

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

Requirements for Third Party Liability -
Identifying Liable Resources

- (1) The requirement in 433.138(f) is met, as follows:
- A. The frequency of the data exchange with the Employment Division (SWICA) is quarterly.
 - B. The frequency of the data exchange with Title IV-A is daily.
 - C. The frequency of the data exchange with the Motor Vehicle Division for accident report data is monthly.
 - D. The frequency of diagnosis and trauma code edits is daily.
 - E. The frequency of the data exchange with Worker's Compensation is monthly.

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(2) The requirement in 433.138(g)(1)(ii) is met, as follows:

A. SWICA

Clients with earnings are in a monthly reporting system. The Monthly Change Report (AFS 859A/1199) is used to report any changes and includes a question to gather new medical insurance information.

On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds \$450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow-up. These forms are used to verify earnings and to gather health insurance information.

For wages paid on or after January 1, 1990, employers in Oregon are required to furnish the Employment Division with information about health insurance coverage offered to employees or to their dependents. The Employment Division will gather the information and pass it to the Adult and Family Services Division on a quarterly basis. The IV-D Agency will develop the medical insurance information as part of the medical support enforcement activities and will pass the information to the Title XIX Agency.

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B. Title IV-A

Health insurance information is passed to the Title XIX Agency via the AFS 415H form on a daily basis. Health insurance information is gathered, but not limited to, initial application and each redetermination.

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On a quarterly basis, a match is made with the Employment Division (SWICA). A report is generated when there is an earned income discrepancy for a client which exceeds \$450 for a quarter. A form is sent to the employer (AFS 851) or to the client (AFS 851F) to follow-up. These forms are used to verify earnings and gather health insurance information.

On a monthly basis, a match is made with the health insurance codes on the CMS system and the third party resources on the MMIS TPR file. A report is generated when there is a discrepancy so that the correct resource information is available for processing claims.

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(3) The requirement in 433.138(g)(2)(ii) is met, as follows:

A. Health Insurance

Adult and Family Services Division (AFS), Children's Services Division (CSD), and Senior and Disabled Services Division (SDSD) employees and Type B AAA contractors of SDSD obtain health insurance information from applicants for and recipients of Medicaid. Such information is gathered during the initial application for assistance and at each subsequent redetermination of eligibility, or at any other time that new information becomes known. Information may include, but is not limited to, the policy holder's name and social security number, the group or plan number, the policy or identification number, and the name and address of the insurance company.

Eligibility staff in branch offices of these Divisions and in Type B AAA offices are responsible for assuring that all available information is recorded on Form AFS 415H, and for sending a copy of the completed form to the Third Party Recovery Unit of the AFS Recovery Services Section. The branch office retains the original AFS 415H in the client's case record file.

Third Party Recovery Unit staff verify the information on the AFS 415H and then enter the information onto the MMIS Recipient Subsystem, Third Party Resource File. If the branch enters a Medicare health insurance code (HIC) on the eligibility file, the Medicare insurance information is electronically transferred to the Third Party Resource file on MMIS.

Health insurance information may also be identified by AFS State Office staff, through such sources as the Title IV-D Child Support Program, BENDEX, or provider billings or refunds that indicate health insurance. In such cases, Third Party Recovery Unit staff obtain all available information, complete the AFS 415H (and send the original to the branch office), and code the information onto the MMIS Third Party Resource file. The Buy-In Unit verifies the electronically transferred Medicare insurance on the TPR file.

The MMIS System uses the health insurance information in processing claims, in accordance with 433.139(b) through (f). Health insurance information is also entered onto the client's medical identification card.

MMIS generates a monthly report (WMMR026R-A) to the Third Party Recovery Unit for review of recovery potential whenever new insurance is added and whenever there is a change in the effective date of known insurance.

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The time frame for completing this process, from the date that Division staff first discover health insurance information until the information appears on Report #WMMR026R-A, is 60 days.

The written agreement between AFS and SDSA provides that SDSA will collect health insurance information and transmit this information to AFS.

The written agreement between AFS and CSD provides that CSD will collect health insurance information and transmit this information to AFS.

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B. Worker's Compensation

Oregon's Medicaid program is in the process of implementing a data exchange with Workers' Compensation. Once this match is implemented, we will update this item.

During the implementation of this data match, we will use the data match that provides employment-related health insurance as described in section II-A above. In addition, the IV-D agency will continue to conduct a data match with Workers' Compensation and perform medical support enforcement activities involving the absent parents.

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(4) The requirement in 433.138(g)(3)(i) is met, as follows:

A. Motor Vehicle Accident Report data match

The Department of Motor Vehicles provides a monthly transaction tape containing motor vehicle accident report information. These transactions are matched with clients on the MMIS Recipient file by name and date of birth. Clients with an eligibility period on or after the date of the accident are matched. The matches are then run by the Expense Avoidance file and any record that has already been followed-up will be eliminated to avoid duplication of effort.

Information from the DMV transaction tape and from MMIS will be downloaded from the mainframe to a floppy disk. The floppy disk is loaded into the Third Party Recovery Unit's DMV Accident Data Base File on a personal computer. This data base is used for generating letters and is used for tickler purposes. The follow-up steps are as follows:

- a) The Third Party Recovery Unit sends a letter to each client, asking for information about the accident. An AFS 451 is sent with each letter. This is the form that clients use to report motor vehicle accident information. The data base is updated when the response is received and serves as the tickler file to keep track of those situations where no response is received within the initial 30 days.
- b) If no response is received within 30 days, a follow-up letter to the recipient is generated from the data base.
- c) If no response is received within 30 days of the second letter, the Third Party Recovery unit obtains a copy of the accident report from the Division of Motor Vehicles.

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(5) The requirement in 433.138(g)(3)(iii) is met, as follows:

A. Motor Vehicle Accident Report data match

After follow-up, all information that identifies legally liable third party resources is entered by staff from the Third Party Recovery Unit on the MMIS Third Party Resource File or the MMIS Expense Avoidance File. The MMIS System automatically enters an indicator in the appropriate field on the MMIS Recipient File. The time frame for incorporating the information is 60 days.

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(6) The requirement in 433.138(g)(4)(i) is met, as follows:

Claims which meet the following edit criteria are suspended on a daily basis:

Through MMIS edit 417, a report is generated for claims that contain diagnosis codes 800 through 999, with the exception of code 994.6. This edit reports all inpatient hospital claims where the billed amount exceeds zero, and outpatient hospital and medical claims where the billed amount exceeds \$250 dollars.

Edit 406 will suspend claims which indicate auto related, with no form AFS 451 information on the Expense Avoidance file.

1) A worksheet/report is generated and is sent to the Third Party Recovery Unit. The worksheets are reviewed, with priority given to the following:

A. Claims with auto accident indicators.

B. Claims with the following diagnosis codes: 810.00, 815.03, 821.00, 850.00, 922.10, and 997.30.

This sub-group of diagnosis codes represents injuries most likely to yield recoveries based on prior experience. On an annual basis the Third Party Recovery Unit will review the related trauma diagnosis codes for medical recoveries which exceed \$5000, to determine which trauma diagnosis codes should receive the highest priority for follow-up activities for the following year.

C. Claims containing diagnosis codes beginning with E, unless such claims clearly do not represent a liability situation.

D. Claims exceeding \$10,000, which are not related to late effects of surgery, unless such claims clearly do not represent a liability situation.

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The Third Party Recovery Unit follows-up all claims included in A -D above, with written correspondence to the client. The client is provided with an AFS 451/AFS 451NV form to complete. The AFS 451/AFS 451NV are used to report accident information to the agency. If no response is received within 30 days, a second letter is sent to the client. If there is no current address for the client, a memo is sent to the branch worker requesting assistance. On a case by case basis, information may be obtained from the medical provider.

The completed AFS 451/AFS 451NV form is reviewed by the Third Party Recovery Unit. Liens are filed in liability situations and the information incorporated into the MMIS Expense Avoidance File. In addition to lienable situations, all claims suspended are reviewed for possible other insurance. All third party resource information identified is incorporated into the MMIS third party data base files. The MMIS Recipient file is updated with an indicator whenever a Third Party Resource file or an Expense Avoidance file is created. The information is used by the MMIS system to process claims in accordance with 433.139(b) through (f).

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(7) The requirement in 433.138(g)(4)(iii) is met, as follows:

After follow-up, all information that identifies legally liable third party resources is incorporated into the Third Party Recovery Unit, the MMIS Recipient File, and either the MMIS Expense Avoidance File or the MMIS Third Party Resource File, within 60 days.

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