
PROVIDER AND THIRD-PARTY PAYOR OBLIGATIONS: MEDICAID THIRD-PARTY BILLING, PAYMENT & ENFORCEMENT

James G. Sheehan
Medicaid Inspector General

Joseph J. Flora, Director
Bureau of Third-Party Liability

<http://www.omig.ny.gov>

October 20, 2010



OMIG WEBINARS-FULFILLING OMIG'S SECTION 32 DUTY-

- **Section 32 of the Public Health Law provides the duties and powers of OMIG, including the power:**
- “17. to conduct educational programs for medical assistance program providers, vendors, contractors and recipients designed to limit fraud and abuse within the medical assistance program”
- These programs will be scheduled to address significant issues identified by OMIG or by the provider community. Your feedback on this program, and suggestions for new topics are appreciated.
- Next webinar: Evaluating Effectiveness of Compliance Programs-
November 17, 2010, 2 pm Eastern Time

THIRD-PARTY RECOVERY- FULFILLING OMIG'S SECTION 22 DUTY-

- **Section 31 of the Public Health Law provides the duties and powers of OMIG, including the power:**
- **22. to take appropriate actions to ensure that the medical assistance program is the payor of last resort.**

TODAY'S AGENDA

- What is a “third-party payor”?
- The responsibility of health care providers and payors under the third-party liability laws.
- Fraud and abuse issues for providers and payers in third-party liability
- Who is a third-party payor subject to liability under federal and state law(s)
- What impact new developments - Section 6035 of DRA of 2005 - in third-party liability law will have on other potential payors- including employer health plans, third-party administrators and benefits managers
- The effect of Section 6402 of the Patient Protection and Affordable Care Act (PPACA or the Obama health plan) on providers’ and payers’ third-party responsibilities
- How we **ensure that the medical assistance program is the payor of last resort**

ISSUES NOT ON TODAY'S AGENDA

- Calculation of state Medicaid subrogation claims arising out of wrongful death or personal injury tort
- The impact of *Arkansas Department of Human Services v. Ahlborn* 126 S. Ct. 1752 (May 1, 2006) and the federal Medicaid anti-lien provision 42 U.S.C. 1396p

WHAT IS A THIRD-PARTY PAYER?

- “*Third party* means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.” 42 CFR 433.36
- Medicare is a "third party" for purposes of the third-party liability provision, 42 U.S.C. Sec. 1396a(a)(25).
- Pharmacy benefit managers, third-party administrators, tortfeasors, workers’ compensation carriers, and fraternal benefit plans are third parties

CAN NY RECOVER MEDICARE PAYMENTS WHEN MEDICARE SHOULD HAVE PAID FIRST?

- Although 42 U.S.C. §1396a(a)(25)(B) clearly imposes a duty on the state to seek Medicaid reimbursement, it does not entitle the state to wholesale reimbursement from Medicare. *New York v. Sebelius* 2009 WL 1834599, at *8.” (ND NY June 2009) *COMMONWEALTH OF MASSACHUSETTS v. KATHLEEN SEBELIUS* C.A. No. 07-11930-MLW) (D. Mass. December 31, 2009); appeal pending in First Circuit)
- “There are no other cases directly on the point.”(Mass. Memorandum Opinion, at 14)
- Burden and risk on providers to seek Medicare reimbursement

MEDICAID ENROLLEES MAY BE ENTITLED TO CLAIMS PAYMENT BY OTHER SOURCES (Third Parties)

- An average of 13 percent of Medicaid recipients have private health coverage at some time during the year, according to a report issued by the Government Accountability Office (GAO) in 2006. **Medicaid *Third-Party Liability*: Federal Guidance Needed to Help States Address Continuing Problems** [GAO-06-862](#), September 15, 2006
- 23 percent of Medicaid enrollees in New York State have other health coverage—considerably more than the national average.
- Those “third parties” must pay before Medicaid pays



PROVIDER RESPONSIBILITIES

FIRST RESPONSIBILITY-TRUTH-TELLING FOR MEDICAID PROVIDER CLAIMANTS

- Cannot fail to bill other insurance if service is or may be covered
- Cannot submit claim that fails to report known other payor
- In general, cannot submit claim reporting “zero fill” unless other payor has received and denied claim
- Cannot retain payments from Medicaid when the other insurer pays in full (even if it is less than Medicaid would have paid)
- Must identify, report, refund to Medicaid, and explain payments from third parties after receipt of payment from third parties

Third-Party Liability - Federal Statute

- Social Security Act Sec. 1902 [42 U.S.C. 1936a] (a) (25) states:

“State or local agency administering such plan (Medicaid) will take all reasonable measures to ascertain the legal liability of third parties.”

“...in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.”

- Establishes Medicaid as the “payor of last resort” for all states

Third Party Liability - Federal Regulations

- Federal regulation 42 CFR 433.139 outlines provisions the state agencies must follow in paying claims where a third party has liability for payment. In most cases, the Medicaid program has payment liability only for that portion of the patient's bill not covered by third-party resources, such as health or accident insurance, workers' compensation, Veterans Administration, Medicare, or other primary coverage.
- In general, if the provider accepts an amount less than the Medicaid payment amount as payment in full by the payor, Medicaid cannot be billed for the balance.

Third Party Liability - Federal Regulations, continued

- As a condition of eligibility, applicants must assign to Medicaid rights to medical support and to payment for medical care from any third party. 42 CFR 433.145
- Where third-party liability exists, the state agency must reject a claim for reimbursement for that service and return it to the provider for a determination of the amount of the third party's liability. See 42 C.F.R. § 433.139(b)(1).
- Providers are required to disclose on the claim form when third-party coverage and/or potential liability exists

Third-Party Liability

NYS Regulations 18 NYCRR 540.6 (e)

- (1) “take reasonable measures to ascertain the legal liability of third parties”

- (2) No claim for reimbursement shall be submitted unless the provider has:
 - (i) “investigated to find third-party resources”
and
 - (ii) sought reimbursement from liable third parties.

Third Party Liability

NYS Regulations 18 NYCRR 540.6 (e)

(3) Each medical assistance provider shall:

(i) ask the recipient

(ii) “make claims against all resources”

(iii) “continue investigation and attempts to recover from potential third-party resources”

(iv) “if the provider is informed”... investigate the possibility of making a claim to the liable third party and make such claim as is reasonably appropriate; and

(v) take any other reasonable measures necessary to assure that no claims are submitted to the medical assistance program that could be submitted to another source of reimbursement.

Third-Party Liability

NYS Regulations 18 NYCRR 540.6 (e)

(4) Any reimbursement the provider recovers from liable third parties shall be applied to reduce any claims for medical assistance submitted for payment to the medical assistance program by such provider or shall be repaid to the medical assistance program within 30 days after third-party liability has been ascertained; when a claim has been submitted to a third party whose liability was ascertained after submission of a claim to the medical assistance program, the provider must make reimbursement to the medical assistance program within 30 days after the receipt of reimbursement by the provider from a liable third party.

- Improper retention liability under False Claims Act

Third-Party Liability

NYS Regulations 18 NYCRR 540.6 (e)

(5) A provider of medical assistance shall not deny care or services to a medical assistance recipient because of the existence of a third-party resource to which a claim for payment may be submitted in accordance with this subdivision.

(6) Comply with other payer billing requirements

(7) Requirements and exceptions

*See Appendix A for full citation



PAYOR RESPONSIBILITIES

The Deficit Reduction Act (DRA) of 2005 – Section 6035

- Requires that the State must impose on an insurer a duty to “as a condition of doing business in the State”: ii) accept the State’s right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
- (iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of such health care item or service; and
- (iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if— (I) the claim is submitted by the State within the three-year period beginning on the date on which the item or service was furnished; and
- (II) any action by the State to enforce its rights with respect to such claim is commenced within six years of the State’s submission of such claim.
- 42 U.S.C. 1396a (25) (I)

CMS Invites Everyone To Be A Third-Party Payor

- We interpret “other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim” (under Section 6035(a) of the 2005 Deficit Reduction Act (DRA)) to include such entities as:
 - Third-party administrators (TPAs)
 - Pharmacy benefit managers (PBMs)
 - Fiscal intermediaries
 - Managed care contractors
 - Health and welfare plans
 - Self-insured plans

CMS Guidance Documents

- Numerous letters/memoranda to state Medicaid directors (SMDs) provide clarification on the 2005 Deficit Reduction Act and third-party liability
 - Letter from US Dept of Labor to State of Texas 2005-05A, March 23, 2005
 - CMS Letter to SMD 06-026, December 15, 2006
 - Letter from US Dept of Labor to CMS 2008-03A, March 21, 2008
 - CMS Letter to SMD 10-011, June 21, 2010
 - http://www.cms.gov/ThirdPartyLiability/04_DRA.asp
 - **Questions and Answers (Qs & As)** on www.cms.gov/ThirdPartyLiability

NYS Statute imposes duties upon “insurers” required by DRA of 2005

- New York Social Services Law Sec. 367(a)(2)(b) states:

“The local social services district or the department shall be subrogated, to the extent of the expenditures by such district or department for medical care furnished, to any rights such person may have to medical support or reimbursement from liable third parties, including but not limited to health insurers, self-insured plans, group health plans, service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.”

- Grants the State subrogation rights for pursuing third-party liability
- More clearly defines insurers who can be deemed a liable third party (e.g., if their member is also enrolled in Medicaid)

NYS Statute imposes duties upon “insurers” required by DRA of 2005 (continued)

- New York State Insurance Law Sec. 320(a) states:

“Every insurer shall, upon request of the state department of social services or of a local social services district for **any records, or any information contained in such records**, pertaining to the coverage of any individual for such individual's medical costs under any individual or group policy or other obligation made by such organizations, or the medical benefits paid by or claims made to such organizations pursuant to such policy or other obligation .”

“Insurer” as used in this section, includes among others, health maintenance organizations, pension funds, “self-funded plans”, and “any person or other entity acting on behalf of the insurer. . .”

PPACA (The Patient Protection and
Affordable Care Act of 2010)

PROVIDER AND PAYOR IMPACT

SECTION 6402 MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *“(d) REPORTING AND RETURNING OF OVERPAYMENTS.—*
- *“(1) IN GENERAL.—If a person has received an overpayment, the person shall—*
- *“(A) **report and return** the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and*
- *“(B) **notify** the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned **in writing of the reason for the overpayment.**”*

The responsibility of health care providers under the third-party liability laws-as affected by PPACA (The Patient Protection and Affordable Care Act of 2010)

- **MANDATORY REQUIREMENT OF REPORTING AND REPAYMENT OF MEDICAID OVERPAYMENTS BY PROVIDERS**
- **IMPROPER RECEIPT OR RETENTION OF OVERPAYMENT IS A FALSE CLAIM (invokes penalties and whistleblower provisions)**

The responsibility of third-party payors under the third-party liability laws-as affected by PPACA (The Patient Protection and Affordable Care Act of 2010)

- “(B) OVERPAYMENT.—The term ‘overpayment’ means any **funds** that a **person** receives or retains under title XVIII (Medicare) or XIX (Medicaid) to which the person, after applicable reconciliation, is **not entitled** under such title.”
- “**funds**” not “**benefit**”
- “**receives or retains**”
- **Payor** who has funds due the Medicaid program because of primary coverage duty is **not entitled** to retain them under Title XIX.

WHEN MUST AN OVERPAYMENT BE RETURNED UNDER PPACA (The Patient Protection and Affordable Care Act of 2010)?

- PPACA 6402(d)(2)
- An overpayment must be reported and returned . . .by the later of-
- (A) the date which is 60 days after the date on which the overpayment was **identified**; or
- (B) the date on which any corresponding cost report is due, if applicable

WHEN IS AN OVERPAYMENT IDENTIFIED?

- Provider billing and payment system shows credit balance after posting of payments
- Employee or contractor identifies overpayment in hotline call or email to provider
- *Qui tam* or government lawsuit allegations disclosed to provider
- Criminal indictment or information

PPACA SECTION 6402 (d) MEDICARE AND MEDICAID PROGRAM INTEGRITY PROVISIONS

- *“(3) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title (False Claims Act)*



**USING TPL AND OTHER
PAYOR DATA FOR
COMPLIANCE WITH AND
ENFORCEMENT OF PPACA
REQUIREMENTS**

Traditional Third-Party Liability Programs



TPL

Data matching

Cost avoidance

Third-party reviews

Estate and casualty recovery

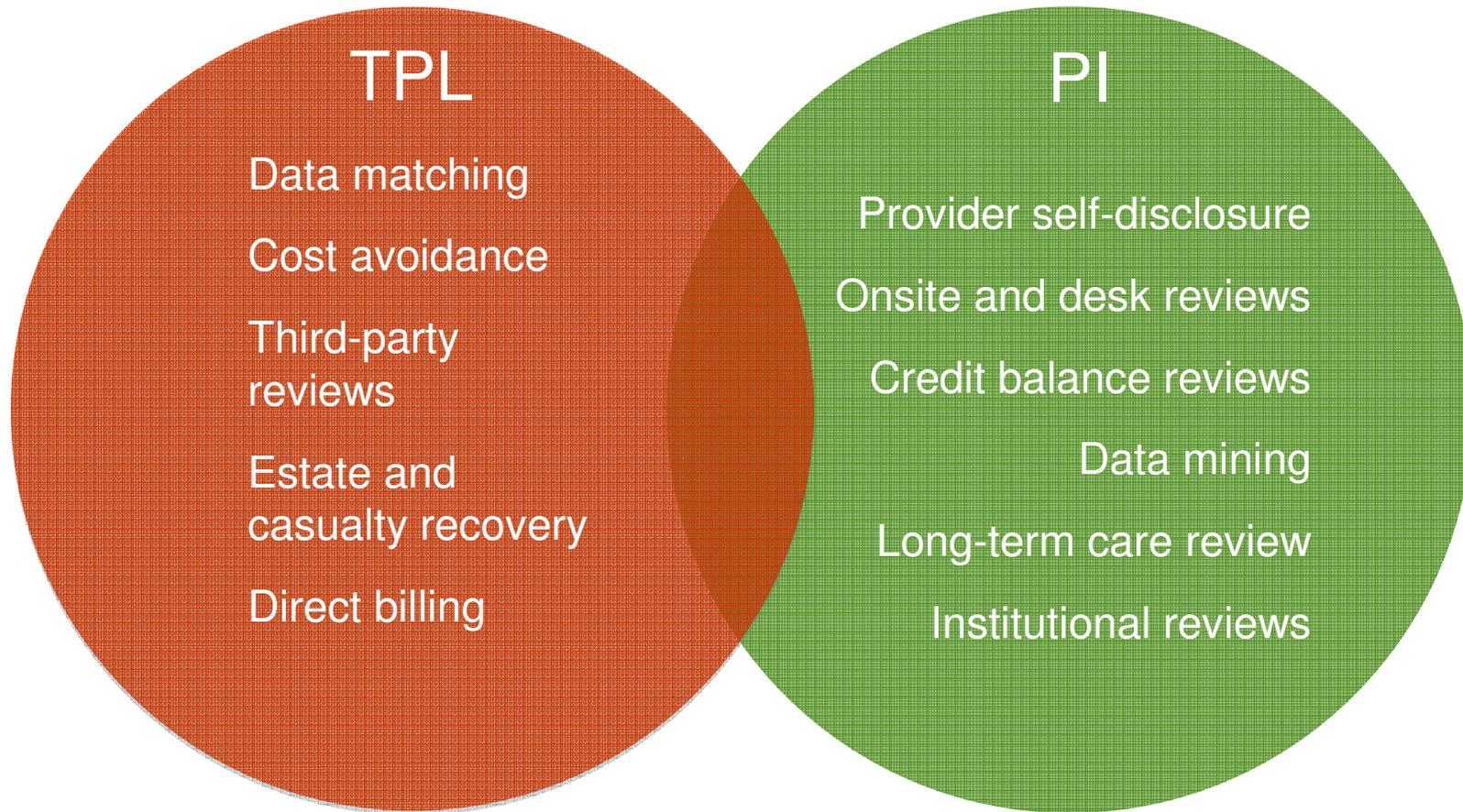
Direct billing

Challenges of Silos

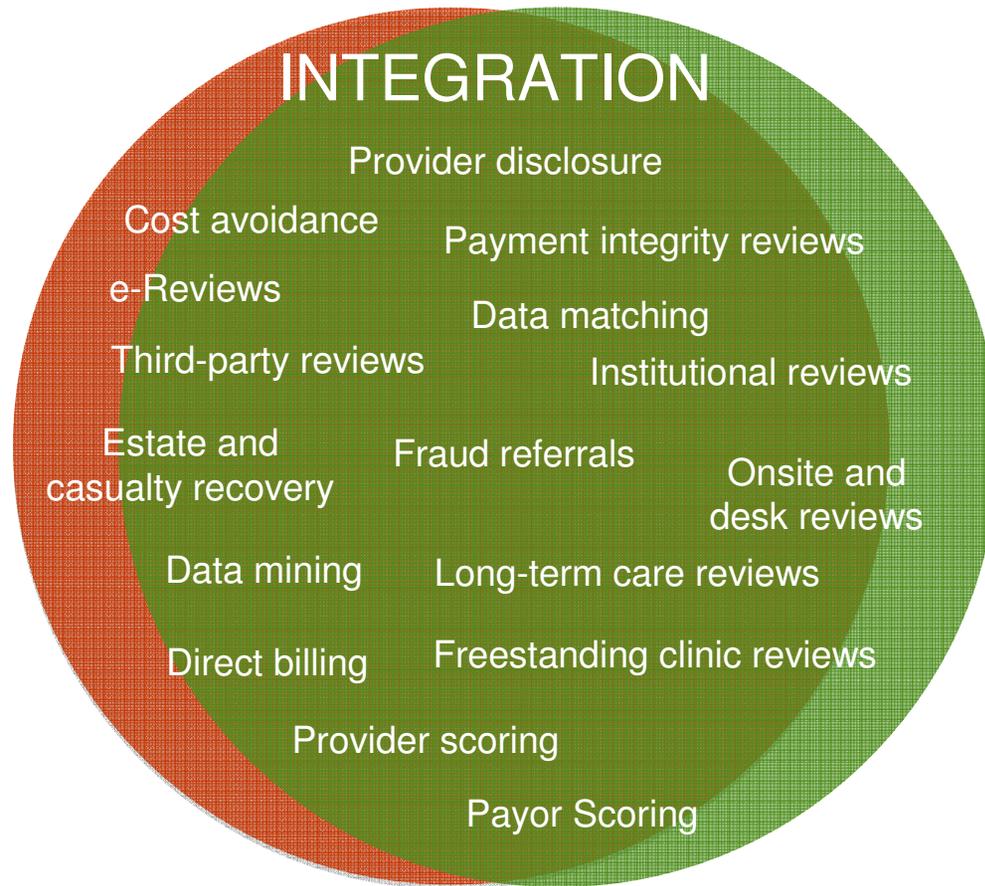
- Some overpayments weren't being identified
- Efforts duplicated
- OMIG's analysis of problem revealed:
 - Limited flow of information across programs
 - Lack of data to validate third-party payments
- Integrated TPL with PI helped to fill gaps
 - Expanded credit balance reviews to include data mining targets
 - Began reviewing third-party denials to identify potential provider abuse

* See Appendix B for TPL Program overview

Where We Are Now



Where We're Headed



Integrated Approach



MMIS

- ▶ Validate coding
- ▶ Check eligibility
- ▶ TPL edits
- ▶ Reimburse

Integrated Approach



MMIS

- ▶ Validate coding
- ▶ TPL edits
- ▶ Check eligibility
- ▶ Reimburse

Integrated Approach



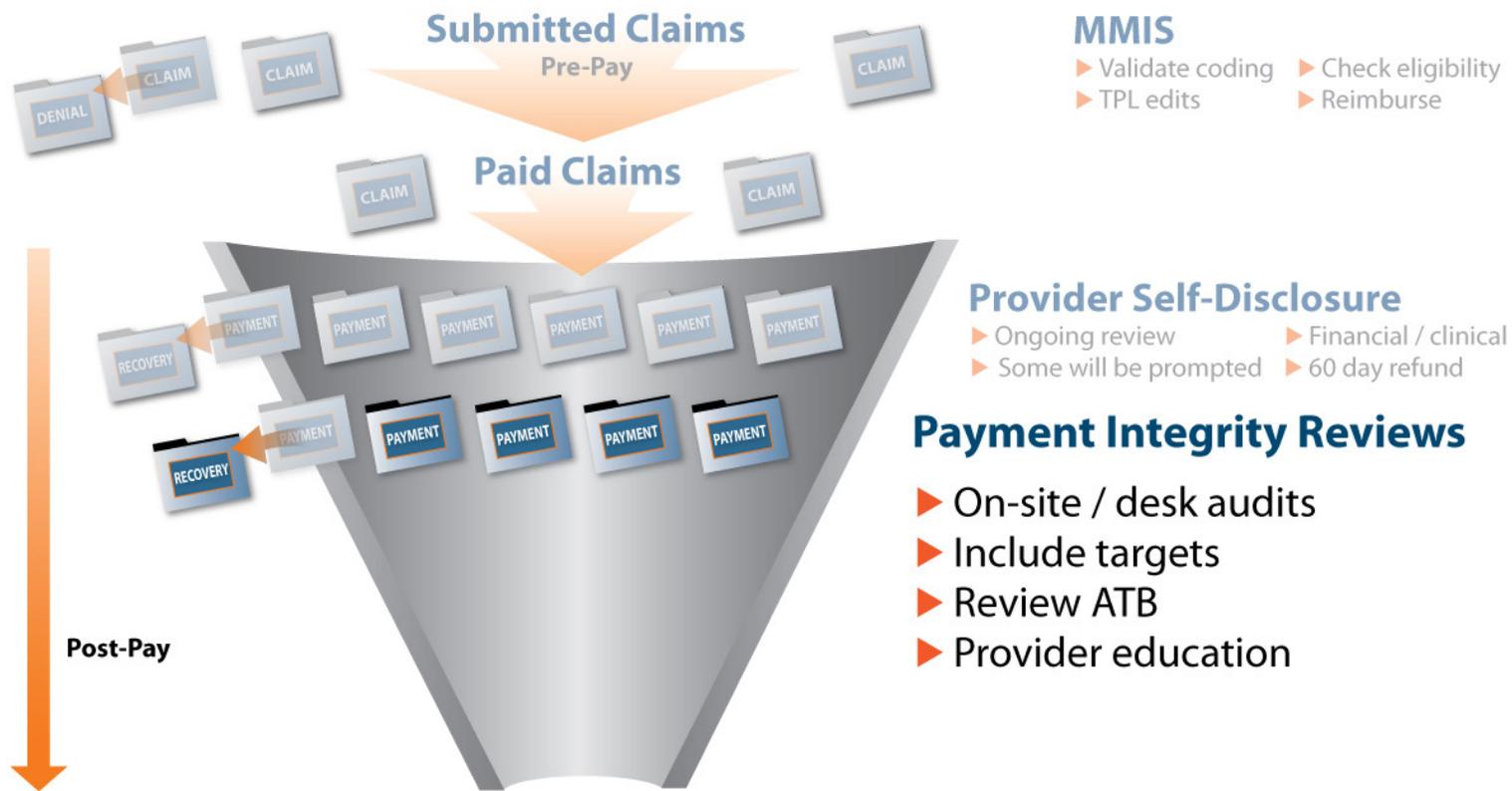
MMIS

- ▶ Validate coding
- ▶ TPL edits
- ▶ Check eligibility
- ▶ Reimburse

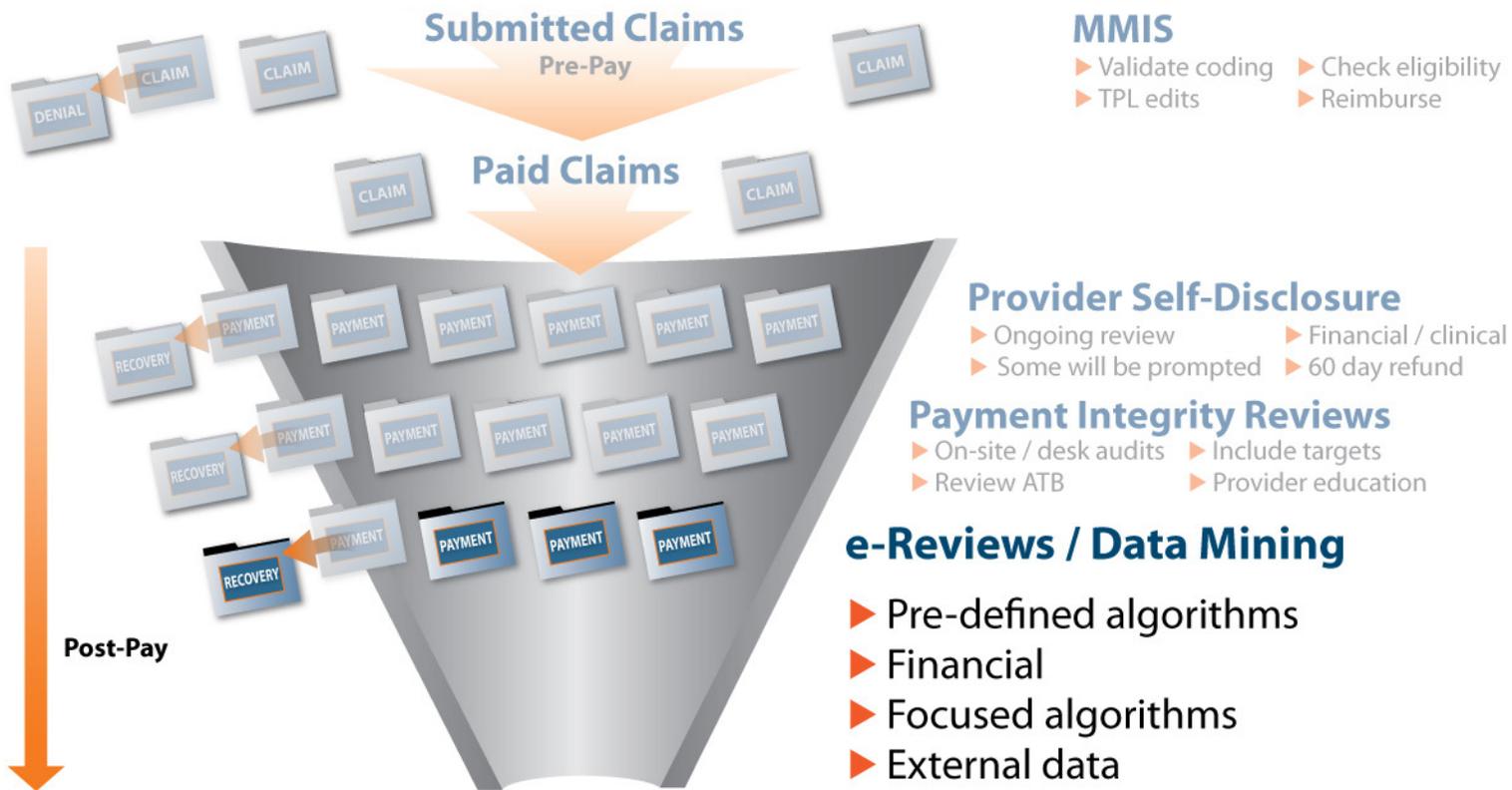
Provider Self-Disclosure

- ▶ Ongoing review
- ▶ Financial / clinical
- ▶ Some will be prompted
- ▶ 60 day refund

Integrated Approach



Integrated Approach



e-Reviews and Data Mining

- Uses paid claims data from third-party payors and other external data
 - Commercial
 - Medicare
 - Provider A/R (Credit & Debit Balances)
- Allows for validation of overpayment at time of data mining
- Notifies providers via mail and portal
- Recoveries initiated electronically through MMIS

e-Reviews and Data Mining (cont.)

- More emphasis on provider compliance and program oversight
- Each overpayment is reviewed at the claim level
- Drives the integration of TPL and PI through data mining

Integrated Approach



Integrated Approach



Integrated Approach



Sentinel Effect = Improved Provider Billing

The New Solution

- Integrated approach shares data across programs
 - Increased identification of potential overpayments
 - Reduce future overpayments
 - Minimize provider burden

- The integrated approach will be a central piece to New York OMIG payment integrity program

FREE STUFF FROM OMIG

- OMIG Web site-www.omig.ny.gov
- Mandatory compliance program-hospitals, managed care, all providers over \$500,000/year
- More than 2,500 provider audit reports, detailing findings in specific industry
- Sixty-six-page work plan issued 4/20/09-shared with other states and CMS, OIG (new one coming in October)
- Listserv (put your name in, get e-mailed updates)
- New York excluded provider list
- Follow us on Twitter: NYSOMIG

APPENDIX A

NYS Regulation 540.6(e)

Third-Party Liability

NYS Regulations 540.6 (e)

- (1) As a condition of payment, all providers of medical assistance must take reasonable measures to ascertain the legal liability of third parties to pay for medical care and services.
- (2) No claim for reimbursement shall be submitted unless the provider has:
 - (i) investigated to find third-party resources in the same manner and to the same extent as the provider would to ascertain the existence of third-party resources for individuals for whom reimbursement is not available under the medical assistance program; and
 - (ii) sought reimbursement from liable third parties.

Third Party Liability

NYS Regulations 540.6 (e) Continued

(3) Each medical assistance provider shall:

(i) request the medical assistance recipient or his representatives to inform the provider of any resources available to pay for medical care and services;

(ii) make claims against all resources indicated on a Medicaid identification card or communicated to the provider via the electronic Medicaid eligibility verification system, via the medical assistance information and payment system (MMIS) toll-free inquiry telephone number or via the MMIS transaction telephone system, and all resources which the provider has discovered, prior to submission of any claim to the medical assistance program;

(iii) continue investigation and attempts to recover from potential third-party resources after submission of a claim to the medical assistance program to at least the same extent that such investigations and attempts would occur in the absence of reimbursement by the medical assistance program;

(iv) if the provider is informed of the potential existence of any third-party resources by an official of the medical assistance program, or by any other person who can reasonably be presumed to have knowledge of a probable source of third-party resources, investigate the possibility of making a claim to the liable third party and make such claim as is reasonably appropriate; and

Third Party Liability

NYS Regulations 540.6 (e) Continued

(v) take any other reasonable measures necessary to assure that no claims are submitted to the medical assistance program that could be submitted to another source of reimbursement.

(4) Any reimbursement the provider recovers from liable third parties shall be applied to reduce any claims for medical assistance submitted for payment to the medical assistance program by such provider or shall be repaid to the medical assistance program within 30 days after third-party liability has been ascertained; when a claim has been submitted to a third party whose liability was ascertained after submission of a claim to the medical assistance program, the provider must make reimbursement to the medical assistance program within 30 days after the receipt of reimbursement by the provider from a liable third party.

(5) A provider of medical assistance shall not deny care or services to a medical assistance recipient because of the existence of a third party resource to which a claim for payment may be submitted in accordance with this subdivision.

Third Party Liability

NYS Regulations 540.6 (e) Continued

- (6) A provider of medical assistance must review and examine information relating to available health insurance and other potential third-party resources for each medical assistance recipient to determine if a health insurance identification card or any other information indicates that prior or other approval is required for non-emergency, post-emergency, non-maternity, hospital, physician or other medical care, services or supplies. If approval is required as a condition of payment or reimbursement by an insurance carrier or other liable third party, the provider must obtain for the recipient, or ensure that the recipient has obtained, any necessary approval prior to submitting any claims for reimbursement from the medical assistance program. The provider must comply with all Medicare or other third-party billing requirements and must accept assignment of the recipient's right to receive payment, or must acquire any other rights of the recipient necessary to ensure that no reimbursement is made by the medical assistance program when the costs of medical care, services or supplies could be borne by a liable third party. If a provider fails to comply with these conditions, any reimbursement received from the medical assistance program in violation of the provisions of this paragraph must be repaid to the medical assistance program by such provider. No repayment will be required if the provider can produce acceptable documentation to the department that the provider reasonably attempted to ascertain and satisfy any conditions of approval or other claiming requirements of liable third-party payors in the same manner and to the same extent as the provider would for individuals for whom reimbursement is not available under the medical assistance program, as described in paragraphs (1) through (5) of this subdivision.

Third Party Liability

NYS Regulations 540.6 (e) Continued

- (7) A provider of medical assistance who becomes aware, or reasonably should have become aware, of available health insurance or other potential third-party resources that can be claimed from a liable third party by the provider as an agent of a social services official, in accordance with the provisions of Part 542 of this Title, must submit a claim for such payment to the liable third party in the manner described in Part 542, except that a provider will not be required to submit such a claim to a liable third party when the claim is for prenatal care for pregnant women or preventive pediatric services (including early and periodic screening, diagnosis and treatment services). If a provider fails to submit such a claim as required by this paragraph, reimbursement for such claim will not be made by the medical assistance program and any reimbursement received in violation of the provisions of this paragraph must be repaid to the medical assistance program by such provider. If a provider has satisfied the requirements described in paragraphs (1) through (6) of this subdivision, no repayment will be required if the provider can produce documentation acceptable to the department that the provider reasonably attempted to ascertain whether such claim could be submitted in the manner described in Part 542 of this Title. If a provider submits a claim in accordance with the provisions of Part 542 of this Title and all or a portion of such claim is rejected by the liable third party through no fault of the provider, that portion of the claim that is so rejected may be submitted to the medical assistance program for payment.

APPENDIX B

New York TPL Programs

NY TPL Program Overview

- Pre-Payment Insurance Verification
 - Verify data match results with insurers to confirm eligibility and scope of benefits
 - Load valid insurance policy/coverage to eMedNY for cost avoidance
 - Edit 131 (Commercial Error Reason Code)
 - Edit 152 (Medicare Error Reason Code)
 - Data sent to providers at point of service
 - Provides data for LDSS review
 - Managed care determinations
 - Family Health Plus determinations

 - Carrier Direct Billing
 - Fee-based and certain rate-based claims are direct billed by OMIG to third-party insurers for reimbursement
 - NYS Social Services Sec. 367 and Insurance Law Sec. 320
-

NY TPL Program Overview *(continued)*

- Third-Party Reviews
 - Certain rate-based claims are selected and sent to providers with instructions for billing third party insurers
 - 18 NYCRR Part 542.2 subrogates providers
 - Third-party reviews are delivered through mail and provider Web site
 - 1,703 registered users, 941 unique provider ID numbers

- Estate & Casualty
 - Recovery of certain Medicaid expenditures against assets, or liable parties in accidents
 - Currently administered by local departments of social services
 - OMIG working with select counties to create a centralized program which other counties can leverage to increase savings

DRA impact on NY Medicaid since April 2009

- Member eligibility data
 - Recruited 19 new third parties to provide required data– current total of 1050+ third parties, 750 million records
 - New third parties include PBMs, third-party administrators, and unions
- Paid claims data
 - Obtained two full files
 - Actively engaged with 14 other insurers
- Overturning timely filing and prior-authorization denials at >85 percent
 - Insurers agreeing to turn off these edits on the front end,
 - Deficit Reduction Act prohibits insurer denials of claims on behalf of Medicaid enrollees based on either requirement

Key New York Stakeholders

Third-Party Payors

- NYS Blue Cross/Blue Shields
 - Empire
 - Excellus
 - Western NY
 - Northeastern NY
- Local/Regional Carriers
 - Oxford Health
 - CDPHP
 - Independent Health
 - MVP
 - HIP
- National Carriers
 - United Healthcare
 - Cigna
 - Aetna
- Pharmacy Benefit Managers
 - Medco
 - Express Scripts
 - Caremark
 - Argus

Medicaid-Enrolled Providers

- Acute-care facilities
- Clinics
- Physicians
- Long-term care facilities
- Pharmacies
- Medical suppliers
- State-operated facilities
- Home health



Government Agencies

- Local departments of social services (LDSS)
- Office of Health Insurance Program (OHIP)
- US Department of Defense
- US Department of Labor
- NYS Department of Health (DOH)
- NYS Elderly Pharmaceutical Insurance Coverage Program (EPIC)
- NYS Department of Labor
- NYS Workers' Compensation Board
- NYS Insurance Department
- NYS Office of Temporary and Disability Assistance (OTDA)
- NYS Office of Attorney General's Office
- NYS Department of Civil Service (DCS)
- New York City Human Resources Administration

Trade Associations and Interest Groups

- Greater New York Hospital Association
- Healthcare Association of New York State
- Pharmacists Society of the State of New York
- United Cerebral Palsy Association

Other Stakeholders

- Medicaid Enrollees
- Managed Care Organizations (MCOs)
- Employers