Ohio Administrative Code

Rule 5160-2-25 Coordination of benefits: hospital services.

Effective: July 9, 2023

Rule 5160-1-08 of the Administrative Code sets forth general provisions that the department make payment for covered services only after any available third-party benefits are exhausted. In addition , this rule identifies other provisions applicable to services provided by hospitals.

(A) All hospitals are to use third-party resources for all services a consumer receives while in the hospital. If a hospital receives reimbursement from a third-party after submitting a claim or after receiving payment from the department, the hospital is to repay the department by submitting a claim adjustment. Patient liabilities associated with persons eligible for medicaid are described in division 5160:1 of the Administrative Code and are considered a third-party resource. Benefits available through Title XVIII of the Social Security Act under medicare part A and part B, including medicare part A lifetime reserve days, or through medicare part C (medicare advantage) are considered third-party resources.

(B) The following payment provisions apply when billing for services provided to medicaid eligible consumers with available resources.

(1) For qualified medicare beneficiaries (QMB), including QMB plus and medicaid consumers enrolled in medicare part A, the following payment provisions apply to cost-sharing liability for inpatient services.

(a) For purposes of paragraph (B)(1) of this rule, the "medicaid maximum allowed amount" is the amount that would be payable by medicaid if the hospitalization were billed, in its entirety, to the department as a medicaid-only claim for a medicaid eligible consumer. The medicaid maximum allowed amount is calculated as:

(i) Described in rule 5160-2-65 of the Administrative Code in the case that a hospital is paid in accordance with the all patient refined diagnosis related groups (APR-DRG) prospective payment system; or

(ii) Described in rule 5160-2-22 of the Administrative Code in the case that a hospital is subject to non-DRG prospective payment.

(b) Except as described in paragraph (B)(3) of this rule, for persons described in paragraph (B)(1) of this rule, the department will pay as cost sharing for inpatient hospital services the lesser of:

(i) The sum of the deductible, coinsurance, and co-payment amount as provided by medicare part A; or

(ii) The medicaid maximum allowed amount, as described in paragraph (B)(1)(a) of this rule, minus the total prior payment, not to equal less than zero. The total prior payment includes the amount paid or payable by medicare and any other applicable third-party payment for services billed.

(c) If the department has a cost-sharing liability but is unable to calculate a medicaid maximum as described in paragraph (B)(1)(a) of this rule, the department may pay the sum of the deductible, coinsurance, and co-payment amount as provided by medicare part A.

(d) If a patient who is jointly eligible for medicare part A and medicaid exhausts medicare part A benefits while hospitalized, and the patient's hospitalization exceeds the applicable medicare threshold, the department will pay the difference between that amount payable by medicare and the medicaid maximum allowed amount as described in paragraph (B)(1)(a) of this rule.

(2) For QMB, including QMB plus and medicaid consumers enrolled in medicare part B, the following payment provisions apply to cost-sharing liability for hospital services covered by medicare part B:

(a) For purposes of paragraph (B)(2) of this rule, the "medicaid maximum allowed amount" is the amount that would be payable by medicaid if the hospitalization was billed, in its entirety, to the department as a medicaid-only claim for a medicaid eligible consumer. The medicaid maximum allowed amount is calculated as:

(i) Described in rule 5160-2-65 of the Administrative Code in the case that a hospital is paid in

accordance with the APR-DRG prospective payment system; or

(ii) Described in rule 5160-2-75 of the Administrative Code in the case that a hospital is paid in accordance with the enhanced ambulatory patient grouping (EAPG) prospective payment system; or

(iii) Described in rule 5160-2-22 of the Administrative Code in the case that a hospital is subject to non-DRG prospective payment.

(b) Except as described in paragraph (B)(3) of this rule, for persons described in paragraph (B)(2) of this rule, the department will pay as cost sharing for hospital services covered by medicare part B the lesser of:

(i) The sum of the deductible, coinsurance, and co-payment amount as provided by medicare part B; or

(ii) The medicaid maximum allowed amount, as described in paragraph (B)(2)(a) of this rule, minus the total prior payment, not to equal less than zero. The total prior payment includes the amount paid or payable by medicare and any other applicable third-party payment for services billed.

(c) If the department has a cost-sharing liability but is unable to calculate a medicaid maximum as described in paragraph (B)(2)(a) of this rule, the department may pay the sum of the deductible, coinsurance, and co-payment amount as provided by medicare part B.

(3) For QMB and medicaid consumers enrolled in medicare part C managed health care plans (medicare advantage plans) the department pays in accordance with rule 5160-1-05.1 of the Administrative Code.

(4) For inpatient hospital services, if a consumer is entitled to hospital insurance benefits other than medicare including health insurance benefits, the department pays either the applicable APR-DRG prospective payment as described in rule 5160-2-65 of the Administrative Code or the payment applicable for services reimbursed on non-DRG prospective payment as described in rule 5160-2-22 of the Administrative Code, minus any resources available to the patient for hospital services including health insurance benefits. Such resources may include medicare part B payments including

health insurance benefits. For outpatient hospital services, if a consumer is entitled to hospital insurance benefits other than medicare, the department pays either in accordance with rule 5160-2-75 of the Administrative Code for hospitals subject to EAPG prospective payment or in accordance with rule 5160-2-22 of the Administrative Code for hospitals subject to non-DRG prospective payment, minus any resources available to the patient. For both inpatient and outpatient services, if the resources available to a recipient equal or exceed amounts payable in accordance with this paragraph, the department makes no payment for the hospital services.