# PART I
GENERAL THIRD-PARTY LIABILITY PAYMENT FEE-FOR-SERVICE
KANSAS MEDICAL ASSISTANCE PROGRAM

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FORMS
All forms pertaining to this provider manual can be found on the public website and on the secure website under Pricing and Limitations.

DISCLAIMER: This manual and all related materials are for the traditional Medicaid fee-for-service program only. For provider resources available through the KanCare managed care organizations, reference the KanCare website. Contact the specific health plan for managed care assistance.

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Third-Party Liability

Third-party liability (TPL) is often referred to as other insurance (OI), other health insurance (OHI), or other insurance coverage (OIC). Other insurance is considered a third-party resource for the beneficiary. Third-party resources can be health insurance (including Medicare), casualty coverage resulting from an accidental injury, or payments received directly from an individual who has either voluntarily accepted or been assigned legal responsibility for the health care of one or more beneficiaries.

The Kansas Medical Assistance Program (KMAP) is a 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:

- Children and Youth with Special Health Care Needs (CYSHCN) program
- Kansas Department for Children and Families (DCF), formerly SRS
- Indian Health Services (IHS)
- Crime Victim's Compensation

The Provider's Role

- **Providers have an obligation to investigate and report the existence of other insurance or liability.**
- 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 significant. Cooperation is essential to the functioning of the KMAP system and to ensure prompt payment.
- At the time, the provider obtains KMAP billing information from the beneficiary, the provider should also determine if additional insurance resources exist. When they exist, these resources must be identified on the claim form in order for the claims to adjudicate properly. Other insurance information can also be sent faxed to KMAP using the Provider TPL Insurance Information Update form under the Beneficiary Information Provider Information heading on the Forms page of the KMAP website.
  - Fax: 785-274-5918
  - Email: LOC_KSIXIX_TPL_DistributionList@external.groups.hp.com
- **Note:** Include ATTN TPL DEPT on all both fax and email correspondence.
  - 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.
  - If a provider receives TPL information contradicting what the fiscal agent's file indicates, they must fill out the TPL Update from with the corrected information.
- **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.

Billing Requirements

- Per 42 CFR §433.139(b), if the probable existence of TPL (such as 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. This means that the provider must attempt to bill the other insurance prior to filing the claim to Medicaid.
Billing Requirements continued

- The provider must follow the rules of the primary insurance plan (such as obtaining prior authorization) or the related Medicaid claim will be denied. 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, the Centers for Medicare and Medicaid Services (CMS), the state Medicaid agency, or any of their representatives.

- KMAP requires beneficiary compliance with the rules of any insurance plan 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. 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 State TPL manager.

- Providers may not charge Medicaid beneficiaries, or any financially responsible relative or representative of that individual any 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, KMAP should be billed as soon as possible. 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 Kansas Medicaid subrogation contractor at the address in Section 3400 of this manual. Providers cannot use the option described in the Billing TPL after Receipt of KMAP Payment portion of Section 3100 if the Medicaid beneficiary simply has a pending personal injury insurance claim or lawsuit.

Other Insurance Pricing

- The amount paid to providers by primary insurance (OI) payers is often less than the original amount billed. This payment shortfall generally breaks into two categories: reductions resulting from a contractual agreement between the payer and the provider (contractual write-offs); and, reductions reflecting patient responsibility (copayment, coinsurance, deductible, etc). Medicaid will pay no more than the remaining patient responsibility (PR) after payment by the primary insurance (OI).

- A provider entering a plan with a third-party resource agrees to accept as full payment the billed amount less the contractual write-off amount reduced by the third-party payment to obtain the remaining patient’s liability, which will be paid only to the extent there remains a liability, such as a copayment, coinsurance, or deductible. The third-party payment plus the Medicaid payment will not exceed the Medicaid Maximum Allowed Amount for the service. In other words, Medicaid will reimburse the provider for the patient liability up to the Maximum Medicaid Allowed Amount.
3100. Updated 12/14

Long-Term Care Insurance

- When a long-term care (LTC) insurance policy exists, it must be treated as TPL and be cost avoided. The provider must either collect the LTC policy money from the beneficiary or have the policy assigned to the provider. Beneficiaries and their family members must comply with assignment of the LTC policy and the money from the LTC policy. If the beneficiary does not comply, the provider should notify the fiscal agent or the beneficiary’s case worker.
- If a beneficiary has LTC insurance and elects hospice care while residing in a nursing facility (NF), the LTC insurance benefit should be collected and reported to Medicaid by the hospice provider. If the LTC insurance money is paid directly to the NF or the NF is collecting the money from the beneficiary, the NF must give the insurance money to the hospice provider while the beneficiary is in hospice care. The hospice must report this money as TPL insurance when submitting claims to Medicaid.
- Routine services and/or supplies are included in NF per diem rate and not billable separately. Therefore, any other insurance payments should be subtracted from the Medicaid-allowed amount for room and board.

Billing TPL after Receipt of KMAP Payment

- A provider should not bill KMAP prior to receiving payment or denial of a claim from another insurance company.
- If a provider discovers an insurance policy or other liable third party that should have paid primary to Medicaid after receiving payment from Medicaid, the provider must bill that insurance carrier and attempt to collect payment. However, the provider should not adjust the claim with Medicaid until after that provider receives payment from the insurance carrier. The State of Kansas has a contractor who collects payments from insurance carriers on claims that Medicaid should have paid secondary but got billed primary. This contractor may have already collected that money. Therefore, the provider should wait until receiving payment from the insurance carrier before adjusting the claim, as the insurance carrier may deny for previous payment.
- If a third-party carrier makes any payment to a provider after KMAP has made payment, the provider must submit an adjustment request within 30 days. If a third-party carrier makes payment to a provider while a claim to KMAP is pending, the provider should wait until the Medicaid claim has been processed and then adjust the KMAP claim within one month. The provider must also notify KMAP of the TPL carrier, as referenced in the Provider’s Role portion of Section 3100.
- Medicaid may be rebilled after the claim has been adjudicated by the third-party resource.

TPL Payment after Medicaid Payment

If a provider receives payment from a third party after Medicaid has made payment to the provider, the provider must reimburse Medicaid. The provider needs to adjust the claim and indicate the TPL payment.
No Response from Other Insurance

- If a provider bills a third-party insurance and after 30 days has not received a written or electronic response to the claim from the third-party insurance, the provider can submit the claim within 12 months of the service date to the KMAP as a denial from the insurance company.
  - If submitting a paper claim, any documentation sent to the third-party insurance must be attached with the claim.
  - If submitting electronically, the documentation must be kept on file as proof of prior billing to the third-party insurance and available upon request.
- This 30-day stipulation does not apply to:
  - Self-insured employer plans
  - Medicare/Medicare supplement policies
  - Medicaid
  - Workers compensation
  - Federal employee plans
  - Vision or drug plans
  - Disability income
  - Medical claims paid by auto or homeowners insurance
- 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 and after 90 days from the date of the original claim to the third-party insurance has not received payment or denial from the third-party insurance, then the provider can submit the claim within 12 months of the service date to KMAP as a denial from the insurance company.
  \textit{Note:} This does not apply to the insurance plan types listed above.
- If submitting a paper claim, any documentation sent to the third-party insurance must be attached with the claim. When submitting a claim electronically, the documentation must be kept on file and available upon request.

Documentation Requirements

Adequate documentation is important for claims with TPL. Attachment of acceptable proof of payment or denial is required for paper claim submissions. Claims billed using electronic submissions are not required to submit paper documentation, but documentation must be retained in the patient’s file and is subject to request and review by the State.

Billing Documentation

The only acceptable forms of documentation proving that insurance was billed first are an RA or 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.

Paper Billing Documentation

- 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.
- Refer to the \textbf{Paper Claim} portion of \textbf{Section 8300} for information on paper claims.
Paper Billing Documentation continued

- The TPL CARC and RARC form is available under the Claim Attachments heading on the Forms page of the KMAP website. If used, it should be submitted with the ADA Dental, CMS-1500, and UB-04 paper claim forms and the EOB/RA from the other insurance payer. One form should be used for each individual insurance payer.

Acceptable Proof of Payment or Denial

Documentation of proper payment or denial of TPL is considered acceptable if it corresponds with the beneficiary name, dates of service, charges, and TPL payment listed on the Medicaid claim. **Exception:** If there is a reason why the charges do not match (such as other insurance requires another code to be billed which generates a different charge), the provider should note this on the EOB.

Acceptable documentation:
- Insurance carrier’s EOB
- Insurance carrier’s RA
- Correspondence from insurance carrier indicating payment
- Copy of provider’s ledger account

Blanket Denials and Noncovered Codes

- 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 insurance carrier should then issue, on company letterhead, a document stating the service is not covered by the insurance plan covering the Medicaid beneficiary. The provider can also use a benefits booklet from the other insurance if it shows that the service is not covered. 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.
- When a provider receives a nonclient specific blanket denial letter, the documentation should be shared with the State of Kansas TPL manager. A nonclient specific blanket denial encompasses a code that is denied overall, not just for a particular member. Once reviewed, if the codes are confirmed to be noncovered, they will be added to the Third-Party Liability Noncovered Procedure Code List page on the KMAP website. Providers can reference this list and use it as a valid denial.
- If a client specific denial letter or EOB is received, the provider can use that denial or EOB as valid documentation for the denied services for that member only throughout the one-year period. The EOB must clearly state that services are not covered. The provider must still follow the rules of the primary insurance prior to filing the claim to KMAP.
- If a provider cannot receive a denial letter from a primary insurance carrier because the provider does not meet the credentialing requirements of the primary carrier, then that provider is excused from the requirement of obtaining a blanket denial from the primary carrier. However, the provider must attest to the fact that it does not meet the credentialing requirements of the primary carrier. This attestation must be in letter form, signed by the provider, and available upon request (including any documentation received from the primary carrier).
- Certain procedure codes are considered noncovered by Kansas Medicaid regardless of coverage by a health insurance carrier. These codes do not require proof of noncoverage prior to billing KMAP. Refer to the Universal Noncovered tab of the most current version of the Third-Party Liability Noncovered Procedure Code List.
3100. Updated 12/14

Blanket Denials and Noncovered Codes continued
- Refer to the Blanket Denials and Noncovered Codes portion of Section 3100 for claim submission requirements.

WORK Program
TPL edits (including Medicare) will be bypassed for Work Opportunities Reward Kansans (WORK) services. WORK services are identified as procedure codes T1016, S5165, and T1023 when billed for beneficiaries in the WORK program.
3200. MEDICARE-RELATED CLAIMS  Updated 06/16

General Medicare Requirements

- This section does **not** apply to qualified Medicare beneficiary (QMB) claims. Refer to Section 2030 of the *General Benefits Fee-for-Service 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). To identify Medicare noncovered procedure codes, refer to the most current [Third-Party Liability Noncovered Procedure Code List](#) on the KMAP website.
  
  If providers are unable to locate a specific procedure code, they can contact KMAP Customer Service for additional information at 1-800-933-6593.
- 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 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.
- When providers allow a Medicare claim to cross over to Medicaid, they are agreeing to accept the 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.
- 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).
- A provider should bill Medicare-noncovered and Medicare-covered services separately to ensure proper reimbursement. Medicare-covered services should be billed to Medicare and automatically crossed over. Services noncovered by Medicare should not be billed to Medicare but instead directly to Medicaid or the other primary payer.
- 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.
- An inpatient stay in which the beneficiary became eligible for Medicare during the stay must be submitted as indicated below.

  - If billing for a fee-for-service (FFS) beneficiary, the provider must submit the FFS claim on paper along with a statement indicating the beneficiary became eligible for Medicare during the inpatient stay. The claim and attachments must be mailed to:
    
    Kansas Medical Assistance Program  
    Office of the Fiscal Agent  
    Attention: Claims Department  
    PO Box 3571  
    Topeka, Kansas 66601-3571

  - If the beneficiary is assigned to a KanCare managed care organization (MCO), follow the instructions provided by the designated MCO.

**Medicare Replacement Plans**

Web and electronic claims for Medicare beneficiaries with a Medicare replacement plan (Medicare Part C, Medicare Advantage Plan) must be submitted as Medicare crossover claims.
Web Claim Submission Process (Medicare)
For submission of web claims, the TPL/Medicare section must be completed and Medicare must be selected as the insurance type.

- **Inpatient Part B Only Claims**
  When submitting web claims for inpatient services when the beneficiary has Medicare Part B only (no Part A benefits) and Part B has made payment, providers must not use Medicare in the Insurance Type drop-down box. These claims are not considered crossover claims since there is not a Part A payment and must be submitted with an insurance type other than Medicare in the Insurance Type drop-down box, for example: CI- Commercial Insurance.

- **LTC Claims**
  When submitting web claims for LTC services when the beneficiary has a Medicare replacement plan, the claims must be submitted with the appropriate Medicare insurance type selected.

EDI Claim Submission Process (Medicare)
For complete instructions regarding submission of Electronic Data Interchange (EDI) claims, follow the National HIPAA Implementation Guide rules for Identification of Medicare Versus Non-Medicare Payers on the Washington Publishing Company website. In conjunction with the Standard Implementation Guide, KMAP requires the SBR09 segment in the 2000B or 2320 loop if the 837 file contains an MB (Medicare B) or MA (Medicare A) in order to create a Medicare crossover claim.

- **Inpatient Part B Only Claims**
  When submitting electronic claims for inpatient services when the beneficiary has Medicare Part B only (no Part A benefits) and Part B has made payment, providers must not use SBR09= MB (Medicare B) or MA (Medicare A) in the electronic 837I. These claims are not considered crossover claims since there is not a Part A payment and should be submitted with SBR09 other than MB or MA, for example: CI- Commercial Insurance. Reference the National HIPAA Implementation Guide for a complete listing.

- **LTC Claims**
  When submitting electronic claims for LTC services when the beneficiary has a Medicare replacement plan, the claims must be submitted with the appropriate MA or MB indicator in the SBR09 segment.

Pursuit of Third-Party Payment Prior to Filing with Medicaid

- 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 cannot bill the beneficiary for any remaining amounts due without first filing the charges to Medicaid along with the RA from Medicare and the third-party insurance.

- Providers must pursue payment from Medicare and other insurance prior to filing with Medicaid. Claims should not crossover to the other insurance and Medicaid simultaneously.

- If Medicare has already made payment and the provider is attempting to file with another potential third-party payer prior to filing with Medicaid, the provider should not submit the claim as a cross over. To do this, the provider can either:
  - Turn off Medicare cross overs and submit the claim electronically
  - Drop the claim to paper and submit both EOBs

- If the provider does file the claim as a crossover simultaneously to the other insurance and Medicaid, once a response from the other insurance has been received, the provider will need to adjust the KMAP paid claim and add the other insurance information.
Medicare 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 the appropriate regional carrier for Kansas.
  - The services are covered by Medicare.
  - The beneficiary's KMAP ID number is identified on the Medicare claim form in the "Other Insurance" field (Box 9a on the CMS-1500 claim form).
  - The "Accept Assignment" field (Box 27 on the CMS-1500 claim form) is checked "yes."
- The provider is notified on the explanation of Medicare benefits (EOMB) that the claim was automatically crossed over for Medicaid processing.
- 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, the provider can check the claim status using the following options:
  - Automated Voice Response System (AVRS)
  - AVRS faxback
  - Secure KMAP website
- If necessary, the claim can be resubmitted through the KMAP website or on a new red claim form.

Adjusting Medicare Crossover Claims

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 the provider’s 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 the provider’s office for full Medicaid reimbursement. Proof of Medicare denial must be attached. Refer to Section 5600 of the General Billing Fee-for-Service Provider Manual for information on filing an adjustment request.

Medicare Claims Not Automatically Crossed Over

- The following claims are not automatically crossed over:
  - Claims billed to Medicare carriers other than the appropriate regional Medicare contractor for Kansas.
  - Claims denied by Medicare.
  - Claims the fiscal agent is unable to find a provider number that cross matches.
  - Part A Medicare (when only Part B makes payment).
- When this occurs, bill Medicaid using the following procedures:
  - Submit a claim to the fiscal agent.
  - Attach Medicare's EOMB or equivalent.
  - Accept assignment.

*Note:* The Medicare Nonassigned Request form under the Claim Attachments heading on the Forms page of the KMAP website 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.
Medicare Claims Not Automatically Crossed Over continued

- 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 noncovered 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.

Medicare 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). The lesser of the two will be used for a determination of the Medicaid paid amount. 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 the Medicare allowed amount any other primary insurance paid amount and the Medicare paid amount are subtracted from the Medicare allowed amount to determine the Medicaid reimbursement amount. KMAP will pay the lesser of the two below:
  - The patient responsibility amount
  - The difference between the Medicare allowed amount and the Medicare and other insurance paid amounts
- When the Medicaid allowed amount is equal to or less than the Medicare allowed amount any other primary insurance paid amount and the Medicare paid amount are subtracted from the Medicaid allowed amount to determine the Medicaid reimbursement amount. KMAP will pay the lesser of the two below:
  - The patient responsibility amount
  - The difference between the Medicaid allowed amount and the Medicare and other insurance paid amounts.

Medicaid Secondary Algorithm
(Lowest allowed) - (Primary payment) = Potential payment (minus any Medicaid patient responsibility)
If the resulting calculation is $0 or less, a payment will not be made and the claim will be considered paid in full.

Medicaid Tertiary Algorithm
(Lowest allowed) - (Primary payment + secondary payment) = Potential payment (minus any Medicaid patient responsibility)
If the resulting calculation is $0 or less, a payment will not be made and the claim will be considered paid in full.
Billing Part B for Inpatient Services

If the patient has no Part A due to lack of eligibility or because benefits have been exhausted but does have Part B, some inpatient services may be covered.

No Part A Due to Lack of Eligibility

- If the patient is admitted to the hospital through the emergency room (ER) or outpatient department, the ER, outpatient, and selected inpatient ancillary services must be billed to Medicare. Charges for ER or outpatient services are billed to Medicare on form SSA 1483 for patients with Part B only.
- 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.
- **KMAP beneficiary payment algorithm for members with Medicaid:** KMAP will pay up to the maximum allowable for Medicaid covered services, less the amount paid by Medicare, up to the deductible and/or coinsurance amount.
- **KMAP beneficiary payment algorithm for members with Medicaid and TPL:** KMAP will pay up to the maximum allowable for Medicaid covered services, less the Medicare allowed amounts, spenddown, copayment, and other third-party payments but no more than the KMAP maximum allowable specified deductible and/or coinsurance amounts.

Part A Benefits Exhausted

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

Part B Inpatient Electronic Claim Submission

When submitting electronic claims for inpatient services for members with Medicare Part B only (no Part A benefits) and Part B has made payment, providers should not use the SBR09 = MB (Medicare B) or MA (Medicare A) on the electronic 837I. These claims should not be submitted as crossovers. In order to have these claims apply to the appropriate logic and not process as an inpatient crossover claim, use one of the following to identify the claim filing indicator in SBR09:

- CI - Commercial Insurance
- ZZ - Mutually Defined

Lifetime Reserve

- 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 will still have the ability to change that decision and elect to use their LTR days. KMAP will accept the written election form outlined by Medicare in Chapter 5 of the Medicare Benefit Policy Manual.
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 Fee-for-Service 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 or any other denial based upon a failure of the beneficiary or provider to follow the rules of Medicare.)

- If a provider is unable to receive a denial letter from Medicare or other insurance because this type of provider is not allowed to enroll, then the provider is not required to maintain a blanket denial letter from Medicare or the other insurance. However, the provider must attest to the fact he or she does not meet the requirements to enroll in Medicare or the other insurance and give the reasons why these requirements cannot be met. 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.
3300. THIRD-PARTY CLAIM SUBMISSION  Updated 12/14

GENERAL FILING
Other Insurance Is Not on File
When the other insurance is not on file with KMAP, 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.

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. KMAP will not pay the provider the amount paid by other insurance. (See the 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.

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 Fee-for-Service 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.

Other Insurance 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 KMAP 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, KMAP considers these to be noncovered services and billable to the beneficiary. KMAP should not be billed for these services.

Blanket Denials and Noncovered Codes
When a carrier issues a blanket denial letter for a noncovered procedure code, the provider should include a copy of the denial and notate CARC code PR192 on the attachment. Refer to the Blanket Denials and Noncovered Codes portion of Section 3100 for documentation requirements.
TPL Pricing Algorithm

FFS claims will calculate payment based on the Medicaid allowed amount minus TPL payments.

- \((\text{Medicaid allowed amount}) - (\text{Primary payment}) = \text{Potential payment (minus any Medicaid patient responsibility)})
- If the resulting calculation is $0 or less, a payment will not be made and the claim will be considered paid in full.

KanCare claims will calculate payment based on the lowest allowed amount minus the primary insurance payment.

- \((\text{Lowest allowed}) - (\text{Primary payment}) = \text{Potential payment (minus any Medicaid patient responsibility)})
- If the resulting calculation is $0 or less, a payment will not be made and the claim will be considered paid in full.

ELECTRONIC/WEB CLAIM

Reason Code and Remark Code

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.

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” to query for effective TPL policies. It is not used in the claim processing.

Most policy information listed below will auto-populate based on the TPL policy information available at the time of the claim. Any information that does not auto-populate 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.
3300. Updated 12/14

**ELECTRONIC/WEB CLAIM continued**

**Professional 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 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 – Auto-calculates 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 coinsurance based on the Medicare EOMB.
- Deductible – Enter the amount applied to the beneficiary’s Medicare deductible based on the Medicare EOMB.
- Allowed Amount – Auto-calculates based on the amounts entered in the Co-Insurance, Deductible, and Paid Amount fields. Information cannot be entered into this field.

**PAPER CLAIM**
When filing an ADA Dental, CMS-1500, UB-04, or Pharmacy paper claim form to Medicaid as the secondary payer, KMAP requires a copy of the RA and/or EOB from the primary insurance payer to be sent with the paper claim form. Paper claims that are submitted through the front-end billing (FEB) process are converted to an electronic 837 x12 transaction file before they are sent to the MCOs. In order for the converted paper claim to become a HIPAA-compliant electronic claim, the RA and/or EOB or TPL CARC and RARC form must contain the information below. Claims received without the information below, will be returned to the provider.

**The information required on all paper claims when indicating other insurance is as follows:**

*Note:* The information must match on **both** the claim form and the RA/EOB or TPL CARC and RARC form.
- **Beneficiary first and last name**
- **Dates of service**
- **Billed charges**
  *Note:* These must be the same amount billed to the primary insurance.
  *Exception:* If there is a reason why the charges do not match (such as other insurance requires another code to be billed which generates a different charge), the provider should note this on the EOB or on the TPL CARC and RARC form.
- **Other insurance name**
PAPER CLAIM continued
The following items must be clearly written on the paper RA/EOB for each detail line item billed on the claim form. In lieu of writing the service line information on the paper RA/EOB, the TPL CARC and RARC form can be used. This form is available under the Claim Attachments heading on the Forms page of the KMAP website. It can be used to report secondary payment HIPAA standard CARCs to explain service line adjudicative decisions made by the other insurance payer. The claim(s) adjudication details provided by the other insurance payer must be used to fill in the form.

• **Reason for nonpayment of billed charges**
  
  
  o **Group Code** - Claim adjustment reason codes communicate the reason a claim or service line was paid differently than it was billed. If there is not an adjustment to a claim/line, then there is not an adjustment reason code.
    
    - CO - Contractual Obligations
    - CR - Corrections and Reversals
    - OA - Other Adjustments
    - PI - Payer Initiated Reductions
    - PR - Patient Responsibility
  
  o **Corresponding CARC**
    
    - Explain service line adjudicative decisions made by the other insurance payer.
    - If the CARC code is not listed on the service line on the EOB/RA, indicate CARC 192.
  
  o **Claim level RARC**
    
    If using a CARC code that requires a RARC code.
  
  o **Amount**
    
    Associated amount not approved/paid.

• **Other insurance payment amount**

  TPL payment listed on applicable claim form below:
  
  o CMS-1500, Field 29
    
    Do not enter copay, spenddown, patient liability, or client obligation payment amounts.
  
  o UB-04, Field 54
    
    Do not enter copay, spenddown, patient liability, or client obligation payment amounts.
  
  o Dental, Field 32
    
    Do not enter copay, spenddown, patient liability, or client obligation payment amounts.

• **Adjudication Date of Other Insurance**

  o This is the date the other insurance company paid or denied the service.
  
  o This information must be clearly labeled on the RA/EOB or TPL CARC and RARC form.

**CMS-1500**

• Complete one of the following to indicate other insurance is involved:
  
  o Fields 9, 9A-D (Other Insured’s Name)
  
  o 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.**
PAPER CLAIM continued

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.

Medicare Replacement Policy

- Indicate in Fields 9A-D, 11A-C, or 50 if the policy is a Medicare replacement plan.
- Complete the remainder of the claim as instructed for paper billers.
- Medicare replacement plans, also known as Medicare Advantage Plan or Medicare Part C, are treated the same as any other Medicare claim.

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.

Fiscal Agent Denies "Suspect 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.
- 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.
DENTAL CLAIM

- 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 Customer Service at 1-800-933-6593. Upon receipt of payment from the insurer, refunds must be sent to KMAP using the adjustment process; checks will only be accepted from providers who are on longer Kansas Medicaid providers.

PHARMACY CLAIM

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 on the Provider Electronic Solutions page of the KMAP website.

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 Fee-for-Service 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 HIPAA Companion Guides page of the KMAP website 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 KMAP 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.
PHARMACY CLAIM continued

- 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 KMAP 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</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 KMAP 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 KMAP 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 KMAP 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

Hospitals cannot file a lien pursuant to K.S.A. 65-406 against any potential claim involving a KMAP beneficiary.

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 Fee-for-Service 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 the Kansas Medicaid subrogation staff will seek recovery directly from the third party.
Beneficiary and Attorney Requests and Subpoenas

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 Kansas Medicaid subrogation contractor whenever providers have a request to release bills or itemized statements to beneficiaries or their lawyers.

You can notify the Kansas Medicaid subrogation contractor by phone, fax, letter, or email at:

HMS
6021 Southwest 29th Street
Suite A, #373
Topeka, KS  66614
Phone: 785-271-9300
Fax: 785-271-9318
Email: ksmedsub@hms.com

Include this information in your notification to the Kansas Medicaid subrogation contractor:
- 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 Kansas Medicaid subrogation contractor if:
- The beneficiary wants treatment records only.
- The beneficiary needs the bill to meet a spenddown.
Health Management Systems, Inc. (HMS) is under contract with the State of Kansas through Hewlett Packard Enterprise Services to conduct TPL recoveries and disallowance processes. As part of the TPL program, HMS receives the KMAP paid claims file each month and these claims are automatically billed by HMS to the insurance carriers.

Additionally, HMS conducts a commercial disallowance process for the State of Kansas. During this process, HMS identifies third-party coverage in effect at the time of service but not billed by the provider. HMS notifies the provider of the other insurance by letter and requests that the provider submit a claim to the third-party carrier. The letter from HMS contains all the information necessary for the provider to bill the other insurance.

In these situations, the KMAP claim is recouped by the fiscal agent 60 days after the date on the HMS notification letter. This 60-day period is the provider’s opportunity to work with HMS regarding the information contained in the letter. If the provider does not respond within 60 days from the date of the cover letter, KMAP and HMS will assume they agree with the overpayments and will send a letter advising the provider of any outstanding ARs as a result of the adjustments to these claims.

To refute any recoupments, the provider can contact HMS at 1-877-266-1071. The provider can send all correspondence, documentation, and inquiries to:

HMS/Third-Party Liability Service Center
5615 High Point Drive, Suite 100
Irving, TX 75038
Fax: 214-905-2064

Note: The provider must not contact KMAP or the fiscal agent regarding the notice. All communications must be directed to the name and address above.

Medicare Disallowance Process

- HMS conducts the Medicare disallowance process for the State of Kansas. This process is required by federal law and requires the provider to submit a bill to Medicare instead of the Single State Medicaid Agency. The provider receives a letter from HMS that a beneficiary may have been eligible for Medicare Part A or B coverage on the claim dates of service. The letter contains the necessary Medicare billing information.
- In these situations, the KMAP claim is recouped by the fiscal agent 60 days after the date on the HMS notification letter. This 60-day period is the provider’s opportunity to work with HMS regarding the information contained in the letter. If the provider does not respond within 60 days from the date of the cover letter, KMAP and HMS will assume the provider agrees with the overpayments and will send a letter advising the provider of any outstanding ARs as a result of the adjustments to these claims.
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Note: The provider must not contact KMAP or the fiscal agent regarding the notice. All communications must be directed to the name and address above.
Electronic Claim Postpay Review (TPL Desktop Review)

- The Centers for Medicare and Medicaid Services (CMS) allow states to perform random sampling reviews on electronic claim submissions with TPL 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 in the Electronic/Web Claim and Paper Claim portions in Section 3300. Providers will receive written instruction from KMAP upon review.
- The provider can recognize any adjustment related to this review on the RA by one of the following:
  - 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.)
  - 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.)
- 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:
  - Office of the Fiscal Agent
  - P.O. Box 3571
  - Topeka, Kansas 66601-3571