Ohio Administrative Code

Rule 5160-1-08 Coordination of benefits.

Effective: September 16, 2019

(A) Definitions.

(1) "Coordination of benefits" (COB) means the process of determining which health plan or insurance policy will pay first 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 a medicaid covered individual.

(2) "Coordination of benefits claim" (COB claim) means any claim that meets either the definition of third party claim as described in paragraph (A)(7) of this rule or the definition of medicare crossover claim as described in rule 5160-1-05 of the Administrative Code.

(3) "Explanation of benefits" (EOB) or "remittance advice" means the information sent to providers or plan beneficiaries (covered individuals) by any other third party payer, medicare, or medicaid to explain the adjudication of the claim.

(4) "Medicare benefits" has the same meaning as in rule 5160-1-05 of the Administrative Code.

(5) "Third party" (TP) has the same meaning as in section 5160.35 of the Revised Code.

(6) "Third party benefit" means any health care service available to individuals through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the third party payer (TPP) or in part the obligation of the individual, the third party payer, or medicaid (examples of a third party benefit include private health or accidental insurance, medicare, CHAMPUS or worker's compensation).

(7)) "Third party claim" means any claim submitted to the Ohio department of medicaid (ODM) for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by ODM:

(a) Any claim received by ODM that shows no prior payment by a TPP, but, ODM's records indicate the medicaid covered individual has third party benefits.

(b) Any claim received by ODM that shows no prior payment by a TPP but the provider's records indicate the medicaid covered individual has third party benefits.

(8) "Third party liability" (TPL) means the payment obligations of the third party payer for health care services rendered to eligible medicaid covered individuals when the individual also has third party benefits as described in paragraph (A)(6) of this rule.

(9) "Third party payer" (TPP) means an entity, other than the medicaid or medicare programs, responsible for adjudicating and paying claims for third party benefits rendered to an eligible medicaid covered individual.

(B) If the existence of a third party benefit is known to ODM, a code number that represents the name of the third party payer covering the individual will be indicated on the individual's medicaid card. The provider shall obtain from the medicaid covered individual the name and address of the insurance company, and any other necessary information, and bill the insurance company prior to billing ODM.

(C) The provider must always review the individual's Ohio medicaid card for evidence of third party benefits. Whether there is or is not an indication of a TPP on the medicaid card, the provider must always request from the medicaid covered individual, or the individual's representative, information about any third party benefit(s). If the medicaid covered individual specifies no TP coverage and the medicaid card does not indicate TP coverage, the provider may submit a claim to medicaid (and the claim for the service is not considered a TP claim). If, as a result of this process, the provider or ODM determines that TP liability exists, the provider may only submit a claim for reimbursement if it first takes reasonable measures to obtain TP payments as set forth in paragraph (E) of this rule.

(D) The medicaid program must be the last payer to receive and adjudicate the claim except for the following:

(1) Medicaid pays after any TPL and medicare but before:

(a) The children with medical handicaps program under sections 3701.021 to 3701.0210 of the Revised Code.

(b) The state sponsored program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code.

(2) Medicaid pays before any TPL and medicare for preventive pediatric services identified in 42 C.F.R. 433.139 (as in effect October 1, 2018).

(E) ODM reimburses for medically necessary covered services only after the provider takes reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing ODM. Providers who have gone through reasonable measures to obtain all third party payments, but who have not received payment from a TPP, or have gone through reasonable measures and received partial payment, may use an appropriate code on the claim to obtain payment and submit a claim to ODM requesting reimbursement for the rendered service.

(1) Providers are considered by ODM to have taken reasonable measures to obtain all third party payments if they comply with one of the following requirements:

(a) The provider submits a claim first to the TPP and receives a remittance advice indicating that a valid reason for non-payment applies for the service as described in paragraph (E)(2) of this rule.

(b) The provider submits a claim first to the TPP for the rendered service no less than three times within a ninety-day period and does not receive a remittance advice or other communication from the TPP within ninety days of the last submission to the TPP. Providers must be able to document each claim submission and the date of the submission.

(c) The provider followed the process described in paragraph (C) of this rule for the billed service and meets the following requirements:

(i) The provider did not find a change in third party coverage;

(ii) The billed service was previously rendered to the medicaid covered individual by the provider within the last three hundred sixty-five days; and

(iii) The claim for the previously rendered service met the requirements of paragraph (E)(1)(a) or paragraph (E)(1)(d) of this rule.

(d) The provider did not send a claim to the TPP, but has received and retained at least one of the following types of documentation that indicates a valid reason for non-payment for the service(s) as set forth in paragraph (E)(2) of this rule:

(i) Written documentation from the TPP;

(ii) Written documentation from the TPP's automated eligibility and claim verification system;

(iii) Written documentation from the TPP's member benefits reference guide or manual; or

(iv) Any other reliable method for obtaining information or documentation from the TPP that there is no third party benefit coverage for the rendered service(s).

(e) The provider submits a claim first to the TPP and receives a partial payment along with a remittance advice documenting the allocation of the billed charges.

(2) Valid reasons for non-payment from a third party payer to the provider for a third party benefit claim include, but are not limited to, the following:

(a) The service is not covered under the medicaid covered individual's third party benefits.

(b) The medical expenses for the medicaid covered individual were incurred prior to the third party benefit's coverage dates.

(c) The medical expenses for the medicaid covered individual were incurred after the third party benefits coverage was terminated.

(d) The medicaid covered individual does not have third party benefits through the TPP for the date of service.

(e) All of the provider's billed charges or the TPP's approved rate was applied to the medicaid covered individual's third party benefit deductible amount.

(f) All of the provider's billed charges or the TPP's approved rate was applied in total across the medicaid covered individual's deductible, coinsurance, or co-payment for the third party benefit.

(g) The medicaid covered individual has not met eligibility requirements, out-of-pocket expenses, required waiting periods, or residency requirements for the third party benefits.

(h) The medicaid covered individual is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.

(i) The medicaid covered individual has reached the lifetime benefit maximum for the medical service being billed to the third party payer.

(j) The medicaid covered individual has reached the benefit maximum of the third party benefits.

(k) The TPP is disputing or contesting its liability to pay the claim or cover the service.

(l) The claim was submitted timely and with the correct information to the TPP but the claim was rejected by the TPP.

(F) Providers who have gone through reasonable measures as described in paragraph (E) of this rule to obtain all third party payments, but who have not received payment from a TPP, or received a partial payment, may submit a claim to ODM requesting reimbursement for the rendered service. If payment from the TPP is received after ODM has made payment, the provider is required to repay ODM any overpaid amount. The provider must not reimburse any overpaid amounts to the medicaid covered individual.

(G) Providers who have billed the TPP and the TPP submits payment directly to the medicaid covered individual should contact the individual to request the payment be remitted to the provider. If the individual is uncooperative with the request, the provider should contact the county department of job and family services (CDJFS).

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

(I) Medicaid reimbursement for third party claims will not exceed the medicaid maximum payment for the service, determined in accordance with applicable rules for the service, less all third party payments for the service. If the result is less than or equal to zero dollars, there will be no further medicaid payment for the service.

(J) ODM will reject a TP claim when a third party claim indicates coverage by a TPP, or when the existence of third party benefits is known to ODM, and the submitted claim does not indicate collection of the third party payment or does not indicate compliance with paragraph (E) of this rule. Providers should complete their investigation of available third party benefits before submitting a TP claim to ODM for payment.

(K) The provider is prohibited from billing the medicaid covered individual any charges in accordance with rule 5160-1-60 of the Administrative Code.

(L) If the medicaid covered individual states his or her private health insurance has changed or been terminated, the provider should advise the individual to contact his or her county caseworker to correct the case record. If the individual is not cooperative in pursuing third party liability as required by rule 5160:1-2-10 of the Administrative Code, the provider should contact the CDJFS. Once the case record has been corrected, the provider may bill ODM directly.

(M) ODM has right of recovery pursuant to section 5160.37 of the Revised Code (medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by ODM, or billable to ODM for payment at a later date. Section 5160.37 of the Revised Code requires that a medicaid covered individual provide notice to ODM prior to initiating any action against a liable third party. ODM will take steps to protect its rights of recovery

if that notice is not provided. If any person, whether the medicaid covered individual or an individual acting on the behalf of a medicaid covered individual requests a financial statement from a medicaid provider for services paid by ODM or to be billed to ODM on behalf of the medicaid covered individual, the provider shall meet all of the following requirements:

(1) Require that the medicaid covered individual or the individual's representative make a request for access to financial statements in writing.

(2) Notify ODM immediately upon receipt of the medicaid covered individual's written request and forward a copy of the request to ODM, bureau of claims operations, coordination of benefits section.

(3) Release the financial statement to the medicaid covered individual or the individual's representative no later than thirty days after the date the request is received.

(4) Stamp or type on each page of the financial statement in bold font "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."

(5) This rule applies to financial statements whether or not the provider has received reimbursement from ODM. This rule is not intended to prevent or restrict the provider from furnishing records of medical treatment and condition to the medicaid covered individual.

(N) Except as otherwise provided in paragraph (D)(2) of this rule, when the medicaid covered individual is covered by medicare, in addition to other third party payers, medicaid is the payer of last resort. Whether or not a TPP is the primary payer, providers must bill all other third party payers and medicare prior to submitting a claim to ODM in accordance with rule 5160-1-05 of the Administrative Code.