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HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Administration Manual and Hospital Services Manual

Third-Party Liability (TPL); Reimbursement for Third-Party Claims; Medicare/Medicaid or Medicare/NJ FamilyCare Claims

Proposed Amendments: N.J.A.C. 10:49-7.3 and 10:52-4.7

Proposed Repeal and New Rule: N.J.A.C. 10:52-4.6

Authorized By: Jennifer Velez, Commissioner, Department of Human Services.

Authority: N.J.S.A. 30:4D-1 et seq. and 30:4J-8 et seq. and P.L. 2011, c. 85.

Calendar Reference: See Summary below for explanation of exception to calendar requirement.

Agency Control Number: 11-P-10.

Proposal Number: PRN 2013-013.

Submit comments by March 25, 2013 to:

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The agency proposal follows:

Summary

The Department proposes to amend N.J.A.C. 10:49-7.3 and 10:52- 4.7 and repeal and replace N.J.A.C. 10:52-4.6 in order to conform to provisions contained in the State Fiscal Year (SFY) 2012 Appropriations Act, P.L. 2011, c. 85 (Act), as well as provisions contained in N.J.S.A. 30:4D-3.m, and also to make other revisions related to the coordination of reimbursement when third-party payers are involved.

The Act requires that the Division of Medical Assistance and Health Services ("DMAHS" or "Division") exclude Medicare Part A crossover payments from inpatient hospital reimbursement for Medicaid beneficiaries who are also eligible for Medicare (dual eligibles), effective January 1, 2005.

An amendment is proposed that would clarify existing N.J.A.C. 10:49-7.3(a), regarding determinations of third-party liability. N.J.S.A. 30:4D-3.m, N.J.A.C. 10:49-7.3, and 42 U.S.C. § 1396a(a)25, all contain broad provisions regarding who and/or what is considered a third-party that may be liable for payment on claims otherwise covered by Medicaid and each of these provisions includes specific mention of various examples of such third parties. Such third parties are all currently covered under the very broadly usage of third-party liability that is contained in N.J.A.C. 10:49-7.3, but not all are also currently specifically named in that section. Therefore, an amendment is proposed that specifically mentions some additional examples of such currently covered third parties for purposes of clarification only. Such a clarification would not add to, or change, the Department's existing authority under N.J.S.A. 30:4D-3.m or N.J.A.C. 10:49-7.3(a).

The proposed amendments also contain numerous other grammatical, technical, citation, and other changes. The specific amendments, repeal, and new rule are described below.

As discussed above, at N.J.A.C. 10:49-7.3(a), the Department proposes an amendment to the explanatory language of third-party liability, in order to clarify existing responsibilities and requirements pursuant to both N.J.A.C. 10:49-7.3(a) and N.J.S.A. 30:4D-3.m. Additional examples of third parties would be specifically mentioned, in order to clarify already existing, exhaustive language, which is intended to broadly include all third parties that are liable in any manner for payment of any part of the cost of medical assistance payable by the Medicaid or NJ FamilyCare program. This clarification would not add to, or change, the Department's existing authority or rights under N.J.A.C. 10:49 or under N.J.S.A. 30:4D-3.m.

At N.J.A.C. 10:49-7.3(b), an amendment is proposed to state that, at the time the provider's claim is filed, either the existence of third-party liability cannot be established or third-party benefits are not available to pay the beneficiary's medical expenses, then the Division will pay the full amount allowed under its payment schedule and seek post-payment recovery in accordance with 42 CFR 433.139(c), (d)(2), and (d)(3).

At N.J.A.C. 10:49-7.3(c), minor grammatical revisions are proposed. At N.J.A.C. 10:49-7.3(c)1, references to Medicare Part A inpatient hospital services would be deleted.

N.J.A.C. 10:49-7.3(c)2 is proposed for amendment to: remove the tagline; make minor grammatical changes; change the word "practitioner" to "provider" because the provision applies to both entities and individuals; and clarify the existing provisions that prohibit Medicaid or NJ FamilyCare payment to a provider when the provider is required by a third-party payer to accept a payment as payment in full.

Proposed new N.J.A.C. 10:49-7.3(c)3 would provide that, when Medicaid or NJ FamilyCare is not the primary payer on a claim, payment will be made at the lesser of: the Medicaid or NJ FamilyCare allowed amount minus any other payments or the patient liability, including: denied charges, deductible, co-insurance, copayment, and non-covered charges.

Proposed new N.J.A.C. 10:49-7.3(c)4 would provide that the State will perform reviews of claims regarding beneficiaries for whom any third-party liability exists. Based on the reviews, the Division will determine whether paying the patient's liability for the service will result in a lower cost to the Division. If paying the patient's liability results in a lower cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

At N.J.A.C. 10:49-7.3(h) and (h)1 and 2, amendments are proposed that would delete existing language regarding TPL being exhausted before a claim is submitted for Medicaid or NJ FamilyCare payment and instead provide that payment will be made by the Division in accordance with the requirements of 42 CFR 433.139(b)(3)(i) and (ii) if either the TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency, or the claim is for prenatal care for a pregnant woman or for preventive pediatric services (including Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services) that are covered by the program. The amendments are being proposed in order to ensure conformity with the cited Federal regulation.

New N.J.A.C. 10:49-7.3(i) contains language deleted from subsection (h) that TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ FamilyCare payment. Existing paragraphs (h)3, 4, and 5 are proposed for recodification as paragraphs (i)1, 2, and 3, and paragraph (i)1 is proposed for amendment to include that if the

claim is for labor, delivery, and post-partum care, then the costs associated with the inpatient hospital stay for labor, delivery, and post-partum care must be cost-avoided in accordance with 42 CFR 433.139(b)(2). The amendments are being proposed in order to ensure conformity with the cited Federal regulations.

Recodified N.J.A.C. 10:49-7.3(j) is proposed with amendments to make minor clarification and grammatical changes and provide that in those situations where a Medicare or health insurance payment, rather than just a health insurance payment, is received after Medicaid or NJ FamilyCare has been billed and has made payment, the provider shall reimburse the Medicaid or NJ FamilyCare payment to the Division and not to the Medicaid or NJ FamilyCare beneficiary. If the provider actually receives, rather than is merely apprised or on notice that, a duplicate or excessive payment as a result of the provider's receipt of a Medicare or health insurance payment, the provider shall have 60 days to refund such overpayments to the Division. To initiate the process, providers shall submit an MMIS Claim Adjustment Request Form.

N.J.A.C. 10:52-4.6 is proposed for repeal and replacement. The new rule states that for beneficiaries for whom any third-party liability exists, claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of N.J.A.C. 10:52. The new rule further states that for beneficiaries eligible for both NJ Medicare and Medicaid (dual eligibles), claims covered under N.J.A.C. 10:52-4.7 shall be reimbursed in accordance with the provisions of that section.

N.J.A.C. 10:52-4.7(b), regarding deductible and coinsurance reimbursement, is proposed for deletion and replacement. The new subsection requires that Medicare/Medicaid and Medicare/NJ FamilyCare third-party claims for hospital services that are not the responsibility of

a Medicaid or NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of N.J.A.C.10:52.

New N.J.A.C. 10:52-4.7(c) would provide that, when Medicaid or NJ FamilyCare is not the primary payer on an inpatient hospital claim, the Medicaid or NJ FamilyCare payment will be made at the lesser of: the Medicaid or NJ FamilyCare allowed amount minus any other payments; or the patient liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

New N.J.A.C. 10:52-4.7(d) would provide that the State will perform post-payment review of inpatient hospital claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits exhaust during the inpatient hospital stay. If the review shows that paying the patient's liability would result in a lower cost to the Division, the provider will be notified by the Division and the excess provider payments would be recouped by the Division.

Existing N.J.A.C. 10:52-4.7(c) is proposed for recodification as paragraph (d)1 and proposed for amendment, that would specify the billing procedure to be used when Medicare Part A benefits have been exhausted, prior to billing Medicaid or NJ FamilyCare, specifically, removing the requirement that the Medicaid or NJ FamilyCare Eligibility Identification Number, including the Person Number be shown on the hospital claim form. The amendments would add that the provider itemize Medicare Part A non-covered services in order to determine the liability of Medicare Part B and other third-party payers.

The Department has determined that the comment period for this notice of proposal will be at least 60 days; therefore, pursuant to N.J.A.C. 1:30-3.3(a)5, this notice is excepted from the rulemaking calendar requirement.

Social Impact

The proposed amendments, repeal, and new rule should not have any social impact on beneficiaries. The social impact of the amendments, repeal, and new rule on providers cannot be precisely determined due to the variety of third-party liability contracts that hospitals and other types of providers have with payers. In general, however, it is expected that the amendments, repeal, and new rule will not cause a significant net reduction in overall reimbursement to any provider that would result in any social impact.

Economic Impact

The proposed amendments, repeal, and new rule should not have any economic impact on beneficiaries. The economic impact of the amendments, repeal, and new rule on providers cannot be precisely quantified due to the variety of third-party liability contracts that hospitals and other types of providers have with payers. However, it is expected that the amendments, repeal, and new rule will not cause a significant net reduction in overall reimbursement from all responsible parties. The Department has estimated there may be an annual State savings on expenditures for hospital services as a result of the rulemaking, based on the Department recouping payments that are duplicative of third-party payments.

Federal Standards Statement

Sections 1905(a)(1) and (2) of the Social Security Act, 42 U.S.C. § 1396d(a)(1) and (2), provide for Medicaid inpatient and outpatient hospital services. Sections 2110(a)(1) and (2) of

the Social Security Act, 42 U.S.C. §§ 1397jj(a)(1) and (2), provide for inpatient and outpatient hospital services for state children's health insurance programs.

Section 1902(a)(25) of the Social Security Act, 42 U.S.C. § 1396a(a)25, contains an exhaustive description of requirements relating to liability of third parties, with numerous examples of those third parties specifically mentioned.

Section 607(1) of the Employee Retirement and Income Security Act of 1974, at 29 U.S.C. § 1167(1), contains a definition of group health plan.

Federal regulations at 42 CFR 440.10 provide a definition of inpatient hospital services. Outpatient hospital services are defined at 42 CFR 440.20. Federal regulations at 42 CFR 433.139 address payment of a claim by a state Medicaid program in instances potentially involving third-party liability.

The Department has reviewed the Federal statutory and regulatory requirements and has determined that the proposed amendments, repeal, and new rule comply with, and do not exceed, the applicable Federal standards. Therefore, a Federal standards analysis is not required.

Jobs Impact

The Department does not anticipate that the proposed amendments, repeal, and new rule will result in the creation or loss of jobs in the State of New Jersey.

Agriculture Industry Impact

No impact on the agriculture industry in the State of New Jersey is expected to occur as a result of this rulemaking.

Regulatory Flexibility Statement

The amendments to N.J.A.C. 10:49-7.3 could apply to small businesses, as the term is defined at N.J.S.A. 52:14B-17 of the Regulatory Flexibility Act (RFA). The amendments, repeal, and new rule at N.J.A.C. 10:52 apply to providers of hospital services, which are not small businesses, as the term is defined in the RFA.

A regulatory flexibility analysis regarding the amendments to N.J.A.C. 10:49-7.3 is not necessary because those amendments do not impose any reporting, recordkeeping, or other compliance requirements on small businesses. Therefore, a regulatory flexibility analysis is not required.

Housing Affordability Impact Analysis

The proposed amendments, repeal, and new rule relate to third-party liability and reimbursement under the State's Medicaid/NJ FamilyCare program; therefore, the Department believes that the rulemaking will have no impact on affordable housing in New Jersey and there is no likelihood that the rules would evoke a change in the average costs associated with housing.

Smart Growth Development Impact Analysis

The proposed amendments, repeal, and new rule relate to third-party liability and reimbursement under the State's Medicaid/NJ FamilyCare program; therefore, the Department believes that the rulemaking will have no impact on smart growth and there is no likelihood that the rules would evoke a change in housing production in Planning Areas 1 or 2, or within designated centers, under the State Development and Redevelopment Plan in New Jersey.

Full text of the proposal follows (additions indicated in boldface **thus**; deletions indicated in brackets [thus]):

CHAPTER 49

ADMINISTRATION MANUAL

SUBCHAPTER 7. SUBMITTING CLAIMS FOR PAYMENT (POLICIES AND REGULATIONS)

10:49-7.3 [Third party] **Third-party** liability (TPL) benefits

(a) ["Third party] **Third-party** liability["] (TPL) exists when any person, institution, corporation, insurance company, **health insurer, self-insured plan, group health plan as defined in section 607(1) of the Federal Employee Retirement and Income Security Act of 1974, 29 U.S.C. § 1167(1), service benefit plan, managed care organization or other prepaid health plan, pharmacy benefits manager, third-party administrator as defined in N.J.S.A. 17B:27B-1,** absent parent, Medicare program, **or any other** public, private, or governmental entity **or party** is or may be liable in contract, **agreement,** tort, or otherwise by law or equity to pay all or part of the cost of medical assistance payable by the Medicaid or NJ FamilyCare program.

1. (No change.)

(b) Medicaid and NJ FamilyCare benefits are last-payment benefits. All TPL, for example, health insurance, Medicare, CHAMPUS, prepaid health plans, workers' compensation**,** and auto insurance, shall, if available, be used first and to the fullest extent in meeting the cost of the medical needs of the Medicaid or NJ FamilyCare beneficiary, subject to the exceptions listed in (h) below. **If, at the time the provider's claim is filed, either the existence of third-party liability cannot be established or third-party benefits are not available to pay the**

beneficiary's medical expenses at the time the provider's claim is filed, then the Division will pay the full amount allowed under its payment schedule and seek post-payment recovery in accordance with 42 CFR 433.139(c), (d)(2), and (d)(3) .

(c) The New Jersey [Medicaid program and the NJ] **Medicaid/NJ** FamilyCare program will supplement the amount paid by a third party, but the combined total paid to the provider shall not exceed the total amount payable under the program in the absence of any TPL[. The following exceptions should be noted:]**, except as provided below:**

1. Medicare: The program will make payment in the full amount of the [Medicare Part A] deductible and co-insurance for [inpatient hospital services, and for] Part B outpatient hospital services. For services rendered on or after July 20, 1998, payment for Part B coinsurance and deductible for other non-hospital services shall be paid only up to the Medicaid or NJ FamilyCare maximum allowable.

2. [Contracting practitioners:] No program payments shall be made when the [third party calls for] **third-party payer requires** a contracting or participating [practitioner] **provider** to accept [the TPL] **that third-party payer's payment** as payment in full.

3. When Medicaid/NJ FamilyCare is not the primary payer on a claim, payment by Medicaid/NJ FamilyCare will be made at the lesser of:

i. The Medicaid/NJ FamilyCare allowed amount minus any other payment(s); or

ii. The patient liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

4. The State will perform reviews of claims regarding beneficiaries for whom any third-party liability exists. Based on the reviews, the Division will determine whether

paying the patient's liability for the service will result in a lower cost to the Division. If paying the patient's liability results in a lower cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

(d) – (g) (No change.)

(h) [TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ FamilyCare payment in any] **Payment will be made by the Division in accordance with the requirements of 42 CFR 433.139(b)(3)(i) and (ii) in either** of the following circumstances:

1. The TPL benefits are derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency; **or**

2. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (include **Early Periodic Screening, Diagnosis, and Treatment (**EPSDT**)** services) that are covered by the program[;]**.**

(i) TPL may be exhausted, but is not required to be, before a claim is submitted for Medicaid or NJ FamilyCare payment in any of the following circumstances:

[3.] **1**. The claim is for labor, delivery, and post-partum care [and does not involve hospital]**; however,** costs associated with the inpatient hospital stay **for labor, delivery, and post-partum care must be cost-avoided in accordance with 42 CFR 433.139(b)(2)**;

[4.] **2.** The claim involves a service for which CMS has granted a waiver of the TPL cost avoidance requirements in accordance with 42 [C.F.R.] **CFR** 433.139(e). Waivers have been granted for services covered by Medicare Part B which are rendered at State and county governmental psychiatric hospitals, State and private ICFs/MR, and Vineland Special Hospital; or

[5.] **3.** (No change in text.)

[(i)] **(j)** In those situations [where a] **in which a Medicare or** health insurance payment is received after Medicaid or NJ FamilyCare has been billed and has made payment, the provider [must] **shall** reimburse the Medicaid or NJ FamilyCare payment to the [Medicaid or NJ FamilyCare program] **Division** and not to the Medicaid or NJ FamilyCare beneficiary. Reimbursement [must] **shall** be made immediately to comply with Federal regulations. [In the event a] **If the** provider [is apprised or otherwise is on notice that] **receives** a duplicate or excessive payment [has been made by the Division] as a result of the provider's receipt of a Medicare or health insurance payment, the provider shall have 60 days to refund such overpayments to the Division. To initiate the process, providers [must] **shall** submit an MMIS Claim Adjustment Request Form. (See Fiscal Agent Billing Supplement following the second chapter of each Provider Services Manual).

1. - 2. (No change.)

Recodify existing 10:49-7.3 (j) through (k) as **(k) through (l)** (No change in text.)

CHAPTER 52

HOSPITAL SERVICES MANUAL

SUBCHAPTER 4. BASIS FOR PAYMENT FOR HOSPITAL SERVICES

[10:52-4.6 Reimbursement for third-party claims

On claims for hospital services rendered to Medicaid or NJ FamilyCare beneficiaries for services provided that are not the responsibility of an HMO and who are also covered by another form of health insurance, the Division shall pay the difference between the insurer's payment amount and that of Medicaid/NJ FamilyCare for covered services. (See N.J.A.C. 10:49-7.3.)]

10:52-4.6 Reimbursement for claims for which there is third-party liability

(a) For beneficiaries for whom any third-party liability exists, claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of this chapter.

(b) For beneficiaries eligible for Medicare and Medicaid (dual eligibles), claims covered under N.J.A.C. 10:52-4.7 shall be reimbursed in accordance with the provisions of that section.

10:52-4.7 Medicare/Medicaid or Medicare/NJ FamilyCare claims

(a) (No change.)

[(b) Reimbursement of the deductible and coinsurance for inpatient and out-patient services for Medicaid or NJ FamilyCare beneficiaries having both Medicare and Medicaid coverage shall be limited to the unsatisfied deductible and coinsurance.]

(b) Medicare/Medicaid and Medicare/NJ FamilyCare third-party claims for hospital services provided that are not the responsibility of a Medicaid/NJ FamilyCare managed care organization shall be reimbursed in accordance with N.J.A.C. 10:49-7.3 and the provisions of this chapter.

(c) When Medicaid or NJ FamilyCare is not the primary payer on an inpatient hospital claim, payment by Medicaid or NJ FamilyCare will be made at the lesser of:

1. The Medicaid or NJ FamilyCare allowed amount minus any other payment(s); or

2. The patient liability, including denied charges, deductible, co-insurance, copayment, and non-covered charges.

(d) The State will perform a post-payment review of inpatient hospital claims for beneficiaries eligible for both Medicare and Medicaid (dual eligibles) when Part A benefits exhaust during the inpatient hospital stay. Based on the post-payment review, the Division will determine whether paying the patient's liability for the stay will result in a lower cost to the Division. If paying the patient's liability results in a lower cost to the Division, the provider will be notified and the excess provider payments will be recouped by the Division.

[(c)] **1.** Where benefits have been exhausted under Medicare **Part A**, the charges to be billed to the Medicaid/NJ FamilyCare Program must be itemized for the Medicare **Part A** non-covered services [and the Medicaid or NJ FamilyCare Eligibility Identification Number, including Person Number, must be shown on the hospital claim form] **in order to determine the liability of Medicare Part B and other third-party payers**.

[(d)] **(e)** (No change in text.)