MEDICAID SERVICES MANUAL (MSM)
TRANSMITTAL LETTER

August 27, 2019

TO: CUSTODIANS OF MEDICAID SERVICES MANUAL

FROM: TAMMY MOFFITT, CHIEF OF OPERATIONS

SUBJECT: MEDICAID SERVICES MANUAL CHANGES
CHAPTER 100 – MEDICAID PROGRAM

BACKGROUND AND EXPLANATION

Revisions to Medicaid Services Manual (MSM) Chapter 100, Section 104.3 – Medicaid Program are being proposed to move the MSM to the State's new Medicaid Operations Manual (MOM) Chapter 900 – Cost Avoidance Programs.

The content of the Health Insurance Premium Payments (HIPP) program has been removed to better align with in-house operations.

Entities Financially Affected: No impact to Medicaid providers.

Financial Impact on Local Government: No financial impact to local Government.

These changes are effective: August 28, 2019.

MATERIAL TRANSMITTED		MATERIAL SUPERSEDED
CL		MTL 04/19
MSM Chapter 100 – Medicaid Program		MSM Chapter 100 – Medicaid Program

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
104.3	**Health Insurance Premium Payment (HIPP)**	Removed sentence outlining HIPP program. Removed NCU reference statement. Added statement for HIPP reference to MOM 900 for program outline.

104 THIRD PARTY LIABILITY (TPL) – OTHER HEALTH CARE COVERAGE

Medicaid is generally the payer of last resort whenever there are any other responsible resources for payment of health care services. Other Health Care Coverage (OHC) includes, but is not limited to: Medicare, worker's compensation insurance, private or group insurance and any self-insured plans.

Recipients who have major medical insurance cannot participate in the NCU program. If a provider discovers a participant in NCU has major medical insurance, they must report to the DHCFP.

A. Providers should question all patients carefully regarding any other possible medical resources. If coverage has lapsed, or if insurance is discovered when none is indicated on the EVS, VRU or swipe card, an explanatory note attached to the claim will enable the fiscal agent to update the Third-Party Liability (TPL) file.

B. Providers are required to bill a recipient's OHC prior to billing Medicaid.

C. Medicaid MCO is not considered an OHC. Providers should refer recipients enrolled in a Medicaid MCO plan to the contact that is identified by the Fiscal Agent's EVS or swipe card vendor unless the provider is authorized to provide services under the plan.

D. If the provider does not participate in a recipient's OHC plan, the provider must refer the recipient to the OHC. Nevada Medicaid will deny payment for OHC services if the recipient elects to seek treatment from a provider not participating in the OHC plan. If the Medicaid recipient is informed by a provider not authorized by the OHC that both the OHC and Medicaid may deny payment for the services, and the recipient then voluntarily elects to receive services from a provider who does not participate in the recipient's OHC plan, the recipient assumes the responsibility to pay for the services personally.

E. The provider must inform the recipient, or responsible individual, before services are provided that they will be financially responsible for the cost of services. If the recipient chooses to continue with the service, the provider must secure a written and signed statement at the time of the agreement which includes the date, type of services, cost of service and the fact that the recipient, or responsible individual, has been informed Medicaid will not pay for the services and agrees to accept full responsibility for the payment. This agreement may not be in the form of a blanket authorization secured only once (for example, at the time of consent for all treatment). It must be specific to each incident or arrangement for which the recipient, or responsible individual, accepts financial responsibility.

F. A Medicaid provider cannot refuse to provide Medicaid covered services to a Medicaid eligible recipient due to potential TPL coverage.

G. Providers are required to bill Medicare for services provided to Medicare beneficiaries and must accept assignment if the recipient is a Medicare beneficiary and eligible for Medicaid, including Medicare/Medicaid (dual eligible) and QMBs.

H. If providers are unable to pursue TPL, assistance may be requested within one year from the date of service through the Fiscal Agent's TPL Unit. See Reference Section of this chapter. Providers are requested to contact the Fiscal Agent's TPL Unit within four weeks after the date of service or TPL date of discovery. In many instances this prompt action will result in additional insurance recoveries.

I. Providers should not release itemized bills to Medicaid patients. This will help prevent prior resources from making payment directly to the patient. Providers are encouraged to accept assignment whenever possible to lessen insurance problems by receiving direct payments.

104.1 PAYMENT LIMITS AND EXCEPTIONS

The total combined payment of other insurance and Medicaid cannot exceed the Medicaid maximum allowable. For Medicare services which are not covered by Medicaid, or for which Nevada does not have an established rate, Medicaid will pay the Medicare co-insurance and deductible amounts. In all instances, Medicaid payment, even a zero-paid amount, is considered payment in full and no additional amount may be billed to the recipient, his or her authorized representative or any other source.

Medicare recipients covered by Medicaid as QMB are entitled to have Medicaid pay their Medicare premiums, co-insurance and deductible amounts for regular Medicare benefits. Some individuals may have this coverage as well as full Medicaid benefit coverage.

Some QMB only recipients may have a Health Management Organization (HMO) for their Medicare benefits. Any services provided to a QMB only recipient by the HMO which exceed the standard Medicare benefit package (i.e., prescription drugs) will not have co-payments and deductible amounts paid by Medicaid for those added benefits.

Co-pays and/or deductibles, set forth by the OHC, cannot be collected from a Medicaid recipient for a Medicaid covered service. Rather, the provider must bill Medicaid for the co-pay and/or deductible. In no instance will Medicaid's payment be more than the recipient's co-pay and/or deductible. Medicaid can make payments only where there is a recipient legal obligation to pay, such as a co-pay and/or deductible. EXCEPTION: Medicaid pays only co-payments and

deductibles for regular Medicare benefits, even if provided through a Medicare HMO.

Nevada Medicaid is not liable for payment of services if the recipient elects to seek treatment from a provider outside the OHC network, or if the provider fails to follow the requirements of the OHC. Exceptions to Medicaid liability policy for OHC coverage are:

A. the service(s) is/are not covered by the OHC plan;

B. the service is an emergency and the recipient is not given an option to choose/select where they are taken; or

C. the recipient resides outside the service area of the OHC and accesses the nearest Nevada Medicaid provider.

Providers who have entered into an OHC agreement agree to accept payment specified in these agreements and must bill Medicaid for the recipient's co-pay and/or deductible. In no instance can the provider bill Medicaid for an amount that exceeds the patient's legal obligation to pay under the OHC agreement.

After receiving payment or a denial letter from the OHC, if the provider is submitting a paper claim, they must also submit the OHC's EOB, computer screen print-out or denial letter to the fiscal agent. All attached documents must reflect the name of the patient, date of service, service provided, the insurance company, the amounts billed, approved and paid.

It is not necessary to bill the OHC if it is known the specific service provided is not a covered benefit under the OHC policy. In this instance, the provider must note on the claim the date, phone number and name of the person from whom the coverage information on the insurance was obtained and submit the claim to the Medicaid fiscal agent for processing. If the recipient's OHC is Medicare and the service is not a covered Medicare service, the provider is not required to contact Medicare.

Providers must bill Medicaid for all claims, regardless of the potential for tort actions, within the specified time frame from the date of service or date of eligibility determination, whichever is later. Time frames are according to the Medicaid stale date period when no third-party resource has been identified; or 365 days, when a third-party resource exists.

Not all medical benefit resources can be discovered prior to claims payment. Therefore, a post payment program is operated. In these instances, Medicaid payment is recovered from the provider and the provider is required to bill the OHC resource. If OHC has been identified by the Medicaid system and the other resource has not been billed and the service(s) is/are a covered benefit of the OHC, the payment will be denied. The insurance carrier information will appear on the Medicaid

remittance advice to enable the provider to bill the OHC.

Exceptions to the TPL rule are:

D. Indian/Tribal Health Services (IHS);

E. Children with Special Health Care Needs; and

F. State Victims of Crime.

Medicaid is primary payer to these three programs; however, this does not negate the provider's responsibility to pursue OHC. For specific information on IHS billing, refer to MSM Chapter 600, Section 603.8.

104.2 SUBROGATION – COST SAVINGS PROGRAM

In certain trauma situations, there may be a source of medical payments other than regular health insurance. This source could be through automobile insurance, homeowner's insurance, liability insurance, etc. A provider may elect to bill or file a lien against those sources, or Medicaid may be billed.

Nevada Medicaid will allow providers who accept(ed) a Medicaid payment for services directly related to injuries or accidents to subsequently return that payment to Medicaid in order to seek reimbursement directly from a liable third party.

Pursuant to NRS 422.293, subrogation cases are considered to be recovery of medical cost incurred and are unusual in that collection is often not a straight-forward process. Subrogation is a Cost Savings Program and resides in the Nevada MOM Chapter 800.

http://dhcfp.nv.gov/Resources/AdminSupport/Manuals/MOM/MOMHome/

104.3 HEALTH INSURANCE PREMIUM PAYMENTS (HIPP)

Nevada Medicaid may pay insurance premiums through Employer-Based Group Health Plans for individuals and families when it is cost effective for the agency. The HIPP program outline can be found in the DHCFP Medicaid Operations Manual (MOM) 900.~~In determining cost-effectiveness, the fiscal agent uses a formula as set forth in the State Plan or considers whether the individual has catastrophic illness or condition (e.g., AIDS or AIDS-related conditions, Down syndrome, cerebral palsy, cystic fibrosis, fetal alcohol syndrome, etc.)~~

~~NCU participants are not eligible for HIPP.~~