DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 10-33

2. STATE: Oklahoma

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: July 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS A NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 433.135

7. FEDERAL BUDGET IMPACT
a. FFY 2011 Budget Neutral
b. FFY 2012 Budget Neutral

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See Attachment

10. SUBJECT OF AMENDMENT

Raising TPL claims threshold from $250.00 to $500.00 and updating plan language.

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor does not review State Plan material.

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Mike Fogarty

14. TITLE
Chief Executive Officer

15. DATE SUBMITTED
September 28, 2010

16. RETURN TO
Oklahoma Health Care Authority
Attn: Cindy Roberts
2401 N.W. 23rd Street Suite 1A
Oklahoma City, OK 73107

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 28 September, 2010

18. DATE APPROVED: 10 December, 2010

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 July, 2010

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS
c: Mike Fogarty
Cindy Roberts
Tywanda Cox
Traylor Rains

FORM CMS-179 (07/92)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Requirements for Third Party Liability –
Payment of Claims

Potential third party payer claims (i.e., diagnosis codes, trauma edits, worker's compensation data exchanges) are reported up to six months from the date of accident or until the cost effective threshold of $500.00 is met or exceeded. The threshold amount of $500.00 represents the amount necessary to investigate, submit claims to third party payers and process recoveries. The six month accumulation limit has been determined by claim data to represent the outermost timeframe for which OHCA would identify the initial claim, emergency room visit, related pharmacy claims and follow up visits if necessary.

Recoveries are pursued when private health insurance coverage is identified after OHCA has paid claims for a Medicaid recipient. OHCA's entire population of medical claims is sent to OHCA's TPL contractor on a weekly basis for review.

OHCA has set a $10.00 threshold for seeking reimbursement for health insurance claims. This threshold amount represents the approximate cost of electronically billing resources and receiving electronic transmittals in response and the minimal manual time for processing. OHCA does not accumulate health insurance claims, rather each claim must meet the $10.00 threshold amount or reimbursement is not sought. OHCA's TPL contractor receives a file extract weekly and performs daily billing functions as well as weekly and monthly reviews to correct denied claims.

The OHCA TPL contractor performs retro billing for the agency. The cost effective threshold is an accumulated 10.00 per member therefore, multiple claims can be lumped together to meet this threshold. OHCA pursues three years of back claims initially and for anything that was previously billed, OHCA pursues up to five years from the date of service.

TN# 10-33 Approval Date 12-10-2010 Effective Date 7-01-2010
Supersedes
TN# 96-03

SUPERSEDES: 96-03

STATE: Oklahoma
DATE: 9-28-2010
DATE: 12-10-2010
DATE: 7-01-2010
10-33

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oklahoma

Requirements for Third Party Liability –
Identifying Liable Resources

1. Data exchanges occur for applicants and recipients between the Oklahoma Health Care Authority (OHCA), the Oklahoma Employment Security Commission, Statewide Information Collection Agency (SWICA), and Unemployment Insurance Benefits (UIB) on a weekly basis.

   The SSA wage and earnings file is accessed through the monthly BENDEX with response frequency as determined by the SSA.

   Data exchanges between the OHCA and the State Workers' Compensation Files are performed monthly.

   Oklahoma MMIS uses Diagnosis and Trauma Code edits to process all Medicaid claims. Diagnosis codes ranging from 800 through 999, with some exceptions, are used for the purpose of determining the legal liability of third parties.

2. Each quarter, the MMIS produces reports that determine by trauma code diagnosis, those codes which yield the highest third party collections. OHCA's DSS ad hoc reporting system also allows for the potential to increase the effectiveness of staff time to determine which claims to invest time and resources in order to maximize the return on investment.

   The OHCA TPL Unit monitors timeliness of response to data exchange matches from all sources through supervisory and system controls to assure compliance with the thirty (30) day follow up requirement. Actions to be taken include update of resource files, retro billing processes and follow up for potential casualty claims. All additions, updates and changes are added directly into the MMIS and trigger the appropriate action. Audit trails and dated activity reports verify action is taken within the thirty (30) day timeframe.

   Upon discovery of a potential workers' compensation case, that information is placed on the MMIS recipient file and a retroactive recovery is initiated if the threshold is met. Future claims are then sent directly to the employer's insurance carrier. This information is reviewed at each data match to determine if the case has been settled. Recovery is initiated within 60 days.

TN# 10-33 Approval Date 12-10-2010 Effective Date 7-01-2010
Supersedes
TN# 96-03

SUPERSEDES TN: 96-03

STATE: Oklahoma
DATE: 9-28-2010
DATE: 12-10-2010
DATE: 7-01-2012
TN: 10-33

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Oklahoma

Requirements for Third Party Liability –
Identifying Liable Resources

All required TPL billing information is entered into the MMIS recipient file. Upon completion, the information is considered valid and verified and results in all future claims being cost avoided, if allowed. On a weekly basis this information is electronically transmitted to OHCA's TPL contractor to initiate the retroactive recovery on all claims previously paid. OHCA has three (3) years from the date of service provided to the Medicaid recipient to submit claims to the insurer for reimbursement. Any action by OHCA to enforce the payment of the claim must be commenced within six (6) years of the submission of the claim by OHCA.

Pursuant to 63 Okla. Stat. § 5051.5, entities that provide health insurance in the state are required to compare data from its files with OHCA. The data provides the state with eligibility and coverage information that enables the state to determine the existence of third party coverage for Medicaid recipients and the necessary information to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided. This process is an electronic transfer either directly between the insurer and the OHCA or among the insurer, OHCA and OHCA's TPL contractor. OHCA currently matches with all of the major insurers in the state as well as many out of state insurance companies and ERISA plans.

For private insurance, retroactive recoveries are initiated within a week of private health insurance coverage being identified.

3. State motor vehicle accident reports files are not reported on a statewide basis through a central registry in Oklahoma. OHCA cooperates with all 77 Oklahoma counties to obtain data regarding motor vehicle accidents and predominately utilizes information provided by the applicant/recipient, insurance companies and the Oklahoma State Bar Association. The method of cooperating with the counties consist of a follow of trauma code edits. Once a motor vehicle accident is indicated, we work in the county of the accident to obtain the police report. Additionally, the State asks the member to send a report upon the initial contact.

   OHCA has strict statutorily authorized claim rights and personal liability may be imposed on attorneys and/or insurance agents that settle claims without OHCA's consent. Oklahoma does not have "no fault" insurance policies in effect.

Revised 07-01-10

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OKLAHOMA

Requirements for Third Party Liability –
Identifying Liable Resources

4. Weekly diagnosis and trauma code editing is performed on all claims. If a claim is paid with a diagnosis in the range of 800 to 999, with some exceptions, and/or accident indicator, the claim is flagged and begins tolling future claims for addition into a TPL casualty case. The claims accumulate for six months or until the cost effective threshold of $500 is reached, at which time the system produces an accident questionnaire which is mailed to the member with a self addressed stamped envelope. The $500.00 threshold is generally met if the Medicaid recipient has an emergency room visit, at least one medication and a follow up visit. OHCA set this minimum threshold based on the fact that this is a predominately manual process and requires more administrative resources. In addition, if an insurance claim is filed, OHCA is statutorily protected regardless of the amount of the claim. If the threshold of $500.00 is not met within six months of the triggering claim, the case will close and no questionnaire is sent to the recipient

   Each questionnaire is reviewed and leads are contacted by letter and/or telephone to determine the extent and availability of third party funds. Upon identification, the information is incorporated into the MMIS. Recovery is initiated within 30 days. A case record is reviewed regularly to allow new related claims to be associated with a case file and to update information for any attorney of record or insurance adjuster/agent. The process is done on a tickler basis. If it is an accident that would incur additional medical review, then the case is set it up to come to a clerk for additional medical review. If no additional medical review is warranted, the next step would be to contact the attorney or contact the court. Which ever step is necessitated, the results would be indicated on the tickler system to go to the appropriate person for follow up. Additionally, one last medical review is done prior to accepting money on any case.