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8.302.3 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES

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TITLE 8 SOCIAL SERVICES
CHAPTER 302 MEDICAID GENERAL PROVIDER POLICIES
PART 3 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES

8.302.3.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.302.3.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 5/1/04]

8.302.3.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.302.3.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 5/1/04]

8.302.3.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See Section 27-2-12 et seq. NMSA 1978 (Repl. Pamp. 1991).
[2/1/95; 8.302.3.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 5/1/04]

8.302.3.4 DURATION: Permanent
[2/1/95; 8.302.3.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 5/1/04]

8.302.3.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.302.3.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 5/1/04]

8.302.3.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.302.3.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 5/1/04]

8.302.3.7 DEFINITIONS: [RESERVED]

8.302.3.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.302.3.8 NMAC - Rn, 8 NMAC 4.MAD.002, 5/1/04]

8.302.3.9 THIRD PARTY LIABILITY PROVIDER RESPONSIBILITIES: The New Mexico medical assistance program (medicaid) is the payer of last resort. When resources are available from third parties, the human services department (department) administers a specific program to ensure that these resources are used to pay for the medical services furnished to eligible recipients. See 42 CFR Section 433.138 (a); Section 27-2-23 (A) NMSA 1978 (Repl. Pamp. 1991). This part provides an overview of this program, the collection process, and the responsibilities of providers, insurers, and the department.
[2/1/95; 8.302.3.9 NMAC - Rn, 8 NMAC 4.MAD.703, 5/1/04]

8.302.3.10 PAYMENT PROVISIONS: For claims for recipients with medical coverage furnished by a third party, such as an insurer or other third party who may be liable for the medical bill, medicaid limits payment for the claim to the medicaid allowed amount less the third party payment amount, not to exceed the co-payment amount calculated by the third party. If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment. The claim is considered paid in full. The provider may not collect any remaining portion of the unpaid co-payment, co-insurance, or deductible from the client. If a hospital is reimbursed under the diagnostic related group (DRG) reimbursement methodology and receives payments from third party insurers, medicaid pays the hospital the difference between the amount received from the third party and the lower of the hospital billed amount or the medicaid allowed DRG amount.

A. **Payment acceptance:** When providers furnish medical services to recipients who have health coverage or coverage from liable third parties, providers must not seek payment from the recipient if the payment from the alternative coverage is at least equal to the amount medicaid pays for the same service [42 CFR Section 447.20 (a)].

B. **Sanctions for seeking recipient payments:** Sanctions are imposed if providers seek payment for services from recipients after receiving payments for these services from the recipient's health insurance company or other third parties if the payment is at least equal to the amount that MAD would have paid for that same service. See 42 CFR Section 447.21(a)]. An amount equal to three (3) times the amount sought from recipients is deducted from providers' next MAD payment. See 42 CFR Section 447.21(b).

C. **Refunds to MAD after receipt of payment:** A provider must immediately refund the lower of the third party or MAD payment, if he/she receives payment from insurance companies or health plans for services already paid for by MAD.

D. **Provider discounts:** MAD does not pay the difference between the payment received from the third party, based on the discount agreement and the actual charges for services, when providers enter into agreements with third party payers to accept payment at less than actual charges.

(1) The provider acceptance of less than actual charges constitutes receipt of a full payment for services and neither medicaid nor recipients have a further legal obligation for payment.

(2) Provider discount arrangements are often referred to as "preferred provider agreements" or "preferred patient care agreements".

[2/1/95; 8.302.3.10 NMAC - Rn, 8 NMAC 4.MAD.703.1 & A, 5/1/04]

8.302.3.11 SUBROGATION RIGHTS: When the department makes payments on behalf of recipients, the department is subrogated to the recipient's right against a third party for recovery of medical expenses to the extent of the payment. See Section 27-2-23(B) NMSA 1978 (Repl. Pamp. 1991). If the recipient is enrolled in the medicaid managed care program, the extent of the payment is the amount actually expended on the provision of care as documented by encounter data and not the capitation amount paid by MAD to the medicaid managed care contractor. All referrals indicating the existence of a third party medical resource are verified by the third party liability unit of the medical assistance division (MAD-TPLU). After verification, indicators are placed in the MAD claims processing contractor's eligibility file for use in claims processing.

[2/1/95; 6/30/97; 8.302.3.11 NMAC - Rn, 8 NMAC 4.MAD.703.2, 5/1/04]

8.302.3.12 PROCESS USED IF THIRD PARTY LIABILITY IDENTIFIED:

A. **Cost avoidance process:** Claims submitted on behalf of a recipient for services covered by his/her insurer, excluding amounts paid by the insurer, are denied and a facsimile claim is sent to the provider to file with that insurer. This process is referred to as "cost avoidance". The claim sent to the provider includes information relating to the recipient's health insurance policy.

(1) Cost avoidance is used when the liable third party is a health insurance policy, health plan or involves personal injury where liability has been established.

(2) Whenever MAD is aware that medical bills should be paid by liable third parties, all claims are subject to cost avoidance procedures. All inpatient and outpatient hospital claims and pharmacy claims are cost-avoided.

(3) If liable third parties responsible for coverage are health maintenance organizations (HMOs) or managed care plans (plans), the claims are cost-avoided. This includes claims for prenatal or preventive pediatric care furnished to HMO/plan eligible recipients and claims for individuals on whose behalf child support enforcement services are being carried out.

B. **Pay and chase process:** When medicaid pays a claim before learning of the existence of health insurance coverage, MAD-TPLU seeks reimbursement, up to the amount paid directly from the insurer. See 42 CFR Section 433.139. This process is referred to as "pay and chase".

(1) MAD is not allowed to use the pay and chase process only in the following situations:

(a) claims for prenatal care or preventive pediatric care, which include early and periodic screening, diagnosis and treatment (EPSDT) services; and

(b) claims for services furnished to recipients on whose behalf child support enforcement is being carried out by the IV-D agency and for which payments have not been made to providers by third parties within thirty (30) days after services are furnished.

(2) The following requirements must be met before MAD uses the pay and chase process for services furnished to recipients on whose behalf child support enforcement is being pursued:

(a) providers must certify in writing that the liable third party failed to pay within thirty (30) days of the date of service; and

(b) providers must certify in writing with each claim submitted that if the services being billed to medicaid are subsequently paid for by the third party, the lower of the third party payment or the medicaid payment will be immediately refunded to MAD.

C. **Reporting of cost-avoidance:** The MAD-TPLU provides each income support division (ISD) county office with a report indicating the amount of money cost-avoided for recipients from that county on a quarterly basis.

[2/1/95; 8.302.3.12 NMAC - Rn, 8 NMAC 4.MAD.703.3, 5/1/04]

8.302.3.13 INSURANCE COVERAGE AND HEALTH MAINTENANCE ORGANIZATIONS: Providers must not refuse to furnish services to recipients solely because an insurance company or third party may be liable for payment. See 42 CFR Section 447.20(b). When providers are aware of the existence of health insurance or health plan coverage for recipients, the providers must seek payment from the insurance carrier before seeking payment from medicaid. Providers who do not participate in a specific health maintenance organization (HMO) or managed care plan (plan) are not required to furnish services to a recipient who has primary coverage with an HMO/plan. The provider should refer the recipient to a provider who participates in the recipient's HMO/plan.

A. **Provider responsibility to relay information to MAD:** If providers learn that recipients have canceled their insurance policies, providers must forward this information to MAD-TPLU.

B. **Recipients with insurance coverage through a health maintenance organization:** When a medicaid eligible recipient belongs to an HMO plan, the medicaid program limits the medicaid allowed amount less the third party payment amount, not to exceed the co-payment amount calculated by the HMO plan. If the third party payment amount exceeds the medicaid allowed amount, the medicaid program makes no further payment and the claim is considered paid in full. The provider may not collect any portion of the unpaid co-payment, co-insurance, or deductible from the client. All other HMO requirements, including servicing provider restrictions, apply to the provision of services.

(1) When the HMO/plan uses a drug formulary, documentation of noncovered drug items require that the medical director of the HMO/plan must sign and attach a written certification for each drug claim to document that a pharmaceutical product is not covered by the HMO/plan. The signature is a certification that the HMO/plan drug formulary does not contain a therapeutic equivalent that adequately treats the medical condition of the HMO/plan subscriber.

(2) Medical services not included in the HMO/plan are covered by medicaid only after review of the documentation and approval by the MAD-TPLU.

(3) Recipients covered by an HMO/plan are responsible for payment for medical services obtained outside the HMO/plan and for medical services obtained without complying with the rules or policies of the HMO/plan.

[2/1/95; 8.302.3.13 NMAC - Rn, 8 NMAC 4.MAD.703.4 & A, 5/1/04]

8.302.3.14 PROVIDER LIENS ON PERSONAL INJURY AWARDS:

A. **Hospital liens:** Hospitals are prohibited from imposing liens on potential lawsuit recoveries for the difference between the MAD payment and hospital billed amounts. MAD payment amount are payment in full.

(1) Hospitals furnishing services to recipients who have been injured in accidents may choose to file claims with MAD or forego medicaid reimbursement and file hospital liens against any potential lawsuit recoveries.

(2) If hospitals choose to bill medicaid, they must file claims within 120 days of the date of discharge.

(3) If hospitals choose to impose a lien, they cannot bill recipients or medicaid for any unpaid balance remaining after future settlement or lack of settlement.

(4) If hospitals file claims with MAD, the amounts received are payment in full.

B. **Non-hospital providers:** For non-hospital providers, medicaid payments are payment in full for medical services furnished to recipients injured in accidents caused by other parties. Providers may not seek additional payment for these services from recipients, even if recipients later receive monetary awards or settlements from liable parties.

[2/1/95; 8.302.3.14 NMAC - Rn, 8 NMAC 4.MAD.703.5, 5/1/04]

8.302.3.15 NOTIFICATION REQUIREMENTS: Providers must notify MAD-TPLU any time they are contacted by an attorney or another interested party who requests information relating to services furnished to

recipients, including information on amounts billed or paid, procedures performed or medical records. If an inquiry is received, providers must report the following information to MAD-TPLU:

A. name and address of the party requesting the information; and

B. name and social security number of the medicaid recipient and dates on which services were furnished.

[2/1/95; 8.302.3.15 NMAC - Rn, 8 NMAC 4.MAD.703.6, 5/1/04]

8.302.3.16 CANCELLATION OF INSURANCE: Providers must not advise or recommend that medicaid recipients cancel their health coverage. Failure to comply with this provision is grounds for termination of the provider agreement.

[2/1/95; 8.302.3.16 NMAC - Rn, 8 NMAC 4.MAD.703.7, 5/1/04]

8.302.3.17 MEDICAL ASSISTANCE DIVISION RESPONSIBILITIES:

A. The medical assistance division has the following responsibilities in administering the TPL program:

(1) determining the legal liability of third parties, including health insurers, in paying for the medical services furnished to recipients [42 CFR 433.138(a)];

(2) pursues claims and recovery against third parties with information collected at the time of any determination or redetermination of eligibility for medicaid when the amount of the third party payment that the department can reasonably expect to recover exceeds the cost of the recovery; and

(3) pays to the extent that the medicaid allowed amount exceeds the TPL amount after the amount of third party liability is established.

B. **Coordination with other agencies:**

(1) The MAD-TPLU receives TPL information from the social security administration at the time of eligibility determination and redetermination. The social security office obtains the mandatory assignment of rights to support and information about health insurance during the initial application process from all applicants.

(2) MAD-TPLU receives TPL information from the children, youth and families department (CYFD) to ensure that the assignment of rights to medical support and payments are on CYFD cases, such as subsidized adoptions and foster children cases. CYFD obtains information as to whether these individuals are covered by health insurance policies or health plans and transmits this information to the MAD-TPLU. CYFD must also obtain the social security numbers for absent and custodial parents of medicaid eligible children.

(3) The MAD-TPLU performs data matches with CHAMPUS, workman's compensation, highway department, wage data exchange (WDX) and private insurance companies to identify individuals covered by private health insurances or other liable third parties.

(4) The child support enforcement division (CSED) provides information to MAD-TPLU on cases identified by CSED as having health insurance. Unless the custodial parent and child(ren) have satisfactory insurance, absent parents can be ordered by the court to provide coverage for the child(ren). See 45 CFR 303.31(b)(1). MAD-TPLU transmits information on absent parents who are not providing health coverage, as required by court order, or who have health insurance available through an employer but have not obtained it for their dependents to CSED.

(5) The New Mexico IV-D agency establishes paternity and obtains support orders for medical payments. MAD-TPLU notifies this agency of lapses and changes of coverage information when it is identified by the MAD-TPLU. See 45 CFR 303.31(b)(8). This notification takes place when the MAD-TPLU learns that claims for dependent child(ren) are rejected by the health insurance companies of the absent parents because their policies have been canceled, revised or no longer cover the child(ren) receiving IV-D services.

(6) In those instances where recipients receive cash settlements, MAD-TPLU advises the appropriate county office or SSI office of amounts received and the approximate date of receipt.

C. **Trauma diagnosis claims processing:** To help identify liable third parties with respect to injuries received by Medicaid recipients, MAD-TPLU has implemented an editing process within its claims processing system which recognizes all claims with a trauma diagnosis. See 42 CFR 433.138(4).

(1) Trauma inquiry letters are mailed to recipients identified in the edit. The letters ask recipients for information about possible accidents, causes of accidents and whether legal counsel has been obtained.

(2) Failure to respond to these inquiries is considered a failure to cooperate and results in termination of medicaid benefits.

D. **Additional responsibilities:** The MAD-TPLU refers all personal injury cases involving MAD payments of 5,000 dollars or more to the department's office of general counsel. The MAD-TPLU helps providers

resolve TPL issues in cases where providers have difficulty dealing with specific insurance companies or recipients and sixty (60) days has elapsed since submitting the claim. Any questions concerning any aspect of TPL are referred to the MAD-TPLU.
[2/1/95; 8.302.3.17 NMAC - Rn, 8 NMAC 4.MAD.703.8, 5/1/04]

8.302.3.18 INSURER RESPONSIBILITIES: Individual, blanket, group accident or health policies or certificates of insurance, including employee retirement income security Act (ERISA) plans, delivered, issued or renewed in the state of New Mexico must not contain exclusions or clauses which deny or limit insurance benefits to medicaid recipients because of their eligibility for medicaid benefits. See Section 59-18-31(D) NMSA 1978 (Repl. Pamp. 1992).

A. **Direct payments to the department:** All individual, blanket, or group accident or health policies or certificate of insurance, including ERISA plans, delivered, issued or renewed in the state of New Mexico must require insurers to reimburse the department for benefits paid on behalf of recipients in the following situations:

(1) the department has paid or is paying benefits;

(2) the department pays medicaid providers for the services in question; and

(3) insurers are notified that insured individuals receive medicaid benefits and that the benefits must be paid directly to the department; the department certifies to insurers at the time the department files its claims for reimbursement that these individuals are eligible for medicaid.

B. **Direct provider payments:** Medicaid providers may be paid directly by insurers for furnishing medical services to recipients. Providers must inform insurers that the recipients are eligible for medicaid benefits by attaching a copy of the recipients' medicaid cards to claims. See Section 59A-18-31(C) NMSA 1978 (Repl. Pamp. 1992).

C. **Level of insurance required:** The minimum standards of acceptable coverage, deductibles, coinsurance, lifetime benefits, out-of-pocket expenses, co-payments, and plan requirements are the minimum standards of health insurance policies and managed care plans established for small businesses in New Mexico. See New Mexico Insurance Code.
[2/1/95; 8.302.3.18 NMAC - Rn, 8 NMAC 4.MAD.703.9, 5/1/04]

HISTORY OF 8.302.3 NMAC:
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ISD 303.1000, Covered Services, filed 1/7/80.
ISD 303.1000, Covered Services, filed 4/2/82.
MAD Rule 303, Benefits, filed 11/8/89.
MAD Rule 303, Benefits, filed 4/17/92.
MAD Rule 303, Benefits, filed 3/10/94.
SP-004.2200, Section 4, General Program Administration Third Party Liability, filed 3/5/81.

History of Repealed Material:
MAD Rule 303, Benefits, filed 3/10/94 - Repealed effective 2/1/95.