Ohio | Medicaid Information Technology System

Provider Information Release

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Subject: Behavioral Health Provider Integration

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Medicaid Claims for Clients with Third Party Insurance Coverage

Medicaid is always the payer of last resort, including claims for behavioral health services. For most claims, Medicaid will deny services if the recipient files indicate that the person has either third party insurance or Medicare coverage with the expectation that the provider will bill the other payer first and include payment information on the claim to Medicaid. In the case of community behavioral health services, many times the services are not covered by another payer. Therefore, to reduce administrative effort, MITS was programmed to not reject behavioral health claims for recipients with third party coverage or Medicare. In these cases, no third party information should be included on the claim. The exception to this rule is CPT codes 90801, 90862 and J codes for office administered medications which must be submitted first to a third party if the client has coverage other than Ohio Medicaid.

It is important to note that the provider still has a responsibility to bill Medicare or any third party payer for a service that **is** covered by the third party, regardless of whether or not Medicaid would have initially denied the claim. Medicaid remains the payer of last resort. This means that third party information must be included on the claim when the third party covers the service. For example, if counseling is a covered service by a Medicaid recipient's third party insurance, then the claim to Medicaid should reflect the appropriate information from the third party.

Billing Medicaid When the Third Party Insurance Coverage Does Not Accept Community Medicaid Service Codes

As stated above, service claims for Medicaid clients with commercial insurance must be submitted to the commercial insurer first for primary coverage. Medicaid is the secondary payer. Sometimes commercial insurers recognize HCPCS codes which are not part of the ODMH or ODADAS Medicaid benefit. In these cases, providers should first bill the third party according to the commercial insurer's billing instructions. After commercial payment has occurred, providers seeking secondary payment from Ohio Medicaid should bill the procedure code within the Ohio Medicaid behavioral health benefit package (ODMH or ODADAS services) that is the equivalent of the service rendered.

A recent example of this was for a child with commercial insurance for whom the provider had billed CPT code 90806, "45-50 minute office visit for psychotherapy." The provider received payment but then wanted to submit the claim to Ohio Medicaid for secondary payment. However, 90806 is not a code recognized for ODMH providers (provider type 84) in MITS; so the claim was denied for Medicaid payment. The provider was advised to rebill the claim to MITS using the Medicaid service code they would have billed if the child did not have commercial coverage. The provider indicated the service rendered was the equivalent of H0004, individual counseling. The provider was instructed to submit a claim for H0004 to MITS billed at the same charge they had submitted to the commercial insurer and indicate the payment amount made by the commercial insurer. Once this claim is submitted, MITS will adjudicate it based on the Medicaid rate for the service being billed. Upon adjudication by MITS, the claim is then considered paid in full.

Providers with additional questions about benefits coordination for Medicaid enrollees should contact the **Ohio Medicaid provider call center at 1-800-686-1516, M-F, 8 am – 4:30 pm.**