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cause will not extend beyond two consecutive quarters.

(b) Circumstances beyond the control of a State. The State must satisfactorily explain the circumstances that are beyond its control. When CMS grants the waiver, CMS will also defer all other system deadlines for the same length of time that the waiver applies.

(c) Waiver of deadline. In no case will CMS waive the December 31, 2015 deadlines referenced in § 433.112(c) and § 433.116(i).


Subpart D—Third Party Liability

SOURCE: 45 FR 8984, Feb. 11, 1980, unless otherwise noted.

§ 433.136 Definitions.

For purposes of this subpart—

Private insurer means:

(1) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services included in the State plan; and

(3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

Title IV-D agency means the organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

§ 433.137 State plan requirements.

(a) A State plan must provide that the requirements of §§ 433.138 and 433.139 are met for identifying third parties liable for payment of services under the plan and for payment of claims involving third parties.

(b) A State plan must provide that—

(1) The requirements of §§ 433.145 through 433.148 are met for assignment of rights to benefits, cooperation with the agency in obtaining medical support or payments, and cooperation in identifying and providing information to assist the State in pursuing any liable third parties; and

(2) The requirements of §§ 433.151 through 433.154 are met for cooperative agreements and incentive payments for third party collections.

(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.


§ 433.138 Identifying liable third parties.

(a) Private insurer means:

(1) Any commercial insurance company offering health or casualty insurance to individuals or groups (including both experience-rated insurance contracts and indemnity contracts);

(2) Any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services included in the State plan; and

(3) Any organization administering health or casualty insurance plans for professional associations, unions, fraternal groups, employer-employee benefit plans, and any similar organization offering these payments or services, including self-insured and self-funded plans.

Third party means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished under a State plan.

Title IV-D agency means the organizational unit in the State that has the responsibility for administering or supervising the administration of a State plan for child support enforcement under title IV-D of the Act.

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(c) The requirements of paragraph (b)(1) of this section relating to assignment of rights to benefits and cooperation in obtaining medical support or payments and paragraph (b)(2) of this section are effective for medical assistance furnished on or after October 1, 1984. The requirements of paragraph (b)(1) of this section relating to cooperation in identifying and providing information to assist the State in pursuing liable third parties are effective for medical assistance furnished on or after July 1, 1986.

the legal liability of the third parties
who are liable to pay for services fur-
nished under the plan. At a minimum,
such measures must include the re-
quirements specified in paragraphs (b)
through (k) of this section, unless
waived under paragraph (l) of this sec-
tion.

(b) Obtaining health insurance informa-
tion: Initial application and redetermi-
nation processes for Medicaid eligibility. (1)
If the Medicaid agency determines eli-
gibility for Medicaid, it must, during
the initial application and each rede-
termination process, obtain from the
applicant or beneficiary such health in-
surance information as would be useful
in identifying legally liable third party
resources so that the agency may proc-
ess claims under the third party liabil-
ity payment procedures specified in
§433.139 (b) through (f). Health insur-
ance information may include, but is
not limited to, the name of the policy
holder, his or her relationship to the
applicant or beneficiary, the social se-
curity number (SSN) of the policy
holder, and the name and address of in-
surance company and policy number.

(2) If Medicaid eligibility is deter-
mained by the Federal agency admin-
istering the supplemental security in-
come program under title XVI in ac-
cordance with a written agreement
under section 1634 of the Act, the Med-
icaid agency must take the following
action. It must enter into an agree-
ment with CMS or must have, prior to
February 1, 1985, executed a modified
section 1634 agreement that is still in
effect to provide for—

(i) Collection, from the applicant or
beneficiary during the initial applica-
tion and each redetermination process,
of health insurance information in the
form and manner specified by the Sec-
cretary; and

(ii) Transmittal of the information to
the Medicaid agency.

(3) If Medicaid eligibility is deter-
mained by any other agency in accord-
ance with a written agreement, the
Medicaid agency must modify the
agreement to provide for—

(i) Collection, from the applicant or
beneficiary during the initial applica-
tion and each redetermination process,
of such health insurance information
as would be useful in identifying le-
gally liable third party resources so
that the Medicaid agency may process
claims under the third party liability
payment procedures specified in
§433.139 (b) through (f). Health insur-
ance information may include, but is
not limited to, those elements de-
scribed in paragraph (b)(1) of this sec-
tion; and

(ii) Transmittal of the information to
the Medicaid agency.

(c) Obtaining other information. Except
as provided in paragraph (l) of this sec-
tion, the agency must, for the purpose
of implementing the requirements in
paragraphs (d)(1)(ii) and (d)(4)(i) of this
section, incorporate into the eligibility
case file the names and SSNs of absent
or custodial parents of Medicaid bene-
ficiaries to the extent such information
is available.

(d) Exchange of data. Except as pro-
vided in paragraph (l) of this section,
to obtain and use information for the
purpose of determining the legal liabil-
ity of the third parties so that the
agency may process claims under the
third party liability payment proce-
dures specified in §433.139(b) through
(f), the agency must take the following
actions:

(1) Except as specified in paragraph
(d)(2) of this section, as part of the data
exchange requirements under §435.945
of this chapter, from the State wage in-
formation collection agency (SWICA)
declared in §435.4 of this chapter and
from the SSA wage and earnings files
data as specified in §435.948(a)(2) of this
chapter, the agency must—

(i) Use the information that identi-
ifies Medicaid beneficiaries that are em-
ployed and their employer(s); and

(ii) Obtain and use, if their names
and SSNs are available to the agency
under paragraph (c) of this section, in-
formation that identifies employed ab-
sent or custodial parents of bene-
ficiaries and their employer(s).

(2) If the agency can demonstrate to
CMS that it has an alternate source of
information that furnishes information
as timely, complete and useful as the
SWICA and SSA wage and earnings files
in determining the legal liability
of third parties, the requirements of
paragraph (d)(1) of this section are
deemed to be met.

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(3) The agency must request, as required under §435.948(a)(6)(1), from the State title IV-A agency, information not previously reported that identifies those Medicaid beneficiaries that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining—

(i) From State Workers’ Compensation or Industrial Accident Commission files, information that identifies Medicaid beneficiaries and, if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid beneficiaries with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid beneficiaries injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) Diagnosis and trauma code edits. (1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid beneficiaries that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD–9–CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(f) Data exchanges and trauma code edits: Frequency. Except as provided in paragraph (e)(2) or (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in §435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) Followup procedures for identifying legally liable third party resources. Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(1) SWICA, SSA wage and earnings files, and title IV-A data exchanges. With respect to information obtained under paragraphs (d)(1) through (d)(3) of this section—

(i) Except as specified in §435.952(d) of this chapter, within 45 days, the agency must followup (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) Health insurance information and workers’ compensation data exchanges. With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section—

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in §433.139(b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) State motor vehicle accident report file data exchanges. With respect to information obtained under paragraph (d)(4)(ii) of this section—
(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) Diagnosis and trauma code edits. With respect to the paid claims identified under paragraph (e) of this section—

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in §433.139 (b) through (f) (Methods must 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.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(h) Obtaining other information and data exchanges: Safeguarding information. (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in part 431, subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify—

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs incurred in furnishing the information if payment is requested.

(i) Reimbursement. The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) Reports. The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under §433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under paragraph (l) of this section, it is not required to provide the reports required in this paragraph.

(k) Integration with the State mechanized claims processing and information retrieval system. Basic requirement—Development of an action plan. (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to—

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in §433.139;
§ 433.139 Payment of claims.

(a) Basic provisions. (1) For claims involving third party liability that are processed on or after May 12, 1986, the agency must use the procedures specified in paragraphs (b) through (f) of this section.

(2) The agency must submit documentation of the methods (e.g., cost avoidance, pay and recover later) it uses for payment of claims involving third party liability to the CMS Regional Office.

(b) Probable liability is established at the time claim is filed. Except as provided in paragraph (e) of this section—

(1) If the agency has established the probable existence of third party liability at the time the claim is filed, the agency must reject the claim and return 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 must then pay the claim to the extent that payment allowed under the agency’s payment schedule exceeds the amount of the third party’s payment.

(2) The agency may pay the full amount allowed under the agency’s