Ohio Administrative Code

Rule 5160-1-60.2 Direct reimbursement to medicaid recipients for out-of-pocket payments for medicaid covered services.

Effective: July 1, 2015

(A) For purposes of this rule only:

(1) "Medicaid covered service" is defined as a service that is eligible for coverage by the Ohio medicaid program and is delivered by a medical provider that qualifies for a medicaid provider agreement.

(2) "Applicant for reimbursement" is defined as:

(a) An individual who has been erroneously determined ineligible for the medicaid program or whose determination was incorrectly delayed, and who is seeking reimbursement for medical expenses incurred during the time period when the individual should have been covered by medicaid but was not due to an error or incorrect delay and for which the applicant paid; or

(b) An individual who has been erroneously charged a medicaid co-pay for a service eligible for a co-pay in accordance with rule 5160-1-09 of the Administrative Code, and who is seeking reimbursement of the co-pay amount incurred during the time period when the individual should not have been subject to a co-pay and for which the applicant paid; or.

(c) A person not legally obligated to pay for an individual's medical bills but who does, in fact, contribute payment toward the individual's medical bills incurred during the time period when the individual should have been covered by medicaid but was not due to an error or incorrect delay as specified in paragraph (B)(3) of this rule and for which an applicant paid.

(B) In the case of an erroneous determination of ineligibility or an incorrect delay in determining eligibility, the Ohio department of medicaid (ODM) will directly reimburse an applicant for medical expenses only if all of the following requirements are met:

(1) The individual was erroneously determined ineligible for medicaid, or the individual was found

to be eligible for medicaid but the determination of eligibilty was incorrectly delayed, and the date on which the individual received the medicaid-covered service was within the period of coverage for which the individual should have been eligible for medicaid.

(2) The service was a medicaid-covered service as defined in paragraph (A)(1) of this rule, and the service was not a nursing facility service included in the nursing facility's per diem rate;

(3) For an erroneous determination of eligibility or an incorrect delay in determining eligibility, the individual requests and receives a documented county department of job and family services (CDJFS) determination of a CDJFS error, or a state hearing, or administrative review, or judicial action to dispute the CDJFS' erroneous finding of ineligibility or incorrect delay in determining eligibility;

(4) The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does agree to reimburse the applicant but does not do so in a timely fashion;

(5) Within ninety days from the date the provider does not agree to reimburse the applicant, the applicant requests direct reimbursement from ODM. The applicant can also request direct reimbursement from ODM if the provider does agree to reimburse the applicant but does not do so within ninety days of the date of the applicant's request;

(6) Within ninety days from the date the applicant asks ODM for direct reimbursement as described in paragraph (B)(5) of this rule, the applicant provides the following documentation to ODM:

(a) Written verification of a bill from the provider which specifies the medicaid-covered services provided;

(b) Written verification that the applicant paid the provider;

(c) Any other documentation that may be requested by ODM, including proof that the provider did not agree to reimburse the applicant, or did agree to reimburse the applicant but did not do so within ninety days of the request, as specified in paragraph (B)(5) of this rule; and

(d) The name, address, and phone number of the provider who rendered the medicaid-covered services to the applicant and the name of the billing provider.

(C) In the case of an erroneous co-pay, ODM will directly reimburse an applicant for co-pay charges only if all of the following requirements are met:

(1) The date of service for the co-pay charge was a date in which the applicant for reimbursement was eligible for coverage by ODM.

(2) The co-pay was applied to a service eligible for a co-pay under rule 5160-1-09 of the Administrative Code.

(3) The date of service for the co-pay charge was within a date in which the applicant for reimbursement was exempt from co-pay requirements by either rule 5160-1-09 of the Administrative Code or 42 CFR 447.56 (January 1, 2015).

(4) The applicant erroneously paid the co-pay.

(5) The applicant for reimbursement contacts the provider and requests reimbursement, and the provider either does not agree to reimburse the applicant or does not agree to reimburse the applicant but does not do so in a timely fashion.

(6) Within ninety days from the date the provider does not agree to reimburse the applicant, the applicant requests direct reimbursement from ODM. The applicant can also request direct reimbursement from ODM if the provideer does agree to reimburse the applicant but does not do so within ninety days of the date of the applicant's request.

(7) Within ninety days from the date the applicant asks ODM for direct reimbursement as described in paragraph (B)(5) of this rule, the applicant provides the following documentation to ODM:

(a) Written verification of a bill from the provider which specifies the medicaid-covered services provided;

(b) Written verification that the applicant paid the provider;

(c) Any other documentation that may be requested by ODM, including proof that the provider did not agree to reimburse the applicant, or did agree to reimburse the applicant but did not do so within ninety days of the request, as specified in paragraph (B)(5) of this rule; and

(d) The name, address, and phone number of the provider who rendered the medicaid-covered services to the applicant.

(D) Within ninety days of meeting the conditions specified in paragraph (B) or (C) of this rule, ODM will process the request for reimbursement. Applicants for reimbursement who receive an approval for reimbursement will be reimbursed either the full documented amount of their out-of-pocket medical expenses or the co-pay charges incurred while the individual received medical care.

(E) The bills identified as satisfying a person's spenddown obligation or paid to the county to meet medicaid eligibilty are not reimbursable by the medicaid program.

(F) All the provisions set forth in agency 5160 of the Administrative Code remain in effect, except that direct reimbursement by ODM to applicants for reimbursement is permitted under the circumstances set forth in this rule. All notice and hearing provisions set forth in division 5101:6 of the Administrative Code apply to determinations made under this rule, and hearing officers have authority to direct ODM to make a determination for reimbursement in accordance with this rule.