AUTHENTICATED,
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COMMISSION
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Ohio Administrative Code

Rule 5160-26-09.1 Managed care: third party liability and recovery.

Effective: July 18, 2022

(A) Tort.

(1) Pursuant to sections 5160.37 and 5160.38 of the Revised Code, the Ohio department of medicaid (ODM) maintains all rights of recovery (tort) against the liability of any third party payer (TPP) for the cost of medical services.

(2) A managed care entity (MCE) is prohibited from accepting any settlement, compromise, judgment, award, or recovery of any action or claim by a member.

(3) The MCE must notify ODM and/or its designated entity within fourteen calendar days of all requests for the release of financial and medical records to a member or the member's representative pursuant to the filing of a tort action. Notification must be made via the "Notification of Third Party (tort) Request For Release" form (ODM 03245, rev. 7/2014) or a method determined by the ODM designated entity, provided ODM approved the designated entity's method and notified the MCE.

(4) The MCE must submit a summary of financial information to ODM and/or its designated entity within thirty calendar days of receiving an original authorization to release a financial claim statement letter from ODM pursuant to a tort action. The MCE must use the "Tort Summary Statement" form (ODM 03246, rev. 7/2014) or a method determined by the ODM designated entity, provided ODM has approved the designated entity's method and notified the MCE. Upon request, the MCE must provide ODM and/or its designated entity with true copies of medical claims.

(B) Fraud, waste, and abuse recovery. ODM assigns to the managed care organization (MCO) its rights of recovery against any TPP for costs due to provider fraud, waste, or abuse as defined in rule 5160-26-01 of the Administrative Code related to each member during periods of enrollment in the MCO. In instances when the MCO fails to properly report suspected fraud, waste, or abuse, before the suspected fraud, waste, or abuse is identified by the state of Ohio, any portion of the fraud, waste, or abuse recovered by the state shall be retained by the state.

(C) Coordination of benefits.

(1) ODM assigns its right to third party resources (coordination of benefits) to the MCO for services rendered to each member during periods of enrollment. ODM reserves the right to identify, pursue, and retain any recovery of third party resources assigned to the MCO but not collected by the MCO after one year from date of claim payment.

(2) Except as specified in paragraph (C)(3) of this rule, the MCE must act to provide coordination of benefits if a member has third party resources available for the payment of medical expenses for medically necessary medicaid-covered services. Such expenses will be paid in accordance with this rule and sections 5160.37 and 5160.38 of the Revised Code.

(3) Children that have been legally placed in the custody of an Ohio county public children's services agency (PCSA) or related entity are excluded from third party liability cooperation and are exempt from post-payment recovery unless it is confirmed that the child will not be put at risk for doing so (e.g. medical support order).

(4) The MCE is the payer of last resort when a member has third party resources available for payment of medical expenses for medicaid-covered services, except:

(a) The MCE pays after any TPP including medicare but before:

(i) Resources provided through the children with medical handicaps program under sections 3701.021 to 3701.0210 of the Revised Code.

(ii) Resources that are exempt from primary payer status under federal medicaid law, 42 U.S.C. 1396 (as in effect July 1, 2022).

(iii) Resources provided through the state sponsored program awarding reparations to victims of crime, as set forth in sections 2743.51 to 2743.72 of the Revised Code.

(b) The MCO pays first for preventive pediatric services before seeking reimbursement from any

liable third party.

(5) The MCE will take reasonable measures to ascertain and verify any third party resources available to a member. When the MCE denies a claim due to third party liability (TPL), the MCE must timely share, on the explanation of payment sent to providers, available information regarding the third party resources for the purposes of coordination of benefits, including:

(a) Insurance company name;

(b) Insurance company billing address for claims;

(c) Member's group number;

(d) Member's policy number; and

(e) Policy holder name.

(6) The MCE must require providers who are submitting TPL claims to the MCE to request information regarding third party benefits from the member or his/her authorized representative. If the member or the member's authorized representative specifies that the member has no third party benefits, or the provider is unable to determine that the member has third party benefits, the MCE must permit the provider to submit a claim to the MCE. If, as a result of requesting the information, the provider determines that third party liability exists, the MCE must allow the provider to submit a claim for reimbursement if he/she first takes reasonable measures to obtain third party payment as set forth in paragraph (C)(7) of this rule.

(7) The MCE must require providers to take reasonable measures to obtain all third party payments and file claims with all TPPs prior to billing the MCE. The MCE must permit providers who have taken reasonable measures to obtain all third party payments, but who have not received payment from a TPP or received partial payment, to submit a claim to the MCE requesting reimbursement for rendered services.

(a) The MCE must process claims when the provider has complied with one or more of the following

reasonable measures:

(i) The provider first submits a claim to the TPP for the rendered services and does not receive a remittance advice or other communication from the TPP within ninety days after the submission date. The MCE may require providers to document the claim and date of the claim submission to the TPP.

(ii) The provider has retained and/or submitted one of the following types of documentation indicating a valid reason for non-payment for the services not related to provider error:

(a) Documentation from the TPP;

(b) Documentation from the TPP's automated eligibility and claim verification system;

(c) Documentation from the TPP's member benefits reference guide/manual; or

(d) Any other documentation from the TPP showing there is no third party benefit coverage for the rendered services.

(iii) The provider submitted a claim to the TPP and received a partial payment along with a remittance advice documenting the allocation of the charges.

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

(i) The service is not covered under the member's third party benefits.

(ii) The member does not have third party benefits through the TPP for the date of service.

(iii) All of the provider's billed charges or the TPP's approved rate was applied, in whole or in part, to the member's third party benefit deductible amount, coinsurance and/or co-payment for the TPP. The provider may then submit a secondary claim to the MCE showing the appropriate amount received from the TPP.

(iv) The member has not met any required waiting periods, or residency requirements for his/her third party benefits, or was non-compliant with the TPP's requirements in order to maintain coverage.

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

(vi) The member has reached the lifetime benefit maximum for the medical service or third party benefits being billed to the TPP.

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

(8) If the provider receives payment from the TPP after the MCE has made payment, the MCE must require the provider to repay the MCE any amount overpaid by the MCE. The MCE must not allow the provider to reimburse any overpaid amounts to the member.

(9) The MCE must make available to providers information on how to submit a claim that will have a zero paid amount in the third party field on the claim.

(10) The MCE payment for third party claims will not exceed the MCE allowed amount for the service, less all third party payments for the service.

(11) The MCE's timely filing limits for provider claims shall be at least ninety days from the date of the remittance advice that indicates adjudication or adjustment of the third party claim by the TPP.

(12) The MCE must ensure that providers do not hold liable or bill members in the event that the MCE cannot or will not pay for covered services unless all of the specifications set forth in rule 5160-26-05 and rule 5160-26-11 of the Administrative Code are met. The provider may not collect and/or bill the member for any difference between the MCE's payment and the provider's charge or request the member to share in the cost through a deductible, coinsurance, co-payment, or other similar charge, other than MCE co-payments.

(D) The MCE is required to submit information regarding members with third party coverage as directed by ODM.