LEGAL NOTICE
STATE OF OHIO
OHIO DEPARTMENT OF MEDICAID
COLUMBUS, OHIO

DATE: **July 15, 2019**
TIME: **2:00pm**
LOCATION: **Room A401, Lazarus Building**
50 W. Town St., Columbus, Ohio 43215

Pursuant to section 5164.02 and Chapter 119 of the Ohio Revised Code, the Director of the Ohio Department of Medicaid (ODM) gives notice of the Department's intent to consider the rescission, adoption or amendment of the rules identified below and of a public hearing thereon.

TO BE AMENDED

Ohio Administrative Code rule 5160-1-05, entitled "Medicaid coordination of benefits with the Medicare program (Title XVIII)", provides definitional information of Medicare, types of dually eligible individual benefit plans, types of Medicare crossover claims, and provides general guidelines for submitting Medicare crossover claims to 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 requires the provider to notify the ODM claims adjustment unit if any overpayment is inadvertently received from both Medicare and Medicaid for the same service.

This rule has been reviewed as part of the five-year rule review process and is being proposed for amendment. This rule is being amended to reflect the change in Medicaid program authority from the Ohio Department of Job and Family Services (ODJFS) to 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 has been 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 are being 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 are being updated in the amended

rule to comply with incorporation by reference requirements. A reference to a specific JFS form was removed as it is 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. A reference to resource limits for qualified Medicare beneficiaries without other Medicaid was removed and replaced with the relevant section of the Social Security Act where the limit is defined. 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 word "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.

TO BE RESCINDED

OAC rule 5160-1-08, entitled, "Coordination of benefits" has been reviewed as part of the five-year rule review process and is being proposed for rescission as greater than fifty percent of the rule is being amended. This rule will be replaced with a new rule of the same name and number. This rule provides definitional information related to coordination of benefits, explanation of benefits, Medicare benefits, and third-party liability. This rule describes provider responsibilities for identifying and billing third party payers and circumstances under which Medicaid is not the payer of last resort. It describes 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. The rule also exempts managed care plans from its provisions.

For providers who do not send a claim to a third-party payer and submit to Medicaid for reimbursement, this rule identifies the type of documentation that must be retained showing a valid reason for non-payment by the third-party payer. This rule identifies some valid reasons for non-payment from a third-party payer. This rule requires third party claims to meet ODJFS' claim submission guidelines and requires providers to maintain documentation to support all required information submitted on a third-party claim. It describes the payment methodology for third party claims and informs 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 describes the audit exceptions and action ODJFS will take if a post-payment review reveals that documentation was not maintained to support the information

submitted on a third-party claim and does not accurately reflect the explanation of benefits or omits information and results in an overpayment or inappropriate payment of a claim. It describes 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 sets 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 requires providers to bill all other third-party payers and Medicare prior to submitting a claim to ODJFS. This rule prohibits providers from billing Medicaid covered individuals any charges.

TO BE ADOPTED

OAC rule 5160-1-08, entitled, "Coordination of benefits" is being proposed for adoption to replace the existing rule of the same title which is being proposed for rescission. This rule includes many of the same provisions as the rule to be rescinded This rule provides definitional information related to coordination of benefits, explanation of benefits, Medicare benefits, and third-party liability. This rule describes provider responsibilities for identifying and billing third party payers and circumstances under which Medicaid is not the payer of last resort. It describes 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 identifies the type of documentation that must be retained showing a valid reason for non-payment by the third-party payer. This rule identifies some valid reasons for non-payment from a third-party payer. This rule requires third party claims to meet ODM's claim submission guidelines and requires providers to maintain documentation to support all required information submitted on a third-party claim. It describes the payment methodology for third party claims and informs providers that ODM will reject a claim when third party coverage is present and there is no indication of third-party payment on the claim.

This rule describes ODM's right to recovery against the liability of a third party for the cost of medical services paid by or billable to ODM. This rule sets 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 ODM. Whether or not the third-party payer is the primary payer, this rule requires providers to bill all other third-party payers and Medicare prior to submitting a claim to ODM unless the claim relates to preventive pediatric services identified in 42 C.F.R. 433.139. This rule prohibits providers from billing Medicaid covered individuals any charges.

The changes from the rule to be rescinded include the addition of clarifying language, updates to references to the Ohio Administrative Code and Ohio Revised Code, and

changes to references to the department, reflecting the change in oversight of the Medicaid program from ODJFS to ODM. The new rule changes references from consumer to Medicaid covered individual to reflect current terminology and rearranges definitions into alphabetical order for better clarity and ease of reference. This new rule updates the programs and sources of funding in which Medicaid is considered the primary payer in the coordination of benefits determination. Language relating to denial by a third-party payer of a timely and correctly completed claim has been added to further clarify to providers the circumstances for which ODM would consider payment. This new rule removes provisions from the rule to be rescinded that are related to audit exceptions and managed care because these provisions are covered elsewhere in the rule and in agency 5160 of the Administrative Code.

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 included in the new rule instructs the provider to contact the County Department of Job and Family Services (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 instructs 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.

A public hearing on the proposed rules will be held at the date, time, and location listed at the top of this notice. Both written and oral testimony will be taken at the public hearing. Additionally, written comments submitted or postmarked no later than the date of the public hearing will be treated as testimony.

A copy of the proposed rules is available, without charge, at the address listed below. The rules are also available on the internet at http://www.registerofohio.state.oh.us/.

Requests for a copy of the proposed rules and testimony on the rules should be submitted by mail to the Ohio Department of Medicaid Rule Administrator, Office of Chief Legal Counsel, 50 W. Town Street, Suite 400, Columbus, Ohio 43215-3414, by fax at (614) 995-1301, or by e-mail at Rules@Medicaid.Ohio.gov. Testimony received may be reviewed at this address.