STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: California

Third Party Liability

(1) The State Medicaid agency will use the pay and chase method for the purpose of recovering Third Party Liability when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State IV-D agency. Pay and chase activities are initiated in accordance with the established threshold for seeking reimbursement of medical benefits from a liable third party.

Non-emergency wheelchair van and litter/medi-van transportation (medical services codes 0015-0029) and Adult Day Health Care (ADHC) services (medical services codes Z8500-Z8506) are not benefits covered by the health insurance industry. Therefore, the Department of Health Care Services (Department) is exempting these services from cost avoidance and post-payment billings because the cost to the State to edit the claims to cost avoid such services and to create post-payment billings on a recovery basis is not justified.

(2) The threshold amounts used in determining whether to seek reimbursement from a liable third party are as follows:

a) Payments for care to eligibles with health insurance are computer billed monthly when $100 in accumulated health care services have been paid by Medi-Cal. If the $100 threshold is not reached within three (3) years, no claim is generated.

b) Potential Casualty Insurance and Workers' Compensation cases are established when Medi-Cal payments of $500 and over have been made.

c) When unsolicited money of any value is received, it is retained, researched to identify why it was received and credited to the proper account or returned to sender.

d) Estate Recovery claims are filed in the probate or distribution of assets of deceased Medi-Cal beneficiaries when the health care services paid by the State exceed $750.

e) Provider and beneficiary overpayments are billed when the amount of the overpayment liability exceeds $100.

(3) The dollar amount or timeframe, used by the State Medicaid Agency for accumulating health care services payments to determine whether to bill a particular third party, are defined in #2 above.

(4) For third-party recoveries, the Department shall comply with 42 U.S.C. Section 1396a(a)(25)(B) and use the following factors and guidelines in determining whether or to what extent to pursue recovery, after deduction of the Department's share of attorney's fees and costs, from a liable party.

a) Ascertain the amount of Medicaid expenditures related to the injury and the amount of the potential gross settlement, judgment, and/or award.

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b) Determine whether the full Medicaid lien, plus attorney's fees and costs, is likely to exhaust or exceed the settlement, judgment, and/or award.

c) If the Medicaid lien, plus attorney's fees and costs, exhausts or exceeds the settlement, judgment, and/or award, and if the Department:

1) Is informed that the Medicaid recipient will not pursue the claim; or has made reasonable efforts to ascertain the recipient's intention regarding the claim, but could not obtain a response; and

2) Finds it cost prohibitive to investigate and prosecute the claim to establish liability if the claim were to be tendered to the Department, then the Department shall follow the procedures stated in d).

d) The Department shall consider cost-effectiveness to the State in determining the estimated net recovery amount to be pursued, based on the likelihood of collections. In determining the estimated net recovery amount, the following factors shall be considered:

1) Settlement as may be affected by insurance coverage, policy limits, or other factors relating to the liable party;

2) The attorney's fees and litigation costs paid for by the Medicaid recipient;

3) Factual and legal issues of liability as may exist between the Medicaid recipient and third party;

4) Problems of proof faced in obtaining the settlement, judgment, and/or award;

5) The estimated attorney's fees and costs required for the Department to pursue the claim;

6) The amount of the settlement, judgment, and/or award allocated to, or expected to be allocated to, medical expenses or medical care; and

7) The extensive administrative burden that would be placed on the Department to pursue claims.

e) To ensure the highest potential recovery, the Department will first consider the above factors and then, on a case-by-case basis, determine if a recovery of a lesser amount is still cost-effective.

f) In the event the Department's lien exceeds the beneficiary's recovery after deducting, from the settlement, judgment, or award, attorney's fees and litigation costs paid for by the beneficiary, the Department will credit CMS with its full federal share regardless whether the Department's lien was settled under state law which prohibits the Department from recovering more than the beneficiary recovers.