group health Cooperative of eau claire

Provider **Updates & Notices**

Changes to Medicaid Billing Requirements

Posted Date: **1/19/2016**
Effective Date: **1/1/2016**
Products: **Group Health Cooperative of Eau Claire, Group Health Cooperative BadgerCare Plus, Group Health Cooperative Medicaid SSI, Compcare BadgerCare Plus, Compcare Medicaid SSI**

Effective with dates of service on or after January 1, 2016, the Wisconsin Department of Health Services (DHS) is requiring HMOs to ensure that all other payor sources are exhausted prior to issuing payment on claims for Medicaid members. While this has been longstanding Federal and State policy to ensure the continued solvency of the program, there are several noteworthy changes that will affect all providers in how claims are billed to and paid by the Cooperative, some of which we are hopeful will eliminate some of the administrative burden associated with benefits coordination. Much of this was driven by changes/clarifications in the Deficit Reduction Act.

- **Relinquishment forms are no longer necessary**. The Cooperative will no longer require (or accept) relinquishment forms to be submitted in order to issue payment on claims where other insurance (like third party liability) may be involved. Instead, however, we will be requiring a copy or verification of any denial (EOB, etc.) from other insurance prior to issuing payment. This is a direct result of changes mandated in the DHS-HMO contract. Providers will be required to bill other applicable insurance sources and receive a denial prior to the Cooperative issuing payment on a claim.
- **Third party liability**. In cases of disputed liability (e.g., a worker's compensation claim that the carrier is denying, claims being actively litigated, etc.), the Cooperative will only require one denial before related claims will process for payment (again, without the need for submission of relinquishment forms each time). For example, if we are notified of a possible worker's compensation claim involving an injury to a member's neck, and with the initial billing the provider submits documentation that the claim is disputed (e.g., denied by the worker's compensation insurance), then the Cooperative will process and pay subsequent neck claims that are related without requiring a relinquishment form or additional EOBs/proof of denial. However, in cases of undisputed third party liability claims, such as a worker's compensation claim that has been accepted by the insurance and for which medical payments are being issued, the Cooperative will be required to treat the worker's compensation insurance as primary and coordinate benefits accordingly.
- **Medical payments coverage is not considered third party liability for purposes of DHS 106**. Any coverage for medical payments that is available and issuable without regard to liability is considered primary to Medicaid payment. This includes a Medicaid members' own auto or other liability policy that includes medical payment provisions separate from liability-related payments. For example, many auto insurance policies include $10,000 of medical payments coverage that is issued to their insured regardless of fault. What this means is that if a Medicaid member is involved in an auto or other accident, the Cooperative will be pending claims or denying claims for coordination of benefits until the medical payments coverage is exhausted, unless we have verification that it has been issued. Importantly, in situations where the medical payments coverage has been issued to a Medicaid member and the payment is itemized/attributable to specific claims, the Cooperative will be denying payment of those claims. Providers will be expected to seek recovery directly from the member.
- **Providers are expected to code for liability**. In cases of auto accidents, worker's compensation, etc., providers will be expected to code claims for liability in accordance with CMS guidance and TPL/COB clarifications under the Deficit Reduction Act (please see: https://www.medicaid.gov/federal-policy-guidance/downloads/faq-09-04-2014.pdf). While we appreciate that this can be challenging, it will also help expedite payments to you by not pending claims unnecessarily.

The Wisconsin Department of Health Services (DHS) has not yet posted the 2016-2017 final contract publicly. If you would like a copy of the actual contract language pertaining to COB/TPL/subrogation, or have any questions or concerns, please contact Provider Relations at (715) 552-4300.