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.