Kansas
Department of Health and Environment

Policy Clarification 2021-02-02

Title: Third Party Liability (TPL)

Date: February 23, 2021

From: Policy Managers

Program(s) Impacted: All Medical Programs

The purpose of this document is to provide clarification on when it is necessary to verify a Third Party Liability (TPL) and how this relates to eligibility. It will also clarify when it is necessary to request TPL information from the consumer, when failure to provide this information would result in a loss of eligibility, and how to handle discrepant information. The direction provided here is effective upon release and may be applied retroactively where applicable.

Third Party Liability and MMIS – Background

The Medicaid Management Information System (MMIS) is our system of record for Third Party Liabilities. The fiscal agent has the responsibility of receiving the TPL information through a nightly KEES file and utilizing this information to locate the insurance record and upload it to MMIS to be used for claims and billing purposes. When the insurance information entered by staff into KEES is insufficient for the fiscal agent to locate the matching record, it cannot be uploaded to MMIS. This causes a risk of improper payments made by Medicaid if the consumer's primary insurance is not billed first.

Verification of a TPL

Per federal regulations, when an applicant reporting other health insurance is determined eligible for Medicaid, the agency has the responsibility to obtain any information from the consumer needed to identify the TPL. This should occur at initial application and at each renewal. Kansas's process for doing this requires eligibility workers to create a record in KEES using information the applicant has provided which the fiscal agent will then use to locate the insurance policy information and upload to the MMIS for correct assignment of payments.

Impact on Eligibility

Per PM2015-06-05, we cannot require an applicant/recipient to provide TPL information as a condition of eligibility, and as long as we have partial information, a referral should be created for the fiscal agent to research and attempt an identification. While these stipulations remain in place, policy is now clarified to further explain how and when the agency is responsible for

requesting this information from the consumer and in what instances coverage would be affected due to the consumer's failure to cooperate.

Note: Condition of eligibility in this sense indicates that Medicaid cannot be denied due to the existence of TPL or for failure to provide full information up front. It does not exempt the consumer from cooperating with the agency in obtaining the information when needed.

As stated above, when partial TPL information or a "lead" is provided by the consumer at application or review, staff will create the record on the Other Health Insurance page in KEES which will transfer to the fiscal agent. The information must at least include the name of the policy holder, the insurance carrier name (ex: Blue Cross Blue Shield of Kansas) and either the policy number/ID or the SSN of the policy holder in order for the fiscal agent to search for a match. In the instance the consumer marks 'yes' for other health insurance but does not supply the minimal information needed, it is appropriate for the eligibility worker to request the policy holder, carrier, and insurance policy number/ID from the consumer, giving them the standard timeframe to provide. If the consumer cooperates in providing the information – partial or otherwise – the record may be created. If the consumer either refuses the information or fails to contact the agency, coverage should be denied/closed due to failure to cooperate.

Note: SSN should never be requested for a non-applicant/recipient.

If the consumer contacts the agency indicating they are unable to provide the information due to some understandable reason but shows an effort to provide whatever information they can, this should be treated as 'good cause' as the consumer is showing an attempt to cooperate, and coverage should not be denied/discontinued. The reasoning should be fully documented. In these cases, the responsibility remains with the agency to seek out the information by any means available.

Example: The consumer calls the agency in response to a request for information and states he is unable to access the insurance policy information since his ex-wife is the holder and he is unable to contact her. He can provide the name of his ex-wife but no other information. The worker documents the reasoning, creates the record with the policy holder's name and enters 'unknown' in other required fields. Though the fiscal agent is unable to locate the record without the additional information, coverage is allowed to continue due to the consumer's attempt to cooperate.

This clarification has no bearing on Medical Subrogation – all policies and processes for Medical Subrogation remain in place as described in KEESM 2910 and KFMAM 2531.01 and 2531.02.

Handling Discrepant Information

MMIS should be checked by staff for each eligible applicant/recipient (meaning either someone determined eligible for or currently receiving coverage) both at application and when processing a pre-populated review for both CHIP and Medicaid. If the information reported by the consumer conflicts with the information found in MMIS, it is necessary for the eligibility worker to make the appropriate adjustments to reconcile the records, such as end-dating or creating the appropriate record in KEES to update the MMIS record. If there is not enough information provided to update the record, it may be necessary to contact the consumer, but only in situations where the information would potentially affect the member's

eligibility; otherwise, although it is best practice to attempt clarification through a phone call, coverage should not be denied or ended due to the consumer's failure to respond.

The KEES record and the MMIS record should always match. If the consumer answers neither yes nor no to having other health insurance, but there is an active record in MMIS, the KEES record should be updated with the information found in MMIS so the consumer is given the opportunity to make changes at the next review.

Example: An application is processed for a child who appears eligible for PLN. The insurance section is left blank, but when the worker checks MMIS, there is an active insurance record showing. The worker is unable to reach the consumer by phone to clarify the discrepancy. Because the potential TPL does not affect Medicaid eligibility, it is not appropriate in this case to formally request the information through a notice, and coverage may be processed without additional information; however, the TPL record found in MMIS should be added to KEES.

For questions or concerns related to this document, please contact one of the KDHE Medical Policy Staff below.

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