TENNCARE POLICY MANUAL

Policy No:	CON 05-001 (Rev. 2)	
Subject:	MCCs' and Providers' Responsibility When Enrollees have Third Party Copays and/or Deductibles	
Approval:	Keith Gattis	**Date:** 5/15/14

PURPOSE:

Some Medicaid eligibles have third party insurance. Each insurance policy has its own sets of rules regarding deductibles and copays. The purpose of this policy is to clarify the obligations of both the TennCare provider and the TennCare Managed Care Contractor regarding payment for covered services when the enrollee has not yet met a deductible or paid a copay required by the third party payer.

NOTE: The area of third party liability (TPL) policy is a broad one. This policy is not intended to address any aspect of TPL policy other than the MCCs' and providers' responsibility when the enrollee has third party copays and/or deductibles.

POLICY:

TennCare MCCs may not reduce or refuse payment for covered services to an enrollee with third party coverage solely on the grounds that (1) the enrollee has not yet reached his deductible for the third party or (2) the enrollee has not met his copay obligations under the third party. The MCCs are supposed to coordinate benefits with third party payers so that services are delivered as cost-effectively as possible and Medicaid regulations regarding enrollee's payment obligations are met.

When delivering TennCare covered services that are also covered by an enrollee's third party payer, providers may only collect from TennCare enrollees the copay allowed by TennCare for that service. This is true even if the third party payer is paying in full for the service and TennCare is making no payment. The provider should first bill the third party and may, subsequently, bill TennCare. If all other criteria are met, TennCare will pay the claim up to the TennCare allowable amount, less the amount paid by the third party payer—not to include contractual write-offs[1]—and the TennCare copay.

[1]For purposes of this policy, "contractual write-offs" refers to discounts that an MCC has negotiated with a provider in its commercial plan. TennCare does not consider such discounts to be actual payments to the provider that can be used to offset what the provider would otherwise be paid.

DISCUSSION:

TennCare is almost always the payer of last resort when an enrollee has third party insurance, or third party liability (TPL). See 42 CFR 433.139 and State Rules 1200-13-13-.09(6) and 1200-13-14-.09(6).

If a service would have been paid for by a third party but was not because of failure to follow the third party's policies for payment, then TennCare MCCs may legitimately deny the claim. An example is a service that requires prior authorization from the third party payer. If the provider has not sought prior authorization from the third party and his claim for payment is therefore denied by the third party payer, his claim is not then payable by TennCare. See State Rules 1200-13-13-.10(1)(n) and 1200-13-14-.10(1)(n).

However, a different situation exists if the third party payer does not make payment or makes a reduced payment for the service on the grounds that the enrollee has not yet met his third party deductible or has not made a required third party co-payment. In the commercial world, insurance companies might deny payment in a situation like this, in which case the provider could bill the patient. However, Medicaid does not permit the patient to be billed except in very limited circumstances. If an MCC does not pay a provider because the enrollee has TPL and has not satisfied his or her third party deductibles and/or copays, then the provider is left without the ability to collect payment for his/her services.

Federal regulations do not permit the state to deny payment for claims for services to enrollees with TPL when "benefits are not available at the time the claim is filed." See 42 CFR 433.139(c). When an enrollee has not satisfied a third party deductible and/or copay requirement, then the third party benefits are not available to him. In that circumstance, the claim should be processed by the MCC according to its usual procedures.

In the case of required third party copays, the provider may ask the patient only for the TennCare allowed copay, not the third party copay. The third party payer may deduct from its payment to the provider the copay that is required under its plan, but the provider can only collect TennCare copays from the enrollee. This only applies when the service is a covered service. Services over the limits become non-covered and it is then appropriate for the provider to collect the third party's co-payment (see example 5 below).

EXAMPLES

Example 1: Dr. Smith delivers a service to TennCare enrollee Mary Brown, who also belongs to XYZ Health Plan, which is offered by her employer. The XYZ Health Plan has a $1000 deductible. Dr. Smith submits a claim for $100 for the service to XYZ Health Plan. XYZ Health Plan approves the claim but does not make payment on the basis that Mary Brown has not yet met her deductible. It is entirely proper for Dr. Smith to then submit the claim to Mary Brown's MCC, which should process the claim in the usual manner as though there were no TPL. If the MCC's payment for the service would have been $70, then that amount is paid to Dr. Smith and he is considered to have received payment in full.

Example 2: In the above situation, Mary Brown has only $90 left on her deductible when she visits Dr. Smith. Dr. Smith submits his claim for $100 to XYZ Health Plan. XYZ pays $10, on the grounds that Mary Brown has $90 remaining on her deductible. It is entirely proper for Dr. Smith to then submit the claim

to Mary Brown's MCC. If the MCC would have paid $70 on the claim, it is acceptable for them to pay $60 ($70 minus the $10 paid by XYZ Health Plan). The provider would be considered to have been paid in full. It is not permissible for the MCC to fail to pay the claim on the basis that Mary Brown has not met her XYZ Health Plan deductible.

Example 3: Dr. Smith orders a prescription for Mary Brown. The drug is a brand-name drug for which XYZ Health Plan and TennCare each pay $50. XYZ Health Plan requires a $10 copay for prescription drugs; TennCare requires a $3 copay in a situation such as this. The pharmacist may collect only $3 from Mary Brown, not the $10 that XYZ Health Plan requires. (The pharmacist may not deny the prescription to Mary Brown if she does not pay the TennCare copay.) XYZ Health Plan then pays the pharmacist $40 for the prescription ($50 minus the $10 copay). The pharmacist may bill TennCare for the remaining $7. TennCare's payment will be reduced by the amount of the TennCare copay, regardless of whether or not the enrollee actually pays the copay.

Example 4: Same as Example 3 except that XYZ Health Plan pays $50 for the drug and TennCare pays $35. The pharmacist may still collect only the $3 TennCare copay from Mary Brown. (The pharmacist may not deny the prescription to Mary Brown if she does not pay the TennCare copay.) The pharmacist's payment from XYZ Health Plan will be $40. Because that amount is more than TennCare would have paid for the drug, TennCare would pay the claim at zero.

Example 5: Dr. Smith writes a prescription for a brand name drug for Mary Brown. Mary Brown has already filled her 5 covered TennCare prescriptions for the month. Mary's other insurance, XYZ Health Plan, has a $15 copay for a brand name drug. The pharmacist may collect the $15 from Mary Brown prior to billing XYZ Health Plan.

DEFINITIONS

Coordination of benefits. The process of working with a third party payer to make certain that benefits are delivered as cost-effectively as possible, with each party assuming its appropriate responsibility and the enrollee being "held harmless" except for allowable Medicaid deductibles, copays, and coinsurance.

Payment in full. TennCare's payment for a covered service, less any applicable Medicaid deductibles or copays. Providers who participate in TennCare are required to accept TennCare's payment as payment in full.

Third party payers. Entities which are responsible for paying medical claims of TennCare enrollees.

OFFICES OF PRIMARY RESPONSIBILITY:

Managed Care Operations

REFERENCES:

Social Security Act § 1916
http://www.ssa.gov/OP_Home/ssact/title19/1916.htm

42 CFR Part 433, Subpart D
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=af13a26860fbf2953be7de0cf28628b3&rgn=div5&view=text&node=42:4.0.1.1.4&idno=42#42:4.0.1.1.4.4

State of Tennessee Rules and Regulations
http://www.tn.gov/sos/rules/1200/1200-13/1200-13.htm

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