Kansas
Medical Assistance
Program

June 2006 **Provider Bulletin Number 602**

General Providers

General TPL Manual Update

Changes have been made to the *General TPL Provider Manual*. These changes include:

- Faxing other insurance information to Kansas Medical Assistance Program
- Notice to bill Medicare
- Advance Beneficiary Notice
- Changes to spenddown beneficiaries' ID cards

To view these changes, visit the provider manual section of the KMAP Web site at https://www.kmap-state-ks.us.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, select the *General TPL Provider Manual*, pages 3-2, 3-4, 3-5, 3-9, 3-15, 3-17 through 3-19.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or 785-274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

3100. IDENTIFYING THIRD PARTY LIABILITY Updated 6/06

KMAP is **secondary payor** to all other insurance programs (including Medicare) and should be billed only after payment or denial has been received from such carriers. The only exceptions to this policy are listed below:

1) Services for Children with Special Health Care Needs (Special Health Services - SHS) Program
2) Kansas Health Policy Authority (KHPA) Vocational Rehabilitation Services
3) Indian Health Services
4) Crime Victim's Compensation Fund

KMAP is primary to the four programs noted above.

The Provider's Role:

To expedite the claims processing and payment function, the provider of Kansas Medical Assistance Program services must actively participate in the identification of primary sources for payment on behalf of the beneficiary. At the time the provider obtains Kansas Medical Assistance Program billing information from the beneficiary, the provider also determines if additional insurance resources exist. When they exist, these resources must be identified on the claim form and must be utilized before filing the claim to Medicaid.

Since providers have direct contact with the beneficiaries, they are the best source of timely third party liability information. The contribution providers can make to the Kansas Medical Assistance Program in the third party liability area is very significant. Providers have an obligation to investigate and report the existence of other insurance or liability. Cooperation is essential to the functioning of the Kansas Medical Assistance Program system and to assure prompt payment.

In the event a Kansas Medical Assistance Program beneficiary fails to cooperate with the provider in identifying and utilizing third party liability other insurance information, the provider must notify the Third Party Liability Manager, ~~Adult and Medical Services, Department of SRS, 915 S.W. Harrison St.,~~ Kansas Health Policy Authority, Landon State Office Building, Rm 900N, 900 SW Jackson St., Topeka, KS 66612-1220 ~~1570~~, in writing, describing in detail the failure to cooperate. It is not an exception to the timely filing rule that the beneficiary was not cooperating with the provider in identifying and utilizing third party liability. The Kansas Medical Assistance Program cannot consider payment on claims that are filed past the 12 months timely filing period. Please refer to Section 5100 of the Provider Manual for additional information and exceptions.

Once Medicaid pays a claim, the provider shall not attempt to collect the same charge from any third party resource. Providers are not allowed to bill Medicaid the other insurance provider writeoff amount (sometimes referred to as contractual writeoff amount).

3100. Updated 6/06

Hospitals may not file a lien pursuant to K.S.A. 65-406 against any potential claim involving a Kansas Medical Assistance Program beneficiary.

It is important that providers maintain adequate records of third party recovery efforts for a period of time not less than five years. These records, like all other Kansas Medical Assistance Program records, are subject to audit by Health and Human Services, ~~SRS~~, Kansas Health Policy Authority, or their representatives.

Third Party Liability Information (Other Insurance and Medicare):

Medical third party liability information on the Kansas Medical Assistance Program identification (ID) card is the provider's first source of information concerning other insurance. Providers should gather insurance information each time the ID card is presented by the beneficiary. If other insurance is identified by name and/or type of coverage, proof of payment or denial, or a letter of explanation of benefits from that company, must be attached to the claim. No other documentation is acceptable. For electronic claim filing, please refer to your electronic claim filing manual for filing instructions.

Other insurance information may also be faxed to KMAP by using the TPL Fax Form, which is included in the Forms section of this manual. The fax number for the form is (785) 274-5918. It is important to fill out the form as completely as possible. Incomplete forms may result in the other insurance not being added to the system.

Primary Insurance Non-Covered Services:

When a service is not covered by a beneficiary's primary insurance plan, a Blanket Denial letter maybe requested from the insurance carrier. The provider will need to request from the insurance carrier a letter, on company letterhead, stating that the service/HCPCS code is not covered by the insurance plan covering the Medicaid beneficiary. Providers can retain this statement on file to be used as proof of denial for one year. The "non-covered" status must be reconfirmed and a new letter obtained at the end of one year.

3100. Updated 6/06

Computer-Generated ID Card Third Party Indicators

All available third party liability information is listed in the "TPL/HMO" section of the paper ID card (Section 2000 of the *General Benefits Manual*). The data will print as listed below, if applicable.

KNOWN INSURANCE	**MEDICARE**
Name	A = Medicare A
Address	B = Medicare B
Policy Number	A&B = Medicare A & B
Group Number	

TYPE OF COVERAGE

ACH	=	Nursing Facility	HPC	=	Hospice
CAN	=	Cancer	MCS	=	Medicare Supplement
CVC	=	Crime Victims Compensation	MED	=	Medical
DEN	=	Dental	RX	=	Pharmacy
HOS	=	Hospital	VIS	=	Vision

Updating File Information:

If you receive TPL information contradicting what the fiscal agent's file indicates, please attach one of the following to your claim or fax the information using the TPL Fax Form to the TPL department at (785) 274-5918:

- Documentation from the insurance company showing coverage terminated or non-existent.
- Document by letter that you, the provider, contacted the other insurance company by phone and spoke with ______________ and were informed that the policy terminated on __________________ or that the policy does not cover the beneficiary.

Remember, if a specific insurance coverage is on file for a beneficiary, proof of termination, denial or exhaustion of benefits must be submitted from that carrier before the file can be corrected.

3200. Updated 6/06

If the patient has no Part A, but does have Part B and is admitted to the hospital through the emergency room or outpatient department, these emergency room, outpatient and selected inpatient ancillary services should be billed to Medicare on form SSA 1483. Medicaid will process all Part A non-payable services billed to Medicaid on the UB-92 **with** appropriate documentation demonstrating Medicare's refusal to pay due to no Part A benefits.

Payment shall be made for Kansas Medical Assistance Program beneficiaries for all Medicaid covered services, less the Medicare allowed amounts, spenddown, copayment and other third party payments but no more than the Kansas Medical Assistance Program maximum allowable specified coinsurance and/or deductible amounts.

If Part A Medicare benefits have been exhausted and the patient is still receiving care, bill Part B Medicare for inpatient benefits.

Notice to bill Medicare:

From time to time you may receive a letter from Health Management Systems, Inc. (HMS) that a beneficiary may have been eligible for Medicare Part A or B coverage on the claim dates of service. The letter will instruct you on how to bill Medicare. Do not send a refund check for these claims. EDS will recoup these claims within 60 days.

To refute any of the recoupments, send all correspondence, documentation, and inquires regarding the recoupment notice to:

Kansas Health Policy Authority
~~Kansas Department of Social & Rehabilitation Service~~
HMS/Third Party Liability Service Center
1140 Empire Central Drive, Suite 450
Dallas, TX 75247-4316

Phone: (877) 260-0318
Fax: (214) 453-3201

Do not contact any unit of the ~~Division of Healthcare Policy and Finance~~ KHPA or ~~EDS~~ fiscal agent regarding the recoupment notice. All communications should be directed to the name and address above.

3400. Updated 6/06

There are many accidents where there is possible liability, but a final determination will not be made until long after the accident. In these cases, the provider should submit claims for services to KMAP clearly stating the details of the accident and giving any information available about the liability of other parties and possible insurance resources. ~~HCPMP~~ KMAP will process these claims for payment by Medicaid and Medical Subrogation staff will seek recovery directly from the third party.

Beneficiary And Attorney Requests And Subpoenas For Bills Or Itemized Statements:

Occasionally a Medicaid beneficiary, or an attorney for a Medicaid beneficiary, will request or subpoena copies of itemized statements or bills. This may mean there is a pending or proposed lawsuit, or some other form of Third Party Liability (TPL). To operate most effectively, Medicaid requires the cooperation from both beneficiaries and providers in identifying TPL. So, Medicaid has the following requirement so Medicaid may discover and recover TPL, and operate the program more efficiently.

Providers must notify the Medical Subrogation staff whenever providers have a request to release bills or itemized statements to beneficiaries or their lawyers.

You may notify the Medical Subrogation staff by phone, fax, or by letter from the staff by contacting:

~~SRS~~ Medical Subrogation staff — Phone: (785) 296-3967
~~SRS~~ Legal Section — Fax: (785) 296-4960
Landon State Office Building, Room 900N
900 S.W. Jackson Street
~~Docking State Office Building, Room 530~~
~~915 S.W. Harrision Street~~
Topeka, KS 66612-1220 ~~1570~~

Please include this information in your notification to the Medical Subrogation Staff:

- Name of the Medicaid beneficiary
- Medicaid ID #
- Date of accident or incident
- Type of injury
- Name, address, and phone number of attorney (if applicable)
- Name, address, and phone number of insurance company (if applicable)

This allows providers to comply with HIPAA Privacy Rules. Under that rule, when Medicaid beneficiaries request to see or obtain a copy of their billing records, covered providers must provide this to the beneficiary within 30 days, under C.F.R. Sec. 164.524(b)(2).

You **do not** need to notify the Medical Subrogation staff if:

! The beneficiary wants treatment records only
! The beneficiary needs the bill to meet a spenddown

3500. BENEFICIARY RESPONSIBILITY Updated 6/06

The KMAP beneficiary can be held responsible for payment of common services and situations. Beneficiaries may be billed only when program requirements have been met and the provider has informed the beneficiary in advance and in writing.

> K.A.R. 30-5-59, "...(e) Payment. Each participating provider shall meet the following conditions: (4) not charge any Medicaid/Medikan program beneficiary for non-covered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for non-covered services;"

Suggested content for the Advance Beneficiary Notice (ABN):
This constitutes advance notice to you, the beneficiary, that if all program requirements are met by (the provider) and payment is not made by Medicaid, you may be held responsible for the charges if your services are not covered by Medicaid.

For services without face to face contact between the beneficiary and the provider (examples are lab and radiology services), the written ABN signed by the beneficiary with the referring provider is an appropriate notification of responsibility for payment of noncovered charges.

- Beneficiary was not eligible when services were provided
- Beneficiary was eligible when services were provided, however, did not inform the provider of his/her Kansas Medical Assistance Program eligibility timely. (This action must have prevented the provider from filing services to the program within the timely filing guidelines outlined in Section 5100 of the *General Billing Manual*.)
- Services Medicaid does not cover, unless:
- Beneficiary is a QMB and
- Service is covered by Medicare
- When other insurance does not reimburse the provider because there was lack of authorization
- Abortions, unless continuation of the pregnancy will endanger the life of the mother, or when a pregnancy is the result of rape or incest
- Any services related to and performed **following** a noncovered abortion
- Acupuncture
- Community Mental Health Center services and alcohol and drug abuse treatment services provided outside the boundaries of Kansas regardless of being within 50 miles of the state border
- Cosmetic surgery
- Services related to and performed **following** a noncovered cosmetic surgery
- Court appearances, telephone conferences/therapy
- Educational/instructional services
- Hospital charges incurred after the physician has discharged the patient from inpatient care
- Hypnosis, biofeedback or relaxation therapy
- Infertility Services (any tests, procedures or drugs related to infertility services)
- Non-restorative (developmental) physical, occupational, or speech therapy

3500. Updated 6/06

- Occupational therapy supplies
- Perceptual therapy
- Psychotherapy for patients whose only diagnosis is mental retardation
- Services for the sole purpose of pain management
- Services provided in cases of developmental delay for purposes of "infant stimulation".
- Services which are pioneering or experimental, and complications from such services.
- Services of social workers, team or therapy coordinators, occupational therapists, and speech therapists in private practice (unless beneficiary is a Qualified Medicare Beneficiary).
- Transcutaneous electrical nerve stimulation treatments.
- Transplant Surgery:
  - Cyclosporine (except when prior authorized, following kidney, liver and bone marrow transplants).
  - All services related solely to non-covered transplant procedures.
- Transplant surgery in some cases, is a covered service for KMAP beneficiary. Call EDS for a list.
- Treatment for obesity **EXCEPTION:** orlistat (Xenical®) and sibutramine (Meridia®), will be covered with prior authorization (PA). Individuals with a body mass index (BMI) >30 or >27 with comorbidity may be eligible to receive orlistat or sibutramine with PA.
- Vocational therapy, employment counseling, marital counseling/therapy and social services.
- Voluntary sterilizations which do not meet federal requirements.
- Services provided to MediKan beneficiary in the following program areas: Alcohol and Drug Addiction Treatment Facility, Behavior Management, Chiropractic, Dental, Head Start Facility, Local Education Agency, Non-Emergency and Non-Ambulance Medical Transportation, Podiatry, Vision.
- The private room difference in a hospital setting.
- Special diet in the hospital when ordered per the patient's request.

Providers are not to charge KMAP program beneficiary for services denied for payment by KMAP because the provider has failed to meet a program requirement including prior authorization.

Laboratory Services

The drawing or collection fee is considered content of service of an office visit or other procedure and is not covered if billed separately. The beneficiary cannot be billed for the drawing or collection since it is considered content of another service or procedure.

***Note*: Providers shall not bill beneficiaries for missed appointments. Missed appointments are not a distinct reimbursable service, but a part of the providers' overall cost of doing business.**

3600. SPENDDOWN Updated 6/06

Introduction to Spenddown:

In some cases the income of a family or individual exceeds the income standard to receive public assistance monies; however, their income is not sufficient to meet all medical expenses. The family group/individual must then incur a specified amount of medical expense before they are eligible for Medicaid benefits. This process is referred to as **spenddown**.

Identifying Spenddown Beneficiaries

All medically needy (spenddown) beneficiaries will receive a special ID card each month with MN listed in the Benefit Plan section of the card. The amount of unmet spenddown, as of the card print date, will be printed on the special medically needy ID cards (it specifically identifies them as a spenddown beneficiary). Possession of a medically needy ID card does not guarantee eligibility.

Claims Processed Against the Spenddown Amount

The spenddown amount will be reduced by expenses for medically necessary services of eligible beneficiaries but not allowed for in the state Medicaid plan in one of two ways. Medicaid enrolled providers may bill Medicaid for these services and the MMIS will deduct appropriate billed amounts from the appropriate spenddown or the beneficiary can mail medical bills from non-Medicaid providers with proof of TPL resolution and these bills will be manually entered into the MMIS as beneficiary billed claims.

The spenddown amount will be handled like a “deductible”. The MMIS will automatically credit the spenddown amount when Medicaid providers bill claims for medically necessary services. Billed charges apply to spenddown in date-processed order. Providers should bill all services regardless of whether they believe they are Medicaid covered services so that all charges can apply toward spenddown.

Providers will be reimbursed for claims submitted for QMB covered services rendered to QMB/Medically Needy dual eligibles. These services are not affected by unmet spenddown.

Beneficiaries Responsible

Each time a provider billed or beneficiary billed claim is used to reduce the spenddown the MMIS will identify the need for a notice to be sent to the beneficiary explaining which service(s) were used to credit the spenddown and what the new remaining spenddown amount is. These notices will be mailed to beneficiaries weekly. The beneficiary is responsible for the payment of all bills used to reduce their spenddown amount.