STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

Requirements for Third Party Liability –
Payment of Claims

The Medicaid Agency's TPL program primarily functions as a cost avoidance system. Claims for medical services, unless excluded by federal law, are cost-avoided when a third party liability policy exists with the Medicaid Agency's claims payment system. Claims paid prior to the identification and input of third party coverage into the claims payment system are pursued by a vendor for post-payment recovery.

Provider compliance with third party billing requirements (42 CFR 433.139(b)(3)(ii)(C)):

The State Plan as referenced herein requires providers to bill liable third party coverage. When a probable third party coverage is established, the Medicaid Agency notifies the provider that the claim was cost-avoided due to the existence of TPL. TPL cost-avoided claims are identified with an Explanation of Benefit Code which provides the third party payer information on the provider's Remittance Advice. Exceptions to the cost-avoidance process:

- claims as specified in 42 CFR 433.139(b)(3)(i),
- when the pursuit of liable third party can result in harm to the beneficiary (Good Cause exemption under 42 CFR 433.147(c)(2)),
- any approved cost-avoidance waiver.

The Medicaid Agency will apply cost-avoidance procedures for prenatal services, including labor, delivery and postpartum care services.

In accordance with 42 CFR 433.139(b)(3)(i), the Medicaid Agency will make payment without regard to potential TPL for pediatric preventive services and will seek recovery from the carrier, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost-avoidance for 90 days. If a provider has billed a third party for pediatric preventive services and has not received a response, the provider will be required to submit proof that at least 90 days has passed from the date of service before the Medicaid Agency will pay the claim.

Where the third party liability is derived from a parent whose obligation to provide medical support is being enforced by the State Title IV-D Agency, providers will be required to bill the third party before filing Medicaid. If a provider has billed a third party and has not received payment, the provider will be required to submit proof that at least 100 days has passed from the date of service before the Medicaid Agency will pay the claim.

Providers are monitored for compliance with insurance billing requirements through post payment recovery by a vendor. If a report of prior payment to either the provider or insured person is received, the amount paid by the carrier is recouped from the provider.

Third Party Collection Procedures to be Cost-Effective:

The Medicaid Agency's MMIS uses a $50 threshold in determining whether to seek recovery from a health insurance carrier for all except drug claims. Claims which do not exceed a paid amount of $50 are placed in an automated suspense file. The suspense file is read monthly to identify recipients whose accumulated claims exceed the threshold. Claims are carried on the suspense file for up to twelve months. The Medicaid Agency's MMIS uses a $25 threshold for drug claims. Drug claims are accumulated monthly for submission to a third party. Accumulated claims which exceed a $25 paid amount are submitted to the third party carrier.

The Medicaid Agency uses a $250 threshold for casualty recovery. Once a liable third party is identified, the entire recipient paid claims history is reviewed. If the accumulated total of paid claims related to the injury third party exceeds $250, recovery is sought from the liable third party.