

THIRD PARTY LIABILITY & COORDINATION OF BENEFITS

COMMUNITY HEALTHCHOICES (CHC) is Pennsylvania’s mandatory managed care program for individuals who are eligible for both Medicaid and Medicare (dual-eligibles), older adults, and individuals with physical disabilities — serving more people in communities while giving them the opportunity to work, spend more time with their families, and experience an overall better quality of life. When implemented, CHC will improve services for hundreds of thousands of Pennsylvanians.

THIRD PARTY LIABILITY (TPL) is when the financial responsibility for all or part of a participant’s health care expenses rests with an individual entity or program other than the CHC managed care organization (CHC-MCO), such as Medicare or commercial insurance.

Providers are required to check the Eligibility Verification System (EVS) to ensure a participant is eligible at the date of — but not prior to — services being rendered. The member must follow the rules of TPL and services may not be provided if the third party was non-par and an out-of-network agreement was not made prior to the visit. EVS will include information of the participant’s CHC-MCO, along with any TPL information. At the date of service, providers should always ask participants for all forms of insurance, not just their CHC Medicaid insurance card or ACCESS card. This is to ensure that benefits are properly coordinated and Medicaid (CHC-MCO) remains the payer of last resort.

Providers will bill the CHC-MCO in which the participant is enrolled for services provided. If the participant has a TPL, including Medicare, providers must bill the TPL first for payment of eligible services and obtain an Explanation of Benefits (EOB) from the primary insurer. Once the TPL has paid or denied the claim, CHC-MCOs should be billed by the provider for the remainder of the claim.

CHC’S IMPACT ON TPL

What’s similar?

- Medicaid (CHC-MCOs) will remain the payer of last resort.
- All forms of medical coverage (TPL) on EVS should be checked at the date of service, not before services are rendered. Participants are to present, at minimum, their ACCESS card and CHC-MCO insurance card.
- Providers may not balance-bill participants when Medicaid, Medicare, or another form of TPL does not cover the entire billed amount for a service delivered.

What’s different?

- Providers will no longer bill fee-for-service at the Department of Human Services. The CHC-MCO will be billed directly if no TPL is present or after an EOB is obtained from the primary insurer for a participant with a TPL.