Ohio | Department of Medicaid

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Medicaid Handbook Transmittal Letter (MHTL) No. 3334-19-01

TO: **Eligible Providers of Medicaid Services**
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: **Maureen M. Corcoran, Director**

SUBJECT: **Rule Updates: Medicaid Coordination of Benefits with Medicare and Other Third-Party Payers**

Summary

The following rules were reviewed as part of the five-year rule review process and have been rescinded, adopted, or amended effective September 16, 2019:

Rule 5160-1-05, entitled "Medicaid coordination of benefits with the Medicare program (Title XVIII)" was reviewed as part of the five-year rule review process and has been amended. This rule provides definitional information of Medicare, types of dually eligible individual benefit plans, types of Medicare crossover claims, and provided general guidelines for submitting Medicare crossover claims to the Ohio Department of Medicaid (ODM). The rule describes reimbursement criteria for Medicare cost sharing on crossover claims and references OAC rules for specific cost sharing methodologies. The rule also provides guidance on submitting claims for services not covered by Medicare and claims for services provided by long term care nursing facility providers.

This rule was amended to reflect the change in Medicaid program authority from the Ohio Department of Job and Family Services (ODJFS) to the Ohio Department of Medicaid (ODM). The use of the term "original Medicare" was changed to "traditional Medicare" and the use of the word "consumers" has been changed to "medicaid covered individual" throughout this rule to align with other Ohio Medicaid regulations. A reference to the spenddown program was removed from the rule since this program no longer exists in the Ohio Medicaid program. Language related to the Medicare central processor and its determination of deductible, coinsurance, and co-payment was removed because it has the same meaning as "Medicare cost sharing payments" as stated in the same sentence.

Rule references cited within the text were updated to reflect the change in agency number for Ohio Administrative Code (OAC) citations and references to one or more ODM forms and the corresponding dates of revision were updated in the amended rule to comply with incorporation by reference requirements. A reference to a specific JFS form was removed as it outdated and no longer used.

References to specific sections of the rule were removed when referencing the Medicare crossover process and replaced with clearer language. Definitions in the section were further clarified to indicate that Medicare submits the claim to ODM for the cost sharing determination and does not always result in a payment by Medicaid. This section was further clarified to indicate providers are required to submit crossover claims directly to ODM when the crossover process does not work.

Language related to services denied by Medicare for lack of medical necessity was clarified and the improper use of the work "then" was corrected to "than." Additionally, references to the Medical Claim Review Request Form and instructions were updated with the revised form number, revision date, and requirement to provide supporting documentation.

Ohio Administrative Code (OAC) rule 5160-1-08, entitled "Coordination of benefits," was reviewed as part of the five-year rule review process and has been rescinded. This rule defined and provided information related to coordination of benefits, explanation of benefits, Medicare benefits, and third-party liability. This rule described provider responsibilities for identifying and billing third-party payers and circumstances under which Medicaid is not the payer of last resort. It described the reasonable measures providers must take to obtain third-party payments and requirements for providers requesting reimbursement from Medicaid when a third-party payer does not make a payment or makes a partial payment.

For providers who do not send a claim to a third-party payer and submit to Medicaid for reimbursement, this rule identified the type of documentation that must be retained showing a valid reason for non-payment by the third-party payer. This rule identified some valid reasons for non-payment from a third-party payer. This rule required third-party claims to meet ODJFS's claim submission guidelines and required providers to maintain documentation to support all required information submitted on a third-party claim. It described the payment methodology for third-party claims and informed providers that ODJFS will reject a claim when third-party coverage is present and there is no indication of third-party payment on the claim.

This rule described the action ODJFS would take if a post-payment review reveals that documentation was not maintained to support the information submitted on a third-party claim and did not accurately reflect the explanation of benefits or omitted information and resulted in an overpayment or inappropriate payment of a claim. The rule also prohibited providers from billing Medicaid covered individuals any charges. It described ODJFS' right to recovery against the liability of a third-party for the cost of medical services paid by or billable to ODJFS. This rule set forth requirements Medicaid providers must meet when a Medicaid covered individual or someone acting on their behalf requests a financial statement from a Medicaid provider for services paid by or billable to ODJFS. Whether or not the third-party payer is the primary payer, this rule required providers to bill all other third-party payers and Medicare prior to submitting a claim to ODJFS. This rule prohibited providers from billing medicaid covered individuals any charges. This rule exempted Medicaid Managed Care Plans (MCPs) and references Chapter 5101:3-26 of the Administrative Code for MCP responsibilities related to coordination of benefits.

Rule 5160-1-08, entitled, "Coordination of benefits" has been adopted to replace the existing rule of the same title which was rescinded. This new rule replaces existing rule, 5160-1-08, entitled "Coordination of Benefits which was rescinded as part of this rule filing. This rule includes the same provisions as the rule that was rescinded but provides clarifying language, updates references to the Ohio Administrative Code and Ohio Revised Code, and changes references to the ODJFS to the ODM, reflecting the change in oversight of the Medicaid program.

This new rule expands the programs and sources of funding in which Medicaid is considered the primary payer in the coordination of benefits determination. It adds an additional valid reason for third-party payer non-payment where ODM would consider payment of the resulting claim. The language relating to a third-party payer denying a claim that was submitted timely and correctly yet was still denied by the third-party payer was included to further clarify to providers the circumstances for which ODM would consider payment.

This new rule includes a provision that when a third-party payer submits payment directly to a Medicaid covered individual, the provider should first contact the individual for payment to be remitted. If the Medicaid covered

individual is uncooperative in doing so, language added to the rule instructs the provider to contact the CDJFS. If the Medicaid covered individual states his/her private health insurance has changed or been terminated and has been uncooperative in reporting this to the CDJFS, the new rule instructed the provider to contact the CDJFS. These provisions were included in the new rule to inform and provide clarity to providers on how to obtain reimbursement in each of these respective situations.

Access to Rules and Related Material

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs, and rules; the address is http://www.medicaid.ohio.gov

Additional Information

Questions pertaining to this letter should be addressed to:

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