Rule No. 560-X-20-.04. Third Party Payments/Denials

(1) Third Party Payments other than Medicare

(a) Third Party payments must be applied to the services for which the third party paid.

(b) Providers receiving a third party payment prior to filing Medicaid must document in the appropriate field on the claim the amount of the third party payment.

(c) Providers receiving a third party payment after Medicaid is filed must within 60 days of receiving duplicate payment:

1. ~~send a r~~Refund ~~of~~ the lessor of the insurance paid amount or the Medicaid paid amount ~~money~~ to the Third Party Division, Alabama Medicaid Agency; or

2. ~~write the Medicaid fiscal agent and request an adjustmentof Medicaid payment (a copy of the request MUST be sent to the Third Party Division, Alabama Medicaid Agency).~~Submit an adjustment request to the Medicaid Fiscal Agent that resolves the duplicate payment. ~~.~~

(d) If the third party pays the recipient or source other than the provider, the provider is responsible for obtaining the third party payment prior to filing Medicaid. ~~The provider is responsible for reimbursing Medicaid if a third party pays the recipient or source other than the provider for Medicaid covered services if the third party makes payment as a result of information released by the provider~~If the Third Party pays a source other than Medicaid, as a result of information released by the Provider and Medicaid has paid the Provider, Medicaid may recoup its payment. ~~.~~

(e) If the provider accepts a patient with a third party resource ~~as~~and Medicaid, the provider cannot bill the patient for Medicaid covered services if:

1. ~~t~~The third party pays more than Medicaid allows ~~which results in Medicaid not making payment~~and Medicaid zero pays the claim.~~.~~

2. ~~the claim is denied by Medicaid because of third party resources and the recipient furnishes in a timely manner~~Medicaid denies a claim because a third party resource exists and recipient has provided -third party information in a timely manner.

(f) A provider may bill a Medicaid patient if Medicaid denies a claim because of available third party benefits and the provider cannot obtain sufficient information needed to file a third party claim from either the recipient, AVRS, MACSAS or the Medicaid Agency.

(2) Third Party Payments - Medicare

(a) Providers must attach a copy of the Medicare EO~~MB~~B to the Medicaid claim.

(b) Within 60 days of receiving duplicate Medicaid and Medicare payments the provider must:

1. Refund the Medicaid payment to the Medicaid fiscal agent and state the reason for the refund; or

2. Request that the Medicaid fiscal agent adjust the Medicaid claim.

(3) Third Party Denials

(a) Providers must attach third party denials of benefits to their Medicaid claim when filing for Medicaid benefits. These claims must be filed as paper claims.

(b) Providers must state on the Medicaid claim "Denied by Third Party" if third party benefits are denied.

(c) Only true denials of benefits are acceptable, i.e., policy has lapsed, benefits applied to deductible, non-covered services, etc.

(d) Denials due to the Third Party's requirement to use participating plan providers, service requires pre-certification, etc. wil not be accepted as valid denials, unless further documentation is provided that justifies that the third party requirement cannot be met

(4) Recipient responsibility regarding third party requirements – A recipient must fulfill the primary insurance's requirement before Medicaid will pay. Claims that are denied by a third party payer because of precertification requirements, failure to use participating providers, etc., may be denied by Medicaid as an invalid denial reason. A recipient cannot be billed if the failure to meet the primary plan's requirements are due to the provider's error. If failure to meet the primary plan's requirement is due to the recipient's failure to notify the provider of the other insurance, then the recipient can be held responsible for the charges.

(45) Questions regarding third party payment/denials should be referred to the Third Party Division, Alabama Medicaid Agency.

(6) Balance Billing – Federal law prohibits Medicare providers from balance-billing QMBs for Medicare cost-sharing. All Medicare physicians, providers, and suppliers who offer services and supplies to QMBs are prohibited from billing QMBs for Medicare cost-sharing, including deductible, coinsurance, and copayments. QMBs have no legal obligation to make further payment to a provider or Medicare managed care plan for Part A or Part B cost sharing. Providers who inappropriately bill QMBs for Medicare cost-sharing are subject to sanctions.

Authority: Wanda Wright, Administrator, Third Party Liability Division.
Statutory Authority: 42 C.F.R. Sections 432 & 433; Section 1902(a)(25), Social Security Act; 22-6-6 of 1975 Code of Alabama. Sections 1902(N)(3)(b) of the Social Security Act.
History: Effective date of this amendment January 13, 1993. Amended: Filed November 18, 2014.