# Ohio Administrative Code

## Rule 5160-1-19 Submission of medicaid claims.

Effective: February 1, 2023

(A) Unless otherwise directed by the Ohio department of medicaid (ODM), paper claims will not be accepted. Except as otherwise provided in section 5164.46 of the Revised Code or a state agency's interagency agreement, claims are to be submitted directly to ODM through one of the following formats:

(1) Electronic data interchange (EDI), in accordance with rule 5160-1-20 of the Administrative Code.

(2) The ODM provider web portal; or

(3) Pharmacy point-of-sale.

(B) Claims should be submitted pursuant to the national correct coding initiative and according to the coding standards set forth in the following guides:

(1) The healthcare common procedure coding system;

(2) The current procedural terminology codebook;

(3) The current dental terminology codebook; or

(4) The international classification of diseases handbooks.

(C) Claims for items and services that necessitate a rendering or supervising provider, order, prescription, referral, or certification will be denied if:

(1) They do not include the national provider identifier (NPI) and the legal name of the rendering, supervising, ordering, prescribing, referring, or certifying provider; and

(2) The provider does not have an active medicaid provider agreement.

(D) Timely filing:

(1) Claims are timely if received by ODM within:

(a) Three hundred sixty-five days of the actual date the service was provided.

(b) Three hundred sixty-five days from the date of discharge for inpatient hospital claims.

(c) Three hundred sixty-five days from the date of service or inpatient hospital discharge, as applicable, for denied claims that are re-submitted for payment.

(2) Provider-reported underpaid claims should be adjusted within three hundred sixty-five days from the date of service or inpatient hospital discharge, as applicable.

(E) Exceptions to timely filing are:

(1) Claims submitted via the "automatic medicare crossover process" (the automatic process of medicare electronically submitting a claim to ODM following medicare adjudication and payment of a claim for a dually eligible individual) are not subject to timely filing provisions in this rule.

(2) Claims for wraparound payment for a federally qualified health center (FQHC) or rural health center (RHC) are timely if submitted to ODM within one hundred eighty days from the date the claim was paid.

(3) Claims submitted to ODM after three hundred sixty-five days of the date of service or discharge, as applicable, due to a delay in eligibility determination or a state hearing decision regarding eligibility are timely if received by ODM within one hundred eighty days of the notice of eligibility determination or state hearing decision to be considered for payment.

(4) Claims submitted to ODM after three hundred sixty-five days of the date of service or discharge,

as applicable, due to a reversal of payment by a third party payer are timely if the adjusted claim is received within one hundred eighty days of the recovery of funds to be considered for payment.

(5) Any claim delayed in submission to, or adjudicated by ODM, due to an action or decision by ODM, at the discretion of ODM, may be reimbursed after three hundred sixty-five days from the date of service or inpatient hospital discharge.

(F) In instances of conflict of claim payment between two providers, ODM may adjust or void a claim as appropriate after notification to the providers.

(G) Overpaid claims.

(1) When a provider identifies an overpayment, the provider will submit an electronic adjustment to ODM within sixty days of discovery to return the overpayment.

(2) When ODM identifies an overpayment, ODM will notify the provider of the overpayment. The provider has sixty days to correct the overpayment. If the provider fails to correct an identified overpayment within sixty days, ODM will make the adjustment from subsequent payments to the provider or void the claim as appropriate. If an ODM adjustment is not possible, ODM will issue an invoice to the provider for the overpaid amount. The provider has sixty days from the date of the invoice to seek reconsideration or remit payment to ODM. If the provider fails to remit the full payment due the unpaid balance will be certified to the Ohio attorney general for collection.

(3) ODM will pursue collections by invoice for overpayments that result in a credit balance owed to ODM that remain outstanding for more than forty-five days.

(4) Appeal rights may be exercised in accordance with Chapter 5160-70 of the Administrative Code. All ODM recoverable amounts are subject to the application of interest in accordance with rule 5160-1-25 of the Administrative Code.

(H) ODM forms that are necessary for a claim to be processed should only be submitted through the ODM provider web portal unless otherwise permitted by ODM.

(I) Claim adjustments should only be submitted through EDI or the ODM provider web portal.

(J) ODM will only process refund checks from providers for an invoice for a claim overpayment, a letter of collection of an outstanding overpayment, audit, or review, or other circumstance deemed appropriate by ODM.