59G-1.052 Third-Party Liability Requirements.

(1) This policy applies to all persons who are required to notify Florida Medicaid of any third-party benefits a recipient may have and to providers rendering Florida Medicaid services to recipients.

(2) Purpose. Third-party liability (TPL) refers to the legal obligation of third-parties to pay part, or all, of the expenditures for medical assistance furnished under the Florida Medicaid program. In accordance with Title 42, Code of Federal Regulations (CFR), section 433, Subpart D, 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.

(3) Definitions.

(a) Dually Eligible Recipient. As defined in rule 59G-1.010, Florida Administrative Code (F.A.C.).

(b) Rate. As defined in rule 59G-1.010, F.A.C.

(4) Third-Party Liability Vendor. The Agency for Health Care Administration (AHCA) contracts 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.

Information regarding AHCA's TPL vendor can be found on the AHCA Web site at http://www.ahca.myflorida.com/Admin/.

(5) Third-Party Liability Notices.

(a) Notices regarding any third-party benefit, including trust, annuity, or estate probate actions, must be submitted in accordance with sections 409.910, 409.9101, Florida Statutes (F.S.), to the appropriate address located on the AHCA Web site at http://www.ahca.myflorida.com/Admin/.

(b) Notice provided to any other AHCA office, or delivered to any other address, is not effective to fulfill the notice requirements.

(6) Exhausting Third-Party Resources.

(a) 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.

(b) The following programs are exceptions to Florida Medicaid being the payer of last resort:

1. Federal funds for the Individuals with Disabilities Education Act, Part B or C.

2. Indian Health Services, according to 42 CFR 136.61.

3. Programs funded through state and county funds, including:

a. Acquired Immune Deficiency Syndrome (AIDS) drug assistance programs.

b. County health departments.

c. Department of Health indigent drug programs.

d. Substance abuse, mental health, and developmental disabilities programs operated by the Department of Children and Families and the Agency for Persons with Disabilities.

e. Victim's compensation funds.

f. Vocational rehabilitation programs.

(7) Refusal of Services. Providers may not refuse to furnish a covered Florida Medicaid service to a recipient solely because of the presence of other insurance, including Medicare, in accordance with 42 CFR 447.20(b).

(8) Reimbursement for Services Provided to Recipients with TPL.

(a) Florida Medicaid reimburses the difference between the Florida Medicaid rate and the third-party payment, minus any applicable Florida Medicaid copayment or coinsurance, unless otherwise specified in this rule.

(b) Florida Medicaid does not reimburse for services when:

1. The amount of any third-party payment(s) (including Medicare) is equal to, or exceeds, the Florida Medicaid rate for the service.

2. The provider's TPL claim is denied for failing to obtain the appropriate authorization from the third-party. Services approved by Medicare do not require Florida Medicaid prior authorization.

(9) Third-Party Liability Resources.

(a) Providers must inquire if a recipient has third-party insurance coverage and if there have been any changes to existing third-party coverage.

(b) Third-party liability information for a recipient, when known to Florida Medicaid, is available for providers on the Florida Medicaid fiscal agent's Web site at http://portal.flmmis.com/flpublic, or by phone using the Florida Medicaid Automated Voice Response System (AVRS) at 1(800)239-7560.

(c) Providers must determine if the insurance on the Florida Medicaid file is applicable to the services being provided. Florida Medicaid uses the following two-digit numeric codes for each associated insurance coverage type, when verifying recipient eligibility and for claims processing purposes:

CODE	INSURANCE COVERAGE TYPE
03	BASIC SURGICAL
04	BASIC HOSPITAL/MEDICAL/SURGICAL
05	PHARMACY ADMINISTRATOR (TPA)
06	MAJOR MEDICAL
07	ACCIDENT ONLY (NON AUTO)
08	VEHICLE ALL INCLUSIVE
09	MAJOR MEDICAL WITH TPA OR NO PHARMACY
10	CANCER
11	MEDICARE SPECIAL NEED PLAN
12	MEDICARE SUPPLEMENT
13	NURSING HOME SUPPLEMENT
14	HEALTH MAINTENANCE ORGANIZATION
15	DENTAL
16	TRICARE
17	HMO WITHOUT PHARMACY
18	CONTINUING CARE/LIFE CARE
19	MEDICARE ADVANTAGE PLAN
20	FULLY LIABLE MEDICARE ADVANTAGE PLAN
21	PHARMACY CARD SERVICE
22	HOSPITAL ROOM – BOARD/INDEMNITY
23	BASIC MEDICAL

(d) Discounted Contracts.

1. Florida Medicaid reimburses providers contracted with a third-party in which the provider agrees to accept as full payment an amount less than its customary charges. Florida Medicaid reimbursement is limited to any remaining recipient liability, such as a copayment or deductible.

2. If the discount contract's allowable fee is less than Florida Medicaid's maximum allowable rate and there remains a recipient liability, providers must:

a. Compute the amount of the recipient's responsibility (deductible, coinsurance, etc.).

b. Deduct the result of sub-subparagraph a. from the Florida Medicaid rate.

c. Include the result of sub-subparagraph b. as the third-party payment on the claim.

3. Providers must prorate the discount contract's allowable TPL payment and the recipient responsibility for each line item, if the explanation of benefits from the TPL is not itemized.

(e) Discounted Contracts for Diagnostic Related Groups (DRG) or Enhanced Ambulatory Patient Grouping (EAPG). Providers must ensure that the Florida Medicaid reimbursement is equal to, or less than, any contracted or negotiated TPL rate(s) for claims reimbursed through DRG or EAPG.

(f) Contributions to a Facility.

1. Providers must treat any contribution made to a facility on behalf of a specific recipient as a third-party payment and include it on the claim form.

2. Providers are not required to report a contribution made to a facility when the contribution is not for a specific recipient, but for the benefit of all residents.

(10) Florida Medicaid Payments for Dually Eligible Recipients.

(a) Medicare Part A Premium. Florida Medicaid will pay the Part A premium for dually eligible recipients with full Florida Medicaid, Qualified Medicare Beneficiaries (QMB), Supplemental Security Income (SSI), or Medically Needy with QMB.

(b) Medicare Part B Premium. Florida Medicaid will pay the Part B premium for dually eligible recipients with full Florida Medicaid, QMB, SSI, Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI1) benefits, or Medically Needy with QMB, SLMB, or QI1 benefits. Florida Medicaid does not reimburse expenditures that could have been paid for under Medicare Part B, but were not, because an individual was not enrolled in Part B in accordance with 42 CFR 431.625(d). This limit applies to all recipients who are eligible for enrollment under Part B, whether individually or through an agreement under section 1843(a) of the Social Security Act.

(c) Florida Medicaid does not pay for Medicare Part C premiums.

(d) Medicare Part D.

1. Florida Medicaid reimburses for drugs that are excluded by Medicare from Medicare Part D coverage for dually eligible recipients who are eligible to receive prescribed drug services in accordance with the Florida Medicaid prescribed drug services coverage policy.

2. Florida Medicaid does not pay for Medicare Part D premiums, or for any Medicare Part D copayments, coinsurance, or deductibles.

3. Florida Medicaid does not reimburse for drugs for dually eligible recipients who are eligible for Medicare Part D, but who are not enrolled.

(11) Florida Medicaid Claim Reimbursement for Dually Eligible Recipients.

(a) Florida Medicaid reimburses Medicare Parts A, B, and C, deductible(s), coinsurance, and copayments for dually eligible recipients in accordance with section 409.908, F.S., based on the lesser of the amount billed or the Florida Medicaid rate.

(b) Florida Medicaid reimbursement for dually eligible recipients is as follows:

Subtract the Medicare paid amount, plus any other third-party payment, from the Medicaid rate.

1. If the calculated amount in paragraph (b) is zero or a negative amount, no payment is made.

2. If the calculated amount in paragraph (b) is a positive amount (rate calculation), compare the rate calculation to the sum of the coinsurance or copayment and deductible amounts; and, pay the lesser of these two amounts, except as otherwise specified in section 409.908, F.S.

(c) For Medicare Part B services not covered by Florida Medicaid provided to dually eligible recipients with QMB benefits (with or without other Florida Medicaid benefits) or SSI recipients, the Florida Medicaid rate referenced in paragraph (11)(a), above, shall be 50% of the Medicare-allowed amount and paid in accordance with paragraphs (a) and (b) of this section.

(12) Inpatient Hospital Services for Dually Eligible Recipients.

(a) Dually eligible recipients with Medicare Part A or C benefits, age 21 years and older, simultaneously deplete both Medicare and Florida Medicaid covered hospital days.

(b) Once a dually eligible recipient has exhausted all Medicare Part A benefits, or if the recipient does not have Medicare Part A Coverage, the provider must:

1. Bill Medicare for Medicare-allowable Part B inpatient ancillary services.

2. Enter any available Medicare Part B reimbursement as TPL on the Florida Medicaid claim for inpatient services.

(13) Florida Medicaid Patient Responsibility for Dually Eligible Recipients. Florida Medicaid reimburses for services in accordance with section (11) above, minus any applicable service specific patient responsibility. Notwithstanding the requirements specified in rule 59G-4.200, F.A.C., if a recipient has QMB benefits and is also eligible for full Florida Medicaid benefits, or is receiving SSI, providers may not charge the patient responsibility during the Medicare coinsurance days (day 21 up to day 100) for nursing facility services.

(14) Payment for Part B Nursing Facility Services for Dually Eligible Recipients. Florida Medicaid reimburses, in accordance with the methodology specified in paragraph (11)(a), above, for Medicare approved Part B services that are not included in the nursing facility's cost report prepared pursuant to rule 59G-6.010, F.A.C.

(15) Timely Filing of Claims for Reimbursement Secondary to Medicare. Providers may submit claims to Florida Medicaid within 12 months from the date of service, or within 6 months after AHCA or the provider receives notice of the disposition of the Medicare claim, whichever is greater.

(16) Fee-For-Service Exceptional Claims Process.

(a) Providers may submit claims for a Florida Medicaid covered service when all of the following are met:

1. When the claim was denied by the Florida Medicaid fiscal agent.

2. Any third-party payer, or Medicare denied the claim (unless Medicare determined the service is not medically necessary).

(b) Providers must submit fee-for-service exceptional claims to the appropriate address listed on the AHCA Web site at http://ahca.myflorida.com/Medicaid/Operations/assistance/providers.shtml.

Rulemaking Authority 409.910, 409.919 FS. Law Implemented 409.910, 409.9101 FS. History–New 8-14-18.