CHAPTER 14:

Medicare and Other Insurance Liability

Reviewed/Revised: 10/1/18, 07/25/19, 1/1/20

14.0 FIRST AND THIRD PARTY/OTHER COVERAGE

Health Choice Arizona, as an AHCCCS contractor is the payor of last resort unless specifically prohibited by applicable state or federal law. This means Health Choice Arizona shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

Under state and federal law and R9-22-1003 (E), Health Choice Arizona must pay the full amount of the claim according to contract or the AHCCCS Capped Fee-For-Service schedule for non-contracted providers and then seek reimbursement from the First- or Third-Party payor (Post-Payment Recovery) when:

1. The claim is for prenatal care for pregnant women; or
2. Preventive pediatric services, including EPSDT services and administration of vaccines under the Vaccines For Children (VFC) Program; or
3. The liability is from an absent parent whose obligation to pay support is being enforced by Division of Child Support Enforcement; or

Per R9-22-1002, AHCCCS is not the payor of last resort (AHCCCS will be the primary payor) when the following entities are the third-party:

1. The payor is Indian Health Services contract health (IHS/638 tribal plan); or
2. Title IV-E; or
3. Arizona Early Intervention Program (AZEIP); or
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300; or
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 USC 300ff et. seq. payer.

For additional information please visit AHCCCS FFS Provider Billing Manual - Chapter 9:
https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

14.1 COST SHARING/MEDICARE COVERAGE

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 (**Q**ualified **M**edicare **B**eneficiary) 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 or AHCCCS eligibility posting, whichever is later 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 or AHCCCS eligibility posting, whichever is later.

Health Choice Arizona utilizes the coordination of benefits information gathered by AHCCCS and by other claims submissions to identify other payor 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 payor.

For QMB Duals and Non-QMB Duals, the Contractor's cost sharing payment responsibilities are dependent upon various factors:

- Whether the service is covered by Medicare only, by Medicaid only or by both Medicare and Medicaid,
- Whether the services are received in or out of network (the Contractor only has responsibility to make payments to AHCCCS registered providers),
- Whether the services are emergency services, and/or
- Whether the Contractor refers the member out of network

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. If it is discovered that a Title XIX/XXI member has third party coverage that is not reported on AHCCCS Online or other automated system, the provider must notify Health Choice Arizona immediately 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. A portal for third party liability lead data has been established for behavioral health providers.

For additional information and guidance please visit AHCCCS Contractors Operations Manual Chapter 434: https://azahcccs.gov/shared/ACOM/

14.2 "LESSER OF" PAYMENT RULE

For QMB Dual members/services, Health Choice Arizona will reimburse the member's cost share as reported by Medicare. For non-QMB Dual members/services, Health Choice Arizona will reimburse the lesser of the following:

1. The Health Choice Arizona Allowed amount (For Contracted providers this is the HCA contracted amount, for non-contracted providers this is the AHCCCS Allowable amount) less all payment amounts by other insurance (including Medicare sequestration when applicable).
2. The other insurance allowed amount (if multiple other insurances the lowest reported allowed amount will be used) less all payment amounts by other insurance (including Medicare sequestration when applicable).
3. The member's cost share as reported by the prior payor.

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 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.

QMB Duals are entitled to all Medicaid and Medicare Part A and B covered services. These members are identified by a Medicare Part C entry in their AHCCCS Medicare record and typically by a two in the third digit of the rate code. A QMB Dual eligible member who receives services under A.A.C.R9-22-2 or A.A.C. R9-28-2 from a registered provider is not liable for any Medicare copayment, coinsurance or deductible associated with those services and is not liable for any balance of billed charges. (A.A.C. R9-29-302)

Health Choice Arizona is responsible for payment of Medicare cost sharing (deductible, coinsurance, and copayment) amounts for all Medicare Part A and B covered services, including services not covered by AHCCCS, subject to the limits outlined in this Policy. See also AMPM Chapter 300, Section 310. These services include:

a. Chiropractic services for adults,
b. Outpatient occupational and speech therapy coverage for adults,
c. Orthotic devices for adults,
d. Cochlear implants for adults,
e. Services by a podiatrist, and
f. Any services covered by or added to the Medicare program not covered by Medicaid.

Health Choice Arizona has no cost sharing obligation if the Medicare payment exceeds the provider's contracted rate for the services. The Contractor's liability for cost sharing plus the amount of Medicare's payment shall not exceed Health Choice Arizona's contracted rate for the service. There is no cost sharing obligation if the Health Choice Arizona has a contract with the provider, and the provider's contracted rate includes Medicare cost sharing.

The exception to these limits on payments is that the Health Choice Arizona shall pay 100% of the member copayment amount for any Medicare Part A SNF days (21 through 100) even if Health Choice Arizona has a Medicaid Nursing Facility rate less than the amount paid by Medicare for a Part A SNF day.

QMB DUALS	
When The Service Is Covered By:	**Health Choice Shall Pay:** *(Subject to the limits outlined in this document)*
Medicare Only	Medicare copayments, coinsurance and deductible
Medicaid Only	The provider in accordance with the contract
By both Medicare and Medicaid	The lesser of: a. The Medicare copay, coinsurance or deductible, or b. The difference between Health Choice Arizona's contracted rate and the Medicare paid amount.

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID *(Subject to the limits outlines in this policy)*			
	EXAMPLE 1	**EXAMPLE 2**	**EXAMPLE 3**
Provider charges	125.00	125.00	125.00
Medicare rate for service	100.00	100.00	100.00
Medicaid rate for Medicare service (Contractor's contracted rate)	100.00	90.00	90.00
Medicare deductible	-	-	40.00
Medicare paid amount (80% of Medicare rate less deductible)	80.00	80.00	40.00
Medicare coinsurance (20% of Medicare rate)	20.00	2.00	20.00
HEALTH CHOICE ARIZONA PAYS	**$20.00**	**$10.00**	**$50.00**

NON-QMB DUALS	
When The Service Is Covered By:	**Health Choice Shall <u>NOT</u> Pay:**
Medicare Only	Medicare copayments, coinsurance and deductible
When The Service Is Covered By:	**Health Choice Shall Pay:** *(Subject to the limits outlined in this document)*
Medicaid Only	The provider in accordance with the contract

By both Medicare and Medicaid	The lesser of the following (unless the subcontract with the provider sets forth different terms): a. The Medicare copay, coinsurance or deductible, or b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (Contractor's contracted rate).
NON-QMB DUALS (OUT OF NETWORK)	
When The Service Is Covered By:	**Health Choice Shall Pay:** *(Subject to the limits outlined in this document)*
Medicaid Only	Has no responsibility for payment.
Medicaid only and the Contractor **has not** referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.
Medicaid only and the Contractor has referred the member to the provider or has authorized the provider to render services or the services are emergent	The lesser of the following (unless the subcontract with the provider sets forth different terms): a. The Medicare copay, coinsurance or deductible, or b. Any amount remaining after the Medicare paid amount is deducted from the subcontracted rate (Contractor's contracted rate).
By both Medicare and Medicaid and the Contractor has not referred the member to the provider or has not authorized the provider to render services and the services are not emergent	Has no responsibility for payment.

Upon receipt of reimbursement or denial from Medicare and/or third party payor, 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.

For additional information and guidance please visit AHCCCS Contractors Operations Manual Chapter 201: https://azahcccs.gov/shared/ACOM/

AHCCCS FFS Provider Billing Manual Chapter 9:
https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

14.3 PAYMENT METHODOLOGY

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

SERVICES ARE COVERED BY BOTH MEDICARE AND MEDICAID *(Subject to the limits outlines in this document)*			
	SCENARIO 1	**SCENARIO 2**	**SCENARIO 3**
AHCCCS FFS RATE	$50.00	$50.00	$50.00
HEALTH CHOICE ARIZONA RATE	$55.00	**$55.00**	$55.00
PRIMARY INSURANCE RATE	**$45.00**	$60.00	$70.00
PRIMARY PAID	$30.00	$40.00	**$60.00**
HEALTH CHOICE ARIZONA PAYS - CONTRACTED PROVIDER	$15.00 (Calculated using the lesser of the primary insurance rate and Health Choice Arizona rate)	$15.00 (Calculated using the lesser of the Health Choice Arizona rate and the primary paid amounts)	$0.00 (Calculated using the lesser of the primary paid amount and the Health Choice Arizona rate)
HEALTH CHOICE ARIZONA PAYS - NON-CONTRACTED PROVIDER	$15.00 (Calculated using the lesser of the primary insurance rate and Health Choice Arizona rate)	$15.00 (Calculated using the lesser of the Health Choice Arizona rate and the primary paid amounts)	$0.00 (Calculated using the lesser of the primary paid amount and the Health Choice Arizona rate)

For additional information and guidance please visit AHCCCS Contractors Operations Manual Chapter 201: https://azahcccs.gov/shared/ACOM/

14.4 COST AVOIDANCE

Cost avoidance is to deny a claim and return the claim to the provider for a determination for the amount of third-party liability. AHCCCS is the payor of last resort unless specifically prohibited by applicable state or federal law.

This means AHCCCS shall be used as a source of payment for covered services only after all other sources of payment have been exhausted.

Health Choice shall take reasonable measures to identify potentially legally liable third-party sources. Health Choice Arizona is responsible for making third party payer information available through our verification systems for use.
Third party payor information may also be obtained through AHCCCS Administration Verification Systems.

AHCCCS is not the payor of last resort when the following entities are the third party:

1. Indian Health Services
2. Title IV-E
3. Arizona Early Intervention Program (AzEIP)
4. Local educational agencies providing services under the Individuals with Disabilities Education Act under 34 CFR Part 300
5. Entities and contractors of entities providing services under grants awarded as part of the HIV Health Care Services Program under 42 U.S.C. 300ff et seq
6. The Arizona Refugee Resettlement Program operated under 45 CFR Part 400, Subpart G
7. Substance Abuse Block Grant (SABG)
8. Mental Health Services Block Grant (MHBG), and any other awarded grants

The two methods used for Coordination of Benefits are Cost Avoidance and Post-Payment Recovery.

Health Choice Arizona shall cost avoid a claim if it has established the probable existence of a liable party at the time the claim is filed. However, there are limited circumstances when cost avoidance is prohibited and Health Choice Arizona must apply post-payment recovery processes as described in Section: *Post-Payment Recovery – Pay and Chase* below.

NOTE: Claims for inpatient stay for labor, delivery and postpartum care including professional fees when there is no global OB package must be cost avoided.

For purposes of cost avoidance, establishing liability takes place when Health Choice Arizona receives confirmation that another party is, by statute, contract, or agreement, legally responsible for the payment of a claim for a healthcare item or service delivered to a member.
If the probable existence of a third party's liability cannot be established or if Post-Payment Recovery is required, Health Choice Arizona must adjudicate the claim and then utilize Post-Payment Recovery processes that include: *Pay and Chase*, *Retroactive Recoveries Involving Commercial Insurance Payor Sources*, and *Other Third-Party Liability Recoveries*.

Pay and Chase – Health Choice Arizona shall pay the full amount of the claim according to the AHCCCS Capped-FFS Schedule or the contracted rate **and then** seek reimbursement from any third party if the claim is for the following:

- Prenatal care for pregnant women, including services which are part of a global OB Package,

- Preventive pediatric services, including Early and Periodic Screening Diagnosis and Treatment (EPSDT) and administration of vaccines to children under the Vaccines for Children (VFC) program, or
- Services covered by TPL that are derived from an absent parent whose obligation to pay support is being enforced by the Division of Child Support Enforcement.

Health Choice Arizona has two years from the date of service to recover payments for a particular claim, or to identify (tag) claims having a reasonable expectation of recovery using a process to be developed by AHCCCS. A reasonable expectation of recovery is established when Health Choice Arizona has affirmatively identified a commercial insurance payor source and has begun the process of recovering payment prior to the end of the Contractor's two-year recovery period.

For additional information and guidance please visit AHCCCS Contractors Operations Manual Chapter 434: https://azahcccs.gov/shared/ACOM/

14.5 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, Restitution Recovery, first and third party liability insurance, worker's compensation, tortfeasors including casualty, estate recovery and Special Treatment Trusts in cases of probable third party liability.

For additional information please visit AHCCCS FFS Provider Billing Manual Chapter 9: https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

14.6 HEALTH CHOICE ARIZONA 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 Arizona Generations where the member is also Health Choice Arizona eligible. There may be exceptions for example, if the Health Choice Arizona member is not enrolled at the time services were rendered or on FQHC/RHC/MSIC claims where specific code requirements need to be met according to AHCCCS billing rules.

14.7 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 payor is received later, the claim must be adjusted. A corrected claim should be submitted to Health Choice Arizona with the corrected EOB.

For additional information please visit AHCCCS FFS Provider Billing Manual Chapter 9:
https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html

14.8 RECOUPMENTS DUE TO OTHER PAYOR RESPONSIBILITY

Health Choice Arizona, through AHCCCS updates or other provider EOB submissions may learn of primary payor 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 payor 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).

14.9 MEDICARE PART D PRESCRIPTION DRUG COVERAGE

All persons eligible for Medicare Part A or enrolled in Medicare Part B are eligible for Medicare Part D Prescription Drug coverage. Dual eligible persons (eligible for Medicaid and Medicare) no longer receive prescription drug coverage through Medicaid.
To access Medicare Part D coverage, persons must enroll in either a Prescription Drug Plan (PDP – fee-for-service Medicare) or a Medicare Advantage-Prescription Drug Plan (MA-PD – managed care Medicare).

Cost sharing and coordination of benefits for persons enrolled in Medicare Part D:

- Title XIX/XXI funds are not available to pay any cost sharing of Medicare Part D.
- Health Choice Arizona will utilize available Non-Title XIX/XXI funds to cover Medicare Part D co-payments for Title XIX/XXI and Non-Title XIX/XXI persons determined to have SMI, with the following limitations:
    - Co-payments are to be covered for medications on the AHCCCS Behavioral Health Drug List.
    - Co-payments are to be covered for medications prescribed by Health Choice Arizona in-network behavioral health/integrated care providers.
- Health Choice Arizona may utilize Non-Title XIX/XXI funds for coverage of medications during the Medicare Part D coverage gap.
- If a request for an exception has been submitted and denied by the Medicare Part D plan, Health Choice Arizona may utilize Non-Title XIX/XXI funds to cover the cost of the non-covered Part D medication for persons determined SMI, regardless of Title XIX/XXI eligibility.
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Persons with limited income and resources may be eligible for the Low Income Subsidy (LIS) or "extra help" program (see the Social Security Administration for income and resource requirements). With this "extra help", all or a portion of the persons' cost sharing requirements are paid for by the federal government. Dual eligible and behavioral health recipients on a Medicare Savings Program through AHCCCS (QMB, SLMB, or QI-1) are automatically eligible for the LIS program. Other persons have to apply for the LIS program.
For more information on LIS see Chapter 2 Member Eligibility and Member Services.

For additional coverage information regarding Medicare Part D Prescription Drug Coverage, please reference the Health Choice Arizona Generations Provider Manual for dual eligible members.

For additional information please visit AHCCCS FFS Provider Billing Manual Chapter 9:
https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/providermanual.html