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TITLE 42 -- PUBLIC HEALTH
CHAPTER IV -- CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER C -- MEDICAL ASSISTANCE PROGRAMS
PART 433 -- STATE FISCAL ADMINISTRATION
SUBPART D -- THIRD PARTY LIABILITY

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42 CFR 433.138

§ 433.138 Identifying liable third parties.

(a) Basic provisions. The agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the plan. At a minimum, such measures must include the requirements specified in paragraphs (b) through (k) of this section, unless waived under paragraph (l) of this section.

(b) Obtaining health insurance information: Initial application and redetermination processes for Medicaid eligibility. (1) If the Medicaid agency determines eligibility for Medicaid, it must, during the initial application and each redetermination process, obtain from the applicant or beneficiary such health insurance information as would be useful in identifying legally liable third party resources so that the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, the name of the policy holder, his or her relationship to the applicant or beneficiary, the social security number (SSN) of the policy holder, and the name and address of insurance company and policy number.

(2) If Medicaid eligibility is determined by the Federal agency administering the supplemental security income program under title XVI in accordance with a written agreement under section 1634 of the Act, the Medicaid agency must take the following action. It must enter into an agreement with CMS or must have, prior to February 1, 1985, executed a modified section 1634 agreement that is still in effect to provide for --

(i) Collection, from the applicant or beneficiary during the initial application and each redetermination process, of health insurance information in the form and manner specified by the Secretary; and

(ii) Transmittal of the information to the Medicaid agency.

(3) If Medicaid eligibility is determined by any other agency in accordance with a written agreement, the Medicaid agency must modify the agreement to provide for --

(i) Collection, from the applicant or beneficiary during the initial application and each redetermination process, of such health insurance information as would be useful in identifying legally liable third party resources so that the Medicaid agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f). Health insurance information may include, but is not limited to, those elements described in paragraph (b)(1) of this section; and

(ii) Transmittal of the information to the Medicaid agency.

(c) Obtaining other information. Except as provided in paragraph (l) of this section, the agency must, for the purpose of implementing the requirements in paragraphs (d)(1)(ii) and (d)(4)(i) of this section, incorporate into the eligibility case file the names and SSNs of absent or custodial parents of Medicaid beneficiaries to the extent such information is available.

(d) Exchange of data. Except as provided in paragraph (l) of this section, to obtain and use information for the purpose of determining the legal liability of the third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f), the agency must take the following actions:

(1) Except as specified in paragraph (d)(2) of this section, as part of the data exchange requirements under § 435.945 of this chapter, from the State wage information collection agency (SWICA) defined in § 435.4 of this chapter and from the SSA wage and earnings files data as specified in § 435.948(a)(2) of this chapter, the agency must --

(i) Use the information that identifies Medicaid beneficiaries that are employed and their employer(s); and

(ii) Obtain and use, if their names and SSNs are available to the agency under paragraph (c) of this section, information that identifies employed absent or custodial parents of beneficiaries and their employer(s).

(2) If the agency can demonstrate to CMS that it has an alternate source of information that furnishes information as timely, complete and useful as the SWICA and SSA wage and earnings files in determining the legal liability of third parties, the requirements of paragraph (d)(1) of this section are deemed to be met.

(3) The agency must request, as required under § 435.948(a)(6)(i), from the State title IV-A agency, information not previously reported that identifies those Medicaid beneficiaries that are employed and their employer(s).

(4) Except as specified in paragraph (d)(5) of this section, the agency must attempt to secure agreements (to the extent permitted by State law) to provide for obtaining --

(i) From State Workers' Compensation or Industrial Accident Commission files, information that identifies Medicaid beneficiaries and, (if their names and SSNs were available to the agency under paragraph (c) of this section) absent or custodial parents of Medicaid beneficiaries with employment-related injuries or illnesses; and

(ii) From State Motor Vehicle accident report files, information that identifies those Medicaid beneficiaries injured in motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists.

(5) If unable to secure agreements as specified in paragraph (d)(4) of this section, the agency must submit documentation to the regional office that demonstrates the agency made a reasonable attempt to secure these agreements. If CMS determines that a reasonable attempt was made, the requirements of paragraph (d)(4) of this section are deemed to be met.

(e) Diagnosis and trauma code edits. (1) Except as specified under paragraph (e)(2) or (l) of this section, or both, the agency must take action to identify those paid claims for Medicaid beneficiaries that contain diagnosis codes 800 through 999 International Classification of Disease, 9th Revision, Clinical Modification, Volume 1 (ICD-9-CM) inclusive, for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability payment procedures specified in § 433.139(b) through (f).

(2) The agency may exclude code 994.6, Motion Sickness, from the edits required under paragraph (e)(1) of this section.

(f) Data exchanges and trauma code edits: Frequency. Except as provided in paragraph (l) of this section, the agency must conduct the data exchanges required in paragraphs (d)(1) and (d)(3) of this section in accordance with the intervals specified in § 435.948 of this chapter, and diagnosis and trauma edits required in paragraphs (d)(4) and (e) of this section on a routine and timely basis. The State plan must specify the frequency of these activities.

(g) Follow-up procedures for identifying legally liable third party resources. Except as provided in paragraph (l) of this section, the State must meet the requirements of this paragraph.

(i) Except as specified in § 435.952(d) of this chapter, within 45 days, the agency must followup (if appropriate) on such information in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(1)(i) of this section.

(2) Health insurance information and workers' compensation data exchanges. With respect to information obtained under paragraphs (b) and (d)(4)(i) of this section --

(i) Within 60 days, the agency must followup on such information (if appropriate) in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f); and

(ii) The State plan must describe the methods the agency uses for meeting the requirements of paragraph (g)(2)(i) of this section.

(3) State motor vehicle accident report file data exchanges. With respect to information obtained under paragraph (d)(4)(ii) of this section --

(i) The State plan must describe the methods the agency uses for following up on such information in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures specified in § 433.139 (b) through (f);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify timeframes for incorporation of the information.

(4) Diagnosis and trauma code edits. With respect to the paid claims identified under paragraph (e) of this section --

(i) The State plan must describe the methods the agency uses to follow up on such claims in order to identify legally liable third party resources so the agency may process claims under the third party liability payment procedures

specified in § 433.139 (b) through (f) (Methods must include a procedure for periodically identifying those trauma codes that yield the highest third party collections and giving priority to following up on those codes.);

(ii) After followup, the agency must incorporate all information that identifies legally liable third party resources into the eligibility case file and into its third party data base and third party recovery unit; and

(iii) The State plan must specify the timeframes for incorporation of the information.

(h) Obtaining other information and data exchanges: Safeguarding information. (1) The agency must safeguard information obtained from and exchanged under this section with other agencies in accordance with the requirements set forth in part 431, subpart F of this chapter.

(2) Before requesting information from, or releasing information to other agencies to identify legally liable third party resources under paragraph (d) of this section the agency must execute data exchange agreements with those agencies. The agreements, at a minimum, must specify --

(i) The information to be exchanged;

(ii) The titles of all agency officials with the authority to request third party information;

(iii) The methods, including the formats to be used, and the timing for requesting and providing the information;

(iv) The safeguards limiting the use and disclosure of the information as required by Federal or State law or regulations; and

(v) The method the agency will use to reimburse reasonable costs of furnishing the information if payment is requested.

(i) Reimbursement. The agency must, upon request, reimburse an agency for the reasonable costs incurred in furnishing information under this section to the Medicaid agency.

(j) Reports. The agency must provide such reports with respect to the data exchanges and trauma code edits set forth in paragraphs (d)(1) through (d)(4) and paragraph (e) of this section, respectively, as the Secretary prescribes for the purpose of determining compliance under § 433.138 and evaluating the effectiveness of the third party liability identification system. However, if the State is not meeting the provisions of paragraph (e) of this section because it has been granted a waiver of those provisions under paragraph (l) of thissection, it is not required to provide the reports required in this paragraph.

(k) Integration with the State mechanized claims processing and information retrieval system. Basic requirement -- Development of an action plan. (1) If a State has a mechanized claims processing and information retrieval system approved by CMS under subpart C of this part, the agency must have an action plan for pursuing third party liability claims and the action plan must be integrated with the mechanized claims processing and information retrieval system.

(2) The action plan must describe the actions and methodologies the State will follow to --

(i) Identify third parties;

(ii) Determine the liability of third parties;

(iii) Avoid payment of third party claims as required in § 433.139;

(iv) Recover reimbursement from third parties after Medicaid claims payment as required in § 433.139; and,

(v) Record information and actions relating to the action plan.

(3) The action plan must be consistent with the conditions for reapproval set forth in § 433.119. The portion of the plan which is integrated with MMIS is monitored in accordance with those conditions and if the conditions are not met; it is subject to FFP reduction in accordance with procedures set forth in § 433.120. The State is not subject to any other penalty as a result of other monitoring, quality control, or auditing requirements for those items in the action plan.

(4) The agency must submit its action plan to the CMS Regional Office within 120 days from the date CMS issues implementing instructions for the State Medicaid Manual. If a State does not have an approved MMIS on the date of issuance of the State Medicaid Manual but subsequently implements an MMIS, the State must submit its action plan within 90 days from the date the system is operational. The CMS Regional Office approves or disapproves the action plan.

(l) Waiver of requirements. (1) The agency may request initial and continuing waiver of the requirements to determine third party liability found in paragraphs (c), (d)(4), (d)(5), (e), (f), (g)(1), (g)(2), (g)(3), and (g)(4) of this section if the State determines the activity to be not cost-effective. An activity would not be cost-effective if the cost of the required activity exceeds the third party liability recoupment and the required activity accomplishes, at the same or at a higher cost, the same objective as another activity that is being performed by the State.

(i) The agency must submit a request for waiver of the requirement in writing to the CMS regional office.

(ii) The request must contain adequate documentation to establish that to meet a requirement specified by the agency is not cost-effective. Examples of documentation are claims recovery data and a State analysis documenting a cost-effective alternative that accomplished the same task.

(iii) The agency must agree, if a waiver is granted, to notify CMS of any event that occurs that changes the conditions upon which the waiver was approved.

(2) CMS will review a State's request to have a requirement specified under paragraph (l)(1) of this section waived and will request additional information from the State, if necessary. CMS will notify the State of its approval or disapproval determination within 30 days of receipt of a properly documented request.

(3) CMS may rescind a waiver at any time that it determines that the agency no longer meets the criteria for approving the waiver. If the waiver is rescinded, the agency has 6 months from the date of the rescission notice to meet the requirement that had been waived.

HISTORY: *[52 FR 5975,* Feb. 27, 1987, as amended at *54 FR 8741,* Mar. 2, 1989; *55 FR 1432,* Jan. 16, 1990; *55 FR 5118,* Feb. 13, 1990; *60 FR 35502,* July 10, 1995]

AUTHORITY: AUTHORITY NOTE APPLICABLE TO ENTIRE PART:
Sec. 1102 of the Social Security Act, *(42 U.S.C. 1302).*

NOTES: NOTES APPLICABLE TO ENTIRE CHAPTER:
[PUBLISHER'S NOTE: Nomenclature changes affecting Chapter IV appear at *45 FR 53806,* Aug. 13, 1980; *50 FR 12741,* Mar. 29, 1985; *50 FR 33034,* Aug. 16, 1985; *51 FR 41338,* Nov. 14, 1986; *53 FR 6634,* Mar. 2, 1988; *53 FR 47201,* Nov. 22, 1988; *56 FR 8852,* Mar. 1, 1991; *66 FR 39450, 39452,* July 31, 2001; *67 FR 36539, 36540,* May 24, 2002; *77 FR 29002, 29028,* May 16, 2012.]

LexisNexis (R) Notes:

CASE NOTES

CASE NOTES Applicable to entire Part:Part Note

Michigan Dep't of Social Services v. Sullivan, 1990 U.S. Dist. LEXIS 17153 (WD Mich Dec. 13, 1990).

Overview: *An agency's motion for a preliminary injunction against the secretary was denied because there was no case law supporting its position and the agency failed to make a showing of at least a strong probability of success on the merits.*

- Title XIX of the Social Security Act, *42 U.S.C.S. § 1396* et seq., establishes a jointly funded, cooperative federal-state program to pay the costs of necessary medical services for beneficiaries whose income and resources are insufficient to meet those costs. This program, known as Medicaid, allows qualifies individuals to receive medical care without cost, or subject to a co-payment. The provider of the medical services submits a claim to the appropriate program, and is reimbursed directly for the service. The statute establishes certain groups of individuals that must be covered, and certain services that must be offered, if a state chooses to participate in the program. The state is required to determine, however, whether a service is covered by a liable third party, *42 U.S.C.S. § 1396*(a)(25), *42 C.F.R. § 433.138(a)*, and may not make payment if it establishes the probability that third party liability exists. *42 C.F.R. § 433.139(b)(1)*. Go To Headnote

Michigan Dep't of Social Services v. Sullivan, 1992 U.S. App. LEXIS 10014 (6th Cir Apr. 30, 1992) (Unpublished).

Overview: *The agency's motion for relief from judgment that was based on evidence that was discoverable before judgment, was cumulative, was not new, and failed to constitute a basis for relief or to show extraordinary circumstances was properly denied.*

- Medicaid, established by Title XIX of the Social Security Act, *42 U.S.C.S. § 1396* et seq., is a jointly-funded, cooperative federal-state program, which pays the costs of necessary medical expenses for beneficiaries whose income and resources are insufficient to meet these costs. Under Medicaid, the state is required to determine if the service is covered by a liable third party, *42 U.S.C.S. § 1396*(a)(25); *42 C.F.R. § 433.138(a)*, and may not make payments if it establishes a probability that third party liability exists. Under state law, Mich. Comp. Laws § 400.106(b)(ii), when Michigan Department of Social Services pays Medicaid benefits to a nursing home, it is subrogated to any claim the patient may have for reimbursement from a responsible third party, including Medicare. Thus, when Medicare should pay, Michigan Department of Social Services may first pay under the Medicaid program, thus incurring state expense, and then recover from Medicare. Go To Headnote

Bozeman v. State, 879 So. 2d 692, 2004 La. LEXIS 2100 (LA July 2, 2004).

Overview: *A wife was unable to recover under the collateral source rule those medical expenses that were "written-off" by healthcare providers as required by the Medicaid program because she did not provide any consideration for the Medicaid benefits.*

- Federal law requires each state participating in the Medicaid program to designate a single agency to administer the program. *42 C.F.R. 431.10*. Among the agency's duties, is a requirement to make efforts to recover Medicaid funds that were paid in connection with a beneficiary's tort action from liable third parties. *42 C.F.R. 433.138*. In Louisiana, that agency is the Louisiana Department of Health and Hospitals (DHH) and La. Rev. Stat. Ann. § 46:446 is the statute that empowers DHH to recover such funds. La. Rev. Stat. Ann. § 46:446(B) states that a plaintiff who files suit for injuries and receives Medicaid benefits for those injuries shall at the time suit is filed cause a copy of the petition to be served on DHH. Also, such person filing suit shall be responsible to the department to the extent of the medical payments or assistance received, interest, and attorney fees if he fails to have service made upon the department. Go To Headnote

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United States Ex Rel. Digital Healthcare, Inc. v. Affiliated Computer Servs.,, 778 F. Supp. 2d 37, 2011 U.S. Dist. LEXIS 42586 (DDC Apr. 20, 2011).

Overview: *Motion to dismiss was granted because the public disclosures did not suggest where the fraud was occurring, what percent of actors within the industry were purportedly engaged in it, the nature of any schemes used to facilitate the payment of false Medicaid claims, or any specific entities that allegedly engaged in such activity.*

- Medicaid is intended be a "payer of last resort." Thus, if a Medicaid beneficiary also has another source of payment for health services, that source is to pay instead of Medicaid. In general, state Medicaid agencies are required whenever possible to avoid paying for services for which thestate agency has reason to believe another party is legally liable. *42 C.F.R. § 433.139(b)*. Therefore, a state Medicaid agency must take reasonable measures to determine the legal liability of the third parties who are liable to pay for services furnished under the state Medicaid plan. *42 C.F.R. § 433.138(a)*. Go To Headnote

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In re Zyprexa Prods. Liab. Litig., 451 F. Supp. 2d 458, 2006 U.S. Dist. LEXIS 64367 (ED NY Sept. 11, 2006).

Overview: *In a multi-district mass tort litigation, states which agreed to resolution of Medicare liens by means of global or traditional-holdback methods and sought to recover Medicaid disbursements from settling plaintiffs were to pay share of attorneys' fees and costs, with total amount of fees capped. Medicare payments to settling plaintiffs continued.*

- If a state Medicaid agency receives reimbursement from a liable third party for care or services, it does not receive federal financial participation (FFP) for the relevant Medicaid expenditures. *42 C.F.R. § 433.140(a)(2)*. Likewise, if the state could have received reimbursement from a third party but failed to comply with federal regulations requiring it to attempt to establish liability and pursue reimbursement from that third party, *42 C.F.R. § 433.138-433.139*, the state does not receive FFP in its Medicaid expenditures. *42 C.F.R. § 433.140(a)(1)*. If a state that has already received FFP in its Medicaid expenditures later receives third party reimbursement for those expenditures, the state must pay the federal government a portion of the reimbursement determined in accordance with the federal medical assistance percentage for the state. *42 C.F.R. § 433.140(c)*. Go To Headnote

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