

5101:3-2-25 ~~Third-party liability~~ Coordination of benefits: hospital services.

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- (A) All hospitals are to utilize third-party resources for all services a consumer receives while in the hospital. If a hospital receives reimbursement from a third-party subsequent to submitting a claim or subsequent to 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 under spend-down provisions are considered a third-party resource. Benefits available through Title XVIII of the Social Security Act under medicare, part A and part B, or through medicare part C (medicare advantage), are considered third-party resources, including medicare part A lifetime reserve days.
- (B) The following payment provisions apply when billing for services provided to medicaid eligibles having available resources.
- (1) For Qualified Medicare Beneficiaries (QMB), QMB Plus, Specified Low-Income Beneficiaries Plus (SLMB Plus), and Full Benefit Dual Eligibles (FBDE), 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 5101-3-2-07.11 of Attachment 4.19-A in the case that a hospital is paid in accordance with the ~~diagnosed~~ diagnosis related grouping (DRG) prospective payment system;
or
- (ii) Described in rule 5101-3-2-22 of Attachment 4.19-A in the case that a hospital is paid on a reasonable cost basis.
- (b) Except as described in paragraph ~~(C)~~ (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 shall 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) When a consumer is entitled to medicare part B benefits, the department pays the amount of the medicare~~

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deductible and coinsurance minus any other resources available to the recipient for hospital services including health insurance benefits.

(2) For Qualified Medicare Beneficiaries (QMB), QMB Plus, Specified Low-Income Beneficiaries Plus (SLMB Plus), and Full Benefit Dual Eligibles (FBDE), 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 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 5101-3-2-07.11 of Attachment 4.19-A in the case that a hospital is paid in accordance with the diagnosis related grouping (DRG) prospective payment system; or

(ii) Described in rule 5101-3-2-22 of Attachment 4.19-A in the case that a hospital is paid on a reasonable cost basis.

(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 shall pay the sum of the deductible, coinsurance and co-payment amount as provided by medicare part B.

(3) For Qualified Medicare Beneficiaries (QMB), QMB Plus, Specified Low-Income Beneficiaries Plus (SLMB Plus), and Full Benefit Dual Eligibles (FBDE) enrolled in medicare part C managed health care plans (medicare advantage plans) the department pays in accordance with Supplement 1 to Attachment 4.19-B.

(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 DRG prospective payment as described in rule 5101-3-2-07.11 of Attachment 4.19-A or the payment applicable for services reimbursed on a reasonable cost basis as described in rule 5101:3-2-22 of Attachment 4.19-A, 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 and patient liabilities associated with persons eligible on a spend-down basis as described in paragraph (A) of this rule. Such resources may include patient liabilities associated with persons eligible on a spend-down basis as described in paragraph (A) of this rule. For inpatient, if the resources available to a recipient

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equal or exceed amounts payable in accordance with this paragraph, the department makes no payment for the hospital services.

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