14 Medicare and Other Insurance Liability

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COST SHARING/MEDICARE COVERAGE

Health Choice Arizona, as an AHCCCS contractor, has liability for payment of benefits after Medicare and all other third party payer benefits have been paid. Health Choice Arizona follows AHCCCS Medicare Cost Sharing policies. Health Choice Arizona is financially responsible for the cost sharing of AHCCCS covered services only, except in the case of QMB members (see below). Providers must determine the extent of the third party coverage and bill Medicare and all private insurance carriers prior to billing Health Choice Arizona.

The initial claim for services rendered must be received by Health Choice Arizona within six (6) months of the date of service regardless of the primary insurance coverage. The clean claim with the corresponding Explanation of Benefits from the primary carrier is still required within 12 months from the date of service.

Health Choice Arizona utilizes the coordination of benefits information gathered by AHCCCS and by other claims submissions to identify other payer coverage. If a claim is received and the primary insurance has not been billed, Health Choice Arizona will deny the claim unless it is a service which is commonly known to be non-covered by the primary payer.

If a provider has information that a recipient's primary coverage has changed, terminated or added, Health Choice Arizona has developed a process in which this information can be reported. Providers can call (800) 322-8670 and ask for the Member Services department or fax the request with any supporting documentation to (480) 760-4708.

"LESSER OF" PAYMENT RULE

Health Choice Arizona will reimburse the lesser of either the Health Choice Arizona contracted amount, AHCCCS Allowable amount or the primary insurer's allowed amount, less any payment amount by the primary insurer. If the primary insurance payment exceeds the Health Choice Arizona contracted rate or AHCCCS allowable amount, no additional reimbursement will be made by Health Choice Arizona. Health Choice Arizona will not pay for more than the recipient's financial responsibility for the service (e.g., any deductible, coinsurance, and/or co-pay).

The provider must contact the commercial insurance, Medicare HMO or Medicare Advantage plan for information regarding covered services and prior authorization as well as Health Choice Arizona prior authorization requirements must be followed.

Note: Services covered by AHCCCS that are not covered by Medicare, such as home health services or non-emergency transportation, may be reimbursed by Health Choice Arizona provided the services are medically necessary and all reimbursement requirements have been met.

There are some services covered by Medicare that can also be covered by Health Choice Arizona, if the member has QMB coverage. QMB – Qualified Medicare Beneficiary – coverage is denoted by a "2x" at the end of the member's rate code (example: 2220 is QMB, but 2210 is not). Health Choice Arizona will cover the Medicare co-pay and deductible for Medicare covered services, such as: chiropractic services, and inpatient and outpatient occupational therapy for adults.

Upon receipt of reimbursement or denial from Medicare and/or third party payer, providers must submit the Explanation of Benefits (EOB) from the primary insurer along with the claim form (UB04, CMS 1500 or ADA Dental Claim form or electronic equivalent) to Health Choice Arizona.

PAYMENT METHODOLOGY

Per Arizona Administrative Code R9-22-1003, Health Choice Arizona shall pay the **lesser** of the **difference** between 1) The Primary Insurance Paid amount and the Primary Insurance rate, i.e., the member's copayment required under the Primary Insurance OR 2) The Primary Insurance Paid amount and Health Choice Arizona's Contracted Rate or AHCCCS Fee for Service rate

The "lesser of" methodology applies unless Health Choice Arizona's contract with the provider requires a different payment scheme. Examples are provided below:

Scenario 1
AHCCCS FFS Rate $50
Health Choice Arizona Rate $55
Primary Insurance Rate $45
Primary Paid $30

Health Choice Arizona Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $45-$30 vs. $55 - $30)
Health Choice Arizona Payment to Non-Contracted Provider in this example	$15(this is calculated from the lesser of: $45-30 vs. $50-30)

Scenario 2
AHCCCS FFS Rate $50
Health Choice Arizona Rate $55
Primary Insurance Rate $60
Primary Paid $40

Health Choice Arizona Payment to Contracted Provider in this example	$15 (this is calculated from the lesser of: $60 - $40 vs. $55-$40)
Health Choice Arizona Payment to Non-Contracted Provider in this example	$10 (this is calculated from the lesser of: $60-$40 vs. $50-$40)

Scenario 3
AHCCCS FFS Rate $50
Health Choice Arizona Rate $55
Primary Insurance Rate $70
Primary Paid $60

Health Choice Arizona Payment to Contracted Provider in this example	$0 (this is calculated from the lesser of: $70 - $60 vs. $55-$60)
Health Choice Arizona Payment to Non-Contracted Provider in this example	$0 (this is calculated from the lesser of: $70-$60 vs. $50-$60)

MOTOR VEHICLE (MVA) OR WORK RELATED INJURIES

If a member requires services for an injury or condition resulting from circumstances involving a third party, (e.g., automobile accident or work related injuries) the provider must notify Health Choice Arizona's Recoveries/TPL department at (800) 322-8670. Providers are required to furnish the following information:

- ☐ Name of provider
- ☐ Address of provider
- ☐ Name of patient
- ☐ Patient's social security number or AHCCCS identification number
- ☐ Address of patient
- ☐ Date(s) of hospitalization and/or outpatient services
- ☐ Amount due for care of patient
- ☐ Date of accident
- ☐ County in which injuries were sustained
- ☐ Names, if known, of liable persons, firms, corporations, and insurance carriers claimed by the patient or patient's legal representative to be liable for damages.

Failure to meet the notice requirements may forfeit the provider's right to reimbursement.

Health Choice Arizona and AHCCCS third party liability administrators will coordinate and pursue collection from underinsured motorist insurance, third party liability insurance, and tortfeasors in cases of probable third party liability.

HEALTH CHOICE GENERATIONS MEDICARE HMO CROSSOVER CLAIMS

Health Choice Arizona will automatically crossover claims that were paid, as well as specific denials, as primary from Health Choice Generations, HMO where the member is also Health Choice Arizona eligible. There may be exceptions for example, if the HCA member is not enrolled at the time services were rendered or on FQHC claims where specific code requirements need to be met according to FQHC/AHCCCS billing rules.

NURSING FACILITY CLAIMS WITH MEDICARE/OTHER INSURANCE

Health Choice Arizona is responsible for reimbursement of Medicare deductible or coinsurance for nursing facility claims.

Nursing facilities should submit claims to Health Choice Arizona for Medicare covered claims for Health Choice Arizona recipients with the corresponding Explanation of Benefits (EOB) from the primary carrier.

When a recipient has exhausted the Medicare benefit for nursing facility coverage, the nursing facility must submit a claim to Health Choice Arizona.

If payment from Medicare or another third party payer is received later, the claim must be adjusted. A corrected claim should be submitted to Health Choice Arizona with the corrected EOB.

RECOUPMENTS DUE TO OTHER PAYER RESPONSIBILITY

Health Choice Arizona, through AHCCCS updates or other provider EOB submissions may learn of primary payer responsibility. A claim that has been submitted without prior submission to the primary insurance carrier and paid by Health Choice Arizona will be recouped from future payments. Claims that have been recouped can be resubmitted with the EOB showing the primary payer decision within twelve (12) months from the date of service. For claims past twelve (12) months, Health Choice Arizona will consider claims that were subsequently denied by the primary insurer based on the timely filing limits, or lack of prior authorization, and that the member failed to disclose additional coverage other than AHCCCS which caused the claim to be denied. In that case, the claim must be received at Health Choice Arizona within ninety (90) days from the date you become aware that payment will not be made by the primary insurer.

For claims that are beyond twelve (12) months from the date of service but still within the timelines described above, please send those to the Claims Disputes department at Health Choice Arizona for proper handling (see Chapter 15 of this manual).