Third Party Liability Information for Administrative Service Organizations

CMS has updated third party liability (TPL) requirements regarding medical support enforcement beneficiaries from February 2018 and August 2021. These requirements are outlined in 42 CFR § 433.139(b)(3), and impact both professional and institutional providers. In order to come into compliance, Maryland Medicaid must pay and chase claims for services rendered to a medical support enforcement beneficiary if (1) the provider has first billed the noncustodial parent's insurance and (2) not received payment after 100 days from the date of service. The intent is to protect the custodial parent and the dependent children from having to pursue the non-custodial parent, their employer, or insurer for third party liability.

In response to CMS's requirement, Maryland Medicaid is enacting a new billing requirement for providers billing medical support enforcement beneficiary claims. Professional Providers billing medical support enforcement beneficiary claims are required to complete the Maryland Medicaid CMS 1500 Box-11 Rejection Reason S Provider Attestation, and submit this form along with the appropriate documentation when submitting their claim. Institutional Providers billing medical support enforcement beneficiary claims are required to complete the Maryland Medicaid UB04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form, and submit this form along with the appropriate attachments when submitting their claim. A new form must be completed and submitted by providers for each relevant claim.

ASOs are similarly required to align their processes with the new medical support enforcement requirements listed above.

Additional information can be found below.

Overview of Attestation Forms

Maryland Medicaid CMS 1500 Box-11 Rejection Reason S Provider Attestation Form: This form is intended for use by professional providers seeking reimbursement for third party liability claims where the provider has not received payment, and the provider is billing the claim using rejection reason S. The purpose of this form is to allow providers to attest their reason for using rejection reason S, and provide appropriate supporting documentation.

Maryland Medicaid UB04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form: This form is intended for use by institutional providers seeking reimbursement for third party liability claims where the provider has not received payment, and no existing occurrence code is applicable. The purpose of this form is to allow providers to attest their reason for billing their claim without an occurrence code, and provide the appropriate supporting documentation. Providers are NOT required to use any of the existing TPL override occurrence codes (24 or 25) listed in the UB04 Billing Guidance.

Overview of Implementation

Medicaid will pay and chase claims submitted for medical support enforcement beneficiaries (i.e. 'absent parent' is responsible for medical care) if the provider has first billed the absent parent's insurance and not received payment 100 days after date of service (DOS)

- Professional Providers will bill with rejection reason "S" in box 11 of the CMS 1500 to indicate that a child has third party liability (TPL) through an absent parent and the provider has not received payment for at least 100 days after the DOS.
    - Proper documentation will include: Proof of claim submission to TPL, completed Maryland Medicaid CMS 1500 Box 11 – Rejection Reason S Provider Attestation Form
    - Claim must have been submitted at least 100 days after DOS to qualify for payment
    - Rejection S: Other Rejection Reason Not Defined Above (Requires documentation, e.g. a statement on the claim indicating the payment was applied to the deductible) may also be used to indicate a payment applied to the deductible.

- Institutional Providers will bill using the Maryland Medicaid UB-04 Medical Support Enforcement Third Party Claim Billing Provider Attestation Form
    - Proper documentation will include: Proof of claim submission to TPL, completed institutional attestation form.
    - Claims must be submitted at least 100 days after the DOS to qualify for payment.
    - Providers are NOT required to use any of the existing TPL override occurrence codes (24 or 25) listed in the UB04 Billing Guidance.

Frequently Asked Questions

Q: How should providers bill these claims for professional services?

A: Professional services providers should complete the CMS 1500 claim and use rejection reason S in Box 11 to indicate they are requesting payment under this pathway. Providers should then complete the Maryland Medicaid CMS 1500 Box 11-Rejection Reason S Provider

Attestation Form. When completing the form, providers are required to select a reason for use of rejection reason S, and must attest that they meet all of the criteria listed for appropriate billing of S.

Providers are required to attach the completed attestation form, alongside documentation providing proof of claim submission to the third-party, to their completed claim. The claim can then be submitted via mail to:

Claims Processing
Department of Health and Mental Hygiene
P.O Box 1935
Baltimore, MD 21203

Q: How should providers bill these claims for institutional services?

A: Institutional providers should complete the UB04 as they normally would – Providers are NOT required to use any of the existing TPL override occurrence codes (24 or 25) listed in the UB04 Billing Guidance. Providers should then complete the Maryland Medicaid UB04 Provider Attestation Form. When completing the form, providers are required to attest to the reason for billing without an occurrence code.

Providers are required to attach the completed attestation form, alongside documentation providing proof of claim submission to the third-party, to their completed claim. The claim can then be submitted via mail to:

Maryland Medical Assistance Program
Attention: Division of Claims Processing
P.O. Box 1935
Baltimore, MD 21203

Q: What should providers do if they receive payment, a denial, or other remittance advice from the medical support enforcement beneficiaries' TPL before billing the Program?

A: If another rejection reason or occurrence code is applicable to the claim, providers should bill using the appropriate rejection reason or occurrence code. Providers should only bill using the attestation forms if no other alternative pathway exists for payment on these claims. Providers should reference the most up-to-date billing guidance for the CMS-1500 or UB04 for a comprehensive list of rejection reasons and occurrence codes.

Q: What happens if the provider does not complete the attestation form?

A: Providers who fail to either correctly complete the attestation form or attach appropriate documentation as required to verify claim submission to the third-party, will have their claims denied. The provider has up to 12 months from the date of service to submit a clean claim with the necessary forms and documentation.