Section 8: Third Party Liability (TPL)

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SECTION 8: THIRD PARTY LIABILITY (TPL)

Table of Contents

8.1 Third Party Liability (TPL) 3

8.2 Verifying a Client's TPR 3

8.3 TPR Sources 4

8.3.1 Exceptions 5

8.3.1.1 Adoption Cases 6

8.4 Non-TPR Sources 6

8.5 TPL for Hospitals 6

8.6 TPL for Managed Care 6

8.7 Tort 7

8.7.1 Accident-Related Claims 7

8.7.1.1 Accident Resources, Refunds 8

8.7.1.2 Workers' Compensation 8

8.7.2 Providers Filing Liens for Third Party Reimbursement 9

8.7.3 Informational Claims 9

8.7.4 Submission of Informational Claims 9

8.7.5 Informational Claim Converting to Claims for Payment 10

8.8 Other Insurance Claims Filing 10

8.8.1 Unbundled Services That Are Prior Authorized and Manually Priced Procedure Codes 11

8.8.2 Other Insurance Credits 11

8.8.2.1 Deductibles 12

8.8.2.2 HMO Copayments 12

8.8.2.3 PPO Discounts 13

8.8.2.4 Verbal Denial 13

8.8.2.5 110-Day Rule 13

8.8.2.6 Filing Deadlines 14

8.9 Other Insurance Appeals 14

8.10 Refunds Resulting from Other Insurance Payments 14

8.11 Contact Information 15

8.12 Forms 15

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8.1 Third Party Liability (TPL)

Texas Medicaid Third Party Liability program recovers payments from third parties that are responsible for paying towards a medical claim for services rendered to a Texas Medicaid client. A third party resource (TPR) is the entity, individual, or other source (other than Medicaid, Medicaid managed care organizations (MCOs), Medicaid managed care dental plans, the client, non-TPR sources, or Medicare) that is legally responsible for paying the medical claims of Texas Medicaid clients. The Third Party Liability program helps reduce Medicaid costs by shifting claims expenses to third party payers.

As a condition of eligibility, Medicaid clients assign their rights (and the rights of any other eligible individuals on whose behalf he or she has legal authority under state law to assign such rights) to medical support and payment for medical care from any third party to Medicaid.

Federal and state laws require the use of Medicaid funds for the payment of most medical services only after all reasonable measures have been made to use a client's TPR or other insurance. To the extent allowed by federal law, a health-care service provider must seek reimbursement from available third party insurance that the provider knows about or should know about before billing Texas Medicaid. Medicaid pays only after the third party has met its legal obligation to pay (i.e., Medicaid is the payer of last resort). All claims submitted for Texas Medicaid payment for clients with other insurance coverage must reference the information, regardless of whether a copy of the explanation of benefits (EOB) from the insurance company is submitted with the claim.

Refer to: Subsection 7.2, "Refunds to TMHP" in "Section 7: Appeals" (*Vol. 1, General Information*) for information regarding refunds to TMHP resulting from other insurance payments and conditions surrounding provider billing of third party insurers.

Eligible clients enrolled in private health maintenance organizations (HMOs) must not be charged the co-payment amount because the provider has accepted Medicaid assignment.

8.2 Verifying a Client's TPR

Providers can verify a client's TPR and other insurance information by:

- Using TexMedConnect.
- Accessing the Medicaid Client Portal for Providers.

To ensure receipt of TPR disposition of payment or denial, providers must obtain an assignment of insurance benefits from the client at the time of service. Providers are asked not to provide claim copies or statements to the client.

Providers that are aware that a client has other health insurance that is not indicated on TexMedConnect or the Medicaid Client Portal for Providers must notify TMHP of the details concerning the type of policy and scope of benefits.

Providers can notify TMHP by calling TPR at 1-800-846-7307, sending a fax to 1-512-514-4225, or mailing the Other Insurance Form to the following address:

Texas Medicaid & Healthcare Partnership
Third Party Resources Unit
PO Box 202948
Austin, TX 78720-2948

Any indemnity insurance policy that pays cash to the insured for wages lost or for days of hospitalization rather than for specific medical services is considered a TPR if the policy is assignable to someone else. The Health and Human Services Commission (HHSC) has assignment to any Medicaid applicant's or client's right of recovery from a third party health insurer, to the extent of the cost of medical care services paid by Medicaid. Texas Medicaid requires a provider take all reasonable measures to use a client's TPR before billing Medicaid.

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Medicaid-eligible clients may not be held responsible for billed charges that are in excess of the TPR payment for services covered by Texas Medicaid. If the TPR pays less than the Medicaid-allowable amount for covered services, the provider should submit a claim to TMHP for any additional allowable amount.

8.3 TPR Sources

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for payment of the services.

TPR includes payments from any of the following sources:

- Other health insurance including assignable indemnity contract
- Health maintenance organization (HMO)
- Public health programs available to clients with Medicaid such as Medicare and Tricare
- Profit and nonprofit health plan
- Employment-related health insurance
- Self-insured plans
- Casualty coverage resulting from an accidental injury such as automobile or property insurance (including no-fault insurance); No-fault automobile insurance such as personal injury protection (PIP) and automobile medical insurance
- Liability insurance
- Life insurance policies, trust funds, cancer policies, or other supplemental policies
- Workers' Compensation
- Medical support from absent parents
- Court judgments or settlements from a liability insurer
- First party probate-estate recoveries
- Other federal programs unless excluded by statute
- Other liable third parties

Claims for family planning services (including Title XIX and the Department of State Health Services [DSHS] Family Planning Program) must be submitted to TMHP before billing a client's TPR. Federal regulations protect the client's confidential choice of birth control and family planning services. Confidentiality is jeopardized when seeking information from TPRs.

School Health and Related Services (SHARS) providers are not required to file claims with private insurance before billing Medicaid.

Early Childhood Intervention (ECI) providers are not required to file claims with private insurance before billing Medicaid for Targeted Case Management services and Specialized Skills Training (SST).

Case Management for Children and Pregnant Women providers are not required to file claims with other health insurance before filing with Medicaid.

THSteps medical and dental providers are not required to bill other insurance before billing Medicaid. If the provider is aware of other insurance, however, the provider must choose whether or not to bill the other insurance. The provider has the following options:

- If the provider chooses to bill the other insurance, the provider must submit the claim to the client's other insurance before submitting the claim to Medicaid.

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- If the provider chooses to bill Medicaid and not the client's other insurance, the provider is indicating acceptance of the Medicaid payment as payment in full. Medicaid then has the right to recovery from the other insurance. The provider does not have the right to recovery and cannot seek reimbursement from the other insurance after Medicaid has made payment.
- If the provider learns of other insurance coverage after Medicaid has paid, and the provider chooses to bill the other insurance, the provider must refund Medicaid before billing the other insurance.

8.3.1 Exceptions

Certain funding sources are an exception to TPR. Adoption agencies or foster parents are not considered a TPR. Medicaid is primary in the STAR Health program (except when court-ordered to provide health insurance). This is an exception to the rule that Medicaid is payer of last resort. Providers must not bill other health insurance unless there is a court order that places this responsibility elsewhere. For Texas Health Steps (THSteps), providers must refer to the MCO, or dental plan that administers the client's managed care benefits for additional information.

Refer to: Subsection 1.1, "About the Vendor Drug Program" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for information about this program.

Non-TPR sources are secondary to Texas Medicaid and may only pay benefits after Texas Medicaid. The following are the most common non-TPR sources:

- Texas Workforce Solutions–Vocational Rehabilitation Services
- Texas Kidney Health Care Program
- Crime Victims' Compensation Program
- Muscular Dystrophy Association
- Children with Special Health Care Needs (CSHCN) Services Program
- Texas Band of Kickapoo Equity Health Program
- Maternal and Child Health
- DSHS Family Planning Program
- State Legalization Impact Assistance Grant (SLIAG)
- Adoption Agencies
- Home and Community-based Waivers Programs through HHSC
- Blind and Visually Impaired Services
- Healthy Texas Women

If providers have questions about others not listed, they may contact a provider relations representative.

Note: *Claims for clients who are seeking disability determination must be submitted to HHSC for consideration of reimbursement. Refer to the HHS website at www.hhs.texas.gov/ for additional information about disability determinations and claims filing.*

Denied claims or services that are not a benefit of Medicaid may be submitted to non-TPR sources.

If a claim is submitted inadvertently to a non-TPR source listed above before submission to TMHP, the claim may be submitted to TMHP within the filing deadlines.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

If a non-TPR source erroneously makes a payment for a dual-eligible client for services also covered by Medicaid, the payment is refunded to the non-TPR source.

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8.3.1.1 Adoption Cases

Texas Medicaid, not the adoption agency, should be billed for all medical services that are a benefit of Texas Medicaid. If a claim is inadvertently sent to the adoption agency before it is sent to TMHP, TMHP must receive the claim within 95 days of the date of disposition from the adoption agency denial, payment, requests for refund or recoupment, to be considered for payment.

If the adoption agency inadvertently makes a payment for services that are covered by Medicaid, the provider must refund the payment to the agency.

Refer to: Subsection 6.1.4, "Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*).

A copy of the non-TPR disposition must be submitted with the claim and received at TMHP within 95 days of the date of the disposition (denial, payment, request for refund, or recoupment of payment by the non-TPR source).

8.4 Non-TPR Sources

A non-TPR is secondary to Texas Medicaid and may only pay benefits after Texas Medicaid. Non-TPR sources include, but are not limited to, accident-only policies, managed care plans, Indigent Health Care, and Medicaid/Children's Health Insurance Program (CHIP).

The provider bills TMHP directly within 95 days from the date of service. However, if a non-TPR is billed first, TMHP must receive the claim within 95 days of the claim disposition by the other entity.

Note: *The provider must submit a copy of the disposition with the claim.*

8.5 TPL for Hospitals

Inpatient and outpatient hospitals and providers enrolled in Texas Medicaid are required to inform TMHP about circumstances that may result in third party liability for health-care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and providers must fax the Other Insurance Form for Health Insurance or the Tort Response Form for accidents to 1-512-514-4225 or mail it to the following address:

Texas Medicaid & Healthcare Partnership
TPL Correspondence
Third Party Liability Unit
PO Box 202948
Austin, TX 78720-2948

8.6 TPL for Managed Care

Medicaid MCO and dental plan claims payments for services rendered to Texas Medicaid managed care clients are subject to the federal and state requirement for other insurance payments. As directed by HHSC, Texas Medicaid will recover payments based on claims data processed by the Medicaid MCO or dental plan.

TPR includes payments from any of the following sources:

- Other health insurance, including assignable indemnity contracts
- Commercial MCOs (other insurance available through a source other than Texas Medicaid or Medicare)

A provider who furnishes services and participates in Texas Medicaid may not refuse to furnish services to an eligible client because of a third party's potential liability for the payment of the services.

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8.7 Tort

HHSC contracts with TMHP to administer third party liability cases. To ensure that Texas Medicaid is the payer of last resort, TMHP performs postpayment investigations of potential casualty and liability cases. TMHP also identifies and recovers Medicaid expenditures in casualty cases involving Medicaid clients.

The Human Resources Code, chapter 32, section 32.033 establishes automatic assignment of a Medicaid client's right of recovery from personal insurance as a condition of Medicaid eligibility.

Investigations are a result of referrals from many sources, including attorneys, insurance companies, health-care providers, Medicaid clients, and state agencies. Referrals should be faxed to 1-512-514-4225 or mailed to:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX, 78720-2948

Referrals must be submitted on the English or Spanish version of the Use and Release of Health Information Authorization on the TMHP website at www.tmhp.com.

TMHP releases Medicaid claims information when an HHSC Use and Release of Health Information Authorization form is submitted. The form must be signed by the Medicaid client. Referrals are processed within ten business days.

Refer to: Use and Release of Health Information Authorization form on the TMHP website at www.tmhp.com.

An attorney or other person who represents a Medicaid client in a third party claim or action for damages for personal injuries must send written notice of representation. The written notice must be submitted within 45 days of the date on which the attorney or representative undertakes representation of the Medicaid client, or from the date on which a potential third party is identified. The following information must be included:

- The Medicaid client's name, address, and identifying information.
- The name and address of any third party or third party health insurer against whom a third party claim is or may be asserted for injuries to the Medicaid client.
- The name and address of any health-care provider that has asserted a claim for payment for medical services provided to the Medicaid client for which a third party may be liable for payment, whether or not the claim was submitted to or paid by TMHP.

If any of the information described above is unknown at the time the initial notice is filed, it should be indicated on the notice and revised if and when the information becomes known.

An authorization to release information about the Medicaid client directly to the attorney or representative may be included as a part of the notice and must be signed by the Medicaid client. The HHSC Use and Release of Health Information Authorization form must be used.

HHSC must approve all trusts before any proceeds from a third party are placed into a trust.

Providers may direct third party liability questions to the TMHP TPL/Tort Contact Center at 1-800-846-7307 with the option for accident, injury, and informational claims.

8.7.1 Accident-Related Claims

TMHP monitors all accident claims to determine whether another resource may be liable for the medical expenses of clients with Medicaid coverage. Providers are requested to ask clients whether medical services are necessary because of accident-related injuries. If the claim is the result of an accident, providers enter the appropriate code and date in Block 10 of the CMS-1500 paper claim form, and Blocks 31-34 on the UB-04 CMS-1450 paper claim form.

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If payment is immediately available from a known third party such as Workers' Compensation or Personal Injury Protection (PIP) automobile insurance, that responsible party must be billed before Medicaid, and the insurance disposition information must be filed with the Medicaid claim. If the third party payment is substantially delayed because of contested liability or unresolved legal action, a claim may be submitted to TMHP for consideration of payment.

TMHP processes the liability-related claim and pursues reimbursement directly from the potentially liable party on a postpayment basis. Include the following information on these claims:

- Name and address of the liable third party
- Policy and claim number
- Description of the accident including location, date, time, and alleged cause
- Reason for delayed payment by the liable third party

8.7.1.1 Accident Resources, Refunds

Acting on behalf of HHSC, TMHP has specific rights of recovery from any settlement, court judgment, or other resources awarded to a client with Medicaid coverage (Texas Human Resources Code, Chapter 32.033). In most cases, TMHP works directly with the attorneys, courts, and insurance companies to seek reimbursement for Medicaid payments. If a provider receives a portion of a settlement for services also paid by Medicaid, the provider must make a refund to TMHP. Any provider filing a lien for the entire billed amount must contact the TPL/Tort Department at TMHP for Medicaid postpayment activities to be coordinated. A provider may not file a lien for the difference between the billed charges and the Medicaid payment. A lien may be filed for services not covered by Medicaid. A lien is the liability of the client with Medicaid coverage.

Providers should contact the TPL/Tort Department at TMHP after submitting an itemized statement and/or claim copies for any accident-related services billed to Medicaid if they received a request from an attorney, a casualty insurance company, or a client.

The provider must submit the following information to TMHP:

- Client's name
- Medicaid ID number
- Dates of service involved
- Name and address of the attorney or casualty insurance company (including the policy and claim number)

This information enables TMHP to pursue reimbursement from any settlement. Providers must use the Tort Response Form to report accident information to TMHP. When the form is completed, providers must remit it to the TMHP TPL/Tort Department (the address and fax number are on the form).

Providers may contact the TMHP TPL/Tort Department by calling 1-800-846-7307, Option 3, sending a fax to 1-512-514-4225, or mailing to the following address:

Texas Medicaid & Healthcare Partnership
TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

8.7.1.2 Workers' Compensation

Payment of covered services under Workers' Compensation is considered reimbursement in full. The client must not be billed. Services not covered by Workers' Compensation must be billed to TMHP.

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8.7.2 Providers Filing Liens for Third Party Reimbursement

Any provider filing a lien for the entire billed amount must contact the TMHP TPL/Tort Department for Medicaid postpayment activities to be coordinated.

A provider may file a lien for the entire billed amount only after meeting the criteria in Title 1 Texas Administrative Code (TAC) §354.2322. Providers who identify a third party, within 12 months of the date of service, and wish to submit a bill or other written demand for payment or collection of debt to a third party after a claim for payment has been submitted and paid by Medicaid must refund any amounts paid before submitting a bill or other written demand for payment or collection of debt to the third party for payment, and they must comply with the provisions set forth in 1 TAC §354.2322, which states:

Providers may retain a payment from a third party in excess of the amount Medicaid would otherwise have paid only if the following requirements are met:

- The provider submits an informational claim to TMHP within the claims filing deadline. (Refer to subsection 8.7.3, "Informational Claims" in this section.)
- The provider gives notice to the client or the attorney or representative of the client that the provider may not or will not submit a claim for payment to Medicaid and the provider may or will pursue a third party, if one is identified, for payment of the claim. The notice must contain a prominent disclosure that the provider is prohibited from billing the client or a representative of the client for any Medicaid-covered services, regardless of whether there is an eventual recovery or lack of recovery from the third party or Medicaid.
- The provider establishes the right to payment separate of any amounts claimed and established by the client.
- The provider obtains a settlement or award in its own name separate from a settlement obtained by or on behalf of the client or award obtained by or on behalf of the client, or there is an agreement between the client or attorney or representative of the client and the provider, that specifies the amount that will be paid to the provider after a settlement or award is obtained by the client.

8.7.3 Informational Claims

If providers determine that a third party may be liable for a Medicaid client's accident-related claim, they can submit an informational claim to the TMHP Tort Department to indicate that a third party is being pursued for payment. This allows providers to secure the 95-day claims filing deadline in the event that the payment is not received from the third party.

TMHP processes informational claims for all claims administered by TMHP, including fee-for-service claims and carve-out services. TMHP does not process informational claims for managed care claims that are administered by the client's MCO or dental plan.

8.7.4 Submission of Informational Claims

Providers must submit informational claims to TMHP:

- On a CMS-1450 UB-04 or CMS-1500 paper claim form. Informational claims cannot be submitted to TMHP electronically or by fax.
- On an Informational Claims Submission Form. Providers should complete only one form per client, regardless of how many separate informational claims are being submitted with the form.
- By certified mail.
- Within the 95-day claims filing deadline. Informational claims will not be accepted after the 95-day claims filing deadline.

Refer to: Informational Claims Submission Form on the TMHP website at www.tmhp.com.

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Providers must complete either the Insurance Information field (liable third party) or the Attorney Information field on the Informational Claims Submission Form.

Providers must send the informational claims and the Informational Claims Submission Form by certified mail to TMHP at:

TMHP TPL/Tort Department
PO Box 202948
Austin, TX 78720-2948

TMHP will send providers a letter to confirm that the informational claim was received. The letter will provide the date on which TMHP must receive a request from the provider to convert the informational claim to a claim for payment. If TMHP receives an informational claim that cannot be processed, TMHP will notify the provider of the reason.

Providers can inquire about the status of an informational claim by calling the TMHP TPL/Tort Department at 1-800-846-7307. If a provider has not received confirmation that TMHP has received the informational claim within 30 days, the provider should contact the TMHP TPL/Tort Department at 1-800-846-7307 to validate the status of the request.

8.7.5 Informational Claim Converting to Claims for Payment

If providers have submitted an informational claim to TMHP but have not received payment from the liable third party, they must make one of the following determinations and notify TMHP within 18 months of the date of service:

- Providers can continue to pursue a claim for payment against the third party and forego the right to convert an informational claim to a claim for payment by Texas Medicaid.
- Providers can submit a request to convert to the informational claim to a claim for payment consideration from Texas Medicaid.

Providers that decide to convert an informational claim to a claim for payment consideration must submit a request to TMHP. The request must be submitted:

- On provider letterhead.
- With the client's name and Medicaid ID, the date of service, and total billed amount that was originally submitted on the UB-04 CMS-1450 or CMS-1500 paper claim form.
- By fax 1-512-514-4225 or by mail to:

TMHP/Tort Department
P0 Box 202948
Austin, TX 78720-2948

TMHP will not accept any conversion request that is submitted more than 18 months after the date of service, regardless of whether an informational claim was submitted timely to TMHP. All payment deadlines are enforced regardless of whether the provider decides to pursue a third party claim. The conversion of informational claims to actual claims is not a guarantee of payment by TMHP.

8.8 Other Insurance Claims Filing

The following information must be provided in the "Other Insurance" field on the paper claim and in the appropriate field of electronic claims. On the CMS-1500 paper claim form, Blocks 9 or 11, and 29 must contain the appropriate information:

- Name of the other insurance resource
- Address of the other insurance resource
- Policy number and group number

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- Policyholder
- Effective date if available
- Date of disposition by other insurance resource (used to calculate filing deadline)
- Payment or specific denial information

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance or copays related to Medicaid-covered services.*

8.8.1 Unbundled Services That Are Prior Authorized and Manually Priced Procedure Codes

Providers that submit prior authorization requests and claims to TMHP must:

- Unbundle any bundled procedure codes that have been submitted to the client's other insurance company.
- Itemize the rates.

If prior authorization has been obtained for services that use manually priced procedure codes, providers must submit claims for the services using the manufacturer's suggested retail price (MSRP) that was submitted with the authorization request and the following information that is listed on the authorization letter:

- The authorization number
- The NPI
- The procedure codes
- The dates of service
- The types of service
- The required modifiers

If the authorization letter shows itemized details, the claim must include all rendered services as they are itemized on the authorization letter and the MSRP rate for each of those services. The procedure codes and MSRP rates that are detailed on the claim must match the procedure codes that are detailed in the authorization letter and the MSRP rates that were submitted with the authorization request. Claims processing and payment may be delayed if there is not an exact match between the detailed information on the authorization letter, the approved authorization, and the information that was submitted on the claim.

Important: *For appropriate processing and payment, the Pay Price that is indicated on the authorization letter should not be submitted on the claim.*

Prior authorization is a condition of reimbursement; it is not a guarantee of payment.

8.8.2 Other Insurance Credits

Providing other insurance payment information, even when no additional payment is expected from TMHP, provides benefit to all parties involved in Texas Medicaid. When a TPR issues a payment or partial payment to a provider, the other insurance credit must be indicated on the claim form submitted to TMHP.

This procedure benefits both providers and TMHP even if the TPR payment exceeds the Medicaid allowed amount. Although additional payment may not be issued by TMHP, informing TMHP of the other insurance credit allows TMHP to track the appropriate use of TPRs. Informing TMHP of a TPR

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credit provides hospitals with a more accurate standard dollar amount (SDA) rate setting and assists the program in tracking recoveries and reducing Medicaid medical expenditures by informing TMHP of liable third parties.

Providers must report TPR payments correctly in the appropriate electronic field or the paper claim form block as follows:

Claim Form	Reference
CMS-1500	Block 29, CMS-1500 Blank Claim Form
UB-04 CMS-1450	Block 54, UB-04 CMS-1450 Blank Claim Form
THSteps Dental	Block 31, ADA Dental Claim Form

Refer to: "Section 6: Claims Filing" (*Vol. 1, General Information*) for claim filing instructions.

8.8.2.1 Deductibles

TMHP will consider deductibles for reimbursement when the original third party payor applied the payment amount directly to the client's deductible. The explanation of benefit reflecting the application of the payment by the other insurance (third party payor) and a completed signed claim copy must be submitted to TMHP for consideration.

8.8.2.2 HMO Copayments

TMHP processes and pays HMO copayments for private and Medicare HMOs as well as private and Medicare preferred provider organization (PPO) copayments for clients who are eligible for reimbursement under Medicaid guidelines.

TMHP pays the copayment in addition to the service the HMO or PPO has denied, if the client is eligible for Texas Medicaid and the procedure is reimbursed under Medicaid guidelines. Providers are not allowed to hold the client liable for the copayment.

An office or emergency room (ER) visit (the ER physician is paid only when the ER is not staffed by the hospital) is reimbursed a maximum copayment of $10 per visit. The hospital ER visit is reimbursed at a maximum of $50 to the facility. TMHP pays up to four copayments per day, per client. ER visits are limited to one per day, per client, and are considered one of the four copayments allowed per day.

Important: *By accepting assignment on a claim for which the client has Medicaid coverage, providers agree to accept payment made by insurance carriers and Texas Medicaid when appropriate as payment in full. The client cannot be held liable for any balance related to Medicaid-covered services.*

The following Medicaid codes have been created for copayments, which are considered an atypical service:

POS 1 - Office	Description
CP001	Private HMO copayment-professional
CP002	Private PPO copayment-professional

POS 5 - Outpatient	Description
CP005	Private HMO copayment-outpatient
CP006	Private PPO copayment-outpatient

Important: *Providers must submit a new claim when filing for procedure codes CP001 and CP002. No explanation of benefits (EOB) or any other accompanying documentation is required to be attached to the claim form when filing for these services.*

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8.8.2.3 PPO Discounts

PPO discounts are not considered a part of other insurance payments. Electronic submitters must supply the PPO discount amount when submitting other insurance information; however, this information is not included in the total other insurance payment during claims processing. Paper submitters are not required to add the PPO discount to the other insurance payment.

8.8.2.4 Verbal Denial

Providers may call the other insurance resource and receive a verbal denial. The other insurance record can either be updated when the provider files the claim or calls the TPL/Tort Customer Service line at 1-800-846-7307. When calling the TPL/Tort Customer Service line and when filing claims to TMHP, the provider must have the following information before any updates are made.

Verbal denial requirements:

- Date of the telephone call to the other insurance resource
- Insurance company's name and telephone number
- Name of the individual contacted at the insurance company
- Policyholder and group information for the client
- Specific reason for the denial, including the client's type of coverage to enhance the accuracy of future claims processing (for example, a policy that covers inpatient services or physician services only)

Providers that update a client's insurance records through the TMHP TPL/Tort Customer Service line must follow the current appeal process once the other insurance information has been updated on the client's file.

8.8.2.5 110-Day Rule

When a service is billed to a third party and no response has been received, Medicaid providers must allow 110 days to elapse before submitting a claim to TMHP. If a TPR has not responded or delays payment or denial of a provider's claim for more than 110 days after the date the claim was billed, Medicaid considers the claim for reimbursement. However, the 365-day federal filing deadline requirement must still be met. The following information is required:

- Name and address of the TPR
- Date the TPR was billed
- Statement signed and dated by the provider that no disposition has been received from the TPR within 110 days of the date the claim was billed

When TMHP denies a claim because of the client's other coverage, information that identifies the other insurance appears on the provider's Remittance and Status (R&S) Report. The claim is not to be refiled with TMHP until disposition from the TPR has been received or until 110 days have lapsed since the billing of the claim with no disposition from the TPR. A statement from the client or family member which indicates that they no longer have this resource is not sufficient documentation to reprocess the claim.

When a provider is advised by a TPR that benefits have been paid to the client, the information must be included on the claim with the date and amount of payment made to the client if available. If a denial was sent to the client, refer to the verbal denial guidelines above for required information. This enables TMHP to consider the claim for reimbursement.

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8.8.2.6 Filing Deadlines

In accordance with federal regulations, all claims must initially be filed with TMHP within 365 days of the date of service (DOS). Claims that involve filing to a TPR have the following deadlines:

- Claims with a valid disposition (payment or denial) must be received by TMHP within 95 days of the date of disposition by the TPR and within 365 days of the DOS. Appealed claims that were originally denied with EOB 00260, which indicates that the provider files with a TPR, must be received within 95 days of the date of disposition by the TPR or within 120 days of the date on which TMHP denied the claim.
- The provider must appeal the claim to TMHP with complete other insurance information, which includes all EOBs and disposition dates. The disposition date is the date on which the other insurance company processed the payment or denial.
- If a provider submits other insurance EOBs without disposition dates, the appeal will be denied. If the other insurance disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being submitted to TMHP is on a subsequent page or pages, the provider must submit the first page that shows the disposition date and all of the pages that show the claim that is being submitted to TMHP.
- If more than 110 days have passed from the date a claim was filed to the TPR without a response, the claim is submitted to TMHP for consideration of payment.

Refer to: Subsection 6.12.2.3, "Crossover Paper Claims Filing Deadlines" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for information about filing deadlines for clients with other insurance.

8.9 Other Insurance Appeals

To appeal a claim denial due to other insurance coverage, the provider must submit complete other insurance information including the disposition date. The disposition date indicates when the other insurance company processed the payment or denial. An appeal submitted without this information will be denied.

If submitting a paper appeal the provider must submit EOBs containing disposition dates. If the disposition date appears only on the first page of an EOB that has multiple pages and the claim that is being appealed is on a subsequent page, the provider must also include the first page of the EOB that shows the disposition date.

Note: *Claims denied for TPL/other insurance cannot be appealed through the TMHP Automated Inquiry System (AIS).*

8.10 Refunds Resulting from Other Insurance Payments

The TMHP Cash Reimbursement Unit is responsible for processing financial adjustments when overlapping payments by Medicaid and a TPR occur.

Providers can use the Texas Medicaid Refund Information Form to:

- Refund the overpayment by issuing a check to TMHP. Providers must submit the refund check to TMHP along with the Texas Medicaid Refund Information Form and all required information requested on the form.
- Request that the claim be reprocessed and the money recouped. The overpayment will be reduced from next weekly payment made after claims are processed.

Refer to: The Texas Medicaid Refund Information Form, which is available in the Forms section of the TMHP website at www.tmhp.com.

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If the amount paid by the other insurance carrier is less than Medicaid's allowed amount, providers may bill TMHP for the difference. All claims must meet all timely filing deadlines.

Providers are prohibited from receiving payment from Medicaid and billing a TPR without refunding the Medicaid payment.

If within 12 months of the date of service a provider identifies that the client has other insurance and wants to submit a claim for payment to the other insurance company, the provider must refund any amounts previously paid by TMHP before submitting the claim to the other insurance.

If other insurance paid for the services submitted on the claim, the provider must submit the following to TMHP:

- The exact amount paid.
- The insurance company's name and address.
- The client's policy number and group number.

Providers are limited to the Medicaid allowed amount for the services. Providers are required to accept the TMHP paid amount as payment in full. If the provider fails to refund a payment to TMHP before submitting a claim to the other insurance, TMHP will recoup the entire other insurance payment.

In accordance with 1 TAC §§354.2321 [g] and 354.2322 [i], providers that do not follow TPR rules "may be referred for investigation and prosecution for violations of state or federal Medicaid or false claims laws." Providers should refer to the full text of these rules for a full description of payment requirements.

8.11 Contact Information

TPL/Tort Telephone and Fax Communication

Contact	General Inquiry Telephone number	Fax Number
Third Party Resources (TPR)	1-800-846-7307	1-512-514-4225
Tort	1-800-846-7307	1-512-514-4225

Written Communication with TMHP

Contact	Address
TPL/Tort	Texas Medicaid & Healthcare Partnership Third Party Liability/Tort PO Box 202948 Austin, TX 78720-2948
HHSC - Third Party Liability (TPL)	Health and Human Services Commission Attn: Third Party Liability 4900 N. Lamar Blvd. Mail Code: 1354 Austin, TX 78751

8.12 Forms

Forms
Your Texas Benefits Medicaid card (English and Spanish)
Informational Claims Submission Form
Other Insurance Form
Use and Release of Health Information Authorization form

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Forms
Use and Release of Health Information Authorization form (Spanish)
Tort Response Form
Texas Medicaid Refund Information Form

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