Third Party Liability (TPL)
Frequently Asked Questions and Answers (FAQs)

1. **Question:** How do clinician's get the most accurate diagnosis code?

Answer: Clinicians get the most accurate diagnosis code from either the student's physician or a Licensed Practitioner of the Healing Arts (LPHA) clinician. A reference that can be used to view the most accurate diagnosis can be found at www.icd10coded.com.

2. Question: With the new Consent form, do we have to get it annually or does sending out the Annual Notification Letter suffice?

Answer: Under the Individuals with Disabilities Education Act (IDEA), the district must provide the parent or eligible student with the annual written notification before billing Medicaid. The consent for release of information to bill Medicaid and any third-party insurer is a one-time consent and is not required annually. The parent may or may not choose to sign the consent. If the consent is signed, the third party insurance can be billed. The parent or eligible student may, however, at any time revoke consent to bill Medicaid or the student's third-party insurance carrier. Please refer to the document entitled "Frequently Asked Medicaid Consent Questions and Answers" found on the website at http://ed.sc.gov/districts-schools/medicaid/medicaid-program-quality-assurance/school-based-rehabilitative-services/frequently-asked-medicaid-consent-questions-and-answers/

3. Question: Do we need BOTH a group National Provider Identifier (NPI) and individual NPIs for each service provider in the district?

Answer: School districts must provide the NPI number for the school district and the Licensed Practitioners of the Healing Arts (LPHA) for the private insurance claims. The individual provider's LPHA NPI number appears on the line level and the pay to provider (school district) appears in box 33 of the CMS 1500 claim form (see attached document). The school district will need to request the NPI number from every LPHA rendering services and place this information in the file.

4. Question: What paperwork do we as a school district already have that covers the Explanation of Benefits (EOB) that you just indicated we had to have in the file?

Answer: Currently, there is no paperwork in the file that covers the EOB. The EOB is a statement sent by a third-party health insurance company to covered individuals explaining what medical treatments and/or services were paid and denied on the behalf of the student. The EOB needs to be kept in the student's financial and Medicaid file.

5. Question (5a): When we look at TPL on the web tool, it lists dental, vision, life insurance, etc. How do we know what policy/coverage type applies to school-based services?

Answer: (5a): Select the insurance policy which closely aligns to the service being rendered. For example, if you are providing vision screening you would select a vision policy and if it is a physical therapy service, you would choose a medical insurance policy.

Question (5b): If we send a claim to private insurance and they deny the claim, do we have to have this denial for each and every individual service?

Answer (5b): Yes, you must have the EOB for each service that was denied by the private insurance party.

6. Question: What happens if parents do not sign a consent form for a TPL student? Will the district have to stop billing all together?

Answer: Yes, the school district must stop billing if the parents do not consent to billing their insurer. The school district cannot bill Medicaid or TPL for the student without having the General Consent form signed by the parent, or the student if the student is age eighteen or older. Every effort should be made by the district to obtain parental signatures.

7. Question: During slide 43, you said something needs to be kept in the file for an audit, but didn't elaborate.

Answer: The EOB must be kept in the student's financial and Medicaid file.

8. Question: Can we choose to bill for students who have ONLY Medicaid?

Answer: No, the school district cannot choose to bill for students with ONLY Medicaid. Clarification was provided by the South Carolina Department of Health and Human Services (SCDHHS) to school districts that states "Federal statutes and regulations require SCDHHS and its providers to take all reasonable measures to identify and pursue Third Party Liability (TPL) payments for services provided to Medicaid beneficiaries. According to 42 CFR 447.20(b), you cannot refuse to treat a Medicaid patient simply because he or she has other health insurance. Therefore, if the school district accepts the student as a Medicaid beneficiary, the school is obligated to follow all Medicaid TPL policies and guidelines." Also, school districts have the added requirement from the Proviso 1.2 of the General Appropriations Act to participate to the fullest extent possible in the Medicaid program.

9. Question: Will there be any hands on training for entering TPL?

Answer: Yes, SCDE staff will be providing future hands on TPL training. A hands-on training designed for district billing staff took place on December 12, 2016.

10. Question: Medicaid is primary under the IDEA. When did that change?

Answer: Medicaid is primary under IDEA; however Medicaid is the payer of last resort to other insurances.

11. Question: Do you know if insurance companies will credential schools?

Answer: Yes, that is the decision of the school district to seek credentialing.

12. Question: Who generates the EOB?

Answer: The insurance company generates the EOB but it is only generated after a claim is submitted to the insurance company. See the response to question number 4 for a definition of "EOB" and instructions for what to do with them when they are received.

13. Question (13a) - How are claims submitted to the different insurance companies?

Answer: (13a) - Claims are submitted electronically, by a billing company (if you are contracted with one) or via the insurance company's website, or on the CMS 1500 claim form.

Question (13b) - Will all of the billing companies have to contract and submit claims to these companies to get a denial/ EOB?

Answer: (13b) - No. Billing companies do not have a contract with an insurance company to submit claims on behalf of school districts. School districts will be responsible for contracting with insurance companies not the billing companies. School districts are not mandated to contract with an insurance company(s) and if they choose not to contract they may receive reduced benefits or the possibility of no benefits; however, they need to submit a claim to receive an EOB prior to submitting the claim(s) to Medicaid. Medicaid will only pay up to the allowable amount on the set fee schedule.

Options to consider when contracting with insurance companies:

1. Contract with an insurance company - The general rule is that the insurance company will pay 100% of the market-based reimbursement rate for the procedure code (definition of market-based pricing: the price is set by an agreement between an insurance company and school district). Also remember that the insurance company could pay more than the Medicaid allowable rate.

2. Non-contract - The insurance company may not pay the 100 percent of the market-based reimbursement rate for the procedure code or the same rate as Medicaid.

3. Non-contract - The insurance company may not reimburse the claim because you are not a contracted provider.

14. Question: Why can't Medicaid bill private insurance carriers to recoup money?

Answer: This is not the responsibility of Medicaid.

15. Question: How do you suggest that we review the DHHS remittance? The ICD-10 codes are not on there.

Answer: The SCDHHS does not include the ICD-10 Codes on their remittance advice. See the response to question 1 for a location of ICD-10 codes. In addition, please make sure your clinical documentation reflects correct ICD-10 codes.

16. Question: Does TPL apply to nursing services?

Answer: No, TPL does not apply to any nursing services.

17. Question: I thought Barbara Drayton said there was a law passed that school districts had to seek reimbursement for services, did I misunderstand?

Answer: A proviso (provision) in the General Appropriations Act, Proviso 1.2, requires districts to participate in the Medicaid program, to the fullest extent possible. The proviso reads:

> All school districts shall participate, to the fullest extent possible, in the Medicaid program by seeking appropriate reimbursement for services and administration of health and social services. Reimbursements to the school districts shall not be used to supplant funds currently being spent on health and social services.

18. Question: What are the names of the managed care organizations (MCO) companies?

Answer: The names of the MCOs are Molina, WellCare, Select Health, Absolute Total Care (ATC), and BlueChoice.

South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov
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MEDICAID BULLETIN

All

TO: Providers Indicated

SUBJECT: Transition to the CMS-1500 Health Insurance Claim Form (02-12) version

In response to guidelines recommended by the National Uniform Claim Committee (NUCC) and set forth by the Centers for Medicare and Medicaid Services (CMS), the South Carolina Department of Health and Human Services (SCDHHS) is implementing the revised CMS-1500 Health Insurance Claim Form (02-12) version effective January 6, 2014.

Although the CMS-1500 form (02-12) is effective January 6, 2014, use of the revised form is optional until March 31, 2014. The transitional dual acceptability period of the current and the revised forms is described as follows:

- January 6, 2014 – March 31, 2014: Providers can use either the current CMS-1500 form (08-05) version or the revised CMS-1500 form (02-12) version.
- April 1, 2014: The current CMS-1500 form (08-05) version is discontinued; only the revised CMS-1500 form (02-12) version is to be used.
  Note: *All rebilling of claims should use the revised CMS-1500 form (02-12) version from this date forward, even though earlier submissions may have been submitted on the prior CMS-1500 form (08-05) version.*

With the release of the revised CMS-1500 form (02-12) version, many field names have changed to "Reserved for NUCC Use." The NUCC has provided instructions regarding how to complete the revised CMS 1500 form (02-12) version, but these are not a national mandate. Individual payers are permitted to use the fields on the CMS 1500 form (02-12) versions that best serve their purposes, even if these are different than the text or direction suggested by the NUCC.

For Providers' convenience, SCDHHS has provided multiple means of obtaining completion instructions for the revised CMS-1500 (02-12) version of the claim form.

- Each provider manual on the SCDHHS website (http://www.scdhhs.gov/provider-manual-list) will contain field-by-field completion instructions in Section 3, Billing Procedures.
- Educational resources are available on the Healthy Connections Medicaid E-Learning website (http://medicaidelearning.com) to assist providers in the use of the revised form.
- A sample of the revised CMS 1500 form (02/12) version is attached to this bulletin for informational purposes only. ***The SCDHHS will not supply the CMS 1500 claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice.***

If you have questions regarding this bulletin or need assistance with completing the form, please contact the SC Medicaid Provider Service Center at 1-888-289-0709. Thank you for your continued support of the South Carolina Healthy Connections Medicaid Program

/s/
Anthony E. Keck
Director

Attachments

Fraud & Abuse Hotline 1-888-364-3224

DRAFT - NOT FOR OFFICIAL USE

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO **If yes**, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

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PLEASE PRINT OR TYPE

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