Ohio Administrative Code

Rule 4123-3-23 Limitations on the filing of fee bills.

Effective: December 1, 2024

(A) Except as otherwise provided in this rule, fee bills for medical or vocational rehabilitation services rendered in a claim shall be submitted to the bureau or commission for payment within one year of the date on which the service was rendered or one year after the date the services became payable under division (I) of section 4123.511 of the Revised Code, whichever is later, or shall be forever barred.

(B) A self-insuring employer may, but is not required to, negotiate with a provider to accept fee bills from the provider for a time period other than as set forth in paragraph (A) of this rule.

(C) Paragraph (A) of this rule does not apply to the following:

(1) Requests made by the centers for medicare and medicaid services in the United States department of health and human services for reimbursement of conditional payments made pursuant to section 1395y(b)(2) of title 42, United States Code (commonly known as the "Medicare Secondary Payer Act");

(2) Requests made by the Ohio department of medicaid, or by a medical assistance provider to whom the department has assigned its right of recovery for a claim for which it has notified the provider that it intends to recoup its prior payment for a claim, for reimbursement under sections 5160.35 to 5160.43 of the Revised Code for the cost of medical assistance paid on behalf of a medicaid recipient;

(3) Requests made by the department of veterans affairs (VA) pursuant to section 1729 of title 38, United States Code for reimbursement of medical treatment provided to an injured worker in or through any VA provider or facility;

(4) Fee bills submitted outside the timeframe set forth in paragraph (A) of this rule due to MCO or bureau error; however, division (A) of section 4123.52 of the Revised Code still applies;

(5) Fee bills submitted outside the timeframe set forth in paragraph (A) of this rule because the fee bills were initially submitted to a patient, different third-party payer, or state or federal program other than medicare, medicaid, or the VA that reimburses for medical or vocational rehabilitation services and that patient, payer, or program has determined it is not responsible for the cost of the services; however, division (A) of section 4123.52 of the Revised Code still applies.

(D) Except in cases involving MCO or bureau error, requests for additional payment on fee bills that were initially timely submitted under this rule shall be submitted within one year and seven days of the adjudication of the initial fee bill by the bureau or shall be forever barred. In cases involving MCO or bureau error, requests for additional payment on fee bills shall be submitted within one year and seven days from the date the provider knew or should have known of an MCO or bureau error impacting payment or shall be forever barred. No medical or vocational rehabilitation provider shall bill a claimant for any request for additional payment that is barred under this paragraph.

(E) Paragraphs (A) to (C) of this rule apply to bills with dates of service on or after July 29, 2011. Paragraph (D) of this rule applies to bills with dates of service on or after September 12, 2011.