SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Third Party Liability BabyNet

December 2019

Please Note

- This presentation is an excerpt from a larger FFS Medicaid/TPL class.
- It is not BabyNet specific, but will mention BabyNet.
- More BabyNet-specific billing training will be provided in the future.
- BabyNet services not covered by TPL should view this presentation as informational only (Service coordination, special instruction, foreign language interpreting and translation, transportation, etc.)
- It does not include information related to MCO billing.

Integration of BabyNet with the Medicaid Program

- SCDHHS integrated these two programs' respective systems, BabyNet Reporting & Intervention Data Gathering Electronic System (BRIDGES) and Medicaid Management Information System (MMIS).
- SCDHHS will no longer accept balance billing as of Oct. 1, 2019.
- MMIS will now adjudicate BabyNet claims and payments. This is applicable for dates-of-service after Nov. 1, 2019.
- SCDHHS has aligned reimbursement rates and standards.
- BabyNet is the next payor of last resort after Medicaid.
- BRIDGES generates electronic claims files; not paper claims or claim forms.

Overview of TPL Policy

Overview

Cost Avoidance

- Federally mandated policy that makes Medicaid the payor of last resort
- BabyNet is the FINAL payor
- Requires Medicaid to search for other potentially liable payors before paying claim

Overview

Provider Responsibilities

- Verify eligibility
- Ask all patients about other insurance coverage
  - Provider cannot refuse beneficiary because of TPL
- Determine payment hierarchy
- Bill all other payors before billing Medicaid
- Report TPL information to Medicaid
- You do not have to get consent for Medicaid eligible BabyNet beneficiaries.
- You do have to get consent for IDEA-Part C only BabyNet beneficiaries.

Overview

TPL Eligibility Verification

- **Medicaid Card**
  - Web Tool
  - Eligibility Verification Vendors

Overview

TPL parties can include:

- Private health insurance
- Medicare
- Employment-related health insurance
- Medical support from non-custodial parents
- Long-term care insurance

Overview

TPL parties can also include:

- Other federal programs
- Court judgments or settlements from a liability insurer
- State Workers' Compensation

Overview

Coordination of Benefits (COB)

- Applies to a beneficiary covered by more than one health plan
- Applies to all health plans and other payors
  - Private insurance
  - Medicare

Overview

Sequential Billing

- **Follow these steps for billing sequentially with SCDHHS**
  - **Step 1**: Determine if there are additional insurers
  - **Step 2**: Declare insurance payment or valid denial
  - **Step 3**: Bill Medicaid/Part C as payor of last resort

Overview

How Medicaid Pays after TPL

- **If payments received by others are more than the Medicaid allowed amount, Medicaid will not pay**
  - If Medicaid copay was received, recipient is due a refund
- **If other insurance payment is less than the Medicaid allowed, Medicaid will contribute the lesser of the allowed minus the insurance payment or the sum of the coinsurance, deductible, and co-pay as determined by a plan with which the provider has a contractual arrangement**

Overview

How Medicaid Pays after TPL

- Medicaid computes an allowable amount for a procedure
- If payments received by other insurance companies are equal to or greater than the Medicaid allowed amount, Medicaid will not make a payment *(Medicaid does not pay an amount greater than the Medicaid allowed amount)*
- Medicaid, however, will not make a payment greater than the amount that the provider has agreed to accept as payment in full from the third party payor, including Medicare

Overview

How Medicaid Pays after TPL

- **Patient Responsibility**
  - Copay + Coinsurance + Deductible

Overview

How Medicaid Pays after TPL

- Medicaid compares two amounts

Medicaid Allowed Amount – Other Carrier's Paid Amount = X

or

The Patient's Responsibility Amount = y

Medicaid pays the smaller of the two x or y.

How Medicaid Pays after TPL - Example

- Example 1 = $55.00 charge

Medicaid Allowed Amount		$17.99	*Cigna Allowed Amount		$11.23
Cigna Payment	-	$ 8.98	Patient Responsibility		$ 2.25
Amount X		$ 9.01	Amount Y		$ 2.25

Medicaid payment = $2.25 (The lesser of the two amounts)

How Medicaid Pays after TPL - Example

- Example 2 = $500.00 charge

Medicaid Allowed Amount		$ 500.00	*BCBS Allowed Amount		$425.00
BCBS Payment	-	$ 400.00	Patient Responsibility		$ 25.00
Amount X		$ 100.00	Amount Y		$ 25.00

Medicaid payment = $25.00 (The lesser of the two amounts)

How Medicaid Pays after TPL - Example

- Procedure 1 = $555.00 charge
- Procedure 2= $525.00 charge

Medicaid Allowed Amount	$ 82.09	*BCBS Allowed Amount	$346.50
Medicaid Allowed Amount	$ 53.61	Patient Responsibility	$ 69.30
	$135.70		
BCBS Payment	$ 277.20		

Medicaid payment = $0.00

If a Medicaid copayment was received, the patient is due a refund

Overview

Medicaid Copayments and TPL

- **The Medicaid copay amount is deducted from the provider's payment**
- **When TPL is involved, the beneficiary is only responsible for the Medicaid copayment**
  - Exception: If the sum of TPL payments exceeds the Medicaid allowed amount, refund all or part of the Medicaid copayment to the beneficiary

TPL Edits

Edits

TPL edits occur if there is:

- Failure to file to all other insurers
- Failure to correctly code TPL information
- Failure to report information, though correct, in the right field

Edits

Common TPL Edits

- 150 - Primary insurer not indicated
- 151 - Additional insurer(s) not indicated
- 400 - Carrier or policy number missing
- 401 - No TPL carrier code

Edits

Common TPL Edits

- 557 - Carrier payments must equal other source payments
- 555 - Other sources amount greater than Medicaid allowed
- 690 - Other sources amount greater than Medicaid allowed
- 732 - Invalid payor/carrier code
- 733 - Insurance payment or denial missing
- 953 - Buy-In indicated, bill Medicare

Edits

Additional Edit

- 636 - Copayment amount exceeds allowed amount

Edits

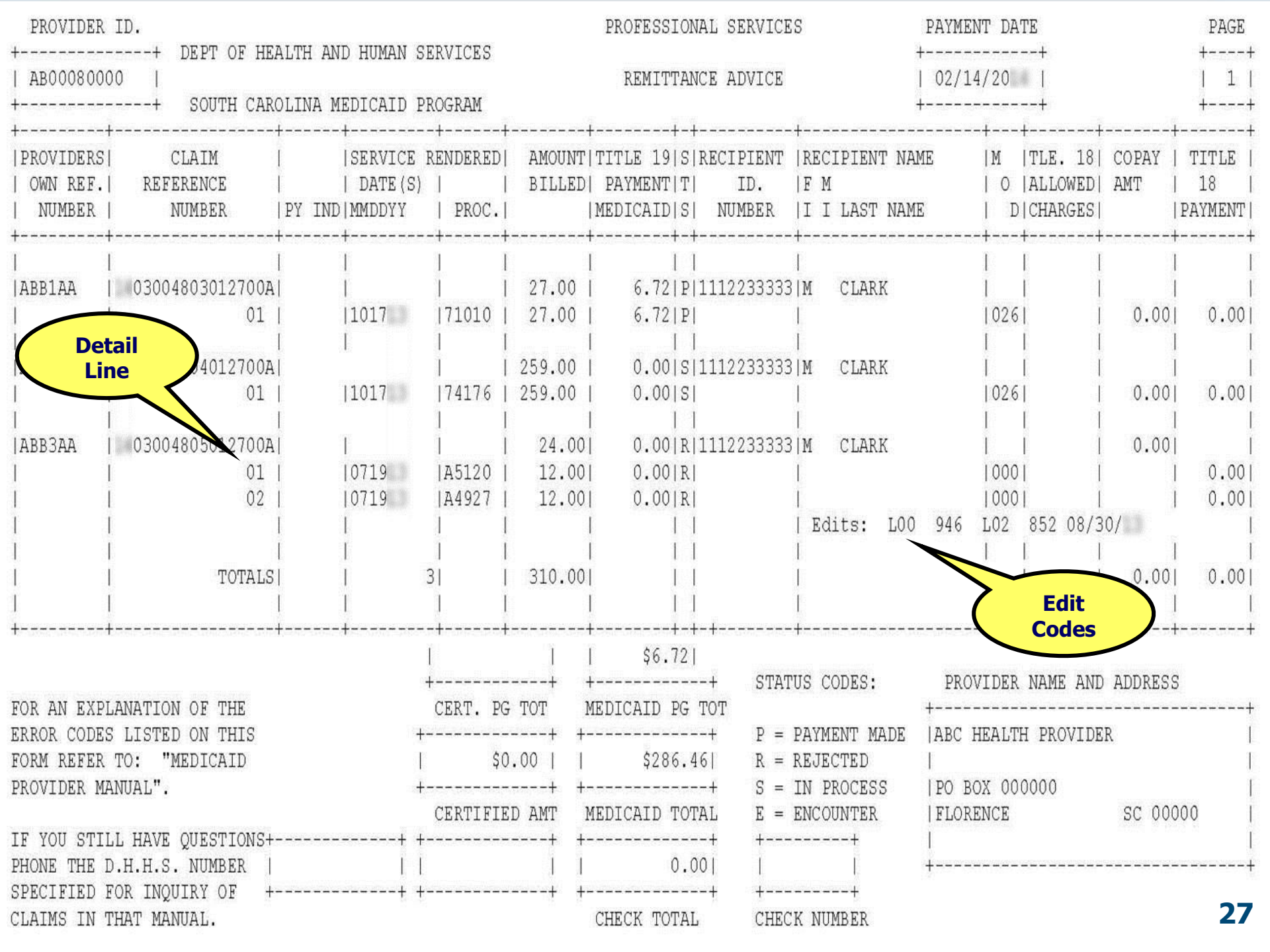
Edit Code Resolution Process

- Verify up-to-date insurance information through use of the available eligibility resources (Example: Carrier Codes, Policy Numbers)
  - Web Tool
  - Vendors
- If the eligibility status in the SCDHHS web tool does not match BRIDGES, providers/service coordinators should contact BRIDGES@scdhhs.gov.
- Request the eligibility information to be updated.
- Once this information is updated in BRIDGES, providers will be able to bill.

Edits

Edit Code Resolution Process

- **Review the Remittance Advice**
  - Look for payment or nonpayment
- **Locate the Edit Code(s) Description and Resolution**
  - Appendix 1 of the provider manual


PROVIDER ID.
AB00080000
DEPT OF HEALTH AND HUMAN SERVICES
SOUTH CAROLINA MEDICAID PROGRAM
PROFESSIONAL SERVICES
REMITTANCE ADVICE
PAYMENT DATE
02/14/20
PAGE
1
PROVIDERS OWN REF. NUMBER
CLAIM REFERENCE NUMBER
PY IND
SERVICE RENDERED DATE(S) MMDDYY
PROC.
AMOUNT BILLED
TITLE 19 PAYMENT MEDICAID
T S
RECIPIENT ID. NUMBER
RECIPIENT NAME F M I I LAST NAME
M O D
TLE. 18 ALLOWED CHARGES
COPAY AMT
TITLE 18 PAYMENT
ABB1AA
03004803012700A
01
1017
71010
27.00
6.72
P
1112233333
M CLARK
026
0.00
0.00
4012700A
01
1017
74176
259.00
0.00
S
1112233333
M CLARK
026
0.00
0.00
ABB3AA
03004805012700A
01
0719
A5120
12.00
0.00
R
1112233333
M CLARK
000
0.00
02
0719
A4927
12.00
0.00
R
000
0.00
Edits: L00 946 L02 852 08/30/
TOTALS
3
310.00
0.00
0.00
$6.72
Detail Line
Edit Codes
FOR AN EXPLANATION OF THE ERROR CODES LISTED ON THIS FORM REFER TO: "MEDICAID PROVIDER MANUAL".
IF YOU STILL HAVE QUESTIONS PHONE THE D.H.H.S. NUMBER SPECIFIED FOR INQUIRY OF CLAIMS IN THAT MANUAL.
CERT. PG TOT
$0.00
CERTIFIED AMT
MEDICAID PG TOT
$286.46
MEDICAID TOTAL
0.00
CHECK TOTAL
STATUS CODES:
P = PAYMENT MADE
R = REJECTED
S = IN PROCESS
E = ENCOUNTER
CHECK NUMBER
PROVIDER NAME AND ADDRESS
ABC HEALTH PROVIDER
PO BOX 000000
FLORENCE SC 00000

Edit Code	Desc.	CARC	RARC	RESOLUTION
150	TPL COVER VERIFIED /FILING NOT IND ON CLM	22 – Payment adjusted because this care may be covered by another payor per coordination of benefits.	MA92 - Our records indicate that there is insurance primary to ours; however, you did not complete or enter accurately the required information.	Please see INSURANCE POLICY INFORMATION for the three character carrier code that identifies the insurance company, as well as the policy number and the policyholder's name. Identify the insurance company by referencing the numeric carrier code list in the applicable provider manual or on the DHHS website. File the claim(s) with the primary insurance before re-filing to Medicaid. If the carrier that has been billed is not the insurance for which the claim received the edit 150, the provider must file with the insurance carrier that is indicated. Verify that the information in the fields below was billed correctly. **CMS 1500 CLAIM:** Enter the carrier code in field 9D and 11C, policy number in field 9A and 11. If payment is made, enter the total amount(s) paid in fields 9C, 11B and 29. Adjust the balance due in field 30. If payment is denied (i.e., applied to the deductible, policy lapsed, etc.) by the other insurance company, put a "1" (denial indicator) in field 10D. **UB CLAIM:** Enter the carrier code in field 50. Enter the policy number in field 60. If payment is made, enter the amount paid in field 54. If payment is denied, enter 0.00 in field 54 and also enter code 24 and the date of denial in the Occurrence Code fields 31-34 A and B. **NOTE:** Please refer to the Medicaid Web-based Claims Submission Tool (Web Tool) to verify insurance information.

Appendix 1

Edit Codes CARCS/ RARCS and Resolutions

Thank You


SOUTH CAROLINA
ANIMIS OPIBUSQUE PARATI
DUM SPIRO SPERO
SPES