TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party ~~resources~~ liability

As the Medicaid Agency, OHCA is ~~the last resource for payment~~ the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. ~~One exception~~ Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in OAC 317:45, Oklahoma Employer and Employee Partnership for Insurance Coverage.

(1) If ~~the children or other individuals in a case are covered~~ a member has coverage by an absent parent's insurance program or any other policy holder, ~~the~~ that insurance resource must be used prior to filing a ~~Medicaid~~ SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring ~~arrangement if the covered individuals live in the coverage area. Clients covered by insurance, who elect to use providers who do not have a contract with their insurance company,~~ arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans as well as prior authorization requirements. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. Denials by private insurance companies because the ~~recipient~~ member did not secure a preauthorization ~~to~~ or use a ~~non-participating~~ participating provider is not a sufficient reason for ~~Medicaid~~ SoonerCare to make payment. ~~When a~~ If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the ~~REVS System or commercial swipe care vendor will reflect an insurance indicator~~ eligibility verification system will reflect that information. If payment is denied ~~from another source~~ by the primary insurance, except as stated above, the provider ~~should~~ must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount ~~should~~ must be ~~shown~~ reflected on the claim form ~~filed with that Fiscal Agent~~.

(2) It is possible that other resources are available but are unknown to OHCA. Providers ~~should~~ will routinely question ~~Medicaid patients~~ SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the ~~patient~~ member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) ~~In the event~~ If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the Title XIX (Medicaid) payment. The provider may retain ~~that portion of the other~~ the primary insurance payment, if any, that represents payment for services that are not covered services under ~~Medicaid~~ SoonerCare. By accepting the ~~Authority's~~ OHCA's payment, the provider agrees to accept ~~the reasonable charge~~ it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the ~~patient~~ member.

(4) ~~There are instances where insurance companies have made payment by a single check for both the hospitalization service and the physician's fees, and the entire amount has been credited to one provider, rather than being distributed according to the type of coverage under the policy. The hospital must show credit for the respective amounts against the billed charges. This calculation is subject to final review and audit by the Fiscal Agent or OHCA.~~ If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) ~~If the patient is a recipient of Medical Assistance only, it is understood that the payment received from OHCA represents full payment for services rendered. In those instances where the patient has excess income, and/or insurance, payment will be made by OHCA for the difference between the amount paid by~~

~~insurance and/or spenddown and the allowable charge, if any.~~ Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) ~~For claims processed by the Fiscal Agent, the excess shown on the OHCA Notification of Eligibility will be applied to providers' claims on a first-in basis. When a provider receives notice on the Detail of Remittance that spenddown was applied to his/her claim, the amount shown may be collected from the patient. The patient will also receive a notice indicating the name of the provider and the amount of spenddown applied.~~ Members must present evidence of SoonerCare and any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS
SUBCHAPTER 13. CLIENT RIGHTS AND RESPONSIBILITIES

317:35-13-4. Release of medical information

~~Medical information paid for by the Agency is not to be released, even at the request of the individual to whom it pertains, except to another agency to which the individual has applied for services having the objective of protecting or advancing his/her welfare. However, there is nothing in Oklahoma law or federal law to prevent a physician from releasing medical information to the patient or an authorized representative of the patient.~~ When a SoonerCare member or an authorized representative of a member, applies for services, explicit consent is given for the OHCA to release information to applicable state or federal agencies, medical providers, or an OHCA designee when the information is needed to provide, monitor or approve medical services or obtain payment of those services. Additionally, a physician may release medical information to the member or an authorized representative of the member upon written request. The physician, in such instance, would be governed by the physician-patient relationship.

~~(1) Medical information that a local office has obtained from Veterans Administration or from the Bureau of Disability Insurance (Social Security Administration) cannot be released to anyone outside the Agency.~~

~~(2) When a request is received in a local office for medical information not covered in the two preceding paragraphs, the local office refers the request immediately to the State~~

~~Office, attention administrator of the division to which the request was made, where a decision will be made as to the appropriate action to be taken. The division administrator requests consultation from the Legal Division, if needed, in making this decision. The division supervisor notifies the local office of the decision.~~

~~(3) The only exception to referral to the DHS State Office is that the Physician's Report form may be released to another physician, medical facility or other medical provider when the medical information in the report is needed for the continuity of medical care of a client. The Form contains a statement giving the physician's consent and authorizing the Agency to furnish the report to other medical providers under this situation.~~