the Buy-In process. If ineligible, BHSF terminates the Buy-In process.

P-530 PART B BUY-IN

To qualify for inclusion in the Part B Buy-In Program, an individual must be eligible for Medicare Part B and Medicaid (SSI, Extended Medicaid, or QMB).

SSA identifies SSI recipients and SSI/QMB recipients eligible for Buy-In and initiates the Buy-In process. For ineligibles, SSA terminates the Buy-In process.

BHSF identifies Extended Medicaid, LTC, and QMB recipients eligible for Buy-In from WIS files and initiates the Buy-In process. If ineligible, BHSF terminates the Buy-In process.