Third-Party Liability

PURPOSE

42 Code of Federal Regulation (CFR) § 433 requires state Medicaid programs to cost avoid for services that have third-party coverage. Providers must identify any liable third-party payers prior to billing Medicaid in most instances. Providers may not refuse services to a member because the member has third-party coverage.

APPLICABILITY

To receive payment from ND Medicaid, the eligible servicing and billing provider National Provider Identifiers (NPI) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll in ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

Third Parties Include:

- Health Insurers (includes private or employer-based coverage),
- Federal programs (includes Medicare, and TRICARE),
- Medicare Supplemental (extended plans)
- Medicare Replacement (advantage part C plans)
- Other government programs (includes Workforce Safety and Insurance),
- Other liable people or entities (includes auto, homeowners', business liability, personal injury (PIP)/no fault insurance, etc.).

A claim submitted to Medicaid must have the third-party Explanation of Benefits (EOB) information which includes all payment, contractual obligations, and patient responsibility details submitted on or with the claim as a claim attachment. For claims to reimburse correctly, EOB information must be submitted at the header or claim level for inpatient claims and at the service or line level for dental, outpatient and professional claims.

Obtaining Third Party Liability Information

Providers are required to obtain health care coverage information including third party liability information from any potential source, which can include the member, the member's representative, the human service zone office, MMIS portal, the claims call center, or through the information provided by the Medicaid remittance advice on the explanation of benefits.

Third Party Liability Recovery

When there is no known third-party liability coverage at the time of claims adjudication, Medicaid may pay claims up to the Medicaid allowed amount. If Medicaid later establishes that a third party was liable for the claim, we will seek to recover the payment. This occurs when the Medicaid beneficiary requires medical services in casualty/tort, medical malpractice, Worker's Compensation, other cases where the third-party liability is not determined before medical care is provided, or when Medicaid learns of the existence of health insurance coverage after medical care is provided.

During third-party liability recovery, health insurers are required to:

- Accept the state's right to recovery.
- Accept that Medicaid members have assigned their rights to the state for any amounts paid by the state on the member's behalf.
- Adjudicate claims for reimbursement from Medicaid to the same extent that the plan would have been liable for had it been properly billed at the point-of-service.
- Not deny claims submitted by Medicaid based on a procedural formality, such as the type or format of the claim form, timely filing, absent prior authorization, or a failure to present proper documentation of coverage at the point of service.

Medicaid has the right to recovery up to 6 years when Medicaid submits a claim to a third-party payer within 3 years from the date of service.

Third Party Liability Exceptions

North Dakota Medicaid is generally the payer of last resort.

In the following situations, providers may submit claims directly to ND Medicaid even if there is a liable third party.

- Services provided for early and periodic screening, diagnostic, and treatment (EPSDT).
- Medicaid-eligible children that are authorized in an Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) under the Individuals with Disabilities Act (IDEA). Public agencies (schools) with general responsibilities to ensure health and welfare are not considered liable third parties. School based services provided outside of an IEP or IFSP are subject to third party liability.
- 1915(c) Waivers (Home and Community Based Services, Developmental Disabilities, Autism (does not include applied behavioral analysis services), Children's Medically Fragile, Children's Hospice)

- 1915(i) Services
- Services that Medicaid has been able to verify are never payable by another payer (ex. Tricare does not cover chiropractic services).

Medicaid Payment for Services with Third Party Liability

ND Medicaid will pay the amount designated as the member responsibility up to the Medicaid allowed amount, Medicaid will pay the claim at $0 if third-party payment exceeds the Medicaid allowed amount.

ND Medicaid providers are required to follow TPL payer policy and procedures for payment.

Providers Billing a Member

Medicaid payment is considered payment in full for covered services. Providers are not allowed to bill the member or seek additional compensation from family, friends, or others after payment is received from the third party and ND Medicaid, even if ND Medicaid payment is $0. A provider may not bill members for:

- Balance billing or the difference between charges and the amount ND Medicaid paid.
- Claims denied by ND Medicaid due to a provider billing error.
- Claims denied for failure to secure the necessary service authorization.

ND Medicaid members may only be billed for the following:

- Client share (recipient liability) amount documented on the remittance advice. Providers may not collect client share at the time of service, unless the service is for outpatient pharmacy billed through the Pharmacy Point of Sale.
- Non-covered ND Medicaid services so long as the member is given advance notice of and accepts financial responsibility for the service prior to its rendering. Notice and acceptance must be in writing and signed.
- Services delivered by a non-enrolled provider if the member signed an advance notice that the provider was not enrolled, and the provider will not enroll in ND Medicaid prior to rendering services.
- Services where the member was paid directly by a third-party payer. A provider may bill a member to recover the amount paid by the third-party payer. Providers may not:
    - bill more than the amount paid to the member.

- demand payment upfront and require members to bill a third-party payer unless third party terms require benefits be paid to the member.

Medicare Provider Enrollment Opt-Out

Providers may choose to opt-out of Medicare. ND Medicaid will not pay for services covered by but not billed to in these instances. Providers must enroll with Medicare if Medicare covers the services to receive payment from ND Medicaid. Providers must notify the member prior to receiving services that they are not a Medicare-enrolled provider and obtain a signed acceptance notice prior to rendering services.

Third Party Restriction on Provider Enrollment or Credentialing

Medicaid requires servicing providers submit the following documentation when the member's third-party liability plan does not cover ND Medicaid-credentialled providers:

- Letter with servicing provider's credentials for claim date of service(s).
- Dated credentialing policy or handbook information from the member's third-party that states the servicing provider is ineligible to enroll. If a policy manual is not available, the servicing provider must seek a dated credentialing denial confirming the provider is ineligible to enroll due to credentials.
- Documentation must accompany every claim that is submitted.

Out-of-Network Providers

Federal regulations allow Medicaid members to obtain services from any enrolled Medicaid provider. Medicaid will require providers to submit claims where members have gone outside the liable third party's network to the third party for a determination of available out of network benefits. Medicaid will process the claim according to the state plan and reimburse the service, if covered and not denied by the third-party liability as a contractual obligation (CO), up to the Medicaid allowed amount or the patient responsibility amount whichever is less.

Medicare Crossovers

A crossover claim is for a member eligible for both Medicare and ND Medicaid. A claim for a member with Medicare coverage must be submitted to Medicare first. Medicare pays a portion of the claim and ND Medicaid is billed for any remaining deductible, copay, and/or coinsurance. Medicare uses a Coordination of Benefits Contractor to automatically crossover claims billed to the Medicare Part A, Part B, and Durable Medical Equipment contractors for Medicare/North Dakota Medicaid eligible members.

In some cases, the claim may not automatically crossover. If billing ND Medicaid for the Medicare co-insurance and/or deductible, providers should only submit a crossover claim after 60 days have passed from the date of the Explanation of Medicare Benefits (EOMB) and the claim is not listed on your North Dakota Medicaid remittance advice as paid, pended, or denied. Proof of payment from Medicare (EOMB, voucher, etc.) must be attached to the crossover claim form.

Make sure to include the correct Claim Filing Indicator Code on electronic claim submissions for correct Medicare primary claims processing.

When submitting Medicare primary claims, including replacement and supplemental, MA (Medicare Part A) or MB (Medicare Part B) should be used as the claim filing indicator. CI (Commercial insurance) should only be used if the primary insurance is a commercial policy.

Companion Guides
837P(Professional)
837I(Institutional)

One EOMB is required if the member has a Medicare Part C/Advantage plan and two EOMBs are required if the member has Medicare and a Supplemental/Extended plan.

North Dakota Medicaid will not pay for any service that has been denied by Medicare as not medically necessary or reasonable.

CLAIMS

Original Claims with Third-Party Liability (Excludes Medicare Crossovers) ND Medicaid must receive an original secondary/tertiary claim submission within three hundred sixty-five (365) days from the date of service. Claims must be submitted with third party payment information on the claim. This time limit may be extended only when there are situations involving member or provider retroactively eligibility.

Original Medicare Crossover Claims ND Medicaid must receive an original Medicare crossover claim submission within one hundred eighty (180) days from the date on the Medicare Explanation of Benefits (EOB). Claims must be submitted with Medicare payment information on the claim. This time limit may be extended only if there are situations involving member or provider retroactive eligibility.

The Timely Filing Policy contains additional information.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

Timely Filing
School Based Services

CONTACT

Third Party Liability Unit
Medical Services
ND Dept. of Health and Human Services
600 E Boulevard Ave-Dept 325
Bismarck ND 58505-0250
Phone:
(800) 755-2604 or (701) 328-2347
Email: medicaidtpl@nd.gov

POLICY UPDATES

January 2025

Section	Update
	Added updated contact information

July 2025

Section	Update
	Format updates and clarifications added throughout.