



TENNCARE POLICY MANUAL

Policy No: CON 09-001 (Rev. 5)	
Subject: The Role of TennCare MCOs in Third Party Liability	
Approved by: <i>[Signature]</i>	Date: 9/21/2018
Approved by: <i>[Signature]</i>	Date: 9/20/2018

Section 1: PURPOSE

The purpose of this policy is to clarify responsibilities of Managed Care Organizations (MCOs) regarding identification and billing of third parties¹ for TennCare-covered services. The policy addresses a number of routine third party billing matters. It does not address issues associated with subrogation, which is defined as TennCare's right to enforce the rights of an injured party against the party causing the injury, or issues associated with estate recovery.

This policy is intended to be a companion to Policy No. CON 05-001, which deals with the responsibilities of MCOs when the enrollee has third party copays and/or deductibles. The whole area of third party payment is often called Third Party Liability, or TPL for short.

TPL has two primary functions: (1) to identify funds that may be available for services to which enrollees have access through third parties, and (2) to use these funds to offset some TennCare expenditures. Every dollar that is made available from a third party for services provided to TennCare enrollees is a dollar that TennCare does not have to spend. A robust TPL program will enable the state to replace a certain amount of program funds with funds from other insurance carriers, thereby freeing up these funds for other uses.

¹ For definitions of the kinds of entities that are considered to be "third parties," see "Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid," CMS, September 11, 2014, which is available at <https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-04-2014.pdf>.

Section 2: BACKGROUND

What is a third party payer? In the language used by health insurers, “party” has a specific meaning. The “first party” is the person who is receiving services; the “second party” is the health care provider; and the “third party” is the health insurance carrier.

TennCare is a third party payer. Some TennCare enrollees have both TennCare and other health insurance, which means there are two third party payers. In these cases, one of the third parties is “primary” and the other is “secondary.” TennCare is almost always the “payer of last resort,”² meaning that TennCare is almost always secondary to other third party payers (commercial insurance, Medicare) that may be obligated to pay for an enrollee’s health care.

Why are recognition and capture of TPL so important? Section 1902(a)(25) of the Social Security Act requires that the state “take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans, . . . service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan.” Once such legal liability is found to exist, the state must seek reimbursement from the TPL source for medical assistance provided, as long as the amount the state can reasonably expect to recover is greater than the cost of such recovery.

Who is responsible for what?

- The state has the overall responsibility for conducting the TPL program. In Tennessee, many of the functions associated with the state’s program have been delegated to the MCOs. However, the state maintains a contract with an outside TPL vendor to pursue TPL that may have been overlooked by the MCOs.
- The MCOs are obligated under their contract with the state to identify and pursue TPL.³ The capitation payments that TennCare makes to the MCOs assume a certain level of TPL opportunity in the marketplace.
- Providers are also involved in identifying and accessing TPL. The MCO contract notes that provider agreements maintained by the MCOs must specify the provider’s obligation to pursue TPL.⁴ Most providers prefer to bill TPL when they know it is available.
- Enrollees have a role, too. Every person who participates in TennCare automatically assigns his right to collect TPL to the “State” (meaning, in this instance, TennCare), which has delegated this authority to the MCOs.⁵

² See TennCare Rules 1200-13-13-.09(6) and 1200-13-14-.09(6).

³ See Section A.2.21.4.1 of the MCO Statewide Contract.

⁴ See Section A.2.12.9.33 of the MCO Statewide Contract.

⁵ Ibid. See also T.C.A. §§ 71-5-117(b) and (f).

Section 3: METHODS FOR ACCESSING TPL

There are two primary methods for accessing TPL. One method is called “cost avoidance,” and in this method the state or its agents withhold payment to the provider until the third party payer has paid its share. The other method is called “pay and chase,” and in this method the state or its agents pay the claim and pursue payment from the third party source.

Under 42 CFR § 433.139(b)(3), the state is obligated to pay certain claims through the “pay and chase” approach (meaning that the MCO pays the provider and then attempts to collect from the TPL source). The services for which the “pay and chase” method is required are identified as (a) preventive pediatric services (including EPSDT) and (b) services to children on whose behalf child support enforcement is being carried out by the state Title IV-D agency.⁶

TennCare’s position is that all services to children fall under the rubric of EPSDT. The MCOs are obligated to pay and chase all claims they receive for services furnished to children. Providers are not prohibited from seeking out TPL and accessing it for services provided to children before they submit their claims to the MCO. However, once they file their claims with the MCOs, the MCOs must pay and chase.

Section 4: HOW PROVIDERS CAN LEARN ABOUT TPL AVAILABILITY

Providers are required by the terms of their provider agreements to attempt to determine at the point of service whether a patient has medical coverage other than TennCare.⁷ They may certainly ask their patients for this information, but patient recall is not the only method available, and it is not always reliable.

There are a number of sources of information about TPL that are generally available. One such source is TennCare Online Services (formerly Tennessee Anytime), a service that primarily offers eligibility information. It provides some TPL information, but it was never intended to be an exhaustive and authoritative source of data about third party payers. The URL for TennCare Online Services is <https://www.tn.gov/tenncare/tenncare-online-services.html>.

Because a person’s access to insurance other than TennCare may change from time to time, providers should check a patient’s TPL status at every visit. A provider may become aware of information about an enrollee’s access to third party insurance that is not reflected in TennCare Online Services. When this happens, the provider should complete the TPL Update Request Fax

⁶ See 42 CFR § 433.139(b)(3). The list of services for which the “pay and chase” approach is required previously included prenatal care for pregnant women. The Bipartisan Budget Act of 2018 (Pub. L. 115-123), however, changed this requirement by obligating states to use the “cost avoidance” approach with regard to claims for prenatal care for pregnant women.

⁷ See Section A.2.12.9.33 of the MCO Statewide Contract regarding the requirements for provider agreements.

Form located at <https://www.tn.gov/content/dam/tn/tenncare/documents/TPLFORM.pdf> and promptly submit it to TennCare in order to help ensure that TennCare Online Services contains the most current information available.

Section 5: TPL PROCEDURES FOR MCOS

MCO procedures for dealing with TPL are determined based on certain factors, including whether the enrollee is a child under the age of 21 or a Medicare beneficiary.

Group #1: TennCare enrollees who do not have Medicare but who are children under age 21.

When an MCO receives a claim for a service provided to an enrollee in this group, then the MCO may not deny the claim on the grounds that TPL is available. Instead, the MCO must pay and chase. When the MCO makes its claim to the third party that is responsible for the claim, the MCO may accept from the third party no more than the amount of its payment to the provider.⁸

Group #2: TennCare enrollees who do not have Medicare and who are adults age 21 and older.

When a claim for an enrollee in this group comes to the MCO before being submitted to a third party payer, the MCO must deny it and return it to the provider with instructions to file the claim with the third party payer. Recognizing that the provider may have been unaware of the availability of TPL, the MCO must give the provider sufficient information about the coverage arrangement so that the provider can appropriately submit his claim to the third party payer. Such information includes, but is not limited to, contact information for the TPL source (i.e., name and address); information about the policy, such as the policy number and/or the member identification number; and information about coverage effective dates and termination dates.

If the MCO pays the provider's claim and subsequently discovers TPL, the MCO may recoup the payment that has been made to the provider if all of the following conditions are met:

1. The claim involved was for a service delivered to an adult aged 21 or older;
2. Less than six months have passed since the date of service;
3. Prior to recoupment of its payment, the MCO notified the provider with a refund request letter that included, at a minimum:
 - The name of the MCO;
 - The name of the provider;
 - The list of claims or a reference to a remit advice date;

⁸ See T.C.A. § 71-5-117.

- The reason the MCO considers the payment to have been made in error (e.g., “Another insurance carrier was the primary carrier at the time of service”);
 - The identification and contact information of insurance carrier who was determined to have been primary at the time of service, together with information about the insurance policy so that the provider can bill the insurance carrier;
 - A time period of at least 45 calendar days in which the provider may return the MCO’s payment and/or appeal the decision;
 - Information about how and where to file an appeal with the MCO (phone number, contact information); and
 - A request that the provider submit the claim(s) to the primary carrier if not already done.
4. When providers choose to appeal the refund request letter from the MCO, they are given 30 calendar days in addition to the 45 initial calendar days stated in the letter to provide sufficient documentation to the MCO prior to the MCO’s recovery of their payment. Providers should include in their appeals a copy of a denial from the primary carrier, if available; and,
5. The MCO has ensured that there is a separate Service Line or Prompt for Provider Inquiries regarding these recoveries.

Only if all of the conditions above are met may the MCO recoup a payment that has already been made to a provider on the basis of TPL availability. Otherwise, the MCO should seek reimbursement directly from the TPL source.

Group #3: TennCare enrollees with Medicare. When an enrollee has both TennCare and Medicare, Medicare is first payer.

If a provider submits a claim to the MCO for a service that could be billed to Medicare, and the MCO is aware of the availability of Medicare, the MCO will deny the claim and return it to the provider with instructions that the provider bill Medicare. The MCO must give the provider sufficient information so that the provider can submit the claim to Medicare. Such information includes contact information for Medicare’s claims division, the Medicare claim number, the type(s) of Medicare coverage to which the enrollee is entitled, and effective dates for each coverage type.

If a provider submits a claim to the MCO and the MCO pays the claim without being aware of the availability of Medicare, the MCO is obligated to recover the payment from the provider when it learns about the availability of Medicare. This exception is necessary because the federal government does not allow state Medicaid programs (or agents acting on behalf of

state Medicaid programs, such as MCOs) to bill and receive payment from Medicare. Only providers may bill and receive payment from Medicare.

MCOs may not recoup a payment in this manner, however, if the date of service is more than 300 days in the past. This is to ensure that the provider has sufficient time to file a reimbursable claim with Medicare, given that Medicare has a timely filing limit of one year.

Some TennCare enrollees who also have Medicare are eligible for the state to pay for some or all of their Medicare cost-sharing. These payments are called “crossover payments.” The MCOs are not responsible for crossover payments for these individuals. However, for all other Medicare beneficiaries who are enrolled in an MCO, the MCO is responsible for coordination of benefits with Medicare.⁹

The following table is provided to summarize the information in this section.

Table 1
TPL and Claims Payment Responsibilities

Enrollee Group	What Provider Should Do After Providing a Service	What the MCO Should Do in Response to the Provider’s Action
#1: Enrollee does not have Medicare but is a child under age 21.	If the provider is aware of TPL, the provider should bill the TPL source.	The MCO is responsible for coordination of benefits.
	If the provider is not aware of TPL, the provider should bill the MCO.*	The MCO must pay and chase once it receives the claim.
#2: Enrollee does not have Medicare and is not a child under age 21.	If the provider is aware of TPL, the provider should bill the TPL source.	The MCO is responsible for coordination of benefits.
	If the provider is not aware of TPL, the provider should bill the MCO.*	The MCO should return the claim and furnish the provider with information

⁹ For more information on this subject, see <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Coordination-of-Benefits/Coordination-of-Benefits.html>. See also Section A.2.9.13 in the MCO Statewide Contract.

Enrollee Group	What Provider Should Do After Providing a Service	What the MCO Should Do in Response to the Provider's Action
		<p>about available TPL so that the provider can bill the TPL source.</p> <p>If the MCO pays the claim and later becomes aware of TPL, and if less than six months have passed since the date of service, the MCO may recoup the payment from the provider according to the procedure described in Section 5 above.</p>
<p>#3: Enrollee has Medicare.</p>	<p>If the provider is aware that the enrollee has Medicare, the provider should bill Medicare.</p>	<p>The State pays crossover claims for QMBs and full-benefit dual eligibles.¹⁰ For other dual eligibles, the MCO is responsible for coordination of benefits with Medicare.</p>
	<p>If the provider is not aware that the enrollee has Medicare, the provider should bill the MCO.*</p>	<p>If the MCO is aware of available Medicare, the MCO will return the claim to the provider and instruct him to bill Medicare.</p> <p>If the MCO pays the claim and then learns about the availability of Medicare, the MCO will recoup its payment from the provider and instruct him to bill Medicare UNLESS it has been 300 or more days since the date of service. If that is the case, the MCO may not recover its</p>

¹⁰ Full-benefit dual eligibles are Medicare beneficiaries who qualify in a TennCare eligibility category (e.g., “QMB-Plus,” “SLMB-Plus”).

Enrollee Group	What Provider Should Do After Providing a Service	What the MCO Should Do in Response to the Provider's Action
		payment to the provider.

* This does not relieve providers of their contractual obligation to seek TPL before billing TennCare.

In some situations, the TPL source may pay only a portion of the claim, returning it to the MCO for payment of remaining charges and coordination of benefits. When this happens, the MCO should use only the third party's actual payment to the provider as the basis for determining its payment. The use of "contractual write-offs" and similar methods that give the appearance of more having been paid to the provider than was actually the case is not permitted.

What happens when a provider learns about the availability of TPL after receiving a payment from the MCO and the provider wishes to return its payment and pursue the TPL source?

These situations are outside the scope of this policy, since disputes in this area are currently being handled by the courts.¹¹ However, the following should be noted: by submitting a claim to the MCO and accepting payment, the provider has indicated his willingness to accept this payment, plus any applicable TennCare copays, as "payment in full."¹² Once a provider has returned a payment to the MCO, the MCO is under no obligation to make that payment a second time if the provider decides to make another request for it.

What happens when a TPL source denies a claim for failure to meet timely filing deadlines?

Some sources of TPL have shorter timely filing deadlines than others do. If a provider receives a denial from the TPL source for lack of timely filing, the provider may then submit the claim to the MCO, attaching documentation of the TPL denial. The MCO will establish a new timely filing deadline for the claim, which will begin on the date that the TPL source denied the claim (not the date of service, which ordinarily starts the clock on timely filing). For a more extensive treatment of the subject of timely filing deadlines in the TennCare program, see TennCare Policy PAY 13-001, a copy of which is available online at <https://www.tn.gov/content/dam/tn/tenncare/documents2/pay13001.pdf>.

OFFICES OF PRIMARY RESPONSIBILITY:

TennCare Office of the Chief Medical Officer
TennCare Office of Managed Care Operations

¹¹ See, for example, *Spectrum Health Continuing Care Group v. Anna Marie Bowling Irrevocable Trust Dated June 27, 2002*, 410 F.3d 304 (2005) and *Diane West et al. v. Shelby County Healthcare Corp., d/b/a Regional Medical Center at Memphis*, No. W2012-00044-SC-R11-CV (Tenn. Dec. 19, 2014).

¹² See TennCare Rules 1200-13-13-.08(1) and 1200-13-14-.08(1).

REFERENCES:

Section 6404 of the Patient Protection and Affordable Care Act of 2010, codified at 42 U.S.C. § 1395f(a)(1) and 42 U.S.C. § 1395n(a)(1)

<http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf>

Section 53102 of the Bipartisan Budget Act of 2018

<https://www.congress.gov/115/bills/hr1892/BILLS-115hr1892eas2.pdf>

42 U.S.C. § 1320a-7k(d)

<http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section1320a-7k&num=0&edition=prelim>

42 C.F.R. § 433, Subpart D

<http://www.gpo.gov/fdsys/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-part433.pdf>

State Medicaid Manual, Section 3900, 3901 and 3904.4.

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021927.html>

Medicaid and CHIP FAQs: Identification of Medicaid Beneficiaries' Third Party Resources and Coordination of Benefits with Medicaid

<https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-04-2014.pdf>

CMCS Informational Bulletin: Medicaid Provisions in Recently Passed Federal Budget Legislation Bipartisan Budget Act of 2018 – Third Party Liability in Medicaid and CHIP

<https://www.medicaid.gov/federal-policy-guidance/downloads/cib060118.pdf>

T.C.A. §§ 71-5-117(b) and (f)

<http://www.lexisnexis.com/hottopics/tncode/>

TennCare Rules 1200-13-13-.09 and 1200-13-14-.09

<https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13.htm>

TennCare/MCO Statewide Contract

<https://www.tn.gov/content/dam/tn/tenncare/documents/MCOStatewideContract.pdf>

TennCare Policy No. CON 05-001

<https://www.tn.gov/content/dam/tn/tenncare/documents2/con05001.pdf>

TennCare Policy No. PAY 13-001

<https://www.tn.gov/content/dam/tn/tenncare/documents2/pay13001.pdf>

TennCare Online Services (formerly Tennessee Anytime)

<https://www.tn.gov/tenncare/tenncare-online-services.html>

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Revision 4: 08/12/16: AB
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