2230 – THIRD PARTY RESOURCES

POLICY STATEMENT

Medicaid applicants and recipients (A/Rs) are required to provide information regarding third party resources (TPRs) available to AU members. Rights to TPRs must be assigned to the Division of Medical Assistance (DMA).

BASIC CONSIDERATIONS

TPRs are medical benefits and include, but are not limited to, the following:

- 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)
  - 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 TPR)
- Worker's Compensation
- **Any** trust
- Any legal document that specifies monies are due to the State (including lawsuit settlements, workers' compensation benefits, etc.)

Payments from TPRs are assigned to DCH when the A/R signs the application form for Medicaid.

Form DMA-285

If a TPR exists a Form DMA-285, Health Insurance Information Questionnaire, must be signed and placed in the case record. The top copy of the signed, completed DMA-285 must be sent to Health Management Systems (HMS). This form is used to transmit TPR information to DCH. The Form DMA-285 also includes a release of information statement and an assignment of payments agreement. Do not submit Form DMA-285 if Medicare is the only TPR.

NOTE: The pre-paid dental services do not have to have a DMA 285 completed. For example: O**nsite** D**ental** Services does not require a DMA 285.

BASIC CONSIDERATIONS

Form DMA-285 (cont.)

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

- Form 94(revised 12/03)
- Form 222(revised 02/08)
- Form 286(revised 10/10)
- Form 297M (revised 11/07) This must be completed with the Form 297
- Form 700(revised 11/07)
- PeachCare for Kids Application
- Peachcare for Kids Rebound application (VIDA screens)

The assignment of TPR rights must be done at each application and review. If a review is completed by phone and no review form is received, a DMA285 must be sent to the a/r for signature, and the form must be returned to prevent penalization/loss of coverage.

For Q track applications, a DMA 285 is not required to be completed even when the AU has TPR. 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
5660 New Northside Drive
Suite 750
Atlanta, Georgia 30328

or fax # 770-937-0180
include name & phone # of MES

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 TPR 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 303**0**1-1984

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**, G**A. 30303-3159

BASIC CONSIDERATIONS

Trusts and Other Legal Documents (cont'd)

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 TPR Unit a copy of the original Form 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 TPR Requirements

ABD and SSI Medicaid recipients who, without good cause, refuse to cooperate with the TPR process, are ineligible for Medicaid effective the month following the expiration of timely notice.

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

Family Medicaid TPR Requirements

Family Medicaid A/Rs must provide information regarding a TPR held by a non-custodial parent unless good cause is asserted and upheld. Good cause for refusing to cooperate is based on Office of Child Support good cause and non-cooperation standards. Complete Form 138 to document waiver of the TPR requirement because of Good Cause for non-cooperation with CSS.

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

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

Refer to Section 2657, Penalized Individuals, for information regarding Family Medicaid failure to comply with TPR requirements.

NOTE: For children in DFCS custody, reference Problem Resolution with Medicaid Billing and TPR, 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 285 notifying DMA 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.

BASIC CONSIDERATIONS

Health Insurance Premium Payment Program

The Health Insurance Premium Payment (HIPP) Referral Form is used to notify DMA 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 DMA/HMS receives a referral for a "priority" A/R (person has cancer, diabetes, etc.), a decision is normally pended for 30 days awaiting the outcome of the Medicaid determination. If the A/R is not approved for Medicaid within the 30 days, the HIPP request is denied and the A/R is sent a denial letter.

If the referral is for a "non-priority" A/R, then a survey letter is sent to the A/R requesting the name of the employer, insurance company, etc. The A/R has 30 days from the date of the survey letter to return the letter to HMS. If the A/R 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 A/R. If the A/R is made eligible for Medicaid by the time the survey letter is returned, the approval process for HIPP begins. If the A/R 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 A/R.

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.

Applicants who refuse to enroll, or who elect to terminate health insurance coverage that has been determined by DMA to be cost effective to purchase under the HIPP program, are ineligible for Medicaid beginning with the month of refusal, disenrollment, or month of notification from DMA regarding HIPP.

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.

BASIC CONSIDERATIONS

Health Insurance Premium Payment (cont.)

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 DMA HIPP Referral Form, 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
5660 New Northside Drive include name & phone
Suite 750 # of MES
Atlanta, Georgia 30328

NOTE: If a TPR pays DMA more than the amount DMA paid for all other services, including HIPP expenses, DMA 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 DMA.

SSI Recipients

SSI recipients who refuse to assign TPRs during the SSI application process are ineligible for Medicaid until TPR 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 TPR. 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 TPR

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 TPR.
2. Worker checks with A/R to validate if TPR actually exists. Also check case record for Form 285 regarding either the existence of TPR or cancellation of TPR.
3. If the TPR is valid, inform A/R that the TPR is the primary payer of prescription. No further action needed.
4. If the TPR is valid, but the benefits have been exhausted for that particular service, that TPR may not be deleted from GAMMIS.. The provider must file the claim manually attaching the denial explanation of benefit (EOB) letter to the claim. The provider would submit the claim using the DMA 410 or DMA 460 available on the GAMMIS website. The provider must maintain documentation in their records concerning the denial in case of an audit.
5. If evidence is that the TPR is no longer valid, complete a Form 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 TPR. Fax to HMS at 770-937-0180. HMS has 30 days to act on the cancellation.
6. If the TPR was cancelled many months ago or has never been a valid TPR for the A/R, complete a Form 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 TPR. 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	0 = Not Specified
		1 = No other coverage identified
		2 = Other coverage exists – payment collected
		3 = Other coverage exists – claim not covered
		4 = Other coverage exists – payment not collected.

Problem Resolution with Medicaid Billing and TPR	
Children in Placement	**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:** **Health Management Systems OR fax: 770-937-0180** **5660 New Northside Drive, Suite 750** **Atlanta, GA 30328**