The Neurological Injury Compensation Association and Florida Medicaid Third-Party Liability

Report to the Florida Legislature
November 2021

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Executive Summary

During the 2021 Florida legislative session, Senate Bill 1786 expanded funding for the Florida Birth-Related Neurological Injury Compensation Association (NICA) while also requiring that the Agency for Health Care Administration (Agency) review NICA and its relationship with Florida Medicaid, specifically Medicaid's Third-Party Liability (TPL) functions which require that Medicaid be a "payer of last resort." The Agency report is required to provide recommendations regarding the development of policies and procedures to ensure "robust implementation of Agency functions and rights relative to the primacy of the plan's third-party benefits."

The Neurological Injury Compensation Association (NICA) was established in Florida in January 1989 to help reduce OB/GYN malpractice premiums and at the same time "provide a dignified existence and financial cushion for families crushed by the delivery of an infant with devastating brain damage" by funding their medical expenses. Hospitals and practitioners are assessed varying amounts by NICA each year to fund its mission which is to "pay for all medically necessary and reasonable expenses over the child's lifetime."

Florida Medicaid was established in 1970 as the primary Federal program for providing care to certain low-income individuals and families. The program is a state-federal partnership with federal law establishing the overarching rules and guidelines, the state designing and running the program, and with costs shared between the two based on a ratio determined by the state's average personal income.

One of the key principles when Medicaid was established was the concept of acting as a "payer of last resort." In other words, Medicaid is meant to pay for health care services only after other responsible third parties have met their burden of costs. Federal and state law have firmly established the concept of Medicaid as a payer of last resort. This means third-party payers are liable for a beneficiary's health care up to their coverage limits before Medicaid will contribute to the health care costs. See 42 U.S.C. § 1396a(a)(25)(A)-(B) Exceptions to this requirement are clearly outlined in Federal Law.

Cost Avoidance – Medicaid providers either identify NICA recipients during eligibility checks and bill NICA directly, or Medicaid denies claims for which NICA is the primary payor and informs the provider of the reason for the denial.

Prospective Medicaid Lien/Claim Recovery – The Agency or SMMC plan would participate in the DOAH hearing to determine NICA eligibility and assert its rights as third party payor for future expenses and the right to recovery of expenses already paid. This option would require modification and clarification in the Florida Statutes by the Florida legislature.

Retrospective Medicaid Lien/Claim Recovery - For NICA DOAH proceedings that have already concluded, in which a recipient's claim was determined to be NICA compensable, the Agency may still have a claim against NICA. If decided by the Legislature, the Agency could attempt to recoup, from NICA, funds previously paid by Medicaid. The Agency will need Legislative guidance as to how to determine the amount to be recovered from NICA.

In summary, Medicaid could be considered payer of last resort with respect to medical expenses for recipients who are also eligible for and enrolled in NICA. There are three possible approaches to ensuring the primacy of NICA's third-party liability, but each will require legislative changes.

The Neurological Injury Compensation Association (NICA)

The Neurological Injury Compensation Association's (NICA) had its origins in the malpractice liability crisis of the early 1980s. During that decade's first six years, Florida OB/GYNs premiums for malpractice liability insurance rose nearly 400 percent. During the 1988 legislative session, Florida lawmakers pursued a two-prong course of action that would greatly decrease OB/GYN malpractice premiums and at the same time "provide a dignified existence and financial cushion for families crushed by the delivery of an infant with devastating brain damage." NICA took effect on January 1, 1989, with the legislature making a one-time $20 million appropriation for its commencement. No further state or federal funds have been used to support this program. Rather, hospitals and practitioners make payments of varying amounts to NICA each year. As of early 2021, 1,238 parents or guardians filed petitions for their infants' acceptance into the program; of these applicants, Florida's NICA program accepted 440 children as beneficiaries.

NICA's website states that "NICA pays for all medically necessary and reasonable expenses over the child's lifetime. Examples of covered expenses may include medical care, co-pays, equipment, therapy, nursing care, medications, handicap modifications, transportation, and supplies that are medically necessary but not covered by another source, such as insurance. NICA aims to treat every family in the program fairly and individually, providing each child with the personalized benefits they are entitled to, based on their specific medical needs. What is medically necessary for one child may not be the same for another, so a one-size-fits-all approach does not work for NICA."

Section 766.31, Florida Statutes, states that each award shall provide for compensation relating to the birth injury, including "(a) Actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel."

Florida Medicaid – Payer of Last Resort

Federal Laws

Medicaid, established by Title XIX of the Social Security Act of 1965, is the primary Federal program for providing care to certain low-income individuals and families who fit in an eligibility group. The program is voluntary, though presently all States and territories maintain Medicaid programs. These programs are administered by states, but financed cooperatively, with the federal government and states sharing the costs incurred for this medical care. A "State plan," the foundation on which State Medicaid programs are established, is a Federally approved document which designates a single agency to administer the program and provides a description and scope of the State's Medicaid program. The State plan ensures that the State's Medicaid program will conform with all federal regulations and requirements.

One issue that all State Medicaid programs face is "third party liability" (TPL). TPL effectuates the "payer of last resort" policy, meaning Medicaid will only pay a beneficiary's health care costs when there are "no other liable third-party payers for the same items and services." Third parties are a broadly defined set of resources, including health insurers, government programs, and liable people or entities, which are responsible for paying for a beneficiary's health care. In instances a third party is responsible for the medical expenses of a beneficiary, the Federal government provides State Medicaid programs with a mandate both establishing the program as, and in exercising its right to be, a "payer of last resort." This means third-party payers are liable for a beneficiary's health care up to their coverage limits before Medicaid will contribute to the health care costs. In other words, the State Medicaid program will only pay for health care services after the third-party payer has reimbursed for services within its responsibility. The exceptions to this payer of last resort right are clearly specified in federal statue. These exceptions mean that State Medicaid programs will pay for beneficiary health care prior to any of the following incurring an expense:

- Crime Victims Compensation Fund
- Parts B and C of the Individuals with Disabilities Education Act (IDEA)
- Ryan White Program
- Indian Health Services
- Women, Infants, and Children Program
- Veteran's benefits, for emergency treatment provided to certain veterans in a non-VA facility
- Veteran's benefits for state nursing home per diem payment
- State health agencies
- State vocational rehabilitation agencies,
- Title IV-E prevention and family services (Section 8082(b)(1) of H.R. 6 was amended by section 471(e)(10) of the Act effective October 3, 2018).

In 2005, to confirm that State Medicaid programs were the "payer of last resort," the Federal government required states to demonstrate they maintain laws which establish this policy beyond the shadow of a doubt. States possess an arsenal of federal laws on which to base their stance on TPL. First, to assist in identifying third party payers, federal statutes require "that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties." To assist in this process, the beneficiary is required "to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan." Second, the Code of Federal Regulations states that if a State Medicaid program "has established the probable existence of third-party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability. When the amount of liability is determined, the agency must then pay the claim to the extent that payment allowed under the agency's payment schedule exceeds the amount of the third party's payment." Florida, through statutes and administrative rules, demonstrates that it observes the 2005 requirement.

In addition, Federal authority establishes provisions that require states to seek reimbursement from liable third parties. Specifically, 42 U.S.C. § 1396a(a)(25)(B) provides in pertinent part: "that in any case in which such a legal liability is found to exist after medical assistance has been made available on behalf of the individual the State will seek reimbursement for such assistance to the extent of such legal liability." To assist with obtaining this reimbursement, Federal law requires that "States must condition Medicaid eligibility on assignment to the state of any Medicaid recipient's rights to payment for medical

care from any third party." By assignment, a Medicaid applicant or recipient automatically gives his/her right to financial recovery from liable third parties to the Agency, to the extent Medicaid has paid for medical services. This allows the recovery of the costs of medical services paid by the Medicaid program. Any applicant or recipient who knowingly withholds information regarding any sources of payment for medical services violates state law.

When Florida chose to participate in Medicaid in 1970, the state developed a "State plan" which defined the program's nature and scope. Through this state plan, Florida agreed to conform to federal Medicaid law, including payer of last resort and collection of reimbursement or TPL. The state similarly enacted laws which established Florida's Medicaid program as the payer of last resort and required the Agency to pursue TPL. Additionally, compliance with federal law implies that Florida has the obligation to collect reimbursement from third party payers.

State Laws

Section 409.910, F.S., also known as the "Medicaid Third-Party Liability Act," governs TPL within Florida. In the first sentence of the statute, the Legislature leaves no doubt regarding its objective: "It is the intent of the Legislature that Medicaid be the payer of last resort for medically necessary goods and services furnished to Medicaid recipients." Consistent with federal law's requirement that State collect third-party reimbursement, Florida law provides that in "applying for or accepting medical assistance [Medicaid], an applicant, recipient, or legal representative automatically assigns to the agency any right, title, and interest such person has to any third-party benefit, excluding any Medicare benefit to the extent required to be excluded by federal law." Section 409.910, F.S., also requires that "if benefits of a liable third party are discovered or become available after medical assistance has been provided by Medicaid, Medicaid be repaid in full and prior to any other person, program, or entity. Medicaid is to be repaid in full, from and to the extent of, any third-party benefits, regardless of whether a recipient is made whole or other creditors paid."

Florida Administrative Code (F.A.C.) Rule 59G-1.052 elaborates upon TPL requirements within the state. Built upon the foundation of the Code of Federal Regulations (CFR), section 433, Subpart D, Rule 59G-1.052 confirms that "all other available third-party resources must meet their legal obligation to pay claims before the Florida Medicaid program pays for a recipient's health care services." Through a combination of Federal and state laws, the following programs are exempt from abiding by the payer of last resort requirement:

- Federal funds for the Individuals with Disabilities Education Act, Part B or C.
- Indian Health Services, according to 42 CFR 136.61.
- Programs funded through state and county funds, including:
    - Acquired Immune Deficiency Syndrome (AIDS) drug assistance programs.
    - County health departments.
    - Department of Health indigent drug programs.
    - Substance abuse, mental health, and developmental disabilities programs operated by the Department of Children and Families and the Agency for Persons with Disabilities.
    - Victim's compensation funds.
- Vocational rehabilitation programs.

For all other third-party resources, “Florida Medicaid is the payer of last resort. Providers must exhaust all TPL sources of payment, such as Medicare, TRICARE, private health insurance, AARP plans, or automobile coverage prior to submitting or resubmitting a claim for reimbursement to Florida Medicaid.” In addition, the rule enables the Agency, to contract with “a TPL vendor to identify, manage, and recover funds and overpayments paid on behalf of recipients when a third-party is, or was, responsible. The TPL vendor also administers Florida Medicaid’s third-party liability recovery programs for casualty, estate, trust, and annuities on behalf of deceased Medicaid recipients.”

Medicaid Third-Party Liability Functions

The Agency Division of Medicaid’s Third-Party Liability (TPL) unit is responsible for identifying and recovering funds for fee-for-service claims paid by Medicaid when a third-party is liable for a recipient’s medical expenses, thereby ensuring Medicaid is the payer of last resort. Some examples of third parties include casualty settlements, recipient estates and/or trusts, Medicare, and commercial health insurance carriers. TPL recovery services are performed by a state procured outside vendor, Health Management Systems, Inc (HMS). The Agency is contracted with HMS through August 31, 2025.

Although Florida Medicaid engages in various recovery efforts, focuses on four areas of TPL activity:

Cost Avoidance – As previously stated, health insurance carriers are required to exchange or share data with state Medicaid agencies for the coordination of benefits or COB. Through these data matches, new and/or updated health insurance information is obtained. Insurance information is also obtained at the time of enrollment into Medicaid. When Medicaid staff or Medicaid providers are informed that a recipient has acquired new insurance, they can contact the TPL vendor. The TPL vendor will verify that the insurance information is correct and current. That information is then added to the Florida Medicaid Management Information System (FMMIS) to cost-avoid future claims that are submitted by Medicaid providers.

When a provider submits a claim and a recipient has other insurance, the provider is instructed to bill the other insurance prior to billing Medicaid. The Agency utilizes automated rule processes maintained in FMMIS to determine whether a claim shall be paid or denied based upon other third-party information contained in the Medicaid recipient's file. Medicaid tracks cost avoidance to illustrate total Medicaid dollars saved or avoided when providers bill the appropriate third-party.

Carrier Billing - Once commercial health insurance is identified for Medicaid recipients and added to their record in FMMIS, the TPL vendor bills the insurance carriers for previously paid Medicaid claims that are covered by the primary health insurance. The primary health insurance then reimburses Medicaid for the amount it paid. This is known as carrier billing.

Under the Florida SMMC, Medicaid Managed Care Plan(s) are required to identify and seek recovery up to the Managed Care Plan’s full legal ability from any third party, as defined by 409.901(27), F.S., to pay for services rendered to enrollees.

The Managed Care Plan is required to assume full responsibility for all third-party recovery actions initiated within one (1) year of identification. All recovery actions not initiated by the Managed Care Plan within one (1) year of identification may be pursued by the Agency, at the Agency’s sole discretion.

Disallowance -Instead of the TPL vendor billing the private health insurance company, they provide the Medicaid claim and private health insurance information to the provider which then directly bills the carrier. If the health insurance company issues payment to the provider for the services, the TPL vendor will recover Medicaid's initial payment to the provider. If the health insurance company does not pay, the Medicaid payment is not recovered from the provider.

Casualty Cases – Medicaid imposes a lien against recipients' recoveries from liable third parties for the amount Medicaid paid for medical services related to injuries sustained as the result of an incident (casualty). Examples of casualties are automobile accidents, slip and fall accidents, medical malpractice, etc. Under normal circumstances, Florida Medicaid learns that a casualty has occurred when an attorney, representing the Medicaid recipient, brings a claim against a liable third-party. When an attorney believes their client may have Medicaid, they are required to notify Florida Medicaid. Then Medicaid relies on section 409.910, F.S., to make recoveries for payments on behalf of Medicaid-eligible persons when other parties are liable. Conduent Payment Integrity Solutions (Conduent) is the approved subcontractor of HMS contracted to identify, manage, and recover all Florida Medicaid paid funds when a Medicaid recipient is involved in a tort or a casualty incident.

When Medicaid is noticed, Conduent opens a casualty case file on behalf of Florida Medicaid, calculates the paid claims amount made on behalf of the Medicaid recipient related to the cause of action, follows up with the attorney regularly, and requests payment when third-party benefits are received. The attorney for the recipient then pays Florida Medicaid out of any recovery the recipient makes against liable third parties.

NICA Liability to Florida Medicaid

Section 766.31, Florida Statutes, requires that NICA pay for all medically necessary and reasonable expenses relative to the birth-related neurological injury over the child's lifetime. Specifically, under the statute, NICA must cover "(a)ctual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care, and service, for medically necessary drugs, special equipment, and facilities, and for related travel." This law, together with federal and state laws providing that Medicaid is the payer of last resort, indicate that NICA should be the primary payer for services provided under the plan that Medicaid otherwise would pay for. In other words, NICA should be considered a third-party provider for purposes of Medicaid's TPL function and responsibility.[1]

[1] In 2015, the United States, by way of relators Theodore Arven III and Veronica N. Arven, filed a qui tam whistleblower lawsuit in federal court against the Virginia Birth-Related Neurological Injury Compensation Program and alleged that because the Virginia program would not pay for expenses covered by Medicaid, it violated federal law which holds that Medicaid is the payer of last resort and that the program violated the Federal False Claims Act by requiring claimants in the program to file Medicaid claims for expenses covered by the fund. The United States sought treble damages from the program for its purported False Claims Act violations. The Virginia Birth-Related Neurological Injury Compensation Program and the Virginia Birth-Related Neurological Injury Compensation Fund settled with the United States by agreeing to pay $20,700,000.00 to resolve the False Claims Act suit against them. *See United States ex rel. Arven III v. The Va. Birth-Related Neurological Injury Comp. Program, No. 1:15CV 870 (E.D.Va. July 7, 2015).* In September 2019, the United States, by way of relators Veronica N. Arven and Estate of Theodore Arven III, filed a qui tam whistleblower lawsuit in federal court against the Florida Birth-Related Neurological Injury Compensation Association (NICA) and the Florida Birth-Related Neurological Injury Compensation Plan. The United States alleges that because NICA will not pay for expenses covered by Medicaid, it violates federal law which holds Medicaid is the payer of last resort and that NICA violates the Federal False Claims Act when it requires participants to submit claims to Medicaid before it will consider them and when it does not reimburse Medicaid for expenses covered by the plan if Medicaid pays first. The United States seeks treble damages from NICA because it purportedly violates the False Claims Act. This case is pending. *See United States ex rel. Arven v. Fla. Birth-Related Neurological Injury Comp. Ass'n, No. 19-61053-CIV (S.D. Fla. Sept. 9, 2019)*.

To identify the potential extent and value of the liabilities owed by NICA as a third-party benefit provider, the Agency obtained a list of Florida recipients from NICA and cross-referenced the list with an additional list of NICA recipients received from the United States Department of Health and Human Services Office of Inspector General. Of the 440 accepted into the NICA program, 284 recipients were found to be also enrolled in the Medicaid program. The list represents all Medicaid recipients from NICA's inception on January 1, 1989, to August 30, 2021. The Agency pulled information representing all services for each recipient for which Medicaid reimbursement was made.

For purposes of this report, data is provided as follows:

(1) All services: This data includes reimbursement amounts associated with all services reimbursed for NICA recipients. No services which may be appropriately covered by the Medicaid program if NICA is a third-party payer have been removed from this analysis.
(2) Services excluding preventive well-child and dental services: This data has had reimbursement amounts relating to certain preventive services removed, including well childcare, immunizations, preventative dental and preventative vision, based on the assumption that these services would be provided to any child enrolled in the Medicaid program, regardless of whether that child has suffered a birth-injury.

Figure 1 – Total Expenditures and Total Routine Expenditures (1989-2021)

Total Expenditures FFS: $93,293,283.52
Total Expenditures MCO: $50,550,487.72

Total Non-Routine* Expenditures FFS: $93,171,652.60
Total Non-Routine* Expenditures MCO: $50,456,435.63

**Non-Routine Expenditures exclude Dental, Visual, and Health Check Up expenditures*

Table 1 – Total Expenditures by Calendar Year (1989-2021)

Calendar Year	Total FFS Expenditures	Total MCO Expenditures	Calendar Year	Total FFS Expenditures	Total MCO Expenditures
1989	$150.00	$0.00	**2006**	$5,631,278.77	$0.00
1990	$374.50	$0.00	**2007**	$6,862,332.78	$40.00
1991	$1,061.26	$0.00	**2008**	$6,983,274.08	$2,463.76
1992	$808.17	$0.00	**2009**	$7,426,973.10	$8,373.58
1993	$15,821.15	$0.00	**2010**	$6,758,166.44	$3,375.14
1994	$18,389.03	$0.00	**2011**	$5,901,883.60	$18,320.70
1995	$53,614.55	$0.00	**2012**	$5,408,140.79	$46,186.73
1996	$315,453.46	$0.00	**2013**	$5,339,190.48	$44,170.35
1997	$205,797.16	$0.00	**2014**	$4,068,199.74	$1,663,070.81

1998	$586,690.32	$0.00		**2015**	$2,174,887.13	$5,224,615.31
1999	$889,526.92	$0.00		**2016**	$2,458,881.03	$5,268,753.03
2000	$1,152,185.64	$0.00		**2017**	$2,403,895.39	$6,132,357.96
2001	$2,062,333.36	$0.00		**2018**	$2,318,733.91	$7,839,789.03
2002	$4,914,402.48	$0.00		**2019**	$2,032,895.32	$9,202,873.53
2003	$3,884,157.86	$0.00		**2020**	$2,316,801.69	$9,897,118.12
2004	$4,234,114.88	$0.00		**2021**	$1,655,835.24	$5,104,927.58
2005	$5,100,453.60	$0.00		**TOTALS**	$93,293,283.52	$50,550,487.72

Table 2 – Top 10 FFS Service Types by Total Expenditures (1989-2021)

Service Type	Total by Service
HOSPITAL INPATIENT SERV	$22,855,626.48
PRIVATE DUTY NURSING SERVICES	$22,671,983.86
UNKNOWN	$13,370,517.49
HOME HEALTH SERVICES	$6,279,081.91
PERSONAL CARE SERVICES	$4,827,328.64
HOSPITAL OUTPATIENT SERVICES	$4,228,886.92
HCB DEVELOPMENTAL SERVI	$3,442,303.88
PHYSICIAN SERVICES	$2,742,592.17
SMMC CMSN DOH MMA	$1,634,418.85
OCCUPATIONAL THERAPY SERVICES	$1,561,214.53

Table 3 – Top 10 MCO Service Types by Total Expenditures (1989-2021)

Service Type	Total by Service
PRIVATE DUTY NURSING SERVICES	$21,180,051.40
HOSPITAL INPATIENT SERV	$11,005,349.31
HOME HEALTH SERVICES	$5,435,789.21
PRESCRIBED MEDICINE	$3,009,319.25
PHYSICIAN SERVICES	$2,798,408.53
HOSPITAL OUTPATIENT SERVICES	$1,999,863.66
HCB AGING	$1,388,804.95
PHYSICAL THERAPY SERVICES	$960,544.15
PATIENT TRANSPORTATION	$638,969.50
OCCUPATIONAL THERAPY SERVICES	$492,329.02

Recommended Agency Policies and Procedures

As outlined in the enacting language, the Agency is required to provide recommendations, based on its findings, regarding the development of policies and procedures to ensure robust implementation of agency functions and rights relative to the primacy of the plan's third-party benefits payable under s. 766.31(1)(a)1. and 3., Florida Statutes, and recoveries due the agency under s. 409.910, Florida Statutes.

The Agency reviewed federal and state law and determined that NICA could be considered a third-party payor. If it is determined that NICA is a third party-payor to Florida Medicaid, to ensure robust implementation of agency functions and rights relative to NICA, the Agency will need to be able to identify any existing and future NICA members who also have Medicaid. As such, the Agency makes the following recommendations for the Legislature and Chief Financial Officer to consider:

Retrospective Medicaid Lien/Claim Recovery:

In this report, the Agency has provided the extent and value of the liabilities by NICA if it is considered a liable third-party. For NICA DOAH proceedings that have already concluded, in which a recipient's claim was determined to be NICA compensable, the Agency may still have a claim against NICA. If decided by the Legislature, the Agency could attempt to recoup, from NICA, funds previously paid by Medicaid. The Agency will need Legislative guidance as to how to determine the amount to be recovered from NICA. Below are potential avenues to seek recovery:

1. The Agency may issue demand letters against NICA requesting payment for which the Agency has a legal right.
2. The Agency may have a claim under a federal statute which renders invalid the restrictions on payment for medical care paid by the Agency. The Agency may be able to turn to the federal district courts for relief in individual cases, or for declaratory relief against NICA.

In order to ensure compliance, the Legislature could amend NICA's statute section 766.31 to expressly provide for repayment to the Agency/Medicaid, thus ensuring that the Agency does have a right to repayment, and it gets repaid. Such an amendment may provide a path for the State to require NICA to repay the Agency for previous services rendered which should have been NICA compensable.

Cost Avoidance

In order to perform cost avoidance measures, the Agency will need to identify NICA members. There are two ways to achieve this goal:

1. Execute a Data-Sharing Agreement: The Agency can execute a data sharing agreement with NICA where NICA will provide the Agency with its existing members and then prospectively inform the Agency of any newly added NICA members; and/or;
2. Obtain enrollment information from the DOAH: Currently, per NICA's statute (Section 766.305, F.S.), the parents or guardians of the infant must file a petition with DOAH to determine NICA eligibility. DOAH then serves a copy of the petition to the Agency. Upon receiving notification, the Agency's TPL vendor checks to see if the petitioner is enrolled in Medicaid.

Once the Agency has identified NICA members who also have Medicaid, the Agency will create and assign a specific carrier code for NICA in FMMIS. This carrier code will be treated the same as any other third-party medical insurer/carrier. With the creation of this carrier code, the Agency will be able to add NICA's "coverage" to their TPL record in FMMIS.

By assigning the carrier code to the recipient's record, the Agency can then program FMMIS to perform two tasks:

1. When Medicaid providers perform eligibility checks in their provider portal, they will receive results stating that NICA coverage is present under TPL. This will inform the provider to reach out and bill NICA before attempting to bill Medicaid.
2. To deny Medicaid provider claims explaining "Recipient has other insurance coverage on Medicaid Third Party file. Please file with other carrier or attach insurance company denial". Then providers will need to bill NICA prior to billing Medicaid. If NICA denies their claim, the provider can attach their denial letter and then submit a claim to Medicaid for adjudication.

Prospective Medicaid Lien/Claim Recovery:

When a Medicaid recipient has suffered a birth-related neurological injury, NICA may be liable for his or her medical care. The recipient (through his or her parents or guardians) must petition DOAH to determine whether the claim is NICA compensable. When a family files a petition with DOAH, the Agency is notified. The claimant is required to furnish to NICA any documentation of related expenses and services incurred to date which identifies any payment made for such expenses and services and the payor. They are also required to document any applicable private or governmental source of services or reimbursement relative to the impairments.

A NICA award through the DOAH proceeding includes up to $250,000 to the family for what are effectively non-economic damages. Additionally, they are provided coverage for all medical care related to the neurological injury. The compensation for medical care expressly excludes state-run programs, but not if that exclusion is prohibited by federal law. Because the Medicaid program is the payer of last resort under federal law, NICA cannot exclude compensation for what Medicaid has paid. The Agency thus has a potential claim for reimbursement under the NICA statute; however, there is no provision that specifically provides for the Agency to be repaid. The Agency or SMMC plan can attempt to intervene as a subrogee/assignee/lienholder in the NICA DOAH proceeding of each Medicaid recipient under section 409.910(11), Florida Statutes, which provides in pertinent part that the Agency can intervene in or join any administrative proceeding in its own name individually, as subrogee of a recipient, as assignee of a recipient, or as lienholder.