



Ohio Administrative Code

Rule 5160-1-05 Medicaid coordination of benefits with the medicare program (Title XVIII).

Effective: September 16, 2019

Paragraphs (A)(7) to (F)(4) of this rule do not apply to pharmacy services covered under the medicare part D program. Pharmacy services covered under the medicare part D program should be billed in accordance with rule 5160-9-06 of the Administrative Code.

(A) Definitions.

(1) "Medicare" is a federally financed program of hospital insurance (part A) and supplemental medical insurance (also called SMI or part B) for aged and disabled persons.

(2) "Medicare Benefits" means the health care services available to an individual through the medicare program where payment for the services is either completely the obligation of the medicare program or in part the obligation of the medicare program with the remaining payment obligations belonging to the individual, some other third party payer, or medicaid.

(3) "Traditional Medicare" is a health plan that pays for medicare benefits provided to individuals on a fee-for-service basis.

(4) "Medicare Advantage Plan (also known as medicare part C plan)" is a managed care delivery system that includes coverage for both hospital insurance and SMI, but the delivery of health care services are contracted to and provided by an approved medicare managed care plan, preferred provider organization, private fee-for-service plans, or medicare specialty plans.

(5) "Medicare Cost Sharing" for the purpose of this rule means the portion of a medicare crossover claim paid by medicaid.

(6) "Dual Eligibles or Dually Eligible Individuals" are individuals who are entitled to medicare hospital insurance and SMI and are eligible for medicaid to pay some form of medicare cost sharing. The following is a list of dual eligibles or dually eligible individuals that qualify to have medicaid



pay all or part of the cost sharing portion of a paid medicare claim:

(a) "Qualified Medicare Beneficiaries without Other Medicaid (QMB Only)" are individuals entitled to medicare hospital insurance, have income of one hundred per cent of the federal poverty level (FPL) or less and resources that do not exceed the maximum amount of resources allowed under section 1905(p)(1) of the Social Security Act (as in effect on October 1, 2018), as adjusted annually according to the change in the consumer price index for urban areas (CPI-U), and are not otherwise eligible for full medicaid benefits.

(b) "QMBs with Full Medicaid (QMB Plus)" are individuals entitled to medicare hospital insurance, have incomes of one hundred per cent FPL or less and resources that do not exceed the maximum amount of resources allowed under section 1905(p)(1) of the Social Security Act (as in effect on October 1, 2018), as adjusted annually according to the change in the consumer price index for urban areas (CPI-U), and are eligible for full medicaid benefits.

(c) "Specified Low-Income Medicare Beneficiaries with Full Medicaid (SLMB Plus)" are individuals entitled to medicare hospital insurance, have income of greater than one hundred per cent FPL, but less than one hundred twenty per cent FPL and resources that do not exceed twice the limit for SSI eligibility, and are eligible for full medicaid benefits.

(d) "Medicaid Only Dual Eligibles (for example Non QMB)" are individuals entitled to medicare hospital insurance and SMI and are eligible for full medicaid benefits. They are not eligible for medicaid in any of the other dual eligible categories (for example QMB).

(7) "Medicare Crossover Claim" means any claim that has been submitted to the Ohio department of medicaid (ODM) for medicare cost sharing payments after the claim has been adjudicated and paid by the medicare central processor, medicare carrier/intermediary or the medicare managed care plan. Claims denied by the medicare carrier/intermediary or the medicare managed care plan are not considered medicare crossover claims. See paragraphs (E) and (F) of this rule for policy on services denied or not covered by medicare.

(a) "Automatic Crossover Claim" is a medicare claim submitted to ODM via the automatic medicare crossover process described in paragraph (B)(2)(a) of this rule.



(b) "Provider-Submitted Crossover Claim" means a medicare crossover claim submitted to ODM as described in paragraph (B)(2)(b) of this rule.

(B) Medicare crossover process.

(1) Medicare crossover claims must meet the claim submission guidelines in accordance with rule 5160-1-19 of the Administrative Code.

(2) The medicare program determines the portion of medicare cost sharing, if any, due to the provider based on medicare's business rules and submits the claim for payment to ODM using the automatic medicare crossover process.

(a) The "Automatic Medicare Crossover Process" is the coordination of benefit (COB) process whereby the provider bills medicare for services provided to a dual eligible or a dually eligible individual described in paragraph (A)(6) of this rule. Medicare adjudicates the claim, pays the provider and electronically submits the claim to ODM for the medicare cost sharing determination. Then, when appropriate, the provider is paid by medicaid within ninety days from the date of payment by medicare.

(b) When the automatic medicare crossover process does not work (i.e., the provider has received payment by medicare, has not received a payment from medicaid for the medicare cost sharing portion and at least ninety days has elapsed from the date of the receipt of the medicare payment), the provider must submit a medicare crossover claim directly to ODM. This is considered the "Provider-Submitted Crossover Claim Process."

(3) For a provider to receive reimbursement through the automatic medicare crossover process, all of the following criteria must be met:

(a) The provider must be recognized as both a medicare and medicaid provider;

(b) The provider must accept medicare assignment; and



(c) The individual must be receiving health care benefits under the traditional medicare part A and part B program (i.e., the individual is not enrolled in a medicare managed care plan). At this time ODM does not have payer-to-payer COB arrangements with medicare managed care plans.

(4) For medicare crossover claims, the total sum of the payments made by ODM, medicare and all other third party payers is considered payment in full and no additional payment may be requested from the individual with the exception of medicare co-payments as specified in paragraph (E)(5) of this rule. This is true whether or not the provider normally accepts assignment under medicare.

(a) When the provider's total reimbursement from medicare and all other third party payers equals or exceeds the medicare approved amount, no additional payment will be made by ODM.

(b) If payment (other than the cost sharing amounts) is inadvertently received from both medicare and medicaid for the same service, the provider must notify the ODM claims adjustment unit in accordance with the provisions set forth in rule 5160-1-19 of the Administrative Code.

(5) Provider submitted crossover claims must be submitted timely in accordance with rule 5160-1-19 of the Administrative Code.

(6) Crossover claims are not subject to medicaid co-payments in accordance with rule 5160-1-09 of the Administrative Code.

(C) When the individual receiving medicaid is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ODM in accordance with rule 5160-1-08 of the Administrative Code.

(D) ODM will not pay for services denied by medicare for lack of medical necessity, but may pay claims denied for reasons other than lack of medical necessity in accordance with paragraph (F) of this rule as long as the services are covered under the medicaid program. ODM will not pay for any service payable by, but not billed to, medicare.

(E) Reimbursement for medicare cost sharing on medicare crossover claims.



Reimbursement for medicare crossover claims is limited to the dual eligibles or dually eligible individuals listed in paragraph (A)(6) of this rule.

(1) The medicaid maximum reimbursement for the medicare cost sharing of hospital inpatient, outpatient or emergency room services is set forth in rule 5160-2-25 of the Administrative Code for individuals that elected to receive medicare benefits under traditional medicare.

(2) The medicaid maximum reimbursement for the medicare cost sharing of nursing facility services included in the nursing facility per diem is set forth in Chapter 5160-3 of the Administrative Code for individuals that elected to receive medicare benefits under traditional medicare.

(3) The medicaid maximum reimbursement for the medicare cost sharing of all other part B services not included in paragraph (E)(1) or paragraph (E)(2) of this rule is set forth in rule 5160-1-05.3 of the Administrative Code for individuals that elected to receive medicare benefits under traditional medicare.

(4) The medicaid maximum reimbursement for the medicare cost sharing of all advantage plan (part C) services is set forth in rule 5160-1-05.1 of the Administrative Code for individuals that elected to receive medicare benefits under a medicare advantage plan.

(5) Cost sharing for medicare part D services is not reimbursable by ODM in accordance with rule 5160-9-06 of the Administrative Code. Dual eligibles or dually eligible individuals may be required to pay medicare co-payments for prescription drugs that are covered by medicare part D.

(F) Services that are not covered by medicare must be submitted to ODM as a regular medicaid claim and should never be submitted as a medicare crossover claim.

With the exception of long term care nursing facilities, when the service is denied by medicare, and is also denied by medicaid with an error message indicating that the service is covered under medicare and the provider has documentation to support the service is not covered under medicare, the provider must do all of the following when requesting payment consideration from ODM:



- (1) Submit the appropriate claim in accordance with rule 5160-1-19 of the Administrative Code;
 - (2) Attach the summary notice of medicare benefits that shows the denied medicare services, and the denial reason code with the denial reason code explanation from the medicare summary of benefits, the provider is requesting ODM to consider for payment;
 - (3) Attach a completed "ODM 06653 Medical Claim Review Request Form (rev. 7/2014)" with supporting documentation; and
 - (4) Submit all forms together to the address indicated on the instruction page accompanying the ODM 06653 form.
- (G) Long term care nursing facility providers must submit the appropriate claim in accordance with Chapter 5160-3 of the Administrative Code.