REIMBURSEMENT POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Effective Date
Overpayment Recovery		PY-1115	09/01/2020-07/31/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Overpayment Recovery

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Retrospective review of claims paid to providers assist CareSource with ensuring accuracy in the payment process. CareSource will request voluntary repayment from providers when an overpayment is identified.

Fraud, waste and abuse investigations are an exception to this policy. In these investigations, the look back period may go beyond 2 years.

C. Definitions

- **Overpayment** - A payment that exceeds amounts properly payable to a provider. These commonly are discovered during a post-payment review. Examples include but are not limited to incorrect coding, non-covered services, and billing discrepancies.
- **Coordination of benefits (COB)** - A payment from another carrier that is received after a payment from CareSource; and the other carrier is the primary insurance for the member.
- **Retroactive eligibility** - A payment for a member who was retroactively terminated by the state. Member is not eligible for benefits.
- **Improper payment** - A payment that should not have been made or an overpayment was made. Examples include but are not limited to payment made for the ineligible member, ineligible service, payment made for a service not received, and duplicate payments.

D. Policy

I. CareSource will provide all the following information when seeking recovery of an overpayment made to a provider:
   A. The name and patient account number of the member to whom the service(s) were provided;

B. The date(s) of services provided;
C. The amount of overpayment;
D. The reason for the recoupment; and
E. That the provider has appeal rights.

II. Overpayment Recoveries
A. Lookback period is 24 months from the claim paid date.
B. Advanced notification will occur 30 days in advance of recovery.
C. If the recovery occurs outside of original claim timely filing limits, the corrected claim submission timeframe is 60 days from the date of the recovery. Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.

III. Coordination of Benefit Recoveries
A. Lookback period is 12 months from claim paid date.
B. Advanced notification will occur 30 days in advance of recovery.
C. If the recovery occurs outside of original claim timely filing limits, the corrected claim submission timeframe is 60 days from the date of the recovery. Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.

IV. Retro Active Eligibility Recoveries
A. Lookback period is 24 months from date CareSource is notified by Medicaid of the updated eligibility status.
B. Advanced notification will occur 30 days in advance of recovery.
C. If the recovery occurs outside of original claim timely filing limits, the corrected claim submission timeframe is 60 days from the date of the recovery. Normal timely filing limits apply to corrected claims being submitted within original claim timely filing guidelines.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

F. Related Policies/Rules

CareSource Ohio Provider Manual
National Agreement, Article V. CLAIMS AND PAYMENTS, 5.11 (d).

G. Review/Revision History

	DATE	ACTION
Date Issued	04/29/2020	New policy
Date Revised		
Date Effective	09/01/2020	
Date Archived	07/31/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

1. Ohio Revised Code. (2002, July 24). *3901.38 Payments considered final – overpayment.* Retrieved January 8, 2020 from www.codes.ohio.gov
2. Ohio Department of Medicaid. (2020, January). *The Ohio Department of Medicaid Ohio Medical Assistance Provider Agreement for Managed Care Plan*. Retrieved January 8, 2020 from www.medicaid.ohio.gov

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.