

Medicaid Coordination of Benefits & Third-Party Liability for Community Behavioral Health Centers

What is Coordination of Benefits?

- » Coordination of benefits means the process of determining which health plan or insurance policy will pay first and determining the payment obligations of each health plan, insurance policy or third-party resource when two or more resources cover the same benefits for a Medicaid recipient.
- » Coordination of benefits is a federal requirement set forth in 42 CFR 433 Subpart D and includes specific activities for state Medicaid agencies related to third-party liability (TPL).
- » Medicaid, and Managed Care Plans (MCPs) as a Medicaid payer, must be the payer of last resort. (Exceptions in OAC rules 5160-1-08 and 5160-26-09.1)
- » **Coordination of benefits is specific to covered services, rather than specific to covered providers.**

How do third party liability (TPL) claims process?

- » Once a provider has gone through reasonable measures to obtain all third-party payments as described in OAC rules 5160-1-08, 5160-26-09.1, and 5160-27-03, a claim may be submitted to ODM/MCPs requesting reimbursement for the rendered service(s). Providers who have received a zero payment from a third-party payer (TPP) or a partial payment will need to use the appropriate adjustment reason codes from the primary's Explanation of Benefits (EOB) on the claim submission to ODM/MCPs.
- » The CBHC must submit claims to the TPP prior to sending the claim to ODM/MCPs except for as described on the BH TPL Bypass list. When the claim is not paid, or a partial payment is made, ODM or the MCP will do a cost sharing analysis and may pay an additional amount.
- » For FFS please see the following link:
<https://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/BillingInstructions/Other-Payer-Submission.pdf?ver=2017-12-15-133852-857>

What is the BH TPL Bypass list?

- » Located at <http://bh.medicaid.ohio.gov/manuals> under Billing and IT Resources is a list of specific procedure codes that continue to bypass the TPL requirements for commercial payers and additional procedure codes that are not required to be billed to Medicare.
- » In addition, there is a list of codes that must be billed to Medicare when the service is performed by certain Medicare-recognized providers. When the services are performed by a lower-level practitioner, they are not billed to Medicare.

- » TPL Bypass list only applies to CBHCs.

Are CBHCs able to bill Medicaid/MCP when the provider does not have a contract with the TPP, but is paid the contract rate?

- » When an individual has a third-party payer, the provider should be in network with that TPP. When the provider is not in network with that insurer, the insurer may pay the claim at the out-of-network (non-par) rate or they may deny the claim. It is in the provider's best interest to be in-network with the individual's primary insurance plan.
- » Medicaid/MCPs may not pay the difference between the out-of-network or non-par rate and the Medicaid maximum payment.

What can I do when a TPP does not respond to a claim submission?

- » ORC 3901.381 "Third-party payers processing claims for payment for health care services," requires TPPs to take an action on a claim (pay or deny) within certain timeframes depending on claim-specific information. It also sets forth requirements related to notification required by the TPP to the provider and/or individual. Please refer to the ORC regarding timeframes for TPP claims payment response. Information about filing a prompt pay complaint can be found at the following Ohio Department of Insurance website:
<https://insurance.ohio.gov/wps/portal/gov/odi/about-us/divisions/market-conduct/resources/prompt-pay-complaints>
- » Per OAC rule 5160-26-09.1 (Managed Care), if the provider first submits a claim to the TPP for the rendered service(s) and does not receive a remittance advice or other communication from the TPP within ninety days after the submission date the provider is considered to have taken reasonable measures. MCPs may require providers to document the claim and date of the claim submission to the TPP. This applies to all provider types except for CBHCs that have an access to care concern for the patient. For CBHCs with access to care concerns, see the next bullet below.
- » Per OAC rule 5160-27-03, effective November 29, 2019, If a behavioral health provider, as defined in paragraph (A)(1) or (A)(2) of rule 5160-27-01 of the Administrative Code, has billed a third party in accordance with either paragraph (I) or paragraph (J) of rule 5160-27-03, and the third party has not paid the claim within thirty days, and the provider has concerns regarding the recipient's access to care, the provider may submit the claim for Medicaid reimbursement. The provider must include, with the submitted claim, a certification statement that the provider waited thirty days, access to care for the recipient is a concern, and no response was received from the third party.

What is Medicaid Maximum Payment rule?

- » For FFS and in accordance with OAC rule 5160-1-60, when an individual has a TPP, Medicaid payment for a covered procedure, service, or supply is the lesser of two amounts:
 - The provider's submitted charge; or
 - The Medicaid maximum payment amount less the sum of all third-party payments and any applicable Medicaid copayment (unless the difference is zero or less, in which case Medicaid will make no further payment).

- » Medicaid maximum rates for CBHC services, are in OAC rule 5160-27-03, Appendix A
- » All providers are expected to submit their usual and customary charge (the amount charged to the general public) on all claims.

My agency received a letter from HMS regarding TPL recovery activities. What action do we have to take?

- » The letter you received is the standard letter HMS sends to a provider when the provider needs to be involved in the pay and chase process, also referred to as disallowance.
- » HMS sends a letter to a provider detailing the claims Medicaid paid as primary for which HMS has found a possible third-party insurance which could be primary. The provider is to bill the third-party insurance and inform HMS if the provider was able to recover money. This process is described in the letter.
- » HMS usually involves the provider in the pay and chase process when:
 - Medicare is the primary payer because Medicaid is unable to bill traditional Medicare directly.
 - Payment is for inpatient claims because the primary payer will typically pay more than Medicaid.
 - The provider will have the medical record information in case needed for billing the primary insurance.

How does TPL impact individuals enrolled on a MyCare Ohio Plan?

- » Per OAC rule 5160-58-02, individuals who have other third-party creditable health care coverage, except Medicare coverage are exempt from enrollment in a MyCare Ohio Plan.
- » When a TPP is identified for a MyCare Ohio enrollee, ODM takes appropriate steps to validate and then disenroll the individual from the MyCare Ohio plan. If Medicaid eligible, the individual would then be enrolled on FFS Medicaid.

What should a CBHC do when the TPP is Medicare and the service is provided by a practitioner who is not a Medicare provider?

- » CBHCs should, as a best practice, provide services rendered by Medicare accepted/certified providers when the individual has Medicare as a primary payer.
- » The TPL Bypass list includes a list of codes and rendering practitioners that are always or never billed to Medicare.

What can CBHCs do when ODM/MCP TPL information seems to be incorrect?

- » Refer to the TPL Provider Information Grid by FFS & Medicaid MCP at <http://bh.medicaid.ohio.gov/manuals> under Billing and IT Resources. The grid lists the contact and resources for providers to utilize when TPL information is inconsistent.

What can the CBHC do when the TPP does not cover BH services? (Example: Delta Dental)

- » If ODM/MCPs lists a TPP that is incorrect, please report that information per the TPL grid. In this example, the payer should not be cost avoiding when Delta Dental does not cover the BH services.

What is the BH provider's responsibility?

- » BH providers require individuals to provide TPP information at the time of service as a best practice.
- » BH providers should use the 270/271 eligibility transaction, check the payer portal, and exhaust any other sources for any TPP information on file, prior to rendering a service.
- » BH providers are required to bill the TPP prior to billing Medicaid for all codes except for the codes listed on the TPL Bypass list.
- » BH providers should always notify ODM or the MCP when they identify that TPL information is incorrect.

What are some other helpful provider resources?

HIPAA 5010 Implementation webpage

- » <https://medicaid.ohio.gov/Provider/MITS/HIPAA5010Implementation>

ODM 837 Companion Guide

- » <https://medicaid.ohio.gov/Portals/0/Providers/MITS/HIPAA%205010%20Implementation/CompanionGuide/Ohio837P-FFS.pdf>

OAC Rule guidelines

- » OAC 5160-1-08: Coordination of benefits
<http://codes.ohio.gov/oac/5160-1-08v1>
- » OAC 5160-26-09.1: Managed health care programs: third party liability and recovery
<http://codes.ohio.gov/oac/5160-26-09.1>
- » OAC 5160-27-03: Reimbursement for community behavioral health services
<http://codes.ohio.gov/oac/5160-27-03>