REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Overpayment Recovery-OH MCD-PY-1115	03/01/2023-05/31/2024
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates 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.
CareSource 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Overpayment Recovery

B. Background

Reimbursement policies are designed to assist providers 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 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 two (2) years.

C. Definitions

- **Claims Adjustment** – A claim that was previously paid and is being updated for one of the following reasons:
  - Denied as a zero payment,
  - a partial payment,
  - a reduced payment,
  - a penalty applied,
  - an additional payment or
  - a supplemental payment.
- **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.
- **Credit Balance/Negative Balance** – Funds that are owed to CareSource because of a claim adjustment.
- **Explanation of Payment (EOP)** – The EOP contains the payment and adjustment information for claims the provider has submitted for payment to CareSource.
- **Forwarding Balance (FB)** – An adjustment that occurs within an EOP to a claim with a prior paid amount. The FB amount does not indicate funds have been withheld from the provider's payment for this remittance advice. It only indicates that a past claim has been adjusted to a different dollar amount and that funds are owed to CareSource.

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- **Improper Payment** – A payment that should not have been made or an overpayment was made. Examples include, but are not limited to the following:
  - Payments made for an ineligible member,
  - Ineligible service payments,
  - Payments made for a service not received, and
  - Duplicate payments.
- **Overpayment** – Any payment made to a network provider by a Managed Care Organization (MCO) to which the network provider is not entitled to under Title XIX of 42 CFR.
  - A claim adjustment is only considered to result in an overpayment when a claim that previously paid is updated to a denied status as a zero payment or results in a reduced payment.
- **Provider Level Balancing (PLB)** – Adjustments to the total check / remit amount occur in the PLB segment of the remit. The PLB can either decrease the payment or increase the payment. The sum of all claim payments (CLP) minus the sum of all provider level adjustments (in the PLB segment) equals the total payment (Beginning Segment for Payment Order/Remittance Advice (BPR), which means total payment within the EOP).
- **Retroactive Eligibility** – A payment for a member who was retroactively terminated by the state. The member is not eligible for benefits.

D. Policy

I. In accordance with 42 CFR 438.608, CareSource requires providers to report any overpayment that has been received by the provider. The overpayment must be returned to CareSource within sixty (60) calendar days after the date on which the overpayment was identified and to notify CareSource in writing of the reason for the overpayment.

II. CareSource will provide all the following information when seeking recovery of an overpayment made to a provider:
   A. The patient's name, date of birth, and Medicaid identification number,
   B. The date or dates of services rendered,
   C. The specific claims that are subject to recovery and the amount subject to recovery, including any interest charges, which may not exceed the amount specified in Ohio law or rule,
   D. The specific reasons for making the recovery for each of the claims subject to recovery,
   E. If the recovery is a result of member disenrollment from the CareSource, the effective date of disenrollment,
   F. An explanation that if a written response to the notice is not received within 30 calendar days from receipt of the notice, the overpayments will be recovered from future claims,
   G. How the provider may submit a written response disputing the overpayment, and
   H. How the provider may submit a written request for an extended payment arrangement or settlement.

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III. 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.

IV. 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.

V. 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.

VI. Management of Claim Credit Balances
   A. Regular and routine business practices, including, but not limited to, the updating and/or maintenance of a provider's record, can create claim credit balances on a provider's record. This may result in claim adjustments, both increases and/or decreases in claim paid amounts, and/or forward balancing may move a provider's record into a negative balance in which funds would be owed to CareSource. This information will be displayed on the EOP in the PLB section.
   B. Negative balance status and the associated reconciliation of that balance that is the result of a claim adjustment that increased the claim paid amount is not considered to be an overpayment recovery and does not fall under the terms of this policy.
      1. Claim Adjustment Example
         a. A claim paid $10 previously but was updated to pay $12. The adjustment created a $10 negative balance and paid the provider the full $12 when adjusted, instead of the $2 difference.
         b. The $10 negative balance is not considered to be an overpayment subject to the guidelines outlined in section D.I – D. IV.
      2. Overpayment Example
         a. A claim previously paid $12 but is updated to pay $10. The claim adjustment with the $2 reduced payment is subject to the guidelines outlines in section D.I – D. IV.

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b. The reduced payment will trigger a 30-day advanced notification with the details related to the claim and overpayment.

C. Reconciliation of negative balance status will be done through claims payment withholds for otherwise payable claims until the full negative balance has been offset, unless otherwise negotiated.

D. Providers are notified of negative balances through (EOPs) and 835s. Providers are expected to use this information to reconcile and maintain their Accounts Receivable (AR) to account for the reconciliation of negative balances.

E. Notification of negative balances and reconciliation of negative balances may not occur concurrently.

1. Providers are expected to maintain their Accounts Receivable (AR) to account for the reconciliation of negative balances when they occur.

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 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	07/21/2021 03/30/2022 10/26/2022	Revision: Added—Management of Claims Balance information. Added compliance with 42 CFR 438.608 for requirement for provider to report identified overpayments. Approved at PGC. No changes. Updated references.
Date Effective	03/01/2023	
Date Archived	05/31/2024	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 Department of Medicaid. (2022, October). The Ohio Department of Medicaid Ohio Medical Assistance Provider Agreement for Managed Care Plan. Retrieved 10/14/2022 from www.medicaid.ohio.gov.
2. Ohio Revised Code. (2002, July 24). 3901.388 Payments considered final – overpayment. Retrieved 10/14/2022 from www.codes.ohio.gov.

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