REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Coordination of Benefits-OH MCD-PY-1412	03/01/2026
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

Coordination of Benefits

B. Background

Federal regulations require that all identifiable financial resources be utilized prior to the expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Coordination of benefits (COB) is the method used to designate the order in which multiple carriers are responsible for benefit payments, which prevents duplication of payments.

Providers must utilize other payment sources to the fullest extent prior to filing a claim with CareSource. The terms "third party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. If other insurance resources are not exhausted and the provider was aware of other insurance coverage, billing Medicaid may be considered fraud under the False Claim Act.

The purpose of this policy is to define the order of coverage and how CareSource will coordinate benefit payments as the secondary payer.

C. Definitions

- **CareSource Provider Agreement** – The contract between a provider and CareSource for the provision of services by the provider to individuals enrolled with the plan, including but not limited to contracts titled “Provider Agreement” and “Group Practice Services Agreement.”
- **Coordination of Benefits (COB)** – The process of determining which health plan or insurance policy will pay first and/or determining the payment obligations of each health plan, medical insurance policy, or third-party resource when 2 or more health plans, insurance policies, or third-party resources cover the same benefits for CareSource members.
- **Explanation of Payment (EOP)** – A detailed explanation of payment or denial of a claim by an insurance carrier.
- **Primary Carrier** – The insurance carrier that has been determined to be responsible for primary payment.

D. Policy

I. Submitted claims must include the total amount billed, total amount paid by the primary carrier, and balance due, along with a valid provider signature. Any balance due after receipt of payment from the primary carrier should be submitted to CareSource for consideration, and the claim must include information verifying the payment amount received from the primary plan. CareSource shall coordinate payment for covered services in accordance with the terms of a member’s benefit plan, applicable state and federal laws, and applicable Centers for Medicare & Medicaid Services (CMS) guidance. If CareSource is not the primary carrier,

providers shall bill the primary carrier for all services provided before submitting claims to CareSource.

II. COB Guidelines
   A. When CareSource coordinates benefits with the primary carrier, reimbursement will be made according to the Medicaid contracted maximum allowable minus any payment made by the primary carrier. Any items or services for which another carrier's reimbursement amount is equal to or greater than the Medicaid contracted maximum allowable amount will be paid at zero. Claims that pay at zero are considered to be paid claims, not denied claims.
   B. When the payment from another insurance carrier is less than the Medicaid contracted amount, CareSource will pay up to the Medicaid contracted total allowed amount. The sum of the payments will not exceed the Medicaid contracted maximum allowable amount (as indicated in the *CareSource Provider Agreement*).

Example 1: Charged amount $100.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$50.00	$10.00	$0	$0	$40.00
CareSource	$35.00				$0.00

Summary: In this example, since the primary carriers paid amount of $40.00 is ≥ to the CareSource allowed amount of $35.00, then CareSource pays zero.

Example 2: Charged Amount $100.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$80.00	$50.00	$0	$0	$30.00
CareSource	$40.00				$10.00

Summary: In this example, subtract the primary paid amount of $30.00 from the CareSource allowed amount of $40.00 (lessor of the allowed amounts). Therefore, CareSource will pay $10.00.

Example 3: Charged Amount $200.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$100.00	$0	$100.00	$0	$0
CareSource	$125.00				$100.00

Summary: In this example, subtract the primary paid amount of $0 from the primary allowed amount of $100.00 (lessor of the allowed amounts). Therefore, CareSource will pay $100.00.

Example 4: Charged Amount $200.00

Carrier	Allowed	Co-pay	Deductible	Co-Insurance	Paid
Primary Insurance	$150.00	$0	$100.00	$40.00	$10.00
CareSource	$125.00				$115.00

Summary: In this example, subtract the primary paid amount of $10.00 from the CareSource allowed amount of $125.00 (lessor of the allowed amounts). Therefore, CareSource will pay $115.00.

III. CareSource as Secondary Payer
   A. Following Medicare reimbursement, Medicaid pays the remaining portion based on the following criteria:
   When a member becomes entitled to Medicare before the member's termination of enrollment, the member may receive covered benefits that are also covered by Medicare. During that time, unless the provider has agreed in writing to an alternative payment methodology or different secondary claims payment rate, CareSource will reimburse Medicare secondary claims as set forth in Ohio Administrative Code (OAC) 5160-1-05.3 for both network and out-of-network providers, including application of the following exemptions to the Part B Medicaid maximum policy in accordance with the OAC and other guidance issued by the Ohio Department of Medicaid:
      1. hospital services
      2. nursing facility services included in the nursing facility per diem
      3. covered supplemental medical insurance benefits under the Medicare program
      4. dual eligible coordinated benefits for members who elect to receive Medicare Part B benefits through the original Medicare program
   B. Secondary Payer for Obstetrical Services
      1. Primary payer EOP is required in order to coordinate coverage. With the primary payer EOP, CareSource will verify if the prenatal visits are a part of the primary carrier’s global reimbursement. If so, CareSource will not make a payment until a delivery charge is received. If the prenatal visits are excluded from the primary carrier’s global reimbursement, including when maternity benefits are not covered by the plan, CareSource will process the claim as the primary payer.
      2. If the first claim that CareSource receives is for a global delivery, the claim will deny for invalid coding. The provider will need to re-bill within 90 days of denial using the delivery-only CPT codes, as CareSource does not recognize global obstetrical codes for claims processing.

3. Once the delivery charge is received, CareSource will combine all prenatal visit charges with the delivery charges. CareSource will subtract the primary carrier's payment from the lesser of the primary carrier allowed amount and the CareSource allowed amount (the benefit allowance for all visits and the delivery charge) and will pay any remaining liability. CareSource will not pay more than CareSource's normal benefit when no other coverage exists or more than the patient responsibility after the primary insurance has paid.

IV. COB Timely Filing Guidelines
   A. If a provider is aware that a member has primary coverage, the provider will submit a copy of the primary payer's EOP along with the claim to CareSource within the claim's timely filing period.
      1. If CareSource receives a claim for a member identified as having other coverage and a primary payer EOP was not submitted with the claim(s), CareSource will deny the claim(s), requesting the required COB information.
      2. If a claim is denied for COB information needed, the provider must submit the primary payer's EOP. If the initial timely filing period has elapsed, the EOP must be submitted to CareSource within 90 days from the primary payer's EOP date.
   B. If a provider has information that the primary payer's policy has terminated or was not in effect during the date of service for the claim(s), the provider must notify CareSource of the dispute within the original timely filing period or within 90 days of the provider's actual receipt of the primary payer's EOP date, whichever is greater.
   C. If the dispute is received within the original timely filing period:
      1. CareSource will confirm whether or not the primary payer was in effect during the date of service. If the policy was NOT in effect, CareSource will process the claim(s) that are within the original timely filing period or 90 days of the provider's actual receipt of the payer's EOP date.
      2. If the policy WAS in effect, the claim will remain denied for lack of primary payer's EOP.
   D. If the provider does not notify CareSource of the dispute within the original timely filing period or if the provider does not submit the primary payer's EOP within 90 days of the provider's actual receipt of the primary payer's EOP date, the claim will re-deny as not being timely filed.

V. COB Claim Submission to CareSource
   A. CareSource follows The Health Insurance Portability and Accountability Act (HIPAA) guidelines and accepts industry standard codes. It is imperative that claims are filed with the same codes that the primary payer presented on the Explanation of Benefits (EOB) to ensure that claims are processed correctly. Claim(s) will be denied if there is a mismatch between the codes on the received claim and the primary payer's EOP.
   B. CareSource applies standard claim adjustment codes.
   C. Claim Adjustment Group Codes are as follows:

1. CO – Contractual Obligation
2. OA – Other Adjustment
3. PI – Payer Initiated Reductions
4. PR – Patient Responsibility

D. When filing claims with patient's responsibility, the following Claim Adjustment Reason Codes should be used:
   1. PR1 – Deductible
   2. PR2 – Coinsurance
   3. PR3 – Copayment

E. When filing claims with contractual obligation, please use Adjustment Group Code "CO". Contractual obligation can be communicated on the Primary Payer's EOB with several different codes. Please use the code reflected on the primary payer's EOB. Some examples of these codes are 24, 45, 222, P24, P25, 26. (This is not an all-inclusive list). The same process should be followed when using Adjustment Group Code "OA" - Other Adjustment.

VI. Denied COB Claims

A. Denied COB claims will be automatically adjusted when primary insurance has been updated retroactively to show coverage was terminated at the time of service. This also has a lookback period of 12 months from the paid date or 18 months to the date of service.

B. Denied COB claims will NOT be automatically adjusted if the updated coverage information was received after 90 days from the denial for COB information. In this case, the provider must request claim adjustment within the original timely filing period or within 90 days from the date of the EOP denial, whichever is greater. Although CareSource has implemented this COB Adjustment Policy, it is still the provider's responsibility to review their accounts and submit COB claims in a timely manner for payment.

VII. Disputes for Denied COB Claims

A. Disputes will NOT be automatically adjusted if the updated coverage information was received after 90 days from the denial for COB information. In this case, the provider must request claim adjustment within the original timely filing period or within 90 days from the date of the EOP denial, whichever is greater. Although CareSource is implementing this COB Adjustment Policy, it is still the provider's responsibility to review accounts and submit COB claims in a timely manner for payment.

B. CareSource will confirm whether or not the primary coverage was in effect during the date of service. If the policy was NOT in effect, CareSource will process the claim(s) that are within the original timely filing period. If the initial timely filing period has elapsed, then CareSource will process the claims that are within 90 days of the original denial. If the policy WAS in effect, the claim will remain denied for needing primary carrier's EOP. If the provider does not notify CareSource of the dispute within the original timely filing period, within 90 days of the CareSource denial, or if the provider does not submit the primary carrier's

EOP within 90 days of the Primary Carriers EOP date, the claim will re-deny as not being filed timely.

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

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	12/14/2022	New policy
Date Revised	02/14/2024 11/19/2025	Annual review. Updated background. Updated references. Approved at Committee. Annual review. Updated background and references. Approved at Committee.
Date Effective	03/01/2026	
Date Archived		

H. References

1. Coordination of Benefits, OHIO ADMIN. CODE 5160-1-08 (2019).
2. Managed Care: Primary Care and Utilization Management, OHIO ADMIN CODE 5160-26-03.1 (2022).
3. Payment for "Medicare Part B" Cost Sharing, OHIO ADMIN. CODE 5160-1-05.3 (2016).

ODM approved 12/04/2025

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