REIMBURSEMENT POLICY STATEMENT
TrueCare

Policy Name & Number	Date Effective
Coordination of Benefits-TrueCare-PY-1424	07/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design, and other factors are considered in developing Reimbursement Policies.

In addition to this policy, reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased, or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

This policy does not ensure an authorization or reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy Statement and the plan contract, then the plan contract will be the controlling document used to make the determination. We may use reasonable discretion in interpreting and applying this policy to services provided in a particular case and we may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

Table of Contents

A. Subject
Coordination of Benefits

B. Background
The purpose of this policy is to establish how TrueCare defines the order of coverage when a subscriber has additional coverage and how TrueCare will coordinate payments as the secondary payer.

C. Definitions
- **Coordination of Benefits (COB)** – The process of determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third-party resource when two or more health plans, insurance policies or third-party resources cover the same benefits for TrueCare members.
- **Explanation of Payment (EOP)** – A detailed explanation of payment or denial of a claim by an insurance carrier.
- **Third Party Liability (TPL)** – The legal obligation of health care sources (third party sources) to pay for all, or part, of a medical claim of a Medicaid beneficiary.

D. Policy
I. COB Steps
A. TrueCare is the payer of last resort. Providers must exhaust all TPL sources of payment, such as Medicare, TRICARE, private health insurance, AARP plans, or automobile coverage prior to submitting or resubmitting a claim for reimbursement to TrueCare.
B. TrueCare claims processing system, Facets, is configured with logic to identify potential subrogation using trauma codes submitted on medical claims.
C. TrueCare utilizes vendor, Rawlings, to review post-payment claim data for possible subrogation opportunities which TrueCare investigates.

II. COB investigation:
A. The Mississippi Division of Medicaid (MS-DOM) will be responsible for maintaining the contract(s) needed for insurance verification services or to identify third party coverage for all Medicaid beneficiaries.
B. The Mississippi Division of Medicaid will provide data to TrueCare regarding any third-party insurance coverage for any covered Member in TrueCare's Health Plan.

III. Reimbursement for Services Provided to Recipients with TPL
A. As per MS Department of Medicaid requirements, claims that meet the following criteria are subject to a "pay and chase" requirement, in which the payer who first receives the claim must pay the claim in full (up to the Medicaid allowable amount), and pursue reimbursement from the third-party payer through subrogation:
1. Preventive pediatric services (including EPSDT (Early and Periodic Screening, Diagnosis, & Treatment) services)

2. Covered services furnished to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D program

B. When a claim is received for which a third-party payer has already adjudicated and paid their portion of the claim, TrueCare shall adjudicate the claim for the remainder of the Medicaid allowed amount or the TrueCare contracted amount, whichever is less. Any member liability required by the primary payer is to be included in the final COB payment amount.

C. The provider's TPL claim will be denied for failing to obtain the appropriate authorization from the third-party. Services approved by Medicare do not require TrueCare prior authorization.

IV. COB Timely Filing Guidelines

A. If a provider is aware that a member has primary coverage, the provider should submit a copy of the primary payer's EOP along with the claim to TrueCare, within the claims timely filing period.

B. Timely Filing of Claims for Reimbursement Secondary to Medicare: Providers may submit claims to TrueCare within 180 calendar days from the date of service, or within 90 days after MS-DOM or the provider receives notice of the disposition of the Medicare claim, whichever is greater.

C. All claims for payment, whether electronic or nonelectronic, must be mailed or electronically transferred to the secondary insurer within 90 days after final determination by the primary insurer. A provider's claim is considered submitted on the date it is electronically transferred or mailed.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/09/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived		

H. References

1. 42 CFR §§ 433.138, 433.145 (2024).
2. Appeals, 23-300 Miss. Code R. §§ 1.1-4.2 (2025).
3. Third Party Recovery, 23-306 Miss. Code R. §§ 1.1 – 1.8 (2025).
4. Miss. Code Ann. § 43-13-121
5. Physician Services, 23-203 Miss. Code R. §§ 1.1-10.1 (2025).
6. Third Party Liability and Recoveries. Mississippi Division of Medicaid. Accessed February 25, 2025. www.medicaid.ms.gov

The REIMBURSEMENT Policy Statement detailed above has received due consideration as defined in the REIMBURSEMENT Policy Statement Policy and is approved.