# Ohio Administrative Code

## Rule 5160-1-60.2 Direct reimbursement for out-of-pocket expenses incurred for medicaid covered services during approved eligibility periods.

Effective: July 1, 2022

(A) For purposes of this rule:

(1) "Applicant for reimbursement" is:

(a) An individual who has been determined eligible for a retroactive eligibility period in accordance with rule 5160:1-2-01 of the Administrative Code, and who is seeking reimbursement for medical expenses for which the individual paid for during this approved time period; or

(b) An individual who, as a result of an eligibility determination or state hearing decision, now has effective dates of eligibility and is seeking reimbursement for medical expenses for which the individual paid during this approved time period; or

(c) An individual who has been erroneously charged a medicaid co-pay for services eligible for a co-pay in accordance with rule 5160-1-09 of the Administrative Code, and who is seeking reimbursement of the co-pay amount incurred during the time period when the individual should not have been subject to a co-pay and for which the individual paid; or

(d) A person not legally obligated to pay for an individual's medical bills, but who does, in fact, contribute payment toward the individual's medical bills incurred during the approved eligibility period.

(2) "Effective dates of eligibility" means the period described in rule 5160:1-2-01 of the Administrative Code.

(3) "Medicaid covered service" is a service or product that meets all the following criteria:

(a) Medically necessary in accordance with 5160-1-01 of the Administrative Code;

(b) Delivered by an eligible provider who qualifies for one of the following:

(i) A medicaid provider agreement as described in rule 5160-1-17.12 of the Administrative Code; or

(ii) An approved contract or single case agreement with a medicaid managed care entity (MCE);

(c) A reimbursable medical service as defined in rule 5160-1-02 of the Administrative Code.

(d) A physician service as defined in Chapter 5160-4 of the Administrative Code, or a dental service as defined in Chapter 5160-5 of the Administrative Code.

(4) "Payer" is the Ohio department of medicaid (ODM), an MCE contracted with ODM, or any entity ODM designates with the authority to issue direct reimbursements.

(5) "Retroactive eligibility period" means the period described in rule 5160:1-2-01 of the Administrative Code.

(B) For any application for reimbursement, the payer will make direct reimbursement, including applicable co-pays, in accordance with 42 C.F.R. 447.25 only if all of the following are met:

(1) The individual has an eligibility period as defined in paragraph (A)(2) or (A)(5) of this rule and the date on which the individual received the medicaid covered service was within the period of eligibility;

(2) The service was a medicaid covered service, and the service was not a nursing facility service included in the nursing facility's per diem rate;

(3) The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does agree to reimburse the applicant but does not do so within ninety days;

(4) Within ninety days from the date the provider does not agree or fails to reimburse the applicant, the applicant requests direct reimbursement from the appropriate payer;

(5) Within ninety days from the date the applicant asks the payer for direct reimbursement described in paragraph (B)(4) of this rule, the applicant provides the following documentation to the payer:

(a) Written verification of a bill from the provider which specifies the medicaid covered services provided;

(b) Written verification that the individual paid the provider;

(c) Any other documentation that may be requested by the payer, including proof that the provider did not agree to reimburse the applicant, or did agree to reimburse the applicant but did not do so within ninety days of the request, as specified in paragraph (B)(4) of this rule;

(d) The name, address, and phone number of the provider who rendered the medicaid covered services to the individual and the name of the billing provider; and

(e) The name, address and phone number of any third party that paid or was liable to pay for any portion of the medicaid covered service.

(6) Requests for direct reimbursement will qualify for reimbursement consideration only if submitted to the payer within three hundred sixty-five days of the date of service or hospital discharge, or within one hundred eighty days of the notice of state hearing decision or eligibility determination;

(7) Reimbursement from a third party as defined in section 5160.35 of the Revised Code is not available;

(8) The request is not for reimbursement of medicare part A out-of-pocket expenses.

(C) Within ninety days of meeting the conditions specified in paragraph (B) of this rule, the payer will process the request for reimbursement. Applicants for reimbursement who receive an approval for reimbursement will be reimbursed either the amount of their out-of-pocket medical expenses or the co-pay charges, whichever is applicable, but in no event will the reimbursement exceed the medicaid maximum allowed amount identified in rule 5160-1-60 of the Administrative Code.

(D) The bills identified as satisfying a person's spenddown obligation or paid to the county to meet medicaid eligibility are not reimbursable by the medicaid program.

(E) All notice and hearing provisions set forth in division 5101:6 of the Administrative Code apply to determinations made under this rule.