

Medicare and Other Insurance

Revised: [May 13, 2022](#)

[Medicare](#) is administered by the Centers for Medicare & Medicaid Services (CMS) and is the federal health insurance program for people 65 years old and older and certain people with disabilities.

Other insurance, or third party liability (TPL), refers to health, long term care or dental insurance coverage an MHCP member may have through private or public funds.

MHCP considers Medicare and TPL primary to MHCP coverage. Verify eligibility through MN-ITS to ensure MHCP and Medicare or other insurance coverage. Providers must bill and receive payment from primary coverage to the fullest extent possible before billing MHCP.

Assignment and Request for Direct Payment

Members are responsible to give providers updated TPL information, Medicare information and assignment of benefits. Providers are responsible to obtain assignment of benefits from the member or responsible party.

Request direct payment to you when:

- A dependent child is insured under a group contract pursuant to a court order
- An MHCP member is insured by a plan approved in Minnesota

The provider must indicate on the insurance claim that the person is receiving benefits through MHCP.

Authorization Requests and Medicare or TPL Coverage

Review information about [authorization requests](#) when a member has Medicare or TPL.

Medicare

Medicare is primary to MHCP. Services covered by Medicare must be provided by a Medicare-enrolled provider and billed to Medicare first. Bill any balance after Medicare payment to other TPL payers. If the total amount received from Medicare and other TPL payers is less than the MHCP allowable, submit a claim for the difference to MHCP for payment of the coinsurance and deductible with appropriate amounts indicated.

- If Medicare pays a claim and the claim does not automatically cross over to MHCP from Medicare, bill MHCP in the same way you billed Medicare.
- If Medicare denies a claim, bill MHCP using MHCP guidelines.

In both cases, complete the [MN-ITS Interactive Field Completion Guide \(PDF\)](#) with all of the adjustments and remarks codes indicated on your Medicare explanation of medical benefits (EOMB) information. A claim that is with charge and adjustments out of balance will suspend for review and are considered complex claims that may take up to 90 days to process.

Submit claims for services that are never covered by Medicare directly to MHCP. You do not need a denial from Medicare.

Medicare B Crossover Claim Payment

The Basic Care Service rate reductions do not apply to service lines allowed (covered) by Medicare. Service lines denied by Medicare where MHCP is the sole payer are subject to the basis care rate reductions.

MHCP payment is the difference between the Medicare payment and the MHCP calculated allowable where the difference is greater than zero. If the difference is less than or equal to zero, the MHCP payment will be zero.

Calculation Example:

Line	Procedure Code	Charge	MHCP Calculated Allowable	Medicare Allowed Rate	Medicare Payment	Medicare Coinsurance or Deductible	MHCP Calculation
1.	98941	\$49.00	\$21.77	\$34.79	\$15.30	\$19.49	\$21.77 - \$15.30 = \$6.47 payment

Line 1: Our allowable in this example, after any add-ons or cutbacks is \$21.77. Because this line has \$19.49 coinsurance, MHCP will pay the difference between the Medicare payment and the MHCP calculated allowable. MHCP pays the MHCP Calculated Allowable of \$21.77 minus the Medicare payment \$15.30, which equals \$6.47. MHCP no longer pays the \$19.49 Medicare determined coinsurance.

Members who are dually eligible (Medicare and Medicaid), may receive a service that is covered by Medicare but that is considered “not covered” by Medicaid. In this situation, MHCP will process the 837P claim and may reimburse the copay and deductible amounts only. This payment is considered payment in full to the provider regardless of the presence of a signed ABN; therefore, no additional payment can be requested from the member.

Medicare Opt-out Option

Providers may choose to opt-out of Medicare (not enroll as a Medicare provider). However, MHCP will not pay for services covered by, but not billed to, Medicare because the provider has chosen not to enroll in Medicare.

Medicare Replacement (Advantage or Risk Plans)

Many companies have Medicare advantage plans, Part C policies, or supplement policies. Providers must verify whether or not a policy is one of these plans. If it is, enter the claim as any other Medicare claim, using Claim Filing Indicator 16. If using MN-ITS Direct Data Entry (DDE) to submit your claim, refer to the [MN-ITS Interactive Field Completion Guide \(PDF\)](#) for instructions on which fields must be completed.

Third Party Liability (TPL)

A health reimbursement arrangement (HRA) is considered a group health plan and must be treated as third party liability (TPL). Members must use funds in the HRA to pay their medical expenses before MHCP pays claims.

TPL coverage, including Veterans benefits, private accident insurance and other health care coverage held by or on behalf of an MHCP member, is primary to MHCP.

Health saving accounts (HSA) are considered the member’s personal funds and are not treated as third party liability. An HSA is secondary to MHCP.

Flexible spending accounts (FSA) are not treated as third party liability (TPL).

Follow specific plan coverage rules and policies. A member with more than one level of private benefits must receive care at the highest level available. MHCP will not pay for services that could have been covered by the TPL payer if the applicable rules of that plan had been followed.

If a member fails to complete forms and cooperate in the TPL billing process, contact the worker at the [local human service agency \(DHS-0005\) \(PDF\)](#) or a MinnesotaCare representative to request help.

Bill TPL payers and receive payment to the fullest extent possible before billing MHCP.

Subrogation

MHCP receives notice that a FFS member has other insurance after a provider has billed and received payment from MHCP. MHCP has the right to subrogate the payment by billing the private accident or health care coverage and be reimbursed for MHCP funds that were paid on behalf of a member for medical services to an enrolled MHCP provider.

After the private accident or health care coverage reimburses MHCP, the payment responsibility is satisfied. Providers must accept the amount paid by MHCP as payment in full and must not bill the other health insurer or member for any additional payment. This includes attempting to replace or void claims with MHCP and then bill the other insurance.

The amount of the MHCP payment substitutes for the TPL payment amount, even if the TPL payment would have been higher.

Unsuccessful TPL Billing

Providers may bill MHCP after three unsuccessful attempts have been made to collect from the TPL payer, except when the TPL payer has already made payment to the recipient. Attach a copy or screen print of the first claim sent to the TPL payer, documentation of two further billing attempts, and any written communication you received from the TPL payer to the MHCP claim. Do not bill MHCP earlier than 90 days after the initial attempt. Each additional attempt to bill must be 30 days after the previous attempt. Bill MHCP correctly within 12 months of the date of service to be considered for payment.

Do not bill MHCP earlier than 100 days after the initial attempt if the unsuccessful billing attempt is for a member that has TPL coverage derived from a parent whose obligation to pay child support is being enforced by DHS.

Billing MHCP with TPL

Bill MHCP only if the TPL payer indicates a patient responsibility. If the TPL does not attribute charges to patient responsibility or non-covered service, MHCP will not pay.

Use only HIPAA-compliant codes to indicate reduction, coinsurance, copay, etc. If the codes you receive from the TPL carrier are not HIPAA-compliant, refer to the [HIPAA Code Lists](#) on the WPC website.

MHCP does not accept an AUC Electronic Claim Attachment for TPL explanation of benefits (EOB). Provide the TPL adjustment and payment information within the claim transaction.

Submit TPL adjustment information at the header or claim level or the service or line level on the claim. Do not submit adjustment information at both levels. If you submit TPL adjustment information

at the header or claim level, MHCP will prorate all paid lines on the claim, which may result in lower payment.

Billing TPL at Header or Claim Level

The following claim transactions and provider types **must submit TPL information at the header or claim level** using MN-ITS or Batch submission to receive appropriate reimbursement:

- Hospital Inpatient
- Child and Teen Checkups (C&TC)
- Federally Qualified Health Center (FQHC)
- Rural Health Clinic (RHC)
- Indian Health Service (IHS) facilities and tribal social services

Adjustments entered at the Claim level are prorated across all service lines.

Refer to the appropriate [MN-ITS User Guide](#) for complete instructions on reporting header or claim level information on the Coordination of Benefits (COB) screen.

Billing TPL at Service or Line Level

TPL information may be entered at the service or line level, (except for the providers listed in the Billing TPL at Header or Claim Level section above).

Submit TPL information at the line level to report adjustments specific to each line:

- 837P Professional
- 837D Dental
- 837I Outpatient

Refer to the appropriate [MN-ITS User Guide](#) for complete instructions on reporting service or line level information on the Services screen, Other Payer section.

Submit line level TPL information for batch claims (except for the provider types listed in the Billing TPL at Header or Claim Level section) to report adjustments specific to each line.

Billing Different Procedure Codes to MHCP

When the TPL payer requires the use of a different procedure code than MHCP accepts for the service provided:

- Submit the procedure code required by the TPL on the claim to the TPL
- Submit the MHCP accepted procedure code for the service on the claim to MHCP and report COB information as usual
- Document the reason for billing different procedure codes in the member's record

Out-of-Balance TPL or Medicare Claims

For a claim to balance, the TPL or Medicare payment and adjustment code amounts must equal the U&C:

(TPL/Medicare payment amount) + (adjustment codes and amounts) = U&C

If you do not report all adjustment codes and amounts on the claim or line level to balance the claim or line, MHCP may suspend the claim for up to 90 days or deny the claim or line.

MHCP uses HIPAA-compliant claims adjustment reason code 129 and remittance advice reason code M04.

Billing TPL or Medicare Noncovered Services

Document any services not covered by Medicare or TPL. Keep documentation (such as a denial, information from policy manual, detailed phone contact information) in the member's file verifying a service is not Medicare or TPL covered. Although a denial is not required for each claim for noncovered services, providers must document the service's non-coverage on the MHCP claim:

- Complete claim COB information
- Use appropriate claim adjustment reason codes and remark codes
- Enter provider determined number or a series of nines (999) for the ICN (individual claim number); document this ICN

Bill services that are never covered by Medicare directly to MHCP without Medicare COB information. See [provider type specific sections](#) for additional information.

Cost Avoidance Requirements

MHCP pursues recovery of benefits when an accident settlement or contested Workers' Compensation benefits are pending, or when legal action may be required.

Providers are not required to bill TPL payers for the following services:

- Prenatal care services. This exclusion does not apply to any inpatient hospital stay related to these services or to coverage provided by an HMO or PPO
- Preventive pediatric care services for members under age 21. This exclusion does not apply to coverage provided by an HMO or PPO
- Prescription drugs, when the type of insurance is major medical or no-fault automobile insurance. Cost avoidance requirements do apply to prescription drug services provided to members with the following coverage types:
 - Private HMO
 - Prescription drug plans
 - PPOs
 - Workers' Compensation
 - Immunosuppressive drugs covered by Medicare

The following government health programs are not considered TPL payers for the purpose of cost avoidance requirements:

- Appalachian Regional Commission
- Comprehensive Health Service Projects
- Crime Victims' Compensation Fund
- Head Start
- Health and Child Development Projects
- Health Under-served Rural Areas
- Indian Health Services
- Migrant Health Projects

Report Health Insurance Effective and Termination Dates

Notify DHS of health insurance terminations and denials for people not covered by the policy. Send a copy of the termination notice or denial, or document on your office letterhead all of the following information:

- Member name
- Member MHCP ID number
- Insurance company name
- Termination date
- Whether the termination applies to the policy or individual
- Name and phone number of the person contacted to obtain the termination information

Fax 651-431-7431

(preferred):

Mail: DHS Benefit Recovery Section
P.O. Box 64994
St. Paul, MN 55164-0994

Request for Statement

If a member requests a billing statement, the statement must clearly state that it is not a bill and payment has been made or could be made by MHCP. Providers must report the request in writing to the Benefit Recovery Section.

Provider Prohibitions Related to TPL

Providers must not:

- Refuse to furnish MHCP-covered services to a recipient because of a TPL's potential liability for payment of the service
- Require MHCP members with primary insurance coverage to bill their insurance carrier. However, members must cooperate by completing and signing required forms

Liability Not Established or Benefits Not Payable

When probable liability is not established, or benefits are not available at the time a claim is submitted, MHCP will pay the maximum allowable except when Medicare has denied payment on the basis of secondary payer. The provider must accept MHCP payment as payment in full and must not continue to seek payment from TPL payers with pending liability. If MHCP learns of the existence of a TPL, or benefits become available, MHCP may recover payment directly from the TPL payer.

Legal References

[Minnesota Statutes 62A.045](#) Payments on Behalf of Enrollees in Government Health Programs

[Minnesota Statutes 256B.37](#) Private Insurance Policies, Causes of Action

[Minnesota Rules 9505.0070](#) Third Party Liability

[Minnesota Rules 9505.0071](#) Assignment of Rights

[Minnesota Rules 9505.0440](#) Medicare Billing Required

[42 CFR 405.410](#) and Balanced Budget Act of 1997 Sec. 4507 Conditions for properly opting-out of Medicare

[42 USC 1396a\(a\)\(25\)\(F\): Services Provided to CSE Beneficiaries](#)