

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: South Carolina

Requirements for Third Party Liability -  
Payment of Claims

The State uses a cost avoidance method of claims processing when third party liability is established at the time a claim is filed. The State Health and Human Services Finance Commission does not utilize a threshold value in the cost avoidance process.

Exceptions to the cost avoidance method are waived claims (pharmacy and crossover physician claims), EPSDT, prenatal or preventive pediatric care and all claims covered by absent parent maintained insurance under Part D of Title IV of the Act.

1. When a recipient's third party liability is derived from an absent parent whose obligation to pay child support is being enforced by the IV-D agency, providers are not required to bill that third party prior to billing Medicaid. Medicaid pays the claims and receives a report listing all claims paid under these circumstances on a weekly basis. Reimbursement is subsequently sought up to the amount of the Medicaid payment.

2. In general, recovery of reimbursement is sought directly from the liable health insurance companies for all identified claims without regard to a threshold amount or any other guideline. The sole exception is for institutional provider claims paid prior to the onset of cost avoidance where other health insurance resources are known to exist. Because recovery of reimbursement for these claims is sought directly from the providers rather than from the liable health insurance companies it is not cost effective to pursue claims with small dollar amounts. For these claims only, a threshold amount of \$20 per claim is utilized in the pay and chase process.

For discovery of Casualty Recovery cases, a minimum threshold of one paid claim of at least \$250 will be established. For cases discovered through other means, the Department will accumulate paid claims until the threshold of \$250 has been reached, at which point a Casualty Recovery claim will be established. For all claims established, the Department shall assert for full reimbursement of the Medicaid Claim from known liable parties. Upon discovery and establishment of a claim, and at all times during the pursuit of recovery of the claim, the department shall determine what portion of the gross settlement to claim based on cost effectiveness. For cases where the potential settlement proceeds available are less than twice the amount of Medicaid Paid Claims, the Department will determine what portion of the total recovery to pursue based upon cost effectiveness principles.

The Department's review of cost effectiveness shall include, but not be limited to, documentation as to the Factual and Legal issues of certainty of liability; the department's previous professional experience with the recipient's Counsel and related Jurisdiction; the involvement of multiple third parties, COB, and other payment sources (ie.. PIP, Worker's Comp, Underinsured Motorist, Uninsured Motorist), the estimated attorney's fees, and any other cost of recovery.

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The Department will at all times pursue that amount which will maximize total net recoveries to the program. When deemed appropriate, the Department will attempt to resolve the case through binding arbitration, arbitration or mediation. The Department will not agree to a lesser recovery amount than that determined by an analysis of cost-effectiveness.

In all instances, the Department, through the assignment of rights to third party benefits as a condition of eligibility, reserves the right to pursue known liable third parties on behalf of the Recipient. In instances where it has been determined that the Recipient has engaged sufficient competent representation, and is in pursuit of known liable third parties, the Department may rely upon their services and seek reimbursement of Medicaid Paid Claims from the obtain settlement proceeds.

The Department shall apply available resources in a manner that ensures maximum average return over the entire caseload, and will apply the cost effectiveness principle established in 1902(a)(25)(B) in determining the amount of recovery to pursue based on the likelihood of collections.

3. All claims which are not cost-avoided, including waived claims (pharmacy and crossover physician claims), EPSDT, prenatal or preventative pediatric care, and all claims covered by absent parent maintained insurance under Part D of Title IV of the Act, are accumulated and billed directly to the liable health insurance companies on a quarterly basis without regard to a dollar amount.

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