COMMONWEALTH *of* VIRGINIA

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TO: **EMILY MCCLELLAN**
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FROM: **JENNIFER L. GOBBLE**
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DATE: **December 27, 2024**

SUBJECT: **Fast-Track Regulations: Third Party Liability Updates (6154 / 9882)**

I have reviewed the attached fast-track regulatory action that would amend existing regulations to comply with changes in federal law concerning third-party liability (TPL) requirements and recent Virginia legislation.

The amendments in this regulatory action reflect updates in federal and state TPL requirements, including a provision in the 2022 Consolidated Appropriations Act (CAA, 2022; P.L. 117-103) requiring states to have laws in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior authorization under the third-party payer's rules. This regulatory action includes changes to reflect this requirement as implemented in the budget by the General Assembly during Special Session 1 of the 2024 Session. Ch. 1, Item 304.T(2). Additionally, this regulatory action includes changes to comply with new requirements in Virginia Code §8.01-66.9:2, effective January 1, 2025, regarding procedures related to lien amounts arising from the Medicaid program.

Based on my review, it is this Office's view that the Director of the Department of Medical Assistance Services, acting on behalf of the Board of Medical Assistance Services pursuant to Virginia Code § 32.1-324, has the authority to amend these regulations, subject to compliance with the provisions of Article 2 of the Virginia Administrative Process Act, and has not exceeded that authority. Please be aware that this review is based solely upon whether DMAS has the legal authority to amend these regulations, not the appropriateness of whether they should be amended pursuant to the fast-track process. Pursuant to Virginia Code § 2.2-4012.1, if an objection to the use of the fast-track process is received within the public comment period from 10 or more persons, any member of the applicable standing committee of either

House of the General Assembly or of the Joint Commission on Administrative Rules, the Department of Medical Assistance Services shall (i) file notice of the objection with the Registrar of Regulations for publication in the Virginia Register, and (ii) proceed with the normal promulgation process with the initial publication of the Fast-Track regulations serving as the Notice of Intended Regulatory Action.

If you have any questions or need any additional information, please feel free to contact me at 786-2071.

cc: Kim F. Piner
Senior Assistant Attorney General/Section Chief

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Action: Third Party Liability Update
Stage: Fast-Track
12/17/24 7:24 AM [latest]

12VAC30-10-610 Third party liability

A. The Medicaid agency meets all requirements of:

1. 42 CFR 433.138 and 433.139

2. 42 CFR 433.145 through 433.148

3. 42 CFR 433.151 through 433.154

4. Sections 1902(a)(25)(H) and (I) of the Act.

B. 12VAC30-20-190, governing the identification of liable resources with respect to third party liability:

1. Specifies the frequency with which the data exchanges required in § 433.138(d)(1), (d)(3) and (d)(4) and the diagnosis and trauma code edits required in § 433.138(e) are conducted;

2. Describes the methods the agency uses for meeting the follow-up requirements contained in §§ 433.138(g)(1)(i) and (g)(2)(i);

3. Describes the methods the agency uses for following up on information obtained through the State motor vehicle accident report file data exchange required under § 433.138(d)(4)(ii) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources; and

4. Describes the methods the agency uses for following up on paid claims identified under § 433.13(a) (methods include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes) and specifies the time frames for incorporation into the eligibility case file and into its third party data base and third party recovery unit of all information obtained through the follow-up that identifies legally liable third party resources.

C. Providers are not required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D agency

D. 12VAC30-20-200, governing the payment of claims with respect to third party liability, specifies:

1. The method used in determining a provider's compliance with the third party billing requirements at § 433.139(b) (3) (ii) (C).

2. The threshold amount or other guideline used in determining whether to seek recovery or reimbursement from a liable third party, or the process by which the agency determines that seeking recovery of reimbursement would not be cost effective.

3. The dollar amount or time period the State uses to accumulate billings from a particular liable third party in making the decision to seek recovery of reimbursement.

E. The Medicaid agency assures that the state has in effect the laws that require third parties to comply with the provisions, including those which require third parties to provide the state with coverage, eligibility, and claims data, under section § 1902(a)(25) of the Social Security Act and specifies the compliance with § 1902(a)(25)(E) and § 1902(a)(25)(F).

F. The Medicaid agency ensures that laws are in effect that bar liable third-party payers from refusing payment for an item or service solely on the basis that such item or service did not receive prior

authorization under the third-party payer's rules. These laws comply with the provisions of Section 202 of the Consolidated Appropriations Act, 2022.

~~E.~~ G. The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.

~~F.~~ H. The Medicaid agency has written cooperative agreements for the enforcement of rights to and collection of third party benefits assigned to the State as a condition of eligibility for remedial assistance with the State Title IV-D agency. The requirements of 42 CFR 433.152(b) are met.

~~G.~~ I. The Medicaid agency assures that the State has in effect the laws relating to medical child support under § 1908 of the Act.

~~H.~~ J. The Medicaid agency specifies the guidelines used in determining the cost effectiveness of an employer-based group health plan; the State provides methods for determining cost effectiveness in 12VAC30-20-210.

12VAC30-20-200 Requirements for third party liability; payment of claims

1. Probable liability is established at the time claim is filed.

a. When the Title XIX agency has established the probable existence of third party liability at the time the claim is filed, the agency rejects the claim and returns it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the agency receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the agency pays the claim to the extent that maximum payment allowed under the agency's payment schedule exceeds the amount of the third party payment.

b. Exhausting all available third party resources is the responsibility of the providers. The Medicaid ~~Management Information~~ Enterprise System ~~(MMIS)~~ (MES) does not allow payments to be made by Virginia Medicaid unless the invoice indicates that the third party has either paid or denied the claim.

c. There are certain circumstances in which cost avoidance may not be utilized:

1) Medical support enforcement. In the case of any service covered under Medicaid provided to an individual on whose behalf child support enforcement is being carried out by the IV-D agency, Medicaid makes payment for such service in accordance with the usual payments schedule. These payments are made without regard to any third party liability, if such third party liability is derived, through insurance or otherwise, from the parent whose obligation to pay support is being enforced by the IV-D agency. Medicaid shall make these payments ~~providing~~ provided that they have not been made by such third party within ~~30~~ 100 days after such service is furnished.

Providers shall not be required to bill the third party in this situation. When the provider ~~does bill~~ bills Medicaid, ~~he~~ it must certify either:

(a) That ~~he~~ it has not billed the third party documented on the claim due to medical support enforcement, or

(b) That ~~he~~ it has billed the third party documented on the claim but ~~that he~~ has not received payment or denial for the service from the third party within ~~30~~ 100 days ~~after the service was furnished~~ after the provider of such services has initially submitted a claim. In this case, ~~30~~ up to 100 days must elapse ~~from the date of service to the date of provider certification~~ after the provider of such services has initially submitted a claim.

~~2. Prenatal Care. When the claim is for prenatal, labor and delivery, or postpartum care that is covered under the State Plan, the Commonwealth makes payment for such services in accordance with the usual payment schedule without regard to the liability of a third party for payment for such services.~~

~~3.~~ 2) Preventive Pediatric Care. When the claim is for preventive pediatric care, including services covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) ~~services that are covered under the State Plan~~ benefit, the Commonwealth makes payment for such services in accordance with the usual payment schedule without regard to the liability of a third party for payment for such services, unless the state has made a determination related to cost effectiveness and access to care that warrants cost avoidance for up to 90 days.

~~4. In order to accomplish this pay and chase activity, in accordance with 42 CFR 433.139, (once the claims have been processed for payment), a report is generated advising the third party unit so that recovery of funds can be made.~~

2. Virginia complies with the following requirements:

a. The requirement for states to apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services, in accordance with the provisions of §1902(a)(25)(E) of the Social Security Act.

b. The requirement for states to make payments without regard to potential third party liability for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days, in accordance with the provisions of §1902(a)(25)(E) of the Social Security Act.

c. The requirement for State flexibility to make payments without regard to potential third party liability for up to 100 days for claims related to child support enforcement beneficiaries, in accordance with the provisions of §1902(a)(25)(F) of the Social Security Act.

~~2.~~ 3. Probable liability is not established or benefits are not available at the time claim is filed.

If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the agency pays the full amount allowed under the agency's payment schedule.

~~3.~~ 4. Recovery of reimbursement.

a. When the Title XIX agency learns of the existence of a liable third party after a claim is paid, or benefits become available from a third party after a claim is paid, the Title XIX agency seeks recovery of reimbursement within 60 days after the end of the month it learns of the existence of the liable third party or benefits become available.

b. Reimbursement is sought by the Title XIX agency unless the agency determines that recovery will not be cost effective. The agency uses the threshold amount of $50 as a guideline in its attempts to recover from liable third parties in casualty cases. This $50 guideline is used in consideration with other factors (i.e., expense and difficulty of recovery) in deciding whether to pursue recoveries in the range of smaller dollar expenditures (less than $50). The threshold amount in the determination for the recovery of funds by the health insurance unit is $40. However, the threshold amount may be waived when the agency deems it to be economically and administratively feasible to collect less than the stated amounts. The threshold amounts are based on effectiveness with normal effort for the recovery of funds. Should it be determined that a recovery effort would be cost effective, then attempts are made for recovery of amounts below the threshold levels.

5. Prior Authorizations

a. The Department's payment of a claim for a medical item or service shall be the equivalent of the medical assistance recipient having obtained prior authorization for the item or service from the third party, other than Medicare plans.

b. Third party payers shall not deny a claim that is submitted by the Department solely on the basis of the medical assistance recipient’s failure to obtain a prior authorization under the third-party payer’s rules for the medical item or service.

c. Third party payers shall respond to an inquiry by the Department regarding a claim for payment of a medical item or service that was submitted to the third party not later than three years after the date of the provision of such medical item or service; the third party payer must respond within 60 days of receiving the inquiry.

~~4.~~ 6. ~~Code of Virginia § 8.01-66.9. Lien in favor of Commonwealth and state institutions or Department of Rehabilitative Services on claim for personal injuries. The State Agency meets the requirements of this section of the Code of Virginia with respect to liens on claims for personal injury.~~ DMAS meets all the requirements of the Code of Virginia § 8.01-66.9, entitled "Lien in favor of Commonwealth, its programs, institutions or departments on claim for personal injuries" and § 8.01-66.9:2, entitled "Lien in favor of the Department of Medical Assistance Services on claim for personal injuries" with respect to liens on claims for personal injury.

7. To obtain information about a Medicaid member's enrollment status or an itemization of lien against a personal injury claim, the member or their authorized representative shall furnish DMAS or its designated representative with any information that DMAS or its designated representative shall request. The member or their authorized representative shall use the DMAS public-facing portal designed for electronic data interchange to submit any requested information to DMAS or its designated representative. The following information is required to be furnished to DMAS or its designated representative:

a. A letter of representation signed by the Medicaid member or their authorized representative and dated within the last twelve months (if the request is made by a representative);

b. A HIPAA-compliant release form signed by the Member and dated within the last twelve months that authorizes both DMAS and the Office of the Attorney General (OAG) to disclose medical information to the member or their authorized representative and to any other third parties or contractors that are or will be involved with the lien.

c. The full legal name of the Medicaid member.

d. The full social security number of the Medicaid member.

e. A copy of the front and back of the Medicaid member's health insurance card(s).

f. A description of the member's injuries sustained as a result of the accident.

g. An itemized statement of the Medicaid member's medical damages including providers and dates of service, along with copies of medical bills.

h. The date and location of the accident, the identities of all parties involved in the accident, and a copy of the police report (if available).

i. The full name, mailing address, telephone number, and email address of the authorized representative named in the HIPAA release to whom DMAS should direct communications about the Medicaid lien.

j. If any of the required information changes after the date the information is submitted to DMAS, the member or their authorized representative shall notify DMAS of the change as soon as the new information is made available to the member or their authorized representative

8. To make a request for a reduction of any portion of a Medicaid lien, the member or their authorized representative shall furnish DMAS or its designated representative with any information that DMAS or its designated representative shall request. The member or their authorized representative shall use the DMAS public-facing portal designed for electronic data interchange to submit any requested information to DMAS or its designated representative. The following information is required to be furnished to DMAS or its designated representative:

a. The member's prognosis and anticipated future treatment expenses.

b. If the member is permanently disabled as a result of the accident, the disability rating.

c. The member’s current income, financial resources, and employment status.

d. The amount of all other liens or claims against the members personal injury claim.

e. Whether any liability insurance policies are available, and if so, the amount paid by each, and the policyholder’s name for each.

f. If any settlements have occurred related to the accident, including the amount of the settlement, the terms, and a copy of the signed settlement agreement.

g. If any lawsuits have been filed related to the accident, the jurisdiction and case number, a copy of the Complaint and any other filings.

h. The amount of all medical reimbursement payments coverage related to the accident, such as Medical Payments Insurance, also known as "medpay."

i. An itemized statement of all attorney’s fees and costs and any voluntary reductions.

j. A written explanation of why the request is being made, along with details about the compromise or waiver that is being requested and any other facts or documentation that are being relied upon to support the request.

k. If any of the required information changes after the date the information is submitted to DMAS, the member or their authorized representative shall notify DMAS of the change as soon as the new information is made available to the member or their authorized representative.

9. To make a request to remove charges contained in DMAS’s itemization of lien that are believed to be unrelated to the personal injury claim of the member, the member or their authorized representative shall furnish DMAS or its designated representative with any information that DMAS or its designated representative shall request. The member or their authorized representative shall use the DMAS public-facing portal designed for electronic data interchange to submit any requested information to DMAS or its designated representative. The following information is required to be furnished to DMAS or its designated representative:

a. A written statement detailing the specific charge(s) that the member or its authorized representative believes is unrelated to the personal injury claim.

b. Any and all documentation from the member or its authorized representative to any third party detailing claimed medical damages, itemized medical bills, or other related information, including, but not limited to, demand package(s), list of medical specials, correspondence concerning medical damages, etc.

c. Any and all documentation showing where the member or its authorized representative informed any third party that certain charges were unrelated.

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