

2230 – THIRD PARTY LIABILITY

POLICY STATEMENT	Medicaid applicants and recipients (A/Rs) are required to provide information regarding third party liability (TPLs) available to AU members. Rights to TPLs must be assigned to the Department of Community Health (DCH).
BASIC CONSIDERATIONS	<p>TPLs are medical benefits and include, but are not limited to, the following:</p> <ul style="list-style-type: none"> • TriCare (formerly known as CHAMPUS) - active duty insurance • TriCare (formerly known as CHAMPVA) or TriCare for Life for veterans enrolled in Medicare Part A & Part B - disabled veteran insurance • Court ordered payments of medical costs by a non-custodial parent (NCP) • Court awards or trusts which provide for payment of medical expenses • Commercial Health insurance policies (including a NCP's policy) <ul style="list-style-type: none"> - private - indemnity - group - liability - Long Term Care - Medicare Supplement Plans - Managed Care Plans (i.e., HMO, PPO, etc.) • Health Reimbursement Accounts • Medicare (does not have to be reported as a TPL) • Worker's Compensation • Any trust • Any legal document that specifies monies are due to the State (including lawsuit settlements, workers' compensation benefits, etc.) <p>Payments from TPLs are assigned to DCH when the A/R signs the application/renewal forms or the DMA 285 form for Medicaid.</p> <p>Form DMA 285 If a TPL exists a Form DMA 285, Health Insurance Information Questionnaire, must be signed and placed in the case record or scanned into DIS. The top copy of the signed, completed DMA 285 must be sent to Health Management Systems (HMS). This form is used to transmit TPL information to DCH. The Form DMA285 also includes a release of information statement and an assignment of payments agreement. Do not submit Form DMA 285 if Medicare is the only TPL.</p> <p>If the AU has a TPL and applies using one of the following:</p> <ul style="list-style-type: none"> • Form 94A Medicaid Streamlined application • Federal Single Streamlined application • COMPASS Online Medicaid application or renewal

**BASIC
CONSIDERATIONS**
**Form DMA 285
(cont.)**

Workers should complete the following steps:

- Complete a DMA 285 with the TPL information provided. Contact the AU if all TPL information is not provided. A copy of the insurance card is **not** required and should not be requested.
- Attach only the signature page of the application used. For COMPASS, this must be printed from the PDF. In these situations, the DMA 285 does not need to be signed.
- Send both the DMA 285 and signature page to HMS.

NOTE: The pre-paid dental services do not have to have a DMA 285 completed. For example: Onsite Dental Services does not require a DMA 285.

If an AU has no TPL, completion of the DMA 285 is **not** required if application for Medicaid is made with the following forms that include the assignment of TPL rights:

- Form 94 (rev. 12/03 or later)
- Form 508
- Form 297M (rev. 11/07 or later) This must be completed with the Form 297
- Form 700 (rev. 11/07 or later)
- COMPASS Online **Medicaid** Application and Renewal
- PeachCare for Kids® Application
- PeachCare for Kids® Rebound application (VIDA screens)
- **Form 94A Medicaid** Streamlined Application
- Form 632 Presumptive Eligible (PE) Pregnancy Medicaid (rev. 4/1/10 or later)
- Form 632W Presumptive Eligible (PE) Women's Health Medicaid (rev. 1/1/13 or later)

NOTE: Form DMA 285 can be accessed by the below link:

https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/10232006_285_Rev-Jan06_RVSD%2013-02-2012%20212123.pdf

The assignment of TPL rights must be done at each application and renewal. If a renewal is completed by phone, a renewal form must be sent to the A/R for signature, and the form must be returned to prevent penalization/loss of coverage.

For MAGI Family Medicaid COAs a separate DMA 285 is not required if the **Form 94A Medicaid** streamlined application, 297M, or pre-populated renewal form 508M has the TPL information included and the form is signed.

**BASIC
CONSIDERATIONS**

For Q track applications, a DMA 285 is not required to be completed even when the AU has TPL. A copy of the application may be submitted in lieu of the DMA 285 with a copy of the insurance card attached, if possible.

Mail or fax Form DMA 285 to:

Health Management Systems or fax # 770-937-0180
900 Circle 75 Pkwy. include name & phone # of MES
Suite 650
Atlanta, Georgia 30339

**Trusts and Other Legal
Documents**

Any trust, such as a Special Needs Trust, Qualified Income Trust (QIT), Pooled Trust or other similar legal document is considered a TPL and is to be reported to DCH. Annotate Form 285 to indicate there is a trust document. Attach a copy of the trust or legal document and mail to the TPL Unit.

Mail the trust document (including QITs that adhere to a DCH approved format along with the QIT Certification form) **and** Form DMA 285, Health Insurance Information Questionnaire, to:

Third Party Liability Unit
P.O. Box 1984
Atlanta, GA 30301-1984

Mail QITs that do not adhere to one of the DCH approved formats to:

DCH Legal Services Section
2 Peachtree St., NW, 40th Floor
Atlanta, GA. 30303-3159

Include "QIT Approved Format Deviation Form", found in Appendix F; explaining how the trust differs from the DCH approved QIT format and proof that a QIT account has been opened.

When the A/R with a trust/QIT dies or becomes ineligible, send to the TPL Unit a copy of the original DMA 285. Annotate in red at the top of the form that the A/R is deceased/ineligible, the date of death/ineligibility, and whether the TPR is a trust or QIT.

**ABD Medicaid
TPL Requirements**

ABD and SSI Medicaid recipients who refuse to cooperate with the TPL process, are ineligible for Medicaid effective the month following the expiration of timely notice.

**Family Medicaid
TPL Requirements**

Family Medicaid A/Rs must provide information regarding a TPL held by a non-custodial parent unless good cause is asserted and upheld. Good cause for refusing to cooperate is based on Division of Child Support Services good cause and non-cooperation standards.

Complete Form 138 to document waiver of the TPL requirement because of Good Cause for non-cooperation with DCSS.

BASIC**CONSIDERATIONS****Family Medicaid
TPL Requirements
(cont'd)**

An adult A/R is penalized for failure to cooperate with the TPL process. If there are two adults in the AU, both would be penalized if there is no TPL cooperation.

Recipients of Newborn Medicaid are not required to provide information regarding TPLs.

A child is never penalized or excluded from the AU because of an adult's failure to cooperate with TPL.

Refer to [Section 2657, Penalized Individuals](#), for information regarding Family Medicaid failure to comply with TPL requirements.

NOTE: For children in DFCS custody, reference Problem Resolution with Medicaid Billing and TPL, Children in Placement.

**Nursing Home
Insurance**

For A/Rs who have insurance that pays for care in a nursing facility, determine if the insurance payment can be assigned to the facility. If the payments **can** be assigned, complete Form DMA 285 notifying DCH that the nursing facility will be paid directly from the insurance carrier. If payments **cannot** be assigned to the facility, treat the payments made to the A/R as income in the month received and include in the patient liability budget.

**Health Insurance
Premium Payment
Program**

The Health Insurance Premium Payment (HIPP) Referral Form is used to notify DCH via HMS of the potential purchase of an A/R's health insurance. HIPP referrals may come from DFCS, a hospital, or other medical providers.

When DCH/HMS receives a referral for a "priority" applicant (person has cancer, diabetes, etc.), a decision is normally pended for 30 days awaiting the outcome of the Medicaid determination. If the applicant is not approved for Medicaid within the 30 days, the HIPP request is denied and the applicant is sent a denial letter.

If the referral is for a "non-priority" applicant, then a survey letter is sent to the applicant requesting the name of the employer, insurance company, etc. The applicant has 30 days from the date of the survey letter to return the letter to HMS. If the applicant is not made eligible for Medicaid by the time the survey letter is received by HMS, the HIPP referral is denied and a denial letter is mailed to the applicant. If the applicant is made eligible for Medicaid by the time the survey letter is returned, the approval process for HIPP begins. If the applicant fails to return the survey letter within the 30 days from the date on the letter, the HIPP referral is denied and a denial letter is mailed to the applicant.

**BASIC
CONSIDERATIONS**
**Health Insurance
Premium Payment
(cont.)**

The earliest HIPP payments will begin is the first month of Medicaid eligibility. Payments are not made for any month(s) in which the A/R is not Medicaid eligible. HIPP payments are not retroactive.

Do **NOT** make HIPP referrals for an A/R:

- with no health insurance or no access to health insurance
- whose only insurance is a Medicare Supplement
- whose only insurance is a per-diem (a policy that reimburses the policyholder a contractual amount per day for specified medical services or procedures) or cancer policy
- who is eligible only for Q-Track
- who does not have ongoing Medicaid coverage (for example, approved for three months prior only)
- who is Medically Needy spenddown eligible and spenddown is met at or near the end of a budget period.

NOTE: A referral **should** be made if the A/R is de facto eligible or spenddown eligible for multiple budget periods.

- whose coverage is through a non-custodial parent
- who is a refugee
- whose employer information is unavailable
- when the name of the policy holder is not known
- when there is no known person to contact for referral.

Refer only the primary policy to HIPP if an A/R has multiple health insurance policies.

Complete a DCH HIPP Referral Form ([DMA 124](#)), if appropriate, and forward the original to Health Management Systems or document why a HIPP referral was not made.

Mail or fax the HIPP Referral Form along with Form DMA 285, Health Insurance Information Questionnaire, to:

Health Management Systems or fax # 770-937-0180
900 Circle 75 Pkwy. include name & phone
Suite 650 # of MES
Atlanta, Georgia 30339

NOTE: If a TPR pays DCH more than the amount DCH paid for all other services, including HIPP expenses, DCH will issue a refund to the A/R and notify the county via the state office of the refund. Refer to Chapter 2400, Income for treatment of refunds from DCH.

BASIC**CONSIDERATIONS****SSI Applicants**

SSI applicants who refuse to assign TPLs during the SSI application process are ineligible for Medicaid until TPL is assigned at the county DFCS office.

**Disability Insurance
Payments**

If the A/R receives payments based on disability from an insurance policy, treat the payments as follows:

- If the payments are designated by the policy owner to cover medical expenses only, consider the payments to be a TPL. Report the payments to Health Management Systems on Form DMA 285.

If the payments are designated to cover lost wages or to be used at the discretion of the policyholder (A/R), consider the payments to be unearned income if the payments cannot be assigned.

**Problem Resolution with
Medicaid Billing and TPL**

Pharmacies should never deny filling an A/R's prescription because of an insurance issue. However, follow the instructions below if the insurance continues to be a barrier to getting prescriptions filled or Medicaid claims paid:

1. Worker is notified by A/R, pharmacy or provider that a claim cannot be processed because of a TPL.
2. Worker checks with A/R to validate if TPL actually exists. Also check case record for Form DMA 285 regarding either the existence of TPL or cancellation of TPL.
3. If the TPL is valid, inform A/R that the TPL is the primary payer of prescription. No further action needed.
4. If the TPL is valid, but the benefits have been exhausted for that particular service, that TPL may not be deleted from GAMMIS. The pharmacy provider may process the claim Point of Sale (POS) using an Other Coverage Code = 4 Other coverage exists-payment not collected. If the pharmacy system does not allow for POS processing the pharmacy provider may submit the claim manually on a Universal Claim Form (UCF). The pharmacy provider should also include an explanation of benefits (EOB) from the primary carrier or a pharmacy screen print/profile with primary carrier detail that should include: the primary amount billed, primary amount paid, and recipient amount paid (copay/deductible), and remaining amount due that is being billed to DCH. The provider must maintain documentation in their records concerning the denial in case of an audit. Mail pharmacy paper claims (Universal Claim Form (UCF)) to:

**Catamaran
PO Box 968021
Schaumburg IL 60196-8021**

**Problem Resolution with
Medicaid Billing and TPL
(cont'd)**

5. If evidence is that the TPL is no longer valid, complete a Form DMA 285 and put a note on the top of the form that the insurance is not valid and attach a copy of the GAMMIS screen showing the invalid TPL. Fax to HMS at 770-937-0180. HMS has 30 days to act on the cancellation.
6. If the TPL was cancelled many months ago or has never been a valid TPL for the A/R, complete a Form DMA 285 and put a note on the top of the form that the insurance is not valid and attach a copy of the GAMMIS screen showing the invalid TPL. Fax to HMS at 770-937-0180.
7. However, if this is an emergency and the prescription needs to be processed immediately, you may need to contact HMS by phone at 770-980-9777 or by fax at 770-937-0180.
8. The pharmacy should immediately fill the prescription, but in the event that the pharmacist, at the "Point of Sale", is unsure of what COB override code to use, the table below provides the appropriate designation for their use. If necessary, direct them to the Medicaid Rx Services Section at 404-656-4044.

FIELD	NAME OF FIELD	VALUES/DEFINITIONS OF FIELDS
308-C8	Other Coverage Code	2 = Other coverage exists – payment collected
		3 = Other coverage exists – claim not covered
		4 = Other coverage exists – payment not collected.
		8 = Claim is billing for patient financial responsibility only (co-pay/coinsurance)

9. Paper processing is allowed if the pharmacy system does not allow for online processing of Medicaid secondary or tertiary claims. If the carrier returns payment for the claim, the pharmacy provider must include EOB from primary carrier or a pharmacy screen print/profile with primary carrier detail that paid, and recipient amount paid (co-pay/deductible), and remaining amount due that is being billed to DCH. If the other carrier denied the claim, attach the denial statement from the other insurance carrier to your claim form for processing. If no response is received from the insurance carrier, attach the coordination of benefits confirmation statement to the back of your claim for payment,.
Please mail pharmacy paper claims (Universal Claim Form (UCF)) to:

**Catamaran
PO Box 968021
Schaumburg IL 60196-8021**

Children in Placement	<p>For children in placement, when there are difficulties in verifying a child's insurance coverage or termination of insurance coverage with an insurance carrier due to HIPAA and custody issues, RevMax RMS should submit form DMA 285 with all known information, including: RMS name and contact number; contact date(s) and name for insurance carrier and issue details. Submit form to:</p> <p>Health Management Systems OR fax: 770-937-0180 900 Circle 75 Pkwy Suite 650Atlanta, GA 30339</p>
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