

Partners pays Coordination of Benefit claims according to the "lesser of" methodology. If the Medicaid allowed amount is more than the third-party payment, Partners will pay the difference up to the contracted allowed amount not to exceed the patient responsibility. If the other insurance payment is greater than the Partners contracted amount, no additional amount will be paid.

- Federal and State regulations require Medicaid to be the “payer of last resort,” except when that member is also accessing State-funded services where State-funded services are “the payer of last resort.”
- Providers are required to collect all first- and third-party funds before submitting Medicaid claims to Partners for reimbursement.
- Third-party payers are any other funding sources that can be billed to pay for the services provided to the member. This can include worker's compensation, disability insurance or other health insurance.
- Third-party payers, including Medicare and private health insurance carriers, must process the claim before Partners processes a Medicaid claim.
- Providers must report any payments or denial reasons from third-party payers on Medicaid claims filed with Partners. Medicaid claims submitted without third-party information will be denied.
- Partners will not pay for any service that could have been paid for by Medicare or other private insurance plans had the member or provider complied with the plan's requirements. Examples of common private plan non-compliance denials include, but are not limited to:
 - Failure to get an authorization referral from a primary care physician.
 - The provider is a “non-participating provider” in the first and/or third-party plan.
 - Failure to obtain prior approval.
- Partners will not reimburse providers for covered services provided by clinicians who are non-paneled or not enrolled under the recipient's third-party coverage plans.
- If the provider is not enrolled or have paneled staff with the primary payer, the provider should refer the member to an eligible provider of third-party covered services.
- First-party payers are the clients/member or their guarantors.

* Partners applies the same guidelines when processing claims for State-funded services.

* Providers are not required to bill Medicare/Third Party Liability for service codes that are listed on the current bypass list.

All claims are required to identify amounts collected from both first and third parties and only request payment for any remaining amounts.