Revision: HCFA-PM-94-1 (MB)
FEBRUARY 1994

State/Territory: NEVADA

REQUIREMENTS FOR THIRD PARTY LIABILITY

Citation: 4.22 Third Party Liability

42 CFR 433.137
1902(a)(25)(H) and (I) of the Act

(a) The Medicaid agency meets all requirements of:

(1) 42 CFR 433.138 and 433.139.
(2) 42 CFR 433.145 through 433.148.
(3) 42 CFR 433.151 through 433.154.
(4) Sections 1902(a)(25)(H) and (I) of the Act.

42 CFR 433.138(f)

(b) ATTACHMENT 4.22-A: IDENTIFING LIABLE RESOURCES

(1) Specifies the frequency with which the data exchanges required in 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in 433.138(e) are conducted;

42 CFR 433.138 (g)(1)(ii) and (2) (ii)

(2) Describes the methods the agency uses for meeting the follow-up requirements contained in 433.138(g)(1)(i) and (g)(2)(i);

42 CFR 433.138 (g)(3)(i) and (iii)

(3) Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under 433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third-party data base and third-party recovery unit of all information obtained through the follow-up that identifies legally liable third-party resources; and

42 CFR 433.138 (g)(4)(i) through (iii)

(4) Describes the methods the agency uses for following up on paid claims identified under 433.138(e) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

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42 CFR 433.139(b)(3)(ii)(A)	X	(c)	Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency.
		(d)	ATTACHMENT 4.22B – PAYMENT OF CLAIMS
CFR 433.139(b)(3)(ii)(C)		(1)	The method used in determining a provider's compliance with the third-party billing requirements at '433.139(b)(3)(ii)(C).
42 CFR 433.139(f)(2)		(2)	The threshold amount or other guideline used in determining whether to seek recovery of reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.
42 CFR 433.139(f)(3)		(3)	The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.
42 CFR 447.20		(e)	The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

Citation

4.22 (continued)

42 CFR 433.151(a)

(f) The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third-party benefits assigned to the State as a condition of eligibility for medical assistance with at least one of the following: (Check as appropriate.)

X State title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

___ Other appropriate State agency(s).

___ Other appropriate agency(s) of another State.

___ Courts and law enforcement officials.

1902(a)(60) of the Act

(g) The Medicaid agency assures that the State has in effect the laws relating to medical child support under Section 1908 of the Act.

1906 of the Act

(h) The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan by selecting one of the following.

___ The Secretary's method as provided in the State Medicaid Manual, Section 3910.

X The State provides methods for determining cost effectiveness on Attachment 4.22-C.

THIRD PARTY LIABILITY – IDENTIFYING LIABLE RESOURCES

Expansion of Third-Party Liability – Payment of Claims associated to Cost Saving Programs in Attachment 4.22-B of the State Plan.

433.138(d)(1) &(d)(3) (IV-A); (Exchange of Data)

(1) Nevada obtains information for the purpose of determining the legal liability of third parties from data exchanges with the Department of Employment, Training and Rehabilitation, Employment Security Division (ESD), Title IV-A Agency, Title IV-D Agency, Commercial Insurance Carriers, Referrals, Health Insurance Premium Program (HIPP), Third Party Liability (TPL) Reviews and from the diagnosis and trauma code edits for a data match. At the time of application for assistance, a match is done automatically.

The Division of Welfare and Supportive Services (DWSS) is the State IV-A agency for employment information. Employment information is utilized to determine Medicaid eligibility and employment TPL. The State's TPL management team updates and populates the data into the Medicaid Management Information System (MMIS).

The State of Nevada Department of Personnel conducts an exchange of data with the states TPL management team. A match of all Medicaid eligibles with responsible absent parent (IV-D) or parent (IV-A) by Social Security Number to determine if they are employed by the state of Nevada.

Support Enforcement (IV-D) has an automated quarterly match with ESD's quarterly wage report and can obtain information upon request. IV-D will follow up on court ordered health insurance or will seek a court order on employed non-custodial parents. TPL information is obtained through data match of majority insurers for court ordered health insurance to be populated into MMIS.

433.138(d)(4) and 433.138 (g)(3)(i) and (iii) (Workers Compensation and Motor Vehicle)

DWSS oversees initial application through single point entry system for Medicaid applications, applicants self-report through a form process; documentation requirement.

THIRD PARTY LIABILITY – IDENTIFYING LIABLE RESOURCES

Worker's Compensation and the Department of Motor Vehicles and Public Safety (DMV&PS) information is not available through Nevada's Department Motor Vehicle and Public Safety.

The DHCFP TPL management is responsible for review and submission of injury accident questionnaires for worker compensation and vehicle accidents. Claims which edit for trauma codes are referred to the Fiscal Agent (FA) Subrogation Unit for follow-up if the billed amount of the claim is greater than the tolerance level. The claim is reviewed to determine the possibility of other liable parties for claim payment. Managed Care Organizations and the Dental Benefit Administrator are required to data mine Medicaid enrollees through identifying potential casualty claims.

The claim is reviewed to determine if the nature of the trauma is one which warrants follow-up (e.g., a broken leg as a result of a fall in individual's own home versus a traffic accident). If an investigation is not in process or probable liability has not been established at the time the claim was filed, the investigator will begin research to determine if a probable third party is liable. If TPL is not established within 60 days, the claim is processed for payment.

The DMV&PS has a computerized system containing information of individuals involved in accidents, associated injuries for Nevada Highway Patrol reported accidents only. No medical insurance coverage information is reported. (A copy of the letter from DMV&PS is attached.)

433.138(e) (Diagnosis and Trauma Edits)

The Medicaid claims processing system on a per claim basis edits were updated to reflect new International Classification of Diseases (ICD) codes:

The TPL management team reviews to determine if the nature of the trauma is one which warrants follow-up (e.g., a broken leg as a result of a fall in individual's own home versus a traffic accident). If an investigation is not in process or probable liability has not been established at the time the claim was filed, the investigator will begin research to determine if a probable third party is liable. If TPL is not established within 60 days, the claim is processed for payment.

As of 2016, the Centers for Medicare & Medicaid Services (CMS) no longer specifies codes for follow up or reviews. CMS approved State Medicaid Agency (SMA) exemptions of specific codes from none productive trauma code recovery.

433.138(g) (1) (i) and (g) (2) (i)

Follow-up procedures for identifying legally liable third-party resources:

Within 45 days from application, redetermination, or anytime TPL is discovered, the DWSS collects TPL coverage and incorporates the information into the eligibility case file. The eligibility case file is shared with the DHCFP and used to update MMIS to be used for medical claims adjudication. TPL data is identified, verified and recorded into the MMIS monthly and used to cost avoid claims, as well as for pay and chase recoveries of claim overpayments.

433.138(g)(2)(i) & (ii) Upon discovery of a liable third party, post payment recovery is sought within 60 days or in the case of legal actions, a lien is filed to protect the State's rights and recoupment of medical payments are sought.

Information regarding probable liability and subrogation is forwarded to the DWSS monthly through a secured HIPAA compliant system. Information is maintained in a secured file by the Fiscal Agent third party recovery unit and/or third-party vendor for subrogation case audits and incorporated into the Medicaid and CHIP third-party data base for claims processing.

The tolerance levels for suspension or termination of recovery efforts are identified in Third Party Liability, Attachment 4.22-B.

THIRD PARTY LIABILITY – PAYMENT OF CLAIMS

The Nevada Medicaid program is designed to function primarily as a cost avoidance system, with cost savings. This method was chosen as the most efficient and least costly due to the multitude of insurance companies utilized by Nevada residents. Also, insurance data is fed through a secured transmittal bill paying system on an individual basis. Direct contact is made by the fiscal agent TPL unit directly with insurance carriers and all available information is collected.

The Nevada bill paying system has a direct connection to the Center for Medicare and Medicaid Services' system. Cost savings occur when post-payment recovery is also incorporated. Criteria have therefore been established for both systems with emphasis on cost effectiveness and FFP compliance.

42 CFR 433.139(b)(3)(ii)(C)

I. Cost Avoidance Method

a. Claims with Medicaid paid amounts greater than zero are rejected on the remittance advice with insurance billing instructions and carrier information.

b. Services identified by individual policies as non-covered are not subject to cost avoidance or recovery.

42 CFR 433.139(f)(2&3), 42 CFR 447.20 and 7 CFR 273.18(e)(8)(ii)

II. Post-Payment Recovery

a. Recovery - Provider

1. States only pursue recoveries from providers whenever Medicare is the primary source.

2. Claims which were unidentified or missed in cost avoidance are subject to claims with Medicaid outlined in 1.a above. Recovery is made by computer history adjustments.

3. Due to Medicare timely filing, recovery efforts are not attempted when more than 12 months have elapsed from date of service to the projected adjustment date.

b. Recovery – Insurance Carrier

1. When necessary, direct recovery is attempted through individual insurance carriers. This can occur when providers are unsuccessful with billing attempts, but the fiscal agent (FA) has sufficient information to pursue collection. Claims with Medicaid paid amounts of less than $25 are not pursued.

A. Claims with Medicaid paid amounts of less than $25 are not pursued.

2. Claims with Medicaid paid amounts of $25 or greater are pursued by the FA through the individual insurance company.

III. Casualty – Subrogation

42 CFR 433.139(f)(e)

A. Claims which edit for trauma codes are processed through the regular processing cycle. If the billed amount is $125 or greater and no insurance has paid on the claim, the claim is referred to the fiscal agent for subrogation follow-up.

B. If the billed amount is less than $125, no investigation is initiated unless large quantities of claims exist for this diagnosis or service date.

C. Claims with billed amounts of $125 or more are investigated and followed through the legal process until settlements are reached or a determination made to drop the case.

IV. Compliance

Nevada complies with the following requirements:

A. Apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services.

B. Make payments without regard to potential TPL for pediatric preventive services unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

C. Make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.

42 CFR 433.139(b)(3), SAA Section 1902 (a)(25)(E)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

1906 of the Act State Method on Cost Effectiveness of Group Health Plans

1. The methodology used by Nevada for determining cost effectiveness of paying individual or group health insurance premiums for existing coverage shall be as follows:

   a. Applicant must be on Medicaid Fee-for-Service (FFS) for a minimum of six months.

   b. The state will take the following steps:

      a. Total 6 months billed group health plan divided by 6 = Average Premium Cost.

      b. Total 6 months Medicaid Medical Expenditures divided by 6 = Recognized Average Medicaid Expenditures.

      c. Recognized Average Medicaid Expenditures greater than Average Group Health Plan Premium plus Administrative Expenditures = Cost Effectiveness.

   c. The average Medicaid cost includes the benefits covered under the Medicaid eligibility group for which the individual would be determined eligible.

   d. Administrative costs include additional administrative cost to Medicaid for administering the premium assistance program as well as the following:

      Benefits wrap. If Medicaid services covered under the State Plan are not part of the services covered by a recipient's employer health care coverage, the recipient may obtain those services from participating Medicaid providers.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

a. Cost-sharing wrap. The State will provide a cost-sharing wrap to any cost-sharing amounts that exceed the cost-sharing limits described in the State Plan.

b. Premiums for non-eligible family members. Non-eligible family members are covered only if it is necessary in order to enroll a Medicaid eligible family member in the group health plan.

e. The state may also cover a recipient who has an existing medical confirmed condition or illness that is determined to be cost-effective under the Health Insurance Premium Program (HIPP) expenditure methodology.

2. Individuals enrolled in the premium assistance program are afforded the same beneficiary protections provided to all other Medicaid enrollees. As discussed in the cost-effectiveness test above, the Nevada Medicaid program will provide a benefit wrap and cost-sharing wrap. To effectuate the cost sharing wrap:

a. The State has a provider enrollment process for non-participating providers to ensure that providers that service Medicaid beneficiaries can be enrolled and paid through the state Medicaid program for any and all cost sharing amounts that exceed the Medicaid permissible limits;

b. The State will encourage non-participating providers to enroll by conducting outreach to the provider community to educate non-participating Medicaid providers on how to enroll in Medicaid for the purposes of receiving payment from the State.

c. The State will inform beneficiaries regarding how to contact the state's fiscal agent if the beneficiary intends to obtain care from a non-participating provider.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nevada

Citation	Condition or Requirements

d. In cases where the State becomes aware of a non-participating Medicaid provider, the State may implement a "single case" agreement with that provider to allow cost-sharing wrap for a specific individual.

The cost sharing wrap is required by section 1906(a)(3) of the Social Security Act.

3. Redetermination Review

a. The DHCFP or contracted vendor shall complete a redetermination review at least yearly for all HIPP enrollees. The yearly review shall consist of:

i. Verifying Medicaid eligibility; and

ii. Completing a cost-effective analysis.

Failure to meet HIPP enrollment eligibility cost-effective criteria during annual redetermination review will result in disenrollment from the Nevada Medicaid HIPP Program.

STATE LAW REQUIRES THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

The 2007 Session of the Nevada Legislative enacted Senate Bill 529 which incorporates the requirements of Section 6035 of the Deficit Reduction Act of 2005 effective July 1, 2007.