

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE WYOMING

Requirements for Third Party Liability -
Identifying Liable Resources

(1) Frequency - Data Exchanges

The agency receives information from SWICA and SSA in the form of a data exchange on a quarterly basis.

The agency receives information from the state Motor Vehicle Accident Report files in the form of a data exchange on a monthly basis.

The agency receives information from the state IV-A agency on employed recipients and their employers in the form of a data exchange on a quarterly basis.

The agency identifies all trauma codes 800 through 999 excluding 994.6 of the ICD-CM 9th edition on a monthly basis.

(2) Methods Used to Meet Follow-up Requirements

Reports received from the data exchange with SWICA, SSA and ESC are submitted by CTD to the MMIS contractor on a quarterly basis. Within 45 days, the MMIS contractor investigates all applicable third party insurance, confirms if appropriate and incorporates such information into the MMIS eligibility case file resource record.

(3) Data Exchange with State Motor Vehicle

Reports received from the data exchange with the state Motor Vehicle Accident Report files are submitted by CTD to the TPL Recovery contractor on a monthly basis. Within 60 days, the TPL Recovery contractor investigates all applicable third party insurance by sending out a questionnaire and requesting copies of the accident reports for all accidents that have a positive insurance indicator on the report, confirms if appropriate and incorporates such information into the MMIS eligibility case file resource record.

(4) Diagnosis and Trauma Code Edits

Questionnaires are sent to individuals meeting the Diagnosis and Trauma Code Edits report criteria on a monthly basis. Reports also list number of trauma diagnosis codes by type of service. Within 45 days, information gathered from the questionnaires is confirmed if appropriate and incorporated into the MMIS eligibility case file resource record. The agency and the Recovery Contractor have access to this information.

(5) Paid claims follow up

The TPL billing file holds the information on all claims billed to insurance companies. The claims are billed and then rebilled 120 and 180 days after initial billing. If no response has been received, the information is then transferred to the recovery contractor who bills the insurance company one more time within 12 months from the date of first billing which includes a minimum of one personal contact with insurance company. After 12 months from date of first billing, if no response is received, claims will be purged from the billing file.

TN No. 93-017

Supersedes

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State: WYOMING

1. Providers are not required to bill the third party when the covered service is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D agency.

Upon billing Medicaid. The providers are required to certify if a third party has been billed prior to submission. The provider must also certify that they have waited 30 days from the date of the service before billing Medicaid and has not received payment from the third party.

2. Thresholds for health insurance claims

Wyoming Medicaid has no thresholds for health insurance claims recovery.

Thresholds for casualty claims

Wyoming Medicaid has no threshold for casualty insurance claims; however, top priority is given to identifying third party liability for those recipients who have had at least \$250.00 in trauma related claims during the month. Those individuals with less than \$250.00 in claims are worked as time permits.

For casualty recoveries, the agency will comply with 42 U.S.C. Section 1396 (a)(25)(B) and use the following factors and guidelines in determining whether to pursue recovery of benefit, after deduction of the agency's proportionate share of attorney's fee and cost, from a liable party.

1. Ascertain the amount of Medicaid right to reimbursement and the amount of the gross settlement.
2. Determine whether the Medicaid right to reimbursement plus attorney's fees and costs will exhaust or exceed the settlement funds.
3. If the answer to 2 is Yes; and if the agency:
 - a. Is informed the client will not pursue the claim; or
 - b. Cannot handle the case, once it is tendered to the agency by the client or the client's attorney to pursue on behalf of the client; or
 - c. Made reasonable effort to ascertain the client's intention regarding the claim, but could not obtain a response; then the agency shall follow procedures stated in 4.

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4. The agency shall consider the cost-effectiveness principle in determining what is the estimated net recovery amount to be pursued, based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors will be considered:
 - a. Settlement as may be affected by insurance coverage or other factors relating to the liable party;
 - b. Factual and legal issues of liability as may exist between the client and liable party;
 - c. Problems of proof faced in obtaining the award or settlement; and
 - d. The estimated attorney's fee and cost required for the agency to pursue the claim.
5. After considering the above factors, the agency may pursue a lesser recovery amount to the extent that the agency determines it to be cost-effective to do so.

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Citation

Condition or Requirement

1906 of the Act

State Method on Cost Effectiveness of Employer-Based Group Health Plans

After screening all Medicaid applicants and recipients at intake and re-application process, the State will pay premium, deductibles and co-insurance charges for a Medicaid recipient who has an active insurance policy and is a high cost utilizer of medical services. These cases include but are not limited to:

1. High cost catastrophic illness cases.
2. Temporary disability cases determined by a medical professional; and
3. Cases requiring continuous care for a period of more than six (6) months.

An individual's enrollment in a group health plan is cost effective when the amount paid for premiums and other cost sharing obligations plus the State's administrative cost are less than third party liability payment for the equivalent set of services and amount paid for the same category of service.

Determination is based on the Medicaid recipient's medical needs. After screening all Medicaid applicants and recipients at intake and re-application process, the State will pay premiums, deductibles and co-insurance for a Medicaid recipient who has an active insurance policy and is a high cost utilizer of medical services. These cases include but are not limited to:

1. High cost catastrophic illness cases.
2. Temporary disability cases determined by a medical professional; and
3. Cases requiring continuous care for a period of more than six (6) months.

1. Annual review of cost effectiveness of eligible cases will be obtained by using the actual annual cost to Medicaid for the recipient from MMIS.

2. Compare costs to Medicaid of purchasing insurance (premiums, co-insurance, deductibles, and other cost sharing) to the actual Medicaid costs (obtain from MMIS) for the same recipient.

3. Subtract from the figure derived in step 2 above, the State's administrative cost for processing the health insurance information. (The Administrative cost is periodically readjusted.)

4. A policy is determined to be cost effective if the costs to the State under the group health plan are lower than the cost to the State for these services under Medicaid.

5. If the plan is determined not to be cost effective due to the lack of explanation of benefit submitted by the insurance company, the recipient may submit all historical medical costs as proof to challenge the above format.

6. The State will pay premiums, deductibles, and coinsurance when it is cost-effective to do so.

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