STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: WISCONSIN

Requirements for Third Party Liability
Payment of Claims

Guidelines Used to Determine When to Seek Reimbursement From a Liable Third Party

The following criteria are used in selecting claims which will be billed to third party insurers, or will be investigated for further collection action:

Health Insurance

Per the provisions in the Consolidated Appropriations Act of 2022 (CAA), the State of Wisconsin has applicable State Law to ensure third party liability. The applicable Statute is Wis. Stat. § 49.475(2)(ac), which states a third part cannot deny the Department's claim for payment solely because of failure by a recipient to present proper documentation at the time of delivery of the service, benefit, or item that is the basis of the claim.

Accumulation thresholds are discontinued.

Through analysis of payment statistics and the denial notices sent to us by insurance carriers, certain items and services have been eliminated from post payment billing. These include, but are not limited to, hearing aid batteries and services supplied by case management providers.

When it is discovered that private insurance benefits have been paid to the provider or the insured in duplication of the Medical Assistance payment to the provider.

a) Recovery of amounts that are greater than $25 is sought from the provider.

b) Amounts of less than $25 are purged, unless staff time permits recovery.

Personal Injury Liability Thresholds

- For purposes of investigating trauma involved claims, hospital bills paid in amounts exceeding $350 are investigated for liable third party involvement.

- If referral information on identification of a billing request is received from a provider source (indicating potential liability action) action for recovery is triggered if the paid amount exceeds $350.

- Trauma claims with paid amounts of less than $350 may be investigated, if staff time permits such action.

- Claims against liable parties having no insurance are not pursued.

REQUIREMENTS FOR THIRD PARTY LIABILITY

PAYMENT OF CLAIMS

Third party billing conditions:

1. Monitoring provider compliance:

433.139(b)(3)(ii)(C): Claims are processed in a totally automated environment, according to claim code grids in the claims processing system. This grid describes avoidance criteria in terms of claim content and provider supplied insurance explanation codes on claims that describe any condition making insurance benefits unavailable. Providers may disable avoidance editing using the insurance explanation codes if prior insurance billing is required, but benefits cannot be obtained.

When a provider has received no response within 45 days of having billed an insurer, a follow-up inquiry must be directed to the insurer. If no response is received after a further 30 days, the provider may bill Medical Assistance using an appropriate insurance explanation code. These claims will be rebilled to the insurer.

Providers are monitored for compliance with insurance billing requirements through post payment recovery billing when the insurer is not an HMO. Claims of types which might be covered by insurance that bear explanation codes other than D (billed to and denied by the insurer) or P (billed to and paid in part by insurance) are rebilled to insurers for recovery. If a report of prior payment to either the provider or the insured person is received, the amount paid by the insurer is recouped from the provider.

If the insurer is an HMO, providers may only obtain payment under the plan by using explanation code H (the provider is eligible for payment by the HMO, but the service in question is either not covered by the HMO, benefit limits are exhausted or the billed amount is less than the HMO's deductible amount) or P (billed to and paid in part by the HMO). Claims bearing explanation code H are manually reviewed on a sampling basis. If an HMO verifies that the service is, in fact, covered when rendered by a member provider, the payment made under the plan is recouped.

If the insurance provided by a non-custodial parent is an HMO, and dependents reside outside the HMO service area, the dependents are treated as uninsured. This kind of insurance information is either not added to the dependent's eligibility record on MMIS or it is removed when the situation is identified. This assures that access to medical care is not precluded or diminished by provider concerns about payment when a non-custodial parent is uncooperative in claiming insurance benefits.

2. Threshold amounts for seeking recovery:

433.139(f)(2):

- Health insurance recovery action on claim types likely to be covered by insurance occurs when:
  - The payment made under the plan is greater than zero for non-HMO plans.
  - For HMOs, the provider billed amount is greater than $10.00.
- Personal injury investigative action occurs when hospital bills with trauma diagnoses having billed amounts equal to or greater than $350 are investigated.

  Investigative resources are scarce and valuable. Resources which would be required to pursue smaller bills can be used more productively to carry out tasks that yield much higher rates of return. (Further, the proportion of injury-involved bills of any size that involve a third party is small. The smaller the bill, the less likely it is that a third party is involved, according to the state's observations.)

- Personal injury recovery action: Payment made under the plan is greater than zero. Cases having recoverable amounts of less than the investigative threshold are sometimes identified by means of provider referrals or attorney or insurance carrier contacts. Although costs of collection may be relatively great as compared to any potential recovery, when a provider reports sending a small bill to an attorney it cannot be determined immediately whether the bill reported by the provider was the only one involved or if it was one of several or many. As a precaution, the attorney or adjustor must be put on notice immediately. Whatever the recoverable amount may later prove to be, recovery is sought because most of the work has already been completed and the costs of obtaining it have been incurred by that time. If billing is requested by an attorney or an adjustor in a small claim, as a matter of public policy it should not be ignored even though it is not cost effective to comply with the request.

3. Accumulation thresholds:

Accumulation thresholds are discontinued.

4. Provider-Based Billing

Provider-based Billing occurs when Medicare Part A and B, and commercial health insurance coverage is discovered after Medicaid has paid provider claims. It is used with claims where additional documentation from the provider, such as a plan of care, is necessary for Medicare or health insurance payment. Under provider-based billing, Medicaid produces claims that are sent to the providers of service with instructions to bill Medicare or the health insurance carrier. If payment is received from Medicare or the insurance carrier, providers need to adjust their original Medicaid claim. If an adjustment is not received, or if the provider does not forward a copy of the Medicare or insurance denial, Medicaid will recoup its payment 120 days from the date of the provider-based billing.

(Effective 2/1/96)