Ohio Administrative Code

Rule 5160-1-19 Claim submission.

Effective: January 1, 2013

(A) The following claims for services rendered to medicaid consumers are exempt from this rule:

(1) Claims for services provided through medicaid managed care plans must be submitted in accordance with Chapter 5101:3-26 of the Administrative Code; and

(2) Claims submitted by nursing facility providers must be submitted in accordance with rules 5101:3-1-05, 5101:3-1-08, and 5101:3-3-39.1 of the Administrative Code.

(3) Claims submitted by a provider or type of provider required by the office of medical assistance to submit claims in a format other than the electronic claims submission formats provided in paragraph (B) of this rule.

(B) All other claims, except for a state agency that has an interagency agreement with the office of medical assistance (OMA) to submit claims in a different format, must be submitted to the OMA through one of the following formats:

(1) Electronic data interchange (EDI) in accordance with standards established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. EDI formats for claims submission include:

(a) The "837 Health Care Claim Professional" (837P) electronic format;

(b) The "837 Health Care Claim Institutional" (837I) electronic format; or

(c) The "837 Health Care Claim Dental" (837D) electronic format.

(2) The medicaid information technology system (MITS) web portal; or

(3) Pharmacy point-of-sale.

(C) Claims must be submitted pursuant to the national correct coding initiative and coding standards set forth in the following guides and described in 45 CFR 162.1000 and 45 CFR 162.1002:

(1) The healthcare common procedure coding system;

(2) The current procedure terminology codebook;

(3) The current dental terminology codebook; or

(4) The international classification of diseases codebook.

(D) Timely filing limitations.

(1) Original claim submissions.

(a) Claims other than inpatient hospital claims must be received by OMA within three hundred sixty-five days of the actual date the service was provided.

(b) Inpatient hospital claims must be received within three hundred sixty-five days from the date of discharge.

(c) Claims received beyond three hundred sixty-five days from the actual date of service or hospital discharge will be denied except when the provisions of paragraph (E) of this rule apply.

(d) For purposes of this rule, the date of receipt is the date OMA assigns an internal control number.

(2) Re-submission of denied claims.

(a) Claims denied by the OMA may be re-submitted for payment and must be received by the later of the following dates:

(i) Three hundred sixty-five days from the actual date or service; or

(ii) One hundred eighty days from the date the claim denied, even if this date is beyond three hundred sixty five days from the original date of service.

(b) Resubmitted claims received beyond seven hundred thirty days from the actual date of service or hospital discharge will be denied.

(3) Claims with prior payment by medicare or another insurance plan must be received within one hundred eighty days from the date medicare or the insurance plan paid the claim.

(E) Exceptions to timely filing requirements.

(1) When submission of a claim is delayed due to the pendency of an administrative hearing decision by the Ohio department of job and family services (ODJFS) or an eligibility determination by a county department of job and family services (CDJFS), the claim must be received within one hundred eighty days from the date of the administrative hearing decision by ODJFS or the eligibility determination by the CDJFS. Documentation showing the date of service and the administrative hearing decision or eligibility determination must be submitted with the claim. In no case shall a delay in processing eligibility information at the CDJFS (as required in rule 5101:1-38-01.2 of the Administrative Code) be a basis for denial of payment under this provision.

(2) When a claim can not be submitted to OMA within three hundred sixty five days of the actual date of service due to coordination of benefits delays with medicare and/or other third party payers, the claim must be received by OMA within one hundred eighty days from the date medicare or the other insurance plan paid the claim.

(3) When a claim has been submitted and denied and is later found to meet the provisions in paragraph (E)(1) or (E)(2) of this rule, the claim may be resubmitted with documentation attached to support the delay in submission.

(F) Adjustments to claims.

(1) Adjustments to underpaid claims must be submitted within one hundred eighty days from the date medicaid paid the claim.

(2) Adjustments to overpaid claims must be submitted, and overpayments refunded, to OMA, within sixty days of discovery.

(a) Overpayments are recoverable by OMA at the time of discovery. Appeal rights under Chapter 119. of the Revised Code may be exercised to the extent provided in accordance with rule 5101:3-1-57 of the Administrative Code. All recoverable amounts are subject to the application of interest in accordance with rule 5101:3-1-25 of the Administrative Code.

(b) OMA will pursue collections by invoice for overpayments that result in a credit balance due to the OMA and remain outstanding for more than sixty days.

(3) Adjustments may be submitted through the EDI format or through the MITS web portal.

(4) OMA will no longer accept paper adjustment forms, except in cases where OMA determines a paper adjustment must be used for a claim to be adjusted.

(5) OMA will no longer process refund checks from providers for claim overpayments, except when an invoice or letter for collection of an outstanding overpayment has been sent to the provider for an OMA audit or review.

(G) Claims that require a specific OMA form to accompany the claim (for example, a claim for a hysterectomy service must have a hysterectomy consent form accompany the claim) may be submitted through the web portal, regular mail, or EDI format.

(1) Claims submitted via EDI shall be consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant format.

(2) All supporting documentation shall be submitted with the designated electronic data management system (EDMS) cover sheet.

(H) Trading partners submitting EDI transactions.

(1) Trading partners must enroll and receive an OMA defined trading partner number in order to submit EDI transactions.

(2) To become an active trading partner with OMA, all trading partners must abide by all OMA testing requirements, including the completing of a ninety per cent pass rate for each transaction type tested.

(3) Only authorized trading partners that are actively submitting and receiving 837 health care claim transaction sets may submit and receive the 270/271 and the 276/277 transaction sets.