KANSAS

MEDICAL

ASSISTANCE

PROGRAM

PROVIDER MANUAL

General Third-Party Liability Payment
# PART I
GENERAL THIRD-PARTY LIABILITY PAYMENT
KANSAS MEDICAL ASSISTANCE PROGRAM

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## FORMS
All forms pertaining to this provider manual can be found on the public website at https://www.kmap-state-ks.us/Public/forms.asp and on the secure website at https://www.kmap-state-ks.us/provider/security/logon.asp under Pricing and Limitations.

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Introduction to Copayment

Federal guidelines allow states to require a copayment (a share of the cost of certain services) for which the Kansas Medical Assistance Program (KMAP) beneficiary must pay.

**Federal law mandates that a provider cannot deny services to a beneficiary because he or she is unable to pay the current or prior copayment.** Providers may ask whether the beneficiary is able to pay the copayment amount at the time of service. If the beneficiary states an inability to pay the copayment, providers must accept this statement and may not collect the copayment from the beneficiary at that time.

Inability to pay copayment at the time of service does not remove the beneficiary's responsibility to make payment at a future time. Providers may offer payment plans to beneficiaries, if necessary.

Copayment Exemptions

The list below is not all inclusive. Refer to Section 8100 of your provider manual for copayment requirements applicable to services you provide.

**Beneficiaries**
- Residents in adult care homes, swing bed nursing facilities or Home and Community Based Services (HCBS)
- Beneficiaries under 18 years of age
- Beneficiaries 18 to 21 years of age, or 65 years of age or older, who are inpatients in a state psychiatric facility
- Beneficiaries enrolled in a Medicaid-funded health maintenance organization (HMO)
- Beneficiaries eligible for Medicaid due to a diagnosis of breast or cervical cancer
- Beneficiaries in out of home placement and in SRS or JJA custody at least 18 but under 21 years of age

**General Services**
- Alcohol and drug addiction treatment
- Family planning
- Services related to pregnancy
- Attendant Care for Independent Living (ACIL)
- Indian Health
- Maternity center
- Emergency services (as defined by the diagnosis)
- Noncovered KMAP services
- Medical services related to an injury incurred on the job during a community work experience project
- Emergency medical services for aliens
KMAP is secondary payer 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 KMAP services must actively participate in the identification of primary sources for payment on behalf of the beneficiary. At the time the provider obtains KMAP 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 used before filing the claim to Medicaid. If a clear determination cannot be made whether the resources are related to Medicare (including Medicare replacement plans or Part C Advantage Plans) or other health insurance, the claim will not be processed but will be returned requesting clarification.

Since providers have direct contact with the beneficiaries, they are the best source of timely third-party liability (TPL) information. The contribution providers can make to KMAP in the TPL 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 KMAP system and to ensure prompt payment.

KHPA requires beneficiary compliance with the rules of insurance plans primary to Kansas Medicaid. If the beneficiary does not cooperate and follow the rules of the insurance plan (such as, staying in network, obtaining a referral, obtaining proper prior authorization), the related Medicaid claim will be denied. The Centers for Medicare and Medicaid Services (CMS) does not allow federal dollars to be spent if a beneficiary with access to other insurance does not cooperate or follow the applicable rules of his or her other insurance plan. Requests for exceptions can be made through written requests to the TPL department of the fiscal agent and will be reviewed and considered for approval by the TPL manager.

The provider must notify the beneficiary in advance if a service will not be covered. To ensure the beneficiary is aware of his or her responsibility, the provider has the option of obtaining a signed Advanced Beneficiary Notice (ABN) from the beneficiary prior to providing services. For more information on the ABN, refer to Section 3500 of this manual.

In the event a KMAP beneficiary fails to cooperate with the provider in identifying and using TPL other insurance information, the provider must notify the TPL manager, KHPA, Landon State Office Building, Room 900N, 900 SW Jackson Street, Topeka, Kansas 66612-1220. The notification must be 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 using TPL. KMAP cannot consider payment on claims that are filed past the 12 months timely filing period. Please refer to Section 5100 of the General Billing Provider Manual for additional information and exceptions.
Once Medicaid pays a claim, the provider must 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).

Providers may not charge Medicaid beneficiaries, or any financially responsible relative or representative of that individual, insurance copayment amounts or any other amount in excess of the Medicaid paid amount. Section 1902(a)(25)(C) of the Social Security Act prohibits Medicaid providers from directly billing Medicaid beneficiaries. Section 1902(g) allows for a reduction of payments otherwise due the provider in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).

Providers may not refuse to furnish services to a Medicaid beneficiary because of a third party’s potential liability for payment for the service (S.S.A.§1902(a)(25)(D)).

In instances which may involve court action or other extended delays in obtaining benefits from other sources (see Section 3300 of this manual), KHPA should be billed as soon as possible. If a third-party carrier makes any payment to a provider after KMAP has made payment, the provider must submit an adjustment request within one month. If a third-party carrier makes payment to a provider while a claim to KMAP is pending, the provider should wait until the claim has been processed. The provider must submit an adjustment request within one month if KMAP makes payment on the claim.

If a provider wishes to pursue a potential third-party liability (such as an insurance or some other identified certain third party), the provider must first refund KMAP through the adjustment process. In block 11 of the Individual Adjustment Form, specify "provider pursuing third party" and attach documentation identifying the potential third party. Once Medicaid has taken a refund by deducting it from a future remittance advice, the provider is free to pursue potential third-party liability directly. Medicaid may be rebilled after the claim has been adjudicated by the third-party resource.

This option is not available if a claim has crossed over from Medicare to Medicaid resulting in a zero paid claim because a zero paid claim cannot be adjusted. When a provider allows a Medicare claim to cross over to Medicaid they are agreeing to accept Medicaid payment as payment in full. In many cases, the claim will result in a zero Medicaid payment because Medicare’s payment is greater than the Medicaid allowed amount. If a provider wishes to pursue potential third parties after Medicare but before filing Medicaid claims, notify Medicaid that you do not want any Medicare claims to cross over. Providers can balance bill Medicaid but are not required if Medicare and other third-party payments received exceed the Medicaid allowed amount.

Providers cannot use the option described above if the Medicaid beneficiary simply has a pending personal injury insurance claim or lawsuit. If a provider knows or hears that a Medicaid beneficiary has or intends to file a personal injury insurance claim or lawsuit, the provider should contact the Medical Subrogation Unit at the address in Section 3400 of this manual.
Hospitals cannot file a lien pursuant to K.S.A. 65-406 against any potential claim involving a KMAP 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 KMAP records, are subject to audit by Health and Human Services, KHPA, or their representatives.

**Third-Party Liability Information** (Other Insurance and Medicare)

Providers should gather insurance information each time the State of Kansas Medical Card is presented by the beneficiary. Refer to Section 2000 of the *General Benefits Manual* for information on the plastic State of Kansas Medical Card and eligibility verification. 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, these 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 can also be faxed to KMAP by using the TPL Update form, available on both the public and secure websites (see the Table of Contents and Introduction pages for hyperlinks), 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 Noncovered Services**

When a service is not covered by a beneficiary’s primary insurance plan, a blanket denial letter can be 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 noncovered status must be reconfirmed and a new letter obtained at the end of one year.

**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 Update form to the TPL department at 785-274-5918:

- Documentation from the insurance company showing coverage was terminated or nonexistent
- Letter that you, the provider, contacted the other insurance company by phone and spoke with ______________ and were informed that the policy terminated on ______________, or 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.
This section does **not** apply to qualified Medicare beneficiary (QMB) claims. Refer to Section 2030 of the *General Benefits Provider Manual* for specific information.

When a patient is eligible for Medicare payment, providers must submit claims to Medicare first (unless the claim is for Medicare exempt services). If a patient is 65 or over, has chronic renal disease, or is blind or disabled, an effort must be made to determine Medicare eligibility.

Providers cannot seek to collect from the Medicaid beneficiary, or any financially responsible relative or representative of that individual, the difference between the Medicare/Medicaid allowable and the provider's billed charges (S.S.A.§1902(a)(25)(C).

Per 42CFR §433.139(b), if the probable existence of TPL (i.e., Medicare or health insurance) is established at the time a claim is filed, Medicaid must reject the claim and return it to the provider for a determination of the amount of liability. Due to this Medicaid requirement, providers must accept assignment, filing claims directly to Medicare in order for Medicare to pay its share directly to the provider. When a claim is unassigned, Medicare pays its share of the bill to the patient (Medicaid in this case) and not the provider. This would involve “pay and chase” for which Medicaid does not have approval.

Medicare-related claims shall be completed according to the instructions in the KMAP provider manual. The diagnosis must support the medical necessity for the service billed and be specific to services provided. Claims are subject to the same limitations used for KMAP claims. These include timely filing, sterilization and hysterectomy consents, and office visit limitations.

**Claims Automatically Crossed Over**

Medicare Part B will automatically cross over claims for professional services when the following criteria are met:

- The provider files Medicare claims to Blue Cross and Blue Shield of Kansas or Blue Cross and Blue Shield of Kansas City.
- The services are covered by Medicare.
- The beneficiary's Medicaid ID number is identified on the Medicare claim form in the "Other Insurance" field (Box 9a).
- The "Accept Assignment" field (Box 27) is checked "yes."

The provider is notified on the explanation of Medicare benefits (EOMB) that the claim was automatically crossed over for Medicaid processing. The claim can be identified by an internal control number (ICN) beginning with "48" on the Medicaid remittance advice (RA).

If thirty days have lapsed since notification appeared on the EOMB and the status of the crossover has not appeared on the provider's RA, providers can check the claim status on the KMAP website or by contacting Customer Service at 1-800-933-6593, option 0. If necessary, the claim can be resubmitted through the KMAP website or on a new red claim form.
When a Medicare-related claim automatically crosses over to the fiscal agent with both covered and noncovered services, the provider must initiate an adjustment to receive the appropriate reimbursement by using either one of the options listed below:

- File an adjustment request to recoup the entire claim so that covered and noncovered services can be rebilled separately by your office.
- File an adjustment request to remove the service that was noncovered by Medicare from the original claim so that the service can be rebilled by your office for full Medicaid reimbursement. Proof of Medicare denial must be attached. Refer to Section 5600 of the General Billing Provider Manual for information on filing an adjustment request.

Claims Not Automatically Crossed Over

- Claims billed to Medicare carriers other than Blue Cross and Blue Shield of Kansas and Blue Cross and Blue Shield of Kansas City.
- Claims denied by Medicare.
- Claims the fiscal agent is unable to find a provider number that cross matches.
- Part A Medicare claims.

When this occurs, bill Medicaid using the following procedures:

- Submit a claim to the fiscal agent.
- Attach Medicare's EOMB or equivalent.
- Accept assignment.
- The Medicare Nonassigned Request Form can be used by providers who have billed Medicare without accepting assignment. The attachment of this signed form to a claim along with the EOMB will meet the Medicaid requirement that a provider must have accepted Medicare assignment. (The Medicare Nonassigned Request Form is available on both the public and secure websites (see the Table of Contents and Introduction pages for hyperlinks) shown at the end of this section.)

When the Medicare EOMB contains both covered and noncovered services specific to a beneficiary claim, submit two separate claims to the fiscal agent. On one claim indicate the covered Medicare services; on the second claim bill only those services not covered by Medicare. Attach a copy of the Medicare EOMB to each claim.

In order for Medicare-related claims to process, the Medicare EOMB attached to the claim must be specific to the beneficiary and match the codes and units.

Please refer to your electronic claim filing manual for instructions.

Pricing Algorithm

Medicaid processes professional and institutional Medicare-related claims using the same algorithm calculation applied to other third-party claims. If Medicare paid more than Medicaid's allowed amount for that service, no additional reimbursement will be made. If a service is noncovered under KMAP, no allowable amount will be computed for the service.
After calculation of the total Medicaid-allowed amount for the claim, comparison of what Medicaid-allowed to the Medicare-allowed will be made (Medicare paid plus coinsurance plus deductible). Noncovered Medicare services are not included in this algorithm. These claims are processed using standard Medicaid pricing methodologies.

When the Medicaid-allowed amount is greater than Medicare's allowed amount, the other insurance amount, Medicare paid amount, patient liability amount and, when applicable, copayment are subtracted from Medicare's allowed amount in order to arrive at the net Medicaid reimbursement amount. Certain products may have exceptions to the usual pricing.

When Medicaid's allowed amount is equal to or less than Medicare's allowed amount, Medicaid's allowed amount is reduced by the other insurance amount, Medicare paid amount, patient liability amount, and, when applicable, copayment in order to arrive at the net Medicaid reimbursement amount.

The reduction is performed for professional claims per detail until the total reduction amount is met. (Copayment is taken from only the applicable detail.) For inpatient and outpatient claims, the total claim-allowed amount is reduced.

**Billing for Beneficiaries Who Have No Part A Due to Lack of Eligibility or Because Benefits Are Exhausted**

Once Medicare Part A regular inpatient benefits are exhausted, dual-eligible beneficiaries (those who have both Medicaid and Medicare) can only receive Medicaid payment if they have already used their lifetime reserve (LTR) days or they elect to use their LTR days. A Kansas Medicaid beneficiary must make a written election not to use LTR days and cannot be “deemed” to have elected not to use LTR days. If a beneficiary makes a written election not to use LTR days after the regular inpatient days are exhausted, Medicaid will not issue payment for any part of the inpatient stay which would have been covered if the beneficiary had elected to use the LTR days. After making a written election not to use LTR days, a beneficiary can still decide to use LTR days. The KHPA Medical Plans will accept the written election form outlined by Medicare in Chapter 5 of the *Medicare Benefit Policy Manual*.

Charges for emergency room or outpatient services are billed to Medicare on form SSA 1483 for patients with Part B only. KMAP will pay up to the maximum allowable for covered services, less the amount paid by Medicare, up to the deductible and/or coinsurance amount.

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 nonpayable services billed to Medicaid on the UB-04 with appropriate documentation demonstrating Medicare's refusal to pay due to no Part A benefits.

Payment shall be made for KMAP beneficiaries for all Medicaid-covered services, less the Medicare-allowed amounts, spenddown, copayment and other third-party payments but no more than the KMAP 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. The fiscal agent will recoup these claims within 60 days.

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

Kansas Health Policy Authority
HMS/Third-Party Liability Service Center
1140 Empire Central Drive, Suite 450
Dallas, TX 75247-4316

Phone: 1-877-260-0318
Fax: 214-453-3201

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

**How to File When Medicare Denies Payment**

Attach a copy of the Medicare EOMB/RA showing denial of the service(s) being billed. If services are over 12 months old, original timely filing must be proven as defined in Section 5100 of the General Billing Provider Manual. If services are over 24 months old, 12-month timely filing must be proven and KMAP must be billed within 30 days of Medicare's denial in order for claim payment to be considered.

If Medicare consistently denies payment for the same services to the same beneficiary, attach a photocopy of Medicare's original denial to the claim and annotate the claim accordingly. An original denial is only acceptable for a one-year period from the claim date of service. When the original denial is older than one year, Medicare must be billed again. (Documentation of this nature may not be used if the denial is related to not having met the Medicare deductible.)

If a provider does not have both a professional degree and a license acceptable by CMS standards for Medicare providers and therefore cannot receive a denial letter from Medicare because this type of provider is not allowed to enroll, then the provider is not required to maintain a blanket denial letter from Medicare. However, the provider must attest to the fact he or she does not meet the requirements to enroll in Medicare and give the reasons why these requirements cannot be met. A blank denial letter from Medicare. The attestation must be on professional letterhead, signed by the provider, and maintained with the other billing documentation. For paper claims, the attestation must be attached to the claim form. For electronic claims, the attestation must be kept on file and available upon request.

*Note: This does not apply to a provider whose license has been revoked.*
WEB CLAIM SUBMISSION PROCESS

Electronic media claim (EMC) submitters are not required to submit paper documentation to support other insurance payment or denial. However, adequate documentation must be retained in the patient's file and is subject to review.

Documentation of proper billing to TPL is considered acceptable if it corresponds with the **beneficiary name, dates of service, charges and TPL payment** listed on the Medicaid claim. The only acceptable forms of documentation proving that insurance was billed first are an RA or EOB letter from the other insurer. The provider can use a copy of the claim filed with the insurance company by the provider or the policyholder as proof of billing, if the other insurance company never responded.

If a beneficiary has other applicable insurance, providers who bill electronic and web claims need to submit the claim adjustment reason code and remittance advice remark code provided by the other insurance company on their EOMB or RA for all affected services. For claims submitted through the KMAP website, there are required fields for this information.

**Billing tip for all electronic billers:** To expand the TPL section of the online claim form, click on the two arrows pointing downward on the far right side of the blue bar containing the word TPL or click on the dots next to the letters TPL in the blue box. This will expand the TPL section and allow information to be entered into the fields. To enter additional lines, click Add. To remove a line previously entered, click on the line and click Remove.

**Completing the TPL Section**
- TPL Paid Amount – Enter the amount previously paid by the beneficiary’s other insurance, when applicable.
- Carrier Denied – Report “Yes” if the primary TPL carrier paid zero or denied the claim. Report “No” if the primary TPL carrier paid on the claim.
- From DOS – Enter the from date of service (DOS) to query for effective TPL policies. It is not used in the claim processing.

Most policy information listed below will autopopulate based on the TPL policy information available at the time of the claim. Any information that does not autopopulate will need to be completed by the billing provider.
- Policyholder’s Last Name – Enter the last name of the policyholder.
- First – Enter the first name of the policyholder.
- MI – Enter the middle initial of the policyholder.
- Suffix – Enter the suffix (if any) of the policyholder (such as Jr. or Sr.).
- Policy # – Enter the policy number of the other insurance.
- Plan Name – Enter the name of the plan under which the policyholder has coverage.
- Date Adjudicated – Enter the appropriate date from the other insurance carrier’s EOB.
- Policyholder’s Relationship (relationship of the policyholder to the beneficiary) – Select the relationship from the drop-down box.
- Insurance Type – Select the type of insurance from the drop-down box.
- Release of Information – Select the release of information from the drop-down box.
Professional Medicare Crossover Claims

- Medicare Paid Date – Enter the date of the explanation of Medicare benefits (EOMB) that corresponds to the Medicare claim for the beneficiary.
- Co-Insurance – Enter the amount applied to the beneficiary’s Medicare coinsurance based on the Medicare EOMB.
- Deductible – Enter the amount applied to the beneficiary’s Medicare deductible based on the Medicare EOMB.
- Psych Amount – Enter the amount reported on the Medicare EOMB as the psych amount.
- Allowed Amount – Autocalculates based on the amounts entered in the Co-Insurance, Deductible, and Paid Amount fields. Information cannot be entered into this field.
- Paid Amount – Enter the amount Medicare previously paid for the same services now being billed.

Institutional Medicare Crossover Claims

- Medicare Paid Date – Enter the date of the EOMB that corresponds to the Medicare claim for the beneficiary.
- Co-Insurance – Enter the amount applied to the beneficiary’s Medicare co-insurance based on the Medicare EOMB.
- Deductible – Enter the amount applied to the beneficiary’s Medicare deductible based on the Medicare EOMB.
- Allowed Amount – Autocalculates based on the amounts entered in the Co-Insurance, Deductible, and Paid Amount fields. Information cannot be entered into this field.

How to File When Other Insurance Is Not on File

When the other insurance is not on file with KHPA, the provider should complete the electronic claims process as if the other insurance policy is on file. The provider must work with the beneficiary to complete all fields.

How to File When Other Insurance Does Not Respond

If a provider bills a third-party insurance and does not receive a written or electronic response to the claim from the third-party insurance within 30 days, the provider can proceed as follows:

- Submit the claim to the KHPA Medical Plans within 12 months of the service date as a denial from the insurance company.
- Keep the documentation on file as proof of prior billing to the third-party insurance and have it available upon request.

Note: This 30-day stipulation does not apply to life insurance, long-term care insurance, Medicare supplemental insurance, worker’s compensation, automobile insurance, health insurance that is funded through federal programs (such as TRICARE and CHAMPVA), or insurance policies that are dental, drug or vision care only.

If the third-party insurance sends any requests to the provider for additional information, the provider must respond appropriately. If the provider complies with the requests for additional information but does not receive payment or denial from the third-party insurance within 90 days from the date of the original claim to the third-party insurance, then the provider can proceed as follows:

- Submit the claim to the KHPA Medical Plans within 12 months of the service date as a denial from the insurance company.
- Keep the documentation on file and have it available upon request.

In the event the other insurance company does not respond to the provider's or the policyholder's claim submission and follow-up request and 30 days have lapsed, proceed as follows:

- Submit the claim within 12 months of the service date.
- Maintain a copy of the claim the provider or policyholder filed with the other insurer which went unanswered with the billing records for future documentation.

How to File When the Other Insurance Company Reimburses the Policyholder
Payment must be pursued from the beneficiary's insurance plan by assisting the policyholder or beneficiary (if not the policyholder) to file the claim. Providers must pursue payment from the patient. However, if there are any further Medicaid/MediKan benefits allowed after the other insurance payment, the provider can still submit a claim for those benefits. The provider must, on submission, supply all necessary documentation of the other insurance payment. The KHPA Medical Plans will not pay the provider the amount paid by other insurance. (See the How to File When Other Insurance Does Not Respond portion in this section if 30 days pass and no payment or EOB is received.) If KMAP benefits exceed the other insurance payment, a claim can be submitted for those benefits.

Electronic Claim Postpay Review
As the payer of last resort, the KHPA Medical Plans uses the electronic claim postpay review process to ensure compliance. The Centers for Medicare and Medicaid Services (CMS) requires each state allowing submission of electronic claims to perform random sample reviews to ensure program compliance and integrity. This process entails randomly selecting claims that have been submitted electronically where a third-party payment or denial was indicated.

If randomly selected, the provider will receive a letter requiring acceptable documentation to be returned showing the claim was properly submitted to the third party. Acceptable TPL documentation guidelines can be found below and on the following pages. The documentation, along with a copy of the original letter, must be submitted within the time-frame identified in the letter. Documentation received without a copy of the letter will be destroyed, and any payment made on the claim will be recouped.

This letter to the provider is the only one notification regarding the request for necessary documentation. A second notification will not be sent. The provider will NOT be notified of the recoupment prior to the adjusted claim appearing on a subsequent RA. The provider must not issue a refund check for claims under review as part of this process. If the provider fails to submit the required documentation within the required time-frame or submits unacceptable documentation, the selected claims will be recouped. All recouped claims will be locked from future adjustments, and new claim submissions for the same services will be denied.

The provider can recognize any adjustment related to this review on the RA by one of the following:
- Explanation of benefit (EOB) code 2528 (KMAP is federally required to ensure that Medicaid is secondary payer to all other insurance programs. As a result of the electronic claim review process, this claim was recouped in full because acceptable TPL documentation was not submitted during the allowed timeframe. This claim has been locked from future adjustments or submission of a new claim for the same service. Refer to Section 3300 of your KMAP TPL Provider Manual for more information.)

Kansas Medical Assistance Program
General Third Party Liability Payment
EOB code 2529 (KMAP is federally required to ensure that Medicaid is secondary payer to all other insurance programs. As a result of the electronic claim review process, this claim was recouped in full because the TPL documentation submitted was not acceptable. This claim has been locked from future adjustments or submission of a new claim for the same service. Refer to Section 3300 of your KMAP General TPL Provider Manual for more information.)

**Note:** To resubmit a claim after it has been recouped, the provider must send the appropriate TPL documentation along with a paper claim and the original letter to Customer Service at the following address:

KHPA Medical Plans  
Office of the Fiscal Agent  
P.O. Box 3571  
Topeka, Kansas 66601-3571

**PAPER BILLING PROCESS**

Documentation of proper billing to TPL is considered acceptable if it corresponds with the **beneficiary name, dates of service, charges and TPL payment** listed on the Medicaid claim. The only acceptable forms of documentation proving that other insurance was billed first are an RA or letter of EOB from the other insurer. The provider can use a copy of the claim filed with the insurance company by the provider or the policyholder as proof of billing, if the other insurance company never responded.

If a beneficiary has other insurance that applies and providers are submitting paper claims, providers need to attach a copy of the EOB from the other insurance company for all affected services.

**CMS-1500**

- Complete one of the following to indicate other insurance is involved:
  - Fields 9 and 9A-D (Other Insured’s Name)
  - Field 11 and 11A-D (Insured’s Policy Group or FECA Number)

- Field 29 (Amount Paid) – Make sure it is completed with any amount paid by insurance or other third-party sources known at the time the claim is submitted. If the amount shown in this field is the result of other insurance, documentation of the payment must be attached. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**

**UB 04**

- Field 50 (Payer Name) – Indicate all third-party resources (TPR). If TPR does exist, it must be billed first. Lines B and C should indicate secondary and tertiary coverage. Medicaid will be either the secondary or tertiary coverage and the last payer. When B and C are completed, the remainder of this line must be completed as well as Fields 58-62.
- Field 54 (Prior Payments Payer) – Required if other insurance is involved. Enter amount paid by other insurance. Documentation of the payment must be attached. **Do not enter copayment or spenddown payment amounts. They are deducted automatically.**
- Field 58 (Insured’s Name) – Required.
Field 59 (Patient’s Relationship to Insured)
   - Line A – Required.
   - Line B and C – Situational.
Field 60 (Insured’s Unique ID) – Required. Enter the 11-digit beneficiary number from the State of Kansas Medical Card on Line C. If billing for newborn services, use the mother’s beneficiary number. The mother’s number should only be used if the newborn’s ID number is unknown.
Field 61 (Insured’s Group Name) – Required, if group name is available. Enter the primary insurance information on Line A and Medicare on Line C.
Field 62 (Insured’s Group Number) – Required, when insured’s ID card shows a group number.

Dental Claim Form
- Locate TPL Amount: Enter the amount paid by the beneficiary’s other insurance, if applicable.
- Retain proof of the other insurance payment in the beneficiary’s file.
- In the event the other insurance company does not respond to the provider's or policyholder's claim submission and follow-up request and 30 days have lapsed, proceed as follows:
  - Submit the claim within 12 months of the service date.
  - Attach a copy of the claim the provider or policyholder filed with the other insurer which went unanswered. State "No response from (name insurer) insurance company" in the Other Insurance field of the current claim. For policyholder-filed claims, documentation that the policyholder was counseled on how to file the claim is acceptable if signed and dated by the beneficiary.

For questions regarding filing third-party claims, contact MACSC at 1-800-933-6593. Upon receipt of payment from the insurer, refunds must be sent to KHPA using the adjustment process; checks will only be accepted from providers who are on longer Kansas Medicaid providers.

How to File When Other Insurance Does Not Respond
If a provider bills a third-party insurance and does not receive a written or electronic response to the claim from the third-party insurance within 30 days, the provider can proceed as follows:
- Submit the claim to the KHPA Medical Plans within 12 months of the service date as a denial from the insurance company.
- Attach a copy of the claim the provider or policyholder filed with the other insurer that went unanswered. Note in the Other Insurance field of the current claim, “No response from (name insurer) insurance company.”
- Any documentation sent to the third-party insurance must be attached with the claim.

Note: This 30-day stipulation does not apply to life insurance, long-term care insurance, Medicare supplemental insurance, worker’s compensation, automobile insurance, health insurance that is funded through federal programs (such as TRICARE and CHAMPVA), or insurance policies that are dental, drug or vision-care only.
If the third-party insurance sends any requests to the provider for additional information, the provider must respond appropriately. If the provider complies with the requests for additional information but does not receive payment or denial from the third-party insurance within 90 days, then the provider can proceed as follows:

- Submit the claim to the KHPA Medical Plans within 12 months of the service date as a denial from the insurance company.
- Attach a copy of the claim the provider or policyholder filed with the other insurer that went unanswered. Note in the Other Insurance field of the current claim, “No response from (name insurer) insurance company.”
- Any documentation sent to the third-party insurance must be attached with the claim.

How to File with a Medicare Replacement Policy
- Indicate in fields 9A-D, 11A-C, or 50 whether the policy is a Medicare-replacement plan.
- Complete the remainder of the claim as instructed for paper billers.

How to File When the Beneficiary Has a Medicare Supplement Policy Only
- Indicate "the name of the insurance company - Medicare Supplement" on the claim form.
- Complete correct field, CMS-1500 – Field 11; UB-04 – Field 50; Dental – Field 15A.
- When a Medicare supplemental plan (for example Plan 65) is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.

How to File When the Fiscal Agent Denies "Suspicious Other Insurance" and Other Insurance Information Cannot Be Secured From the Beneficiary
- Annotate the claim accordingly. Indicate active attempts to secure other insurance information by noting on the claim, "Beneficiary does not respond" or "Beneficiary says there is no other insurance." This reflects an active attempt to secure other insurance information. Information must be entered in Field 11 (No Other Insurance) on the CMS-1500 or Field 50 on the UB-04 claim form.
- **Remember:** If the fiscal agent denies the claim with “Bill beneficiary’s other insurance first” to a specific insurance carrier (name and address given), that carrier's denial or payment response must be attached to the claim.

How to File When the Other Insurance Company Reimburses the Policyholder
Payment must be pursued from the beneficiary's insurance plan by assisting the policyholder or beneficiary (if not the policyholder) to file the claim. Providers must pursue payment from the patient. However, if there are any further Medicaid/MediKan benefits allowed after the other insurance payment, the provider can still submit a claim for those benefits. The provider must, on submission, supply all necessary documentation of the other insurance payment. The KHPA Medical Plans will not pay the provider the amount paid by other insurance. (See the How to File When Other Insurance Does Not Respond portion in this section if 30 days pass and no payment or EOB is received.)
If KMAP benefits exceed the other insurance payment, a claim can be submitted for those benefits. Proof of other insurance payment as previously defined must be attached. (See the How to File When Other Insurance Makes Partial Payment portion in this section.)

How to File When Other Insurance Denies Payment

- Attach proof of other insurance denial (an RA or letter of EOB from the insurer). Denials requesting additional information from the primary insurance company will not be accepted as proof of denial from the other insurance. If dates of service are over 12 months old, original timely filing must be proven as defined in Section 5100 of the General Billing Provider Manual. An original denial is only acceptable for the same service date(s) on the claim.
- When a Medicare supplemental plan (for example Plan 65) is the only other insurance applicable to the beneficiary and Medicare has denied payment on the claim, the provider is not required to submit the claim to the Medicare supplemental for denial. In this instance, the provider should resolve all denials through Medicare prior to billing the Medicare supplemental plan and Medicaid.

How to File When Other Insurance or Third Party Denies Liability Pending Investigation or Litigation

If an insurance company or other third party denies liability or denies payment pending investigation or litigation, the provider should file the claim with the KHPA Medical Plans and attach documentation showing the potential third party. It is not an exception to the timely filing rule that the provider was pursuing a third party or insurance (other than Medicare). However, if the beneficiary has used a provider that is outside the carrier's network or lacks authorization from the carrier's case manager and the other insurance carrier does not reimburse the provider, the KHPA Medical Plans considers these to be noncovered services and billable to the beneficiary. The KHPA Medical Plans should not be billed for these services.

PHARMACY CLAIM SUBMISSION

Pharmacy claims can be submitted three different ways:

- Point of sale (POS)
- Web
- Paper

Each of these pharmacy submission methods differ regarding TPL billing.

Note: Provider Electronic Solutions (PES), a batch software submission method available at no cost, is a fourth submission method but is not used by the pharmacy provider community. Additional information on PES is available at https://www.kmap-state-ks.us/Public/EDI/PES.asp. Do not use the following instructions for any Medicare Part D copay claims. Medicare Part D copay claims must be submitted according to the guidelines in Section 7010 of the Pharmacy Provider Manual.

POS TPL Pharmacy Claims

POS transactions must follow the National Council for Prescription Drug Programs (NCPDP) 5.1 based guidelines found in the companion guide on the public website at https://www.kmap-state-ks.us/Public/EDI/companion.asp under NCPDP on the drop-down box.
In addition to the NCPDP 5.1 standards, pharmacy providers must do the following:

- Submit the identical amounts to the KHPA Medical Plans as were submitted to the primary insurance in the Gross Amount Due (430-DU) and Usual and Customary (426-DQ) fields. Do not submit the copay from the primary insurance on the claim.
- Submit the amount reimbursed to the pharmacy provider by TPL in the Other Payer Amount Paid (431-DV) field if the primary insurance paid on the claim. Submit all other KMAP-specified fields from the Coordination of Benefits (COB) segment as defined in the current companion guide.
- Submit the appropriate Other Coverage Code (308-C8) on the claim. Other coverage codes as defined by NCPDP represent a specific response received by the pharmacy provider from the primary insurance regarding the pharmacy claim. Other coverage codes recognized when the KHPA Medical Plans is secondary (excluding Medicare Part D copay claims) are included on the following table.

**TPL Pharmacy Claims Other Coverage Codes**

<table>
<thead>
<tr>
<th>OTHER COVERAGE CODES</th>
<th>DEFINITION (Other coverage exists.)</th>
<th>ALLOWANCES FOR USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 02</td>
<td>Payment collected.</td>
<td>Primary insurance makes a payment on the claim.</td>
</tr>
<tr>
<td>3 03</td>
<td>This claim is not covered.</td>
<td>Primary insurance denies payment and all avenues of primary payment are exhausted.</td>
</tr>
</tbody>
</table>
| 4 04                 | Payment not collected.              | Primary insurance:  
  - Pays the claim at zero  
  - Reimburses the beneficiary instead of the pharmacy  
  - Indicates the full amount is the beneficiary’s responsibility/deductible |

**What Other Coverage Code should be used?**

- **When the primary insurance makes a payment, use 2 or 02.**
  When the primary insurance pays less than the billed amount, a claim can be submitted to the KHPA Medical Plans for consideration of payment.
  - Submit 2 or 02 in the Other Coverage Code field (308-C8).
  - Submit the amount the primary insurance paid in the Other Payer Amount Paid field (431-DV).

- **When the primary insurance denies payment, use 3 or 03.**
  When the primary insurance does not make a payment on the claim due to plan limitations, a claim can be submitted to the KHPA Medical Plans for consideration of payment.
  - Submit 3 or 03 in the Other Coverage code field (308-C8).
  - Retain proof of denial from the primary insurance on file.
When the primary insurance does not reimburse the pharmacy provider for a covered drug, use 4 or 04.

When the primary insurance responds with a paid claim but does not reimburse the pharmacy provider any amount, a claim can be submitted to the KHPA Medical Plans for consideration of payment.

- Examples include situations where the primary insurance reimburses the beneficiary instead of the pharmacy or the primary insurance indicates the full amount is the beneficiary’s responsibility and will be applied to the deductible.
- Submit 4 or 04 in the Other Coverage Code field (308-C8).
- Retain proof of the primary insurance not making a payment on file.
Provider's Role in Identifying Claims

The State closely follows all accident claims to determine if another party may have liability. Information given on the claim form is of the utmost importance to assist the State of Kansas in researching these accident cases.

The following information is required when filing a claim for a beneficiary who has been involved in an accident:
- Date and time of accident
- Location
- Cause
- Possible other insurance resources

Fill out all blocks on the claim form concerning accident information when applicable. If the accident is self-inflicted, it should be stated clearly.

Typical Accident Situations

Often accident situations present difficulties to the provider in determining liability. KMAP should be billed as a second payor if another party is liable. Some common examples are:
- A beneficiary is a pedestrian hit by a car driven by a person with auto insurance.
- A beneficiary who is employed is injured in a work-related accident.
- A beneficiary falls in a store, and the store accepts liability.

The above list is not intended to be all-inclusive but rather to provide examples of cases where a responsible party should be billed first.

After receiving payment from the liable party, a claim may then be submitted to KMAP for any unpaid charges for eligible services within 12 months of the service date. The payment by the liable party must be indicated on the claim. If payment is not received from the other insurance company within 12 months of the service date, the claim should be submitted to Medicaid for timely filing purposes only. The provider should continue to seek reimbursement from the other liable party. If payment is not received within 24 months of the service date, KMAP may be rebilled for payment. Be sure to bill before the 24-month filing limitation actually expires (refer to Section 5100 of the General Billing Provider Manual). The provider must include all details regarding the liable party so that the State can seek reimbursement from the liable party.

There are accidents where KMAP may be primary because no other insurance offers coverage (i.e., an accident such as contusion or laceration occurs at home).

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. 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 TPL. To operate most effectively, Medicaid requires the cooperation from both beneficiaries and providers in identifying TPL. 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:

Medical Subrogation Staff
KHPA Legal Section
Landon State Office Building, Room 900N
900 S.W. Jackson Street
Topeka, KS  66612-1220

Please include this information in your notification to the Medical Subrogation staff:
• Name of the Medicaid beneficiary
• Medicaid ID number
• 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 45 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.

Third-Party Liability Payment After Medicaid Payment

If a provider receives payment from a third party (TPL) after Medicaid has made payment to the provider, the provider must reimburse Medicaid. The provider may retain only the larger of the Medicaid payment and the third-party payment. So, for example, if a provider receives $100 from a third party after Medicaid paid $80.00, the provider must submit an adjustment and reimburse Medicaid the $80.00. If, on the other hand, Medicaid paid $80 and the TPL paid only $60, the provider must refund Medicaid the full $60. The provider may not combine and keep both payments.
3500. BENEFICIARY RESPONSIBILITY  Updated 05/10

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 where there is normally no face-to-face contact between the beneficiary and the provider (examples are lab and radiology services), the written ABN signed annually 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 or her KMAP 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 Provider Manual.)
- Services Medicaid does not cover, unless both of the following apply:
  - Beneficiary is a QMB.
  - 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).
- Nonrestorative (developmental) physical, occupational, or speech therapy.
3500. Updated 05/10

- 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, and speech therapists in private practice (unless beneficiary is a QMB).
- Transcutaneous electrical nerve stimulation treatments.
- Transplant surgery.
  - Cyclosporine (except when prior authorized, following kidney, liver and bone marrow transplants).
  - All services related solely to noncovered transplant procedures.
- Transplant surgery, in some cases, is a covered service for a KMAP beneficiary. Call Customer Service 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) greater than 30 or greater than 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 a MediKan beneficiary in the following program areas: alcohol and drug addiction treatment facility, behavior management, chiropractic, dental, Head Start facility, Local Education Agency, nonemergency and nonambulance medical transportation, podiatry, and 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 a KMAP beneficiary for services denied for payment by KMAP because the provider has failed to meet a program requirement including PA.

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.
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 expenses before they are eligible for Medicaid benefits. This process is referred to as spenddown.

Identifying Spenddown Beneficiaries

Refer to Section 2000 of the General Benefits Provider Manual for information on the plastic State of Kansas Medical Card and eligibility information.

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 appropriately 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 Responsibility

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.

Providers Reimbursement Maximized

Each claim used to reduce a beneficiary’s spenddown amount will be flagged to identify whether the claim would have paid if spenddown had been met. In the event a claim is submitted which exceeds the amount of spenddown remaining, all claims for the beneficiary will be reviewed. Claims that are for noncovered services or for services that would not otherwise have been paid by Medicaid will be applied to spenddown first. Processed claims that would have paid if spenddown were met will be applied to spenddown in reverse date order. Once the spenddown amount is met, the fiscal agent will adjust any remaining payable claims so that the provider may receive reimbursement from the MMIS for the services rendered.