State/Territory: OHIO

Citation

433.137(a)

4.22 Third Party Liability and State Laws Requiring Third Parties to Provide Coverage, Eligibility, and Claims Data

(a)(1) The Medicaid agency meets the requirements of CFR 433.138 and 433.139 as specified in attachments 4.22A and 4.22B.

1902(a)(25)(I)

(a)(2) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility, and claims data in accordance with 1902(a)(25)(I) of the Social Security Act.

433.138 (f)

52 FR 5967

(b) ATTACHMENT 4.22-A

(1) The State agency coordinates data exchanges in the cited planned frequency.

a. State wage information matches occur on a monthly basis.

b. Each initially approved applicant has his/her name and social security number forwarded to the Social Security Administration which completes a wage and earnings information match according to their schedule and policy.

c. Employment/employer information matches occur on a six-month interval.

d. State workers' compensation information matches occur on a six month interval.

e. State motor vehicle information matches occur on a six month interval.

f. The computer processing cycle extracts diagnosis and trauma code information from each payment run and produces a monthly research extract report.

433.138(g)(1)(ii) and (2)(ii)
52 FR 5967

(2) The State agency follow-up processes on the data exchanges involve these methods:

a. After each state wage information data exchange the county departments identify all recipients who have potential third party resources and they forward an ODHS 6612, Medicaid Health Questionnaire, to the State agency for each. The State agency key enters the data into the Third Party Case Master File.

b. After the Social Security wage and earnings information match run, the county departments identify all recipients who have potential third party resources and they forward an ODHS 6612, Medicaid Health Questionnaire, to the State agency. The State agency then key enters the data into the Third Party Case Master File.

c. The on-going IV-D cooperative agreement requires the county departments to forward an ODHS 6612, Medicaid Health Questionnaire, to the State agency. The ODHS 6612 is initiated at the IV-A level upon initial eligibility determination and redetermination for each applicant/recipient. Further, for each newly detected applicant/recipient, the county child support enforcement agency forwards a 6612 to the IV-A level for review and submission to the State agency. The State agency then key enters the data into the Third Party Case Master File.

d. After each industrial injury information data exchange, the State agency key enters the data in the Third Party Case Master File.

e. Health insurance information obtained by the county departments at the initial application and redetermination process for Medicaid eligibility as well as that received on the ODHS 6612, Medicaid Health Questionnaire, from data exchanges, becomes part of the Third Party Case Master File.

f. Control of data exchanged in 4.22-A(b)(2)a. through 4.22-A(b)(2)f. becomes a part of the Third Party Case Master File as follows:

1. The data receives visual screening, comparison with other data already in the on-line Third Party Case Master File, and/or data within the computerized eligibility file. Information deemed inadequate requires a return to the county departments for missing data, resolution through coordination with the insuring carrier (mail or telephone), or through further eligibility file search on the on-line eligibility file.
2. Completion of a telephone call, or when more appropriate, submission of a letter to the insuring carrier to confirm information on hand is required for health data and a subrogation notice to the casualty carrier for verification of liability.

3. The documents are annotated for claim type (drugs, physician, etc.) which sets the system to deny payment (that is, cost avoid).
4. Key enter the data into the Third Party Case Master File within 45 days.

433.138(g)(3)(i) and (iii)
52 FR 5967

(3) Agency follow-up on data exchanges with state motor vehicles or workers' compensation agency involves integration of the information with the active and open casualty cases. Follow-up on non-active cases occurs within 60 days of data receipt with the opening of a post payment recovery case, and/or wherein health insurance is determined, establishment into the Third Party Case Master File for future cost avoidance and the initiation of post payment recovery. Post payment involves the following processes:

1. Examination of the data and development of a "high dollar sort" enabling recovery of the high Medicaid dollars first (normally inpatient hospital payments).

2. Using the subrogation statute, submit request for refunds to the designated third party payer. The Medicaid staff will submit "claims" on a format acceptable to the liable third party, e.g., Bureau of Workers' Compensation forms for that agency.

3. When funds are received, coordination occurs between the accounting staff for verification of accuracy, depositing, and processing the data into the Medicaid payment history data base.

433.138(g)(4)(i) through (iii)
52 FR 5967

(4) Diagnosis and trauma code edits will be followed up within 60 days of receipt of the computerized printout. Whenever health insurance is determined, establishment into the Third Party Case Master File for future cost avoidance is accomplished.

a. Using the subrogation statute, the agency submits a questionnaire to the recipient to obtain sufficient information to establish a casualty recovery case.

b. Using the subrogation statute, the agency submits a refund request to the designated liable third party.

c. When funds are received, the agency coordinates with the accounting staff to verify accuracy of funds recovered and subsequent processing of funds and update of the paid history accounts.

d. Comparison of the highest fiscal returns by trauma code will determine the priority of trauma codes to be followed up.

433.139(b)(3)(ii)(A)
55 FR 1423

☐ (c) Providers are required to bill liable third parties when services covered under the plan are furnished to an individual on whose behalf child supprt enforcement is being carried out by the State IV-D agency.