

TPL and Coordination of Benefits Billing Requirements

Jefferson Health Plans

Third Party Liability (TPL) – All Lines of Business

Third Party Liability (TPL) exists when another individual, entity, or program is legally responsible for payment of all or part of a member's health care expenses. This includes health insurance providers (such as Medicare and employer-sponsored insurance), Workers' Compensation, automobile insurance, personal injury liability insurance, and other third-party resources.

We use Pennsylvania Department of Human Services (DHS) Third Party Liability Resource information and other available sources as a base for identifying other insurance coverage for all members. If evidence of probable other insurance is identified through secondary claim submission, contact from other carriers, or the member, this information will be recorded in our processing systems and reported to DHS, as required. Providers must report any newly discovered third-party resources or updates to existing coverage.

If a provider receives payment from both Jefferson Health Plans and a primary insurer and an overpayment is identified, the provider is required to return the excess payment to Jefferson Health Plans in accordance with applicable regulatory requirements and must cooperate with recovery efforts. See the Overpayments section for additional information regarding recovery processes.

TPL Reporting and Investigation Requirements

Investigation of potential other insurance coverage is required prior to payment, except when preventive pediatric care services are involved (not including hospital delivery claims).

If a provider learns of other insurance coverage during service provision that is not reflected in the member's file, or learns that existing coverage is no longer effective, the provider must notify Jefferson Health Plans promptly and should make reasonable efforts to include the member's identification number for the other insurance coverage to support outreach to the primary insurer and accurate updates to the member's coverage record.

Providers must report newly discovered third-party resources or updates to existing coverage by calling the Provider Services Helpline at 1-888-991-9023 or by submitting the primary insurer's Explanation of Benefits (EOB). Information on file is available to providers through the helpline.

Third Party Liability Recovery and Subrogation

Third Party Liability includes automobile insurance, personal injury protection, and other liability coverage (such as homeowners' or business liability insurance) that may be responsible for payment of medical services related to an accident or injury.

- Providers must bill applicable liability carrier(s) as primary when services are related to an accident or injury.
- Providers should not delay billing medical insurers pending the outcome of a legal settlement or judgment.

If Jefferson Health Plans makes payment for services for which another party is legally responsible, Jefferson Health Plans is responsible for identifying and pursuing recovery from the liable third party in accordance with applicable program requirements, contracts, and state and federal law.

If a provider receives payment from Jefferson Health Plans and a third party for the same services and an overpayment is identified, the provider is required to return the excess payment in accordance with applicable laws and regulations. Providers must cooperate with recovery efforts, including timely repayment of identified overpayments and submission of documentation when requested.

For Jefferson Health Plans EverWell members, the Pennsylvania Department of Human Services (DHS) retains statutory rights of recovery and subrogation for Medicaid-paid services, after Jefferson Health Plans has pursued recovery in accordance with applicable recovery timeframes and program requirements. DHS may assert liens or recovery rights against settlements or judgments in accordance with state and federal law, including in circumstances where recovery is not otherwise obtained.

Coordination of Benefits – Claim Submission and Billing Order (All Lines of Business)

Coordination of Benefits (COB) establishes the order of payment when a member is covered under more than one health plan and prevents duplicate payment for the same service. When other insurance coverage exists, providers are required to submit claims to the primary payer first (such as Medicare, employer-sponsored insurance, Workers' Compensation, etc.) and obtain a primary insurer's Explanation of Benefits (EOB) before submitting a secondary claim to Jefferson Health Plans.

Claim Submission Process

- **Submit to the primary insurer first:** Providers must submit the claim to the primary payer for adjudication.
- **Obtain the primary insurer's EOB or EOP:** Providers must obtain and retain documentation from the primary insurer reflecting the claim adjudication and payment determination, such as an Explanation of Benefits (EOB) or Explanation of Payment (EOP), including any applicable cost-sharing (coinsurance, deductible, copayments).
- **Submit secondary claim to Jefferson Health Plans:** After the primary insurer has made a payment determination, providers should submit a secondary claim to Jefferson Health Plans. This secondary claim must include the primary insurer's EOB or EOP as an attachment, as applicable and consistent with HIPAA transaction standards.
- **Adhere to appropriate timelines:** Providers must submit secondary claims within 60 days of the primary payer's EOB paid date. If a claim is submitted after the 60-day period, it may be denied for timely filing.
- **Provider appeals:** Provider appeals must be submitted within 180 days of the denial date for the primary insurer.

Primary Payer Documentation Submission Requirements

- **Primary Payer Documentation (EOB or EOP):** When submitting secondary claims, providers must attach documentation from the primary insurer reflecting the claim adjudication and payment determination, such as an Explanation of Benefits (EOB) or Explanation of Payment (EOP). Claims submitted without required documentation (EOB, EOP, denial letter, exhaustion of benefits notice, or equivalent primary payer documentation) will be denied for lack of documentation.
- **Incomplete or Incorrect Information:** Claims submitted with incomplete or incorrect primary insurance documentation (such as missing member or provider details, dates of service, billed charges, payment amounts, or denial codes and reasons) will be denied for incomplete primary payer documentation.

Coordination of Benefits – Payment When Jefferson Health Plans Is Secondary

When a Jefferson Health Plans member is covered by more than one health plan, Jefferson Health Plans coordinates benefits in accordance with applicable federal and state laws, including Medicaid Third Party Liability (TPL) requirements, Medicare Secondary Payer (MSP) rules, and applicable commercial coordination of benefits standards.

When another payer is determined to be primary, providers must submit claims to the primary payer prior to billing Jefferson Health Plans, unless otherwise permitted by law.

Payment When Jefferson Health Plans is Secondary

When Jefferson Health Plans is the secondary payer, payment will be made up to the lesser of:

- The difference between the applicable Jefferson Health Plans allowable amount and the amount paid by the primary payer; or
- The remaining amount of applicable coinsurance, deductible, or copayment.

In no event will the combined payment from the primary payer and Jefferson Health Plans exceed the applicable Jefferson Health Plans allowable amount for the covered service.

Jefferson Health Plans Medicaid operates as a payer of last resort, and Jefferson Health Plans CHIP, which is a state-regulated program administered by Jefferson Health Plans, coordinates benefits in alignment with applicable Medicaid Third Party Liability (TPL) principles and state CHIP requirements; Medicare Advantage benefits are coordinated in accordance with CMS Medicare Secondary Payer (MSP) rules, and ACA plans coordinate benefits in accordance with applicable federal and state commercial coordination of benefits requirements.

If the primary payer's payment fully satisfies the provider's reimbursement obligation for the covered service (i.e., the provider has been made whole) and no Jefferson Health Plans-recognized payment responsibility remains, no additional payment will be made.

Payment determinations are subject to applicable federal and state law and provider-specific payment requirements, including prospective payment system (PPS) obligations for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), where applicable.

Member Billing Rules

Providers must comply with applicable federal and state law, program requirements, and Jefferson Health Plans provider contracts when billing members. Member billing obligations vary by line of business.

General Rule (All Jefferson Health Plans): Member billing rules depend on the applicable line of business, program requirements, and benefit design.

Providers must:

- Bill other responsible payers first, when applicable.
- Apply all payments before determining any member financial responsibility.
- Bill members only when permitted under the applicable plan, law, and provider contract.
- Not bill members for any remaining balance when both the primary payer and Jefferson Health Plans deny a claim in accordance with applicable requirements.

Member billing is strictly prohibited where federal or state law requires members to be held harmless.

Jefferson Health Plans EverWell (Medical Assistance) and CHIP: Jefferson Health Plans EverWell operates as a payer of last resort, and members are generally not responsible for payment of covered medical services. Jefferson Health Plans CHIP, which is a state-regulated program administered by Jefferson Health Plans, follows similar member billing protections in alignment with applicable Medicaid Third Party Liability (TPL) requirements and state regulations.

Providers must not:

- Collect copayments, coinsurance, or deductibles at the time of service when Jefferson Health Plans EverWell or CHIP is secondary.
- Bill members for covered services.
- Deny services based on a member's inability to pay a copayment.

Members may be billed for non-covered services only when the member has been notified in writing and in advance, in accordance with applicable law.

Paid-in-Full Requirement: Once the applicable contracted Medicaid allowable amount is satisfied through payment by the primary payer, Jefferson Health Plans, or both, the provider is considered paid in full. No additional amounts may be billed to the member, and any excess amounts collected must be refunded. Billing beyond permitted limits violates Medicaid regulations and Pennsylvania law.

Medicare and Medicaid Dual-Eligible Member: Providers may not bill Medicare–Medicaid dual eligible members for Medicare Part A or Part B cost-sharing. Cost-sharing must be billed to the member's assigned Community HealthChoices (CHC) plan.

Medicaid payment of Medicare cost-sharing is limited to the difference between the Medicare payment amount and the applicable contracted Medicaid rate for the service. If the contracted Medicaid rate is lower than the Medicare payment amount, Jefferson Health Plans may not remit payment, and the provider will be considered paid in full.

Participation in the CHC plan's provider network is not required in order to submit claims for Medicare cost-sharing.

Jefferson Health Plans Medicare Advantage: Medicare Advantage cost-sharing includes copayments, coinsurance, and deductibles as defined under Medicare rules and the member's benefit plan. Member billing is limited to cost-sharing amounts permitted under applicable federal requirements, benefit design, and provider contract.

Prohibition on Member Billing (QMB): Federal law prohibits providers from billing Qualified Medicare Beneficiary (QMB or QMB Plus) members for any Medicare Part A or Part B cost-sharing. Providers must never bill QMB members for Medicare cost-sharing, even if the service is not covered by Medicaid.

Note: While Jefferson Health Plans Medicare Special (D-SNP) limits enrollment to members with cost-share protection, dual eligible individuals may also be enrolled in other Jefferson Health Plans products.

Jefferson Health Plans Individual and Family Plans (ACA): Members enrolled in Jefferson Health Plans Individual and Family Plans may be billed for applicable copayments, coinsurance, and deductibles in accordance with their benefit plan and provider contract. When Jefferson Health Plans is secondary, member billing is limited to permitted cost-sharing after all other payments have been applied.

Program-Specific Rules and Exceptions: The following program-specific rules and exceptions apply to certain Jefferson Health Plans products and supersede general Coordination of Benefits or billing rules where noted.

Preventive Pediatric Care Exception (Medicaid): For Jefferson Health Plans EverWell members, preventive pediatric care is subject to special Coordination of Benefit rules.

- For covered preventive pediatric services, Jefferson Health Plans will not require proof that other insurance was billed prior to claim submission solely for coordination of benefits purposes, except for hospital delivery claims.
- When other insurance or third-party liability is not identified at the time services are rendered, claims for covered preventive pediatric services may be submitted directly to Jefferson Health Plans.
- Jefferson Health Plans may pursue recovery from other responsible third parties after payment when permitted under applicable state and federal law.
- This exception applies only to services defined as preventive pediatric care under applicable Medicaid and EPSDT guidelines.

Jefferson Health Plans CHIP – Enrollment and Other Insurance Restrictions: Jefferson Health Plans CHIP is designed for children who are not eligible for Medical Assistance and generally may not have other creditable health insurance coverage.

If a CHIP member presents with other active health insurance, providers must:

- Verify eligibility with the other payer;
- Submit claims to the other payer first; and
- Notify Jefferson Health Plans for eligibility review.
- Jefferson Health Plans will determine whether CHIP coverage remains valid and will contact the member if coverage termination or changes are required.

Providers should report other insurance by calling the Provider Services Helpline at 1-888-991-9023 or by submitting the primary insurer's Explanation of Benefits (EOB).

Authorization and Payment Requirements When Jefferson Health Plans Assumes Primary Responsibility

When a primary payer denies a claim, Jefferson Health Plans will evaluate whether it may assume primary payment responsibility in accordance with applicable law, contract, and program requirements.

Assumption of Primary Responsibility

If a primary payer denies a claim for reasons not attributable to provider noncompliance with that payer's claim submission, authorization, or utilization management requirements, Jefferson Health Plans may assume primary payment responsibility when required by law, contract, or program rules and only when all of the following conditions are met:

- The service is covered under the applicable Jefferson Health Plans benefit plan; and
- All Jefferson Health Plans authorization, referral, billing, and utilization management requirements have been satisfied.

Failure to obtain required authorization or to comply with applicable Jefferson Health Plans requirements may result in claim denial.

Provider Noncompliance with Primary Payer Requirements

Claims that could have been paid by a primary payer but were denied due to the provider's failure to comply with that payer's utilization management, authorization, or claim submission requirements will not be considered for payment by Jefferson Health Plans, unless payment is otherwise required by regulation, statute, or contract.

If payment is required despite a primary denial:

- Jefferson Health Plans' payment obligation may be limited to the amount that would have been payable had Jefferson Health Plans been the secondary payer, subject to applicable Jefferson Health Plans allowable amounts and contract terms.
- In no event may the member be billed for copayments, coinsurance, or deductibles that are prohibited under applicable program rules.