Provider Network Update
April 2024

UPDATE: Third Party Liability Claim Recoveries

What is occurring:

Medicaid is the payer of last resort. McLaren Health Plan, like all other Medicaid Health Plans in Michigan, is required to by The Michigan Department of Health and Human Services – Third Party Liability Division (MDHHS-TPL) to recover funds from providers and other insurance companies when it was determined that there was an appropriate primary payer. This is based on state and federal contractual and regulatory requirements.

ALL Managed Care Organizations (MCOs) in the State of Michigan, including McLaren Health Plan, are reviewing coordination of benefits information provided by MDHHS-TPL. The guidance from MDHHS-TPL requires that all MCO's initiate recoveries where a primary payer has been identified.

What will this look like?

A previously submitted claim that falls under this will be voided/denied. The voided/denied claim will indicate to the provider that the reason was there was another primary payer. This will alert the provider to the fact that Medicare is the primary provider.

Primary Coverage Type	HealthRules and paper remittance denial code	HealthRules and paper remittance denial desc	835 remittance CARC	835 remittance CARC Desc	835 remittance RARC	835 remittance RARC Desc
Commercial	86	This claim is a candidate for coordination of benefits, but payment information from the other insurer was not provided.	22	This care may be covered by another payer per coordination of benefits.	MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
Medicare	M86	This claim is a candidate for Medicare coordination of benefits, but payment information from Medicare was not provided.	22	This care may be covered by another payer per coordination of benefits.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).

The first round of recoveries (starting April 17, 2024) will be related to Medicare Parts A and B for claims from 2014 to 2024.

What can a provider do to be made whole?

Medicare allows claims to be billed up to one year from the date of service.

How can a provider be reimbursed for claims with dates of service over 6 months old?

The provider will have to provide documentation and seek approval from the Medicare Claims Processing Contractor.

To be reimbursed by Medicare Part A or B, following a McLaren Health Plan initiated recovery, you will have to provide the Medicare claims processing contractor with the following information:

1. Documentation verifying the date that McLaren Health Plan recouped money from you;
2. Documentation verifying that your patient was retroactively entitled to Medicare to or before the date of the furnished service. Verification can be in the form of an official SSA letter to the patient.
    a. NOTE: If an official SSA letter is not available, the Medicare contractor will check the common working file (CWF) database and may interpret the CWF date of accretion and the CWF Medicare entitlement date for a beneficiary in order to verify a beneficiary's retroactive entitlement; and,
3. Documentation verifying the service(s) furnished to the beneficiary and the date of the furnished service(s).

If the Medicare claims contractor determines that all the conditions described above are met, the contractor will notify you in writing that a billing extension will be allowed. The extension will expire at the end of the 6th calendar month from the month in which the McLaren Health Plan recovered from you.

To Contact your Medicare Claims Processing Contractor, send correspondence to:

Michigan
WPS GHA
Claims Department
P.O. Box 8604
Madison, WI 53708-8604

For more information on this:
Medicare Claims Processing Manual, Chapter 1, section 70.7.3.