Third Party Liability
Medicaid as the Payer of Last Resort

According to federal law, providers are obligated to bill all third party payers before filing a claim with Medicaid. Questions arise regarding this policy given that it may be inconvenient for the provider and/or result in lower payments. This Fact Sheet – part of an ongoing series developed by the Geriatric Technical Assistance Center – attempts to address that issue using citations from state and federal law, as well as links to and references from the Office of the Medicaid Inspector General in New York State.

In almost all cases, it is required that the provider submits a claim to Medicare first for all dually-eligible Medicare/Medicaid beneficiaries. This is true regardless of the service, the provider, and the outcome of the service. In fact, New York State Medicaid is instructed by the federal government to not adjudicate the claim without prior adjudication by the primary payer.

According to former Medicaid Inspector General of New York, James G. Sheehan, during a 2011 webcast, “the first responsibility is truth-telling for Medicaid provider claimants.” According to Sheehan, this means that a provider:

- Cannot fail to bill other insurance if the service is or may be covered;
- Cannot submit a claim that fails to report known other payor;
- In general, cannot submit claim reporting “zero fill” unless the other payor has received and denied the claim;
- Cannot retain payments from Medicaid when the other insurer pays in full (even if it is less than Medicaid would have paid), except for OMH-licensed clinics; and
- Must identify, report, refund to Medicaid, and explain payments from third parties after receipt of payment from third parties.

GY Modifier: Submitting Claims when Medicare Will Deny the Claim

When an item or service is statutorily excluded or does not meet the definition of a Medicare benefit, the provider may append the modifier “GY.” Medicare will deny the claim, and then it can be submitted to the beneficiary’s secondary insurance.

Memorandum Report OEI-02-10-00160 for Part B Claims with G Modifiers, 3/3/2013, HHS-OIG to CMS

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There are several federal and state statutes that govern this requirement. First, §1902(a)(25) of the Social Security Act requires participating states to:

“take all reasonable measures to ascertain the legal liability of third parties...to pay for care and services [provided to Medicaid recipients]” and “in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability.”

Federal regulations further outline provisions that state Medicaid agencies must follow in paying claims when a third party has liability for payment. In most cases, the Medicaid program has payment liability only for that portion of the patient’s bill not covered by third-party resources, such as health or accident insurance, workers' compensation, Veterans Administration, Medicare, or other primary coverage. Specific provisions include:

- In general, if the provider accepts an amount less than the Medicaid payment amount as payment in full by the payor, Medicaid cannot be billed for the balance.
- As a condition of eligibility, provider applicants must assign to Medicaid rights to medical support and to payment for medical care from any third party.
- Where third-party liability exists, the state agency must reject a claim for reimbursement for that service and return it to the provider for a determination of the amount of the third party's liability.
- Providers are required to disclose on the claim form when third-party coverage and/or potential liability exists.

In addition, the Deficit Reduction Act of 2005 (Section 6035) requires that the State must impose on an insurer a duty to, “as a condition of doing business in the State”:

- accept the State’s right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
- respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of such health care item or service; and
- agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if—(I) the claim is submitted by the State within the three-year period beginning on the date on which the item or service was furnished; and (II) any action by the State to enforce its rights with respect to such claim is commenced within six years of the State’s submission of such claim.
New York State has similar legal requirements applicable to Third-Party Liability and Medicaid.5

(1) Providers must “take reasonable measures to ascertain the legal liability of third parties”
(2) “No claim for reimbursement shall be submitted unless the provider has:
   (i) “investigated to find third-party resources” and
   (ii) sought reimbursement from liable third parties.”
(3) Each medical assistance provider shall:
   (i) ask the recipient about resources available
   (ii) “make claims against all resources”
   (iii) “continue investigation and attempts to recover from potential third-party resources”
   (iv) “if the provider is informed”...investigate the possibility of making a claim to the liable third party and make such claim as is reasonably appropriate; and
   (v) “take any other reasonable measures necessary to assure that no claims are submitted to the medical assistance program that could be submitted to another source of reimbursement.”
(4) Any reimbursement the provider recovers from liable third parties shall be applied to reduce any claims for medical assistance submitted for payment to the medical assistance program by such provider or shall be repaid to the medical assistance program within 30 days after third-party liability has been ascertained; when a claim has been submitted to a third party whose liability was ascertained after submission of a claim to the medical assistance program, the provider must make reimbursement to the medical assistance program within 30 days after the receipt of reimbursement by the provider from a liable third party.

According to the Office of the Medicaid Inspector General, improper retention of funds could lead to liability under False Claims Act.

2 For individuals with both Medicaid and Medicare coverage, Medicaid will pay the “higher of” what Medicare or Medicaid would pay for the services provided in the OMH-licensed clinic.
3 See 42 CFR 433.139, 42 CFR 433.145, 42 CFR 433.139(b)(1)
5 18 NYCRR 540.6 (e)