CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid

Regulation/Package Title: Medicaid Coordination of Benefits with Medicare and Other Third-Party Payers

Rule Number(s):

5160-1-05 Medicaid Coordination of Benefits with the Medicare Program (Title XVIII)

(Amend); and

5160-1-08 Coordination of Benefits (Rescind and New)

Date: 11/21/2018

Rule Type:

X New

X Amended

X 5-Year Review

X Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

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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 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 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. 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.

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. 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.

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 the same provisions as the rule to be rescinded but provides clarifying language, updates references to the Ohio Administrative Code and Ohio Revised Code, and changes references from ODJFS to ODM, reflecting the change in oversight of the Medicaid program. This new rule updates the programs and sources of funding in which Medicaid is considered the primary payer in the coordination of benefits determination. 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.

The new rule does not include language related to audit exceptions because this provision is covered elsewhere in the rule and in Chapter 5160 of the Administrative Code.

This new proposed 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. This rule also removes the exemption for managed care plans.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   5164.02

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   These regulations implement Section 1902(a)(25)(A) of the Social Security Act which requires states to take all reasonable measures to ascertain the legal liability of third parties for health care items and services provided to Medicaid beneficiaries.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   The public purpose of these regulations is to ensure compliance with federal regulations and to ensure proper Medicaid cost sharing for dually eligible individuals and individuals with other responsible third-party payers.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   ODM will measure the success of these regulations by evaluating claims received in the Medicaid Information Technology System (MITS) to determine if the intended outcomes of proper cost sharing calculations were reached.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   Drafts of these amended rules were posted for all stakeholders to review for seven calendar days on the ODM rules webpage and notification was sent to the ODM stakeholder list to seek public comment.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   No concerns were raised in response to the draft rules.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   No scientific data was used to develop these rules or the measurable outcomes of the rules.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    These rules have been in effect since at least 8/2/2011. ODM did not consider any regulatory alternatives because the rules, as implemented, serve the intended purpose and continue to be applicable to Medicaid coordination of benefits with the Medicare program and other responsible third-party payers.

11. **Did the Agency specifically consider a performance-based regulation? Please explain.**
    Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

    ODM did not consider performance-based regulations because the Medicaid program is the payer of last resort under federal law. For this reason, ODM does not have the flexibility to implement a performance-based regulation.

12. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    ODM's staff reviewed the Ohio Revised Code and Ohio Administrative Code to ensure they do not duplicate existing Ohio regulations.

13. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    The implement these regulations, ODM will provide a notice of changes to providers and other interested parties. ODM will post this information on the agency website to ensure thorough communication with the regulated community.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

The scope of the business community impacted by 5160-1-05 is limited to Ohio Medicaid providers who participate in the Medicare program and provide services to individuals dually eligible for Medicare and Medicaid.

The scope of the business community impacted by 5160-1-08 is limited to Ohio Medicaid providers who provide services to Medicaid covered individuals who have additional health insurance coverage or another third-party payer responsible for medical coverage.

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

Rule 5160-1-05 that is being proposed for amendment requires providers seeking reimbursement through the automatic crossover process to be recognized as both Medicare and Medicaid providers and to accept Medicare assignment.

If an overpayment is inadvertently received from both Medicare and Medicaid for the same service, this rule requires the provider to notify the ODM claims adjustment unit. The nature of the adverse impact is employee time and enrollment fees.

Rule 5160-1-08 that is being proposed for rescission states that ODJFS will reject a third-party claim that indicates coverage by a third-party payer and the submitted claim does not indicate collection of the third-party payment or compliance with this rule. The nature of the adverse action is a sanction of non-payment of the claim. This sanction can be corrected by resubmitting the claim within the allowed time frame for submitting claims.

This rule states that ODJFS will-make an audit exception if documentation to support information on a third-party claim is not maintained or if omission of required third party claim information resulted in an overpayment or an inappropriate payment of the claim. The sanction necessitates the return of the overpayment or inappropriate payment to the state.

This rule also 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. Providers must notify ODJFS and provide a copy of the written request to ODJFS when a Medicaid covered individual or someone acting on his/her behalf requests a financial statement from a Medicaid provider for services paid by or billable to ODJFS. The provider must also release the financial statement no later than 30 days after the date of receipt of the request to the individual or individual's representative and stamp or type on each page the following text in bold font: "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY." The nature of the adverse impact is employee time.

New rule 5160-1-08 that is being proposed to replace the rescinded rule of the same number and title, requires that when a third-party payer submits payment directly to a Medicaid covered individual, the provider must first contact the individual for payment to be remitted. If the Medicaid covered individual is uncooperative in doing so, this rule instructs the provider to contact the CDJFS. In addition, 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, this rule instructs the provider to contact the CDJFS. The nature of the adverse impact for both requirements is employee time.

The rule states that ODM will reject a third-party claim when the claim indicates coverage by a third-party payer or when the existence of third-party benefits is known to ODM and the submitted claim does not indicate collection of the third-party payment. The nature of the adverse action is a sanction of non-payment of the claim. This sanction can be corrected by resubmitting the claim within the allowed time frame for submitting claims.

This rule also 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. Providers must notify ODM and provide a copy of the written request to ODM when a Medicaid covered individual or someone acting on his/her behalf requests a financial statement from a Medicaid provider for services paid by or billable to ODM. The provider must also release the financial statement no later than 30 days after the date of receipt of the request to the individual or individual's representative and stamp or type on each page the following text in bold font: "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE

TO COMPLY MAY RESULT IN PERSONAL LIABILITY." The nature of the adverse impact is employee time.

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

Rule 5160-1-05 that is being proposed for amendment requires providers seeking reimbursement through the automatic crossover process to be recognized as both Medicare and Medicaid providers and to accept Medicare assignment.

Generally, all institutional providers enrolling in Medicare or Medicaid are subject to an enrollment fee of $569. Medicare providers who have paid this fee are not required to pay an application fee when applying as an Ohio Medicaid provider. Non-institutional or individual providers are generally not subject to an application fee but other costs may be incurred that result from gathering documentation, or required screenings such as a background check.

To enroll as an Ohio Medicaid provider, an online application must be completed through the Medicaid Information Technology System (MITS). This process takes roughly 25 minutes for an individual provider application but can take longer if the applicant is an institutional provider. Non-institutional or individual providers are generally not subject to an application fee, but other costs may be incurred that result from gathering documentation or required screenings such as a background check.

Providers enrolling in Medicare make a selection to accept Medicare assignment at the time of the provider enrollment application. If this was not indicated on the application at time of completion, the provider must contact Medicare to make the attestation. The contact may be made by telephone or e-mail.

Other than the Medicare enrollment fee, the cost of employee time to enroll in Medicare and Medicaid and accept Medicare assignment will vary by provider. These tasks may be performed by administrative personnel. The cost will be determined by the amount of time taken to gather, complete and provide necessary information multiplied by the hourly rate of the person performing the function.

If an overpayment is inadvertently received from both Medicare and Medicaid for the same service, this rule requires the provider to notify the ODM claims adjustment unit. Providers may notify ODM by calling provider support and speaking with a representative, a process that takes roughly 10 minutes. The total cost would equal the employee time multiplied by the employee's hourly rate.

Rule 5160-1-08 that is being proposed for rescission states that ODJFS will reject a third-party claim that indicates coverage by a third-party payer and the submitted claim does not indicate collection of the third-party payment or compliance with this rule. This sanction can be corrected by resubmitting the claim within the allowed time frame for submitting claims. The cost for this sanction cannot be determined as it will vary based on the number of claims impacted and how the claims are resubmitted.

This rule states that ODJFS will make an audit exception if documentation to support information on a third-party claim is not maintained or if omission of required third party claim information resulted in an overpayment or an inappropriate payment of the claim. The sanction necessitates the return of the overpayment or inappropriate payment to the state. The cost for this sanction cannot be determined as it will vary based on the amount of the overpayment or inappropriate payment determined by the auditor.

This rule also 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. Providers must notify ODJFS and provide a copy of the written request to ODJFS when a Medicaid covered individual or someone acting on his/her behalf requests a financial statement from a Medicaid provider for services paid by or billable to ODJFS. The provider must also release the financial statement no later than 30 days after the date of receipt of the request to the individual or individual's representative and stamp or type on each page the following text in bold font: "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."

These tasks may be performed by administrative personnel. The cost will vary by provider and be determined by the amount of time taken to gather, complete and provide necessary information multiplied by the hourly rate of the person performing the function.

New rule 5160-1-08 that is being proposed to replace the rescinded rule of the same number and title

This rule requires that when a third-party payer submits payment directly to a Medicaid covered individual, the provider must first contact the individual for payment to be remitted. If the Medicaid covered individual is uncooperative in doing so, this rule instructs the provider to contact the CDJFS. In addition, 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, this rule instructs the provider to contact the CDJFS.

These tasks may be performed by administrative personnel. The cost will vary by provider and be determined by the amount of time taken to gather, complete and provide necessary information multiplied by the hourly rate of the person performing the function.

The rule states that ODM will reject a third-party claim that indicates coverage by a third-party payer and the submitted claim does not indicate collection of the third-party payment or compliance with this rule. This sanction can be corrected by resubmitting the claim within the allowed time frame for submitting claims. The cost for this sanction cannot be determined as it will vary based on the number of claims impacted and how the claims are resubmitted.

This rule also 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. Providers must notify ODM and provide a copy of the written request to ODM when a Medicaid covered individual or someone acting on his/her behalf requests a financial statement from a Medicaid provider for services paid by or billable to ODM. The provider must also release the financial statement no later than 30 days after the date of receipt of the request to the individual or individual's representative and stamp or type on each page the following text in bold font: "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."

These tasks may be performed by administrative personnel. The cost will vary by provider and be determined by the amount of time taken to gather, complete and provide necessary information multiplied by the hourly rate of the person performing the function.

15. **Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?**

    ODM determined that the regulatory intent justifies the adverse impact to the regulated business community because these rules clearly define the requirements for ODM's coordination of benefits with the Medicare program and other responsible third-party payers. This ensures compliance with federal requirements to properly calculate cost sharing as the payer of last resort.

Regulatory Flexibility

16. **Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.**

    These regulations do not provide any exemptions or alternative means of compliance for small businesses because these regulations are applied consistently in the Medicaid program.

17. **How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?**

    Per ORC 119.14 paragraph (E), this section shall not apply to any violation by a small business of a statutory or regulatory requirement mandating the collection of information by a state agency or regulatory body if that small business previously violated any such requirement mandating the collection of information.

18. **What resources are available to assist small businesses with compliance of the regulation?**

    All providers have access to several resources to assist with compliance of these regulations. The ODM website houses valuable information and providers can contact the provider support team with any questions by calling 1-800-686-1516.

5160-1-05 **Medicaid coordination of benefits with the medicare program (Title XVIII).**

Paragraphs (A)(7) to (F)(4) of this rule do not apply to pharmacy services covered under the medicare part D program. Pharmacy services covered under the medicare part D program should be billed in accordance with rule ~~5101:3-9-06~~ 5160-9-06 of the Administrative Code.

(A) Definitions.

(1) "Medicare" is a federally financed program of hospital insurance (part A) and supplemental medical insurance (also called SMI ~~and/~~or part B) for aged and disabled persons.

(2) "Medicare Benefits" means the health care services available to an~~the consumer~~individual through the medicare program where payment for the services ~~are~~is either completely the obligation of the medicare program or in part the obligation of the medicare program with the remaining payment ~~(cost sharing)~~ obligations belonging to the ~~consumer~~individual, some other third party payer ~~and/~~or medicaid.

(3) "~~Original~~ Traditional Medicare ~~(also known as traditional medicare)~~" is a health plan that pays for medicare benefits provided to ~~beneficiaries~~ individuals on a fee-for-service basis.

(4) "Medicare Advantage Plan (also known as medicare part C plan)" is a managed care delivery system that includes coverage for both hospital insurance and SMI, but the delivery of health care services are contracted to and provided by an approved medicare managed care plan, preferred provider organization, private fee-for-service plans or medicare specialty plans.

(5) "Medicare Cost Sharing" for the purpose of this rule means the portion of a medicare crossover claim paid by medicaid.

(6) "Dual Eligibles or Dually Eligible ~~Consumer~~Individuals" are individuals who are entitled to medicare hospital insurance and~~/or~~ SMI and are eligible for medicaid to pay some form of medicare cost sharing. The following is a list of dual eligibles or dually eligible individuals that qualify to have medicaid pay all or part of the cost sharing portion of a paid medicare claim:

(a) "Qualified Medicare Beneficiaries without Other Medicaid (QMB Only)" are individuals entitled to medicare hospital insurance, have income of one hundred per cent of the federal poverty level (FPL) or less and resources that do not exceed the maximum amount of resources allowed

under section 1905(p)(1) of the Social Security Act (as in effect on October 1, 2018), as adjusted annually according to the change in the consumer price index for urban areas (CPI-U)~~twice the limit for supplemental security income (SSI) eligibility~~, and are not otherwise eligible for full medicaid benefits.

(b) "QMBs with Full Medicaid (QMB Plus)" are individuals entitled to medicare hospital insurance, have incomes of one hundred per cent FPL or less and resources that do not exceed the maximum amount of resources allowed under section 1905(p)(1) of the Social Security Act (as in effect on October 1, 2018), as adjusted annually according to the change in the consumer price index for urban areas (CPI-U)~~twice the limit for SSI eligibility~~, and are eligible for full medicaid benefits.

(c) "Specified Low-Income Medicare Beneficiaries with Full Medicaid (SLMB Plus)" are individuals entitled to medicare hospital insurance, have income of greater than one hundred per cent FPL, but less than one hundred twenty per cent FPL and resources that do not ~~in~~ exceed twice the limit for SSI eligibility, and are eligible for full medicaid benefits.

(d) "Medicaid Only Dual Eligibles (for example Non QMB)" are individuals entitled to medicare hospital insurance and~~/or~~ SMI and are eligible for full medicaid benefits. They are not eligible for medicaid in any of the other dual eligible categories (for example QMB). ~~Typically, these individuals need to spend down to qualify for medicaid or fall into a medicaid eligibility poverty group that exceeds the limits of other dual eligible categories.~~

(7) "Medicare Crossover Claim" means any claim that has been submitted to the Ohio department of ~~job and family services (ODJFS)~~ medicaid (ODM) for medicare cost sharing payments after the claim has been adjudicated and paid by the medicare central processor, medicare carrier/intermediary or the medicare managed care plan ~~and the medicare central processor or medicare carrier/intermediary has determined the deductible, coinsurance and/or co-payment amounts~~. Claims denied by the medicare carrier/intermediary or the medicare managed care plan are not considered medicare crossover claims. See paragraphs (E) and (F) of this rule for policy on services denied or not covered by medicare.

(a) "Automatic Crossover Claim" is a medicare claim submitted to ~~ODJFS~~ODM via the automatic medicare crossover process described in paragraph (B)(2)(a) of this rule.

(b) "Provider-Submitted Crossover Claim" means a medicare crossover claim submitted to ~~ODJFS~~ODM as described in paragraph (B)(2)(b) of this rule.

(B) Medicare crossover process.

(1) ~~ODJFS will no longer accept the JFS 06780 "Medicaid Claim Billing" form (rev. 10/2001) for processing and payment of medicare crossover claims.~~ Medicare crossover claims must meet the claim submission guidelines in accordance with rule ~~5101:3-1-19~~ 5160-1-19 of the Administrative Code.

(2) The medicare program determines the portion of medicare cost sharing, if any, due to the provider based on medicare's business rules and submits the claim for payment to ~~ODJFS~~ODM using the automatic medicare crossover process.

(a) The "Automatic Medicare Crossover Process" is the coordination of benefit (COB) process whereby the provider bills medicare for services provided to ~~the patient who meets the criteria described in paragraphs (A)(6)(a) to (A)(6)(d) of this rule or is~~ a dual eligible or a dually eligible individual described in paragraph (A)(6) of this rule. Medicare adjudicates the claim, pays the provider and electronically submits the claim to ~~ODJFS~~ODM for the medicare cost sharing ~~amounts~~determination. Then, when appropriate, the provider is paid by medicaid within ninety days from the date of payment by medicare.

(b) When the automatic medicare crossover process does not work (i.e., the provider has received payment by medicare, has not received a payment from medicaid for the medicare cost sharing portion and at least ninety days has elapsed from the date of the receipt of the medicare payment), the provider ~~may~~ must submit a medicare crossover claim directly to ~~ODJFS~~ODM. This is considered the "Provider-Submitted Crossover Claim Process."

(3) For a provider to receive reimbursement through the automatic medicare crossover process, all of the following criteria must be met:

(a) The provider must be recognized as both a medicare and medicaid provider;

(b) The provider must accept medicare assignment; and

(c) The ~~consumer~~individual must be receiving health care benefits under the ~~original~~traditional medicare part A and part B program (i.e., the ~~consumer~~individual is not enrolled in a medicare managed care plan). At this time ~~ODJFS~~ODM does not have payer-to-payer COB arrangements with medicare managed care plans.

(4) For medicare crossover claims, the total sum of the payments made by ~~ODJFS~~ODM, medicare and~~/or~~ all other third party payers is considered payment in full and no additional payment may be requested from the ~~consumer~~individual with the exception of medicare co-payments as specified in paragraph (E)(5) of this rule. This is true whether or not the provider normally accepts assignment under medicare.

(a) When the provider's total reimbursement from medicare and all other third party payers equals or exceeds the medicare approved ~~(allowed/covered)~~ amount, no additional payment will be made by ~~ODJFS~~ODM.

(b) If payment (other than the cost sharing amounts) is inadvertently received from both medicare and medicaid for the same service, the provider must notify the ~~ODJFS~~ODM claims adjustment unit ~~must be notified~~ in accordance with the provisions set forth in rule ~~5101:3-1-19~~ 5160-1-19 of the Administrative Code.

(5) Provider submitted crossover claims must be submitted timely in accordance with rule ~~5101:3-1-19~~ 5160-1-19 of the Administrative Code.

(6) Crossover claims are not subject to medicaid co-payments in accordance with rule ~~5101:3-1-09~~ 5160-1-09 of the Administrative Code.

(C) When the ~~medicaid consumer~~individual receiving medicaid is covered by other third party payers, in addition to medicare, medicaid is the payer of last resort. Whether or not medicare is the primary payer, providers must bill all other third party payers prior to submitting a crossover claim to ~~ODJFS~~ODM in accordance with rule ~~5101:3-1-08~~ 5160-1-08 of the Administrative Code.

(D) ~~ODJFS~~ODM will not pay for services denied by medicare for lack of medical necessity, but may pay claims denied for reasons other ~~then~~than lack of medical necessity in accordance with paragraph (F) of this rule as long as the services are covered under the medicaid program. ~~ODJFS~~ODM will not pay for any service payable by, but not billed to, medicare.

(E) Reimbursement for medicare cost sharing on medicare crossover claims.

Reimbursement for medicare crossover claims is limited to the dual eligibles or dually eligible individuals listed in paragraph (A)(6) of this rule.

(1) The medicaid maximum reimbursement for the medicare cost sharing of hospital inpatient, outpatient or emergency room services is set forth in rule ~~5101:3-2-25~~ 5160-2-25 of the Administrative Code for ~~consumer~~individuals that elected to receive medicare benefits under ~~original~~traditional medicare.

(2) The medicaid maximum reimbursement for the medicare cost sharing of nursing facility services included in the nursing facility per diem is set forth in Chapter ~~5101:3-3~~ 5160-3 of the Administrative Code for ~~consumer~~individuals that elected to receive medicare benefits under ~~original~~ traditional medicare.

(3) The medicaid maximum reimbursement for the medicare cost sharing of all other part B services not included in paragraph (E)(1) or (E)(2) of this rule is set forth in rule ~~5101:3-1-05.3~~ 5160-1-05.3 of the Administrative Code for ~~consumer~~individuals that elected to receive medicare benefits under ~~original~~ traditional medicare.

(4) The medicaid maximum reimbursement for the medicare cost sharing of all advantage plan (part C) services is set forth in rule ~~5101:3-1-05.1~~ 5160-1-05.1 of the Administrative Code for ~~consumer~~individuals that elected to receive medicare benefits under a medicare advantage plan.

(5) Cost sharing for medicare part D services is not reimbursable by ~~ODJFS~~ODM in accordance with rule ~~5101:3-9-06~~ 5160-9-06 of the Administrative Code. ~~Dually~~ Dual eligibles or dually eligible ~~consumer~~individuals may be required to pay medicare co-payments for prescription drugs that are covered by medicare part D.

(F) Services that are not covered by medicare must be submitted to ~~ODJFS~~ODM as a regular medicaid claim and should never be submitted as a medicare crossover claim.

With the exception of long term care nursing facilities, when the service is denied by medicare, and is also denied by medicaid with an error message indicating that the service is covered under medicare and the provider has documentation to support the service is not covered under medicare, the provider must do all of the following when requesting payment consideration from ~~ODJFS~~ODM:

(1) Submit the appropriate claim in accordance with rule ~~5101:3-1-19~~ 5160-1-19 of the Administrative Code;

(2) Attach the summary notice of medicare benefits that shows the denied medicare services, and the denial reason code with the denial reason code explanation from the medicare summary of benefits, the provider is requesting ~~ODJFS~~ODM to consider for payment;

(3) Attach a completed "~~JFS~~ ODM 06653 Medical Claim Review Request Form (rev. ~~05/2010~~7/2014)"with supporting documentation; and

(4) Submit all forms together to the address indicated on the ~~JFS~~ instruction page accompanying the ODM 06653 form.

(G) Long term care nursing facility providers must submit the appropriate claim in accordance with Chapter ~~5101:3-3~~ 5160-3 of the Administrative Code.

TO BE RESCINDED

5160-1-08 **Coordination of benefits.**

(A) Definitions.

(1) "Coordination of benefits (COB)" means the process of determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third party resource when two or more health plans, insurance policies or third party resources cover the same benefits for a medicaid consumer.

(2) "Explanation of benefits (EOB)" or "remittance advice" means the information sent to providers and/or plan beneficiaries (consumers) by any other third party payer, medicare and/or medicaid to explain the adjudication of the claim.

(3) "COB claim" means any claim that meets either the definition of third party claim as described in paragraph (A)(9) of this rule or the definition of medicare crossover claim as described in rule 5101:3-1-05 of the Administrative Code.

(4) "Medicare benefits" is as defined in rule 5101:3-1-05 of the Administrative Code.

(5) "Third party (TP)" is as defined in section 5101.571 of the Revised Code.

(6) "Third party payer (TPP)" means an entity, other than the medicaid or medicare programs, responsible for adjudicating and paying claims for third party benefits rendered to an eligible medicaid consumer.

(7) "Third party benefit" means any health care service(s) available to consumers through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the TPP or in part the obligation of the consumer, the TPP and/or medicaid. (Examples of a third party benefit include private health or accidental insurance, medicare, CHAMPUS or worker's compensation.)

(8) "Third party liability (TPL)" means the payment obligations of the TPP for health care services rendered to eligible medicaid consumers when the consumer also has third party benefits as described in paragraph (A)(7) of this rule.

(9) "Third party claim" means any claim(s) submitted to ODJFS for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by ODJFS:

(a) Any claim received by ODJFS that shows no prior payment by a TPP, but, ODJFS's records indicate the consumer has third party benefits.

(b) Any claim received by ODJFS that shows no prior payment by a TPP, but, the provider's records indicate the medicaid consumer has third party benefits.

(B) If the existence of a third party benefit is known to ODJFS, a code number that represents the name of the third party payer covering the consumer will be indicated on the consumer's medicaid card. The provider shall obtain from the consumer the name and address of the insurance company, and any other necessary information, and bill the insurance company prior to billing ODJFS.

(C) The provider must always review the consumer's Ohio medicaid card for evidence of third party benefits. Whether there is or is not an indication of a TPP on the medicaid card, the provider must always request from the consumer or his or her representative information about any third party benefit(s). If the consumer specifies no TP coverage and the medicaid card does not indicate TP coverage, the provider may submit a claim to medicaid (and the claim for the service is not considered a TP claim). If, as a result of this process, the provider determines that TP liability exists, the provider may only submit a claim for reimbursement if it first takes reasonable measures to obtain TP payments as set forth in paragraph (D) of this rule.

(D) The medicaid program must be the last payer to receive and adjudicate the claim, except as determined by rule 5101:3-1-03 of the Administrative Code, and the state sponsored program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code. ODJFS reimburses for covered services only after the provider takes reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing ODJFS. Providers who have gone through reasonable measures to obtain all third party payments, but who have not received payment from a TPP, or have gone through reasonable measures and received partial payment, may use an appropriate code on the claim to obtain payment and submit a claim to ODJFS requesting reimbursement for the rendered service(s).

(1) Providers are considered by ODJFS to have taken reasonable measures to obtain all third party payments if they comply with one of the following requirements:

(a) The provider submits a claim first to the TPP and receives a remittance advice indicating that a valid reason for non-payment applies for the service as described in paragraph (D)(2) of this rule.

(b) The provider submits a claim first to the TPP for the rendered service(s) no less than three times within a ninety-day period and does not receive

a remittance advice or other communication from the TPP within ninety days of the last submission to the TPP. Providers must be able to document each claim submission and the date of the submission.

(c) The provider followed the process described in paragraph (C) of this rule for the billed service and meets the following requirements:

(i) The provider did not find a change in third party coverage;

(ii) The billed service was previously rendered to the medicaid consumer by the provider within the last three hundred sixty-five days; and

(iii) The claim for the previously rendered service met the requirements of paragraph (D)(1)(a) or (D)(1)(d) of this rule.

(d) The provider did not send a claim to the TPP, but has received and retained at least one of the following types of documentation that indicates a valid reason for non-payment for the service(s) as set forth in paragraph (D)(2) of this rule:

(i) Written documentation from the TPP;

(ii) Written documentation from the TPPs automated eligibility and claim verification system;

(iii) Written documentation from the TPPs member benefits reference guide/manual; or

(iv) Any other reliable method for obtaining information and/or documentation from the TPP that there is no third party benefit coverage for the rendered service(s).

(e) The provider submits a claim first to the TPP and receives a partial payment along with a remittance advice documenting the allocation of the billed charges.

(2) Valid reasons for non-payment from a third party payer to the provider for a third party benefit claim include, but are not limited to, the following:

(a) The service(s) is not covered under the medicaid consumer's third party benefits.

(b) The medical expenses for the medicaid consumer were incurred prior to the third party benefits coverage dates.

(c) The medical expenses for the medicaid consumer were incurred after the third party benefits coverage was terminated.

(d) The medicaid consumer does not have third party benefits through the TPP for the date of service.

(e) All of the provider's billed charges or the TPPs approved rate was applied to the consumer's third party benefit deductible amount.

(f) All of the provider's billed charges or the TPPs approved rate was applied in total across the consumer's deductible, coinsurance and/or co-payment for the third party benefit.

(g) The medicaid consumer has not met eligibility, out-of-pocket expenses, required waiting periods or residency requirements for his/her third party benefits.

(h) The medicaid consumer is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.

(i) The medicaid consumer has reached the lifetime benefit maximum for the medical service being billed to the third party payer.

(j) The medicaid consumer has reached the benefit maximum of his/her third party benefits.

(k) The TPP is disputing or contesting its liability to pay the claim or cover the service.

(E) Providers who have gone through reasonable measures as described in paragraph (D) of this rule to obtain all third party payments, but who have not received payment from a TPP, or received a partial payment, may submit a claim to ODJFS requesting reimbursement for the rendered service(s). If payment from the TPP is received after ODJFS has made payment, the provider is required to repay ODJFS any overpaid amount. The provider must not reimburse any overpaid amounts to the consumer.

(F) Third party claims must meet the claim submission guidelines in accordance with rule 5101:3-1-19 of the Administrative Code.

(G) Medicaid reimbursement for third party claims will not exceed the medicaid maximum payment for the service, determined in accordance with applicable rules for the service, less all third party payments for the service. If the result is less than or equal to zero dollars, there will be no further medicaid payment for the service.

(H) ODJFS will reject a TP claim when a third party claim indicates coverage by a TPP, or when the existence of third party benefits is known to ODJFS, and the submitted claim does not indicate collection of the third party payment or does not indicate compliance with paragraph (D) of this rule. Providers should complete their investigation of available third party benefits before submitting a TP claim to ODJFS for payment.

(1) Providers and/or trading partners must maintain documentation to support all required information submitted on a third party claim (for example, if the submitted information indicates one hundred per cent of approved charges were allocated to the plan deductible, then the provider must have documentation to support the TPP allocated the approved charges to the plan deductible).

(2) Providers and/or trading partners must not omit from a TP claim any required TP claim information issued to them by the TPP, by the consumer or any other source (for example, the omission of the payment denial reasons that were issued by the TPP).

(I) ODJFS will make audit exceptions if a post-payment review reveals that the provider and/or trading partner did not maintain documentation to support the information submitted on a TP claim or reveals that the omission of required TP claim information resulted in an overpayment or an inappropriate payment of the claim.

(J) The provider is prohibited from billing the consumer any charges in accordance with paragraph (A) of rule 5101:3-1-60 of the Administrative Code.

(K) If the consumer states his/her private health insurance has changed or been terminated, the provider should advise the consumer to contact his/her county caseworker to correct the case record. Once the case record has been corrected, the provider may bill ODJFS directly.

(L) ODJFS has right of recovery pursuant to section 5101.58 of the Revised Code (medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by ODJFS, or billable to ODJFS for payment at a later date. Section 5101.58 of the Revised Code requires that a medicaid consumer provide notice to ODJFS prior to initiating any action against a liable third party. ODJFS will take steps to protect its rights of recovery if that notice is not provided. If any person, whether the consumer or an individual acting on the behalf of a consumer, requests a financial statement (a claim) from a medicaid provider for services paid by ODJFS or to be billed to ODJFS on behalf of the medicaid consumer, the provider shall meet all of the following four requirements:

(1) Require that the consumer or the consumer's representative make his/her request for access to financial statements in writing.

(2) Notify ODJFS immediately upon receipt of the consumer's written request and forward a copy of the request to ODJFS, bureau of consumer and operational support, coordination of benefits section.

(3) Release the financial statement to the consumer or the consumer's representative no later than thirty days after the date the request is received.

(4) Stamp or type on each page of the financial statement in bold font "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5101.58 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."

This rule applies to financial statements whether or not the provider has received reimbursement from ODJFS. This rule is not intended to prevent or restrict the provider from furnishing records of medical treatment and condition to the consumer.

(M) When the medicaid consumer is covered by medicare, in addition to other third party payers, medicaid is the payer of last resort. Whether or not a TPP is the primary payer, providers must bill all other third party payers and medicare prior to submitting a claim to ODJFS in accordance with rule 5101:3-1-05 of the Administrative Code.

(N) Medicaid managed care plans (MCPs) are exempt from this rule. MCPs are responsible for coordination of benefits pursuant to Chapter 5101:3-26 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under: 119.03
Statutory Authority:
Rule Amplifies:

5160-1-08 **Coordination of benefits.**

(A) Definitions.

(1) "Coordination of benefits" (COB) means the process of determining which health plan or insurance policy will pay first or determining the payment obligations of each health plan, medical insurance policy, or third party resource when two or more health plans, insurance policies or third party resources cover the same benefits for a medicaid covered individual.

(2) "Coordination of benefits claim" (COB claim) means any claim that meets either the definition of third party claim as described in paragraph (A)(9) of this rule or the definition of medicare crossover claim as described in rule 5160-1-05 of the Administrative Code.

(3) "Explanation of benefits" (EOB) or "remittance advice" means the information sent to providers or plan beneficiaries (covered individuals) by any other third party payer, medicare, or medicaid to explain the adjudication of the claim.

(4) "Medicare benefits" has the same meaning as in rule 5160-1-05 of the Administrative Code.

(5) "Third party" (TP) has the same meaning as in section 5160.35 of the Revised Code.

(6) "Third party benefit" means any health care service(s) available to individuals through any medical insurance policy or through some other resource that covers medical benefits and the payment for those services is either completely the obligation of the TPP or in part the obligation of the individual, the third party payer, or medicaid (examples of a third party benefit include private health or accidental insurance, medicare, CHAMPUS or worker's compensation).

(7)) "Third party claim" means any claim(s) submitted to the Ohio department of medicaid (ODM) for reimbursement after all TPPs have met their payment obligations. In addition, the following will be considered third party claims by ODM:

(a) Any claim received by ODM that shows no prior payment by a TPP, but, ODM's records indicate the medicaid covered individual has third party benefits.

(b) Any claim received by ODM that shows no prior payment by a TPP but the provider's records indicate the medicaid covered individual has third party benefits.

(8) "Third party liability" (TPL) means the payment obligations of the third party payer for health care services rendered to eligible medicaid covered

individuals when the individual also has third party benefits as described in paragraph (A)(6) of this rule.

(9) "Third party payer" (TPP) means an entity, other than the medicaid or medicare programs, responsible for adjudicating and paying claims for third party benefits rendered to an eligible medicaid covered individual.

(B) If the existence of a third party benefit is known to ODM, a code number that represents the name of the third party payer covering the individual will be indicated on the individual's medicaid card. The provider shall obtain from the medicaid covered individual the name and address of the insurance company, and any other necessary information, and bill the insurance company prior to billing ODM.

(C) The provider must always review the individual's Ohio medicaid card for evidence of third party benefits. Whether there is or is not an indication of a TPP on the medicaid card, the provider must always request from the medicaid covered individual, or the individual's representative, information about any third party benefit(s). If the medicaid covered individual specifies no TP coverage and the medicaid card does not indicate TP coverage, the provider may submit a claim to medicaid (and the claim for the service is not considered a TP claim). If, as a result of this process, the provider or ODM determines that TP liability exists, the provider may only submit a claim for reimbursement if it first takes reasonable measures to obtain TP payments as set forth in paragraph (E) of this rule.

(D) The medicaid program must be the last payer to receive and adjudicate the claim except as determined by the following where medicaid is the primary payer:

(1) The children with medical handicaps program under sections 3701.021 to 3701.0210 of the Revised Code, as specified in rule 5160-1-03 of the Administrative Code.

(2) The state sponsored program awarding reparations to victims of crime under sections 2743.51 to 2743.72 of the Revised Code.

(3) 42 C.F.R. 433.139 (as in effect October 1, 2018) regarding preventive pediatric services.

(E) ODM reimburses for medically necessary covered services only after the provider takes reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing ODM. Providers who have gone through reasonable measures to obtain all third party payments, but who have not received payment from a TPP, or have gone through reasonable measures and received partial payment, may use an appropriate code on the claim to obtain payment and submit a claim to ODM requesting reimbursement for the rendered service(s).

(1) Providers are considered by ODM to have taken reasonable measures to obtain

all third party payments if they comply with one of the following requirements:

(a) The provider submits a claim first to the TPP and receives a remittance advice indicating that a valid reason for non-payment applies for the service as described in paragraph (E)(2) of this rule.

(b) The provider submits a claim first to the TPP for the rendered service(s) no less than three times within a ninety-day period and does not receive a remittance advice or other communication from the TPP within ninety days of the last submission to the TPP. Providers must be able to document each claim submission and the date of the submission.

(c) The provider followed the process described in paragraph (C) of this rule for the billed service and meets the following requirements:

(i) The provider did not find a change in third party coverage;

(ii) The billed service was previously rendered to the medicaid covered individual by the provider within the last three hundred sixty-five days; and

(iii) The claim for the previously rendered service met the requirements of paragraph (E)(1)(a) or (E)(1)(d) of this rule.

(d) The provider did not send a claim to the TPP, but has received and retained at least one of the following types of documentation that indicates a valid reason for non-payment for the service(s) as set forth in paragraph (E)(2) of this rule:

(i) Written documentation from the TPP;

(ii) Written documentation from the TPP's automated eligibility and claim verification system;

(iii) Written documentation from the TPP's member benefits reference guide or manual; or

(iv) Any other reliable method for obtaining information or documentation from the TPP that there is no third party benefit coverage for the rendered service(s).

(e) The provider submits a claim first to the TPP and receives a partial payment along with a remittance advice documenting the allocation of the billed charges.

(2) Valid reasons for non-payment from a third party payer to the provider for a

third party benefit claim include, but are not limited to, the following:

(a) The service(s) is not covered under the medicaid covered individual's third party benefits.

(b) The medical expenses for the medicaid covered individual were incurred prior to the third party benefits coverage dates.

(c) The medical expenses for the medicaid covered individual were incurred after the third party benefits coverage was terminated.

(d) The medicaid covered individual does not have third party benefits through the TPP for the date of service.

(e) All of the provider's billed charges or the TPP's approved rate was applied to the medicaid covered individual's third party benefit deductible amount.

(f) All of the provider's billed charges or the TPP's approved rate was applied in total across the medicaid covered individual's deductible, coinsurance, or co-payment for the third party benefit.

(g) The medicaid covered individual has not met eligibility, out-of-pocket expenses, required waiting periods or residency requirements for the third party benefits.

(h) The medicaid covered individual is a dependent of the individual with third party benefits, but the benefits do not cover the individual's dependents.

(i) The medicaid covered individual has reached the lifetime benefit maximum for the medical service being billed to the third party payer.

(j) The medicaid covered individual has reached the benefit maximum of the third party benefits.

(k) The TPP is disputing or contesting its liability to pay the claim or cover the service.

(l) The claim was submitted timely and with the correct information to the TPP but the claim was rejected by the TPP.

(F) Providers who have gone through reasonable measures as described in paragraph (E) of this rule to obtain all third party payments, but who have not received payment from a TPP, or received a partial payment, may submit a claim to ODM requesting reimbursement for the rendered service(s). If payment from the TPP is received after ODM has made payment, the provider is required to repay ODM any overpaid

amount. The provider must not reimburse any overpaid amounts to the medicaid covered individual.

(G) Providers who have billed the TPP and the TPP submits payment directly to the medicaid covered individual should contact the individual to request the payment be remitted to the provider. If the individual is uncooperative with the request, the provider should contact the county department of job and family services (CDJFS).

(H) Third party claims must meet the claim submission guidelines in accordance with rule 5160-1-19 of the Administrative Code.

(I) Medicaid reimbursement for third party claims will not exceed the medicaid maximum payment for the service, determined in accordance with applicable rules for the service, less all third party payments for the service. If the result is less than or equal to zero dollars, there will be no further medicaid payment for the service.

(J) ODM will reject a TP claim when a third party claim indicates coverage by a TPP, or when the existence of third party benefits is known to ODM, and the submitted claim does not indicate collection of the third party payment or does not indicate compliance with paragraph (E) of this rule. Providers should complete their investigation of available third party benefits before submitting a TP claim to ODM for payment.

(K) The provider is prohibited from billing the medicaid covered individual any charges in accordance with rule 5160-1-60 of the Administrative Code.

(L) If the medicaid covered individual states his or her private health insurance has changed or been terminated, the provider should advise the individual to contact his or her county caseworker to correct the case record. If the individual is not cooperative in pursuing third party liability as required by rule 5160:1-2-10 of the Administrative Code, the provider should contact the CDJFS. Once the case record has been corrected, the provider may bill ODM directly.

(M) ODM has right of recovery pursuant to section 5160.37 of the Revised Code (medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by ODM, or billable to ODM for payment at a later date. Section 5160.37 of the Revised Code requires that a medicaid covered individual provide notice to ODM prior to initiating any action against a liable third party. ODM will take steps to protect its rights of recovery if that notice is not provided. If any person, whether the medicaid covered individual or an individual acting on the behalf of a medicaid covered individual requests a financial statement (a claim) from a medicaid provider for services paid by ODM or to be billed to ODM on behalf of the medicaid covered individual, the provider shall meet all of the following four requirements:

(1) Require that the medicaid covered individual or the individual's representative make a request for access to financial statements in writing.

(2) Notify ODM immediately upon receipt of the medicaid covered individual's written request and forward a copy of the request to ODM, bureau of claims operations, coordination of benefits section.

(3) Release the financial statement to the medicaid covered individual or the individual's representative no later than thirty days after the date the request is received.

(4) Stamp or type on each page of the financial statement in bold font "SUBJECT TO RIGHT OF RECOVERY PURSUANT TO SECTION 5160.37 OF THE OHIO REVISED CODE. FAILURE TO COMPLY MAY RESULT IN PERSONAL LIABILITY."

(5) This rule applies to financial statements whether or not the provider has received reimbursement from ODM. This rule is not intended to prevent or restrict the provider from furnishing records of medical treatment and condition to the medicaid covered individual.

(N) When the medicaid covered individual is covered by medicare, in addition to other third party payers, medicaid is the payer of last resort. Whether or not a TPP is the primary payer, providers must bill all other third party payers and medicare prior to submitting a claim to ODM in accordance with rule 5160-1-05 of the Administrative Code.