STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia

Requirements for Third Party Liability -
Payment of Claims

Payment of Claims

The District of Columbia is a cost-avoidance state, with 50 percent of more of the health insurance coverage provided by one large carrier with whom we do tape verification. The following describes, by resource type, the procedures utilized to determine whether to seek reimbursement from a liable third party.

Probably Liability is Established at the Time Claim is Filed

Cost Avoidance

Cost-avoidance procedures using the Third Party Resource Data Base can take either of two paths. First, a provider will determine that third party resources exist, and bill the liable third party. It is expected that the provider will make the billing without contacting the TPL/Estates Section. If providers have any questions concerning health insurance coverage, they make telephone calls to the TPL/Estates Section and the TPL staff makes an inquiry to the TPR Data Base.

The second means of cost-avoidance occurs in the automated processing of provider claims by MMIS. The computer checks the status of the third party resources of each recipient who has a claim submitted by a provider. It rejects the claims of those recipients for whom an appropriate third party resource exists. As a part of this rejection procedure, a notation is added to the "Remittance Advice" that goes to the provider. This document provides sufficient information to the provider to submit a claim to the appropriate party. If the claim is rejected by the insurance company, Medicare or other third parties, the provider resubmits the claim along with the rejection notice to the Third Party Liability/Estates staff for processing. The TPL/Estates staff updates the TPR, certifies the claim for payment and sends it to the Fiscal Agent for additional processing.

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After the amount of liability is determined, the MMIS pays the claim to the extent that the payment is allowed under the District's Medicaid Payment Schedule exceeds the amount of the third party's payment.

Probably Liability is not Established or Benefits are not Available at the Time Claim is Filed.

For claims where a liable third party exists, but was not known to the provider, the MMIS, or the Third Party Liability Estates Section when the claim was originally processed, nor were third party benefits available to pay the recipients medical expenses, the MMIS pays the claim in the full amount allowed under the District of Columbia's Medicaid Program Payment Schedule.

Recovery of Reimbursement

Procedures for seeking reimbursement of Medicaid payments which should have been paid by a third party, are initiated by the TPL/Estates Section within 60 days after the end of the month in which the third party is identified, or within 60 days when a claim could not be accurately cost-avoided.

TPL Report Processing

The TPL Report, CPO-04, is produced by MMIS during the regular payment cycle. This report provides a list of claims not cost avoided for which third party resources may exist. For each case listed on the TPL Report, there was a trauma code on a claim submitted for payment, but the claim was paid.

The TPL Collection Agent must determine if the code indicating trauma is correct and whether some party (other than Medicaid) has paid the provider, or could potentially pay the provider for the services indicated. The first step in the determination is to gather more information about the case from the provider by mailing a form letter.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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When the form is returned, the collection agent examines the information to see if further action is required. If the case was not accident-related and there are not indicators of Third Party Liability, no further action is required.

If there is an indication that the provider has received reimbursement from a third party, then a patient profile is requested. Full information on a recipient's claim paid by Medicaid can be assembled from the following sources:

Microfiche for data covering the last 18 months; and

MMIS report CPO-09 for data in the MMIS historical files from April, 1981 to approximately 18 months before the current date.

Information from these sources is tabulated to determine the total cost of claims that are covered by the Third Party resources.

If the provider is not a hospital, the provider is notified of the requirement to reimburse the Department of Human Services, preferably by check. In the case of hospitals, the provider is notified of the requirement to file an adjustment-void with MMIS. A copy of the adjustment-void is to be sent to the TPL Section so that note of the correction can be made of the savings for the TPL Collection Report and is integrated into the TPL case file.

Liability (Casualty Cases)

Accident-related claims can involve Workmen's Compensation, liability claims, or insurance claims. All liability referrals from casualty insurance companies, attorneys or any other source are treated as active cases. Once a profile is received and the

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State/Territory: District of Columbia

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claim paid within the accident or injury-related period exceeds $50.00, recovery is sought. The case is immediately updated into the TPR within 30 days from the date of referral and recovery sought within 60 days. Cases are assigned alphabetically. A manual claims tracking system is used to monitor case activity.

The District of Columbia has a Subrogation Law which requires that all cases be referred to the Office of the Corporation Counsel to file a lien against the responsible third party, and negotiate settlement in cases requiring litigation.

Medicare

Medicare eligibility information a well as health insurance information is stored in the Third Party Resource Data Base. Retroactive eligibility is processed in the MMIS. The TPL staff manually sends "Notices of Intent to Void" to providers in order that they may bill and reimburse the Medicaid program. If providers fail to respond within the prescribed time period, the amount paid by Medicaid is deducted from a future remittance. The MMIS will be updated beginning October 1988, and manual processing will be alleviated.

Estate Planning

Probate claims are filed against estates of Medicaid recipients who are over age 65, or having no surviving spouse or minor children or who are over age 65, or minor children or who resided in the District of Columbia's long-term care or Mental Health facilities, for Medicaid payments correctly made after age 65. Claims filed for Mental Health services are not limited to age. Cases are referred from the facilities, attorneys, and the Office of the Corporation Counsel. Data matches are performed with the Registrar of Wills, the Vital Statistics and Research Division and the BENDEX. The cases are assigned alphabetically, and agents perform daily research at the Registrar of Wills

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: District of Columbia

Requirements for Third Party Liability -
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Office, or by scanning the newspapers and the Washington Law Reporter to ascertain the existence of estates. If there are no known relatives or the Department is the principal creditor, the Department petitions as Administrator of the recipient's estate. The cases are updated into the TPR within 45 days from the date of the referral, and collection activity immediately initiated.

Insurance Coverage Exception Processing

From time to time, claims made by providers to insurance carriers will be rejected because a specific service or services are not covered by the insurance policy. When this happens, the provider submits a Medicaid claim, along with a copy of the rejection to the TPL/Estates Section for TPL processing. Processing of these claims is limited to verifying the existence of a provider service indicator on the TPR Data Base, and addition the appropriate indicator if it does not exist. After verification, the claim is certified for payment and set to MMIS where claim processing.

Suspension or Termination of Recovery of Reimbursement

The Department's threshold remains $50.00. Currently, our MMIS does not allow the accumulation of claims, however, we will propose that the change be a part of the new contract with our Fiscal Agent. Because the Department does not accumulate claims, this low dollar amount guarantees, as nearly as possible, that all TPL claims are captured. The method of ordering patient profiles of claims history technically provides an accumulation of all claims paid. Further, the average case settlement value is $7,362.