ADMINISTRATIVE POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
MyCare Payer Sequencing Guideline-OH MyCare-AD-1115	03/01/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement 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.

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.

Table of Contents

A. Subject

MyCare Payer Sequencing Guideline

B. Background

The purpose of this policy is to provide understanding of the proper payer sequencing regarding billing for products and services to MyCare members. MyCare members are both Medicare and Medicaid eligible and adherence to the information contained within this policy will decrease delay in proper payment.

People who are dually enrolled in both Medicare and Medicaid, also known as dually eligible individuals or Medicare-Medicaid enrollees, fall into several eligibility categories. These individuals may either be enrolled first in Medicare and then qualify for Medicaid, or vice versa.

Medicare and Medicaid cover many of the same services. All providers, including Medicare providers, must enroll in their Medicaid system for provider claims review, processing, and payment. Providers should contact the state Medicaid agency for additional information regarding Medicaid provider enrollment.

Medicare pays first for Medicare-covered services that are also covered by Medicaid, because Medicaid is always the payer of last resort. Medicaid may cover care that Medicare does not cover, such as a variety of long-term services and supports.

Medicaid waiver is a program that allows individuals with disabilities and chronic conditions to have more control over their care and remain active in their community.

C. Definitions

- **Waiver Services** – Medicaid waivers allow individuals with disabilities and chronic conditions to receive care in their homes and communities rather than in long-term care facilities, hospitals or intermediate care facilities.
- **Community Well** – Individuals who are eligible for Medicare and Medicaid services creating dual eligibility but who do not meet level of care for Waiver services.

D. Policy

I. Providers who do not adhere to the appropriate processing, according to this policy, may be subject to claims auditing and recoupment.
   A. In the event of any conflict between this policy and a provider's contract with CareSource, the provider's contract will be the governing document.

II. Members who do not have CareSource for their Medicare coverage **and** have CareSource for their Medicaid coverage are considered **opt-out members**.
   A. All providers for opt out members **must** submit the Medicare denial documentation with the request for prior authorization once a request for a product or service is denied by Medicare.
   B. CareSource will then review for medical necessity under Medicaid guidelines.
   C. Medicaid is the payer of last resort.

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

III. Members who have CareSource for their Medicare **and** Medicaid coverage are considered **opt-in members**.
   A. CareSource will determine whether the product or service can be covered under the member's Medicare Part B.
   B. If the request is denied under Medicare guidelines, CareSource will review for medical necessity under Medicaid guidelines.
   C. Medicaid is the payer of last resort.

IV. Members who are eligible for Medicaid coverage and have been approved to receive waiver services are considered **waiver members.**
   A. Products and services provided to waiver members are only reimbursed through the waiver program after all other payment options are exhausted.
   B. Waiver is the payer of last resort.
   C. If the member is a Waiver member, the provider must seek denials through Medicare and Medicaid as appropriate.
   D. Documentation of the denial must be submitted before a request can be considered under the Waiver benefit.

V. No separate payment will be made for items or services for which full remuneration is made through other payment mechanisms (e.g., diagnosis-related groups, per diem payments, workers' compensation, commercial insurance).

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATES	ACTION
Date Issued	07/21/2021	New policy
Date Revised	10/26/2022	No changes. Updated references.
Date Effective	03/01/2023	
Date Archived		

H. References

1. Ohio Department of Medicaid. The Ohio Home Care Waiver Program. 2022. Retrieved 10/14/2022 from www.medicaid.ohio.gov.
2. Ohio Department of Medicaid. Ohio Home Care Waiver Handbook. August 1, 2021. Retrieved 10/14/2022 from www.medicaid.ohio.gov.