

5101:3-1-19                    **General principles regarding claim submission [except for services provided through a medicaid managed care program].**

Providers must follow business practices of the medicaid managed care plans (MCP) for the purposes of billing claims for consumers enrolled in a medicaid MCP.

With the exception of paragraph (D) of this rule, these general principles do not apply to nursing facility room and board claims that must be submitted in accordance with rule 5101:3-3-39.1 of Administrative Code.

(A) All medicaid claims must be submitted in one of the following billing methods: electronic data interchange (EDI), paper claim form, or pharmacy point-of-sale.

Effective May 23, 2007, the Ohio department of job and family services (ODJFS) will no longer accept cartridge tape as a method of provider claim submission. Except for sister state agencies and the ODJFS contracted data entry vendor, all provider claims must be submitted by either EDI or a paper claim form.

(B) Claims submitted must meet:

(1) ODJFS companion guide (rev. 5/2007) requirements for EDI;

(2) Paper claim form instruction requirements (rev. 5/2007); or

(3) Pharmacy point-of-sale program guidelines in accordance with the "ODJFS Point-of-Sale Pharmacy Provider Manual Policy and Procedure Guide (rev. 5/2007)".

(C) A claim that requires an attachment for processing must be submitted hard copy on the appropriate paper claim form for the service rendered. Claims that require attachments for processing include:

(1) Claims submitted or resubmitted greater than three hundred sixty-five days from the date of service with the required documentation attached to support the delay in submission and that the provisions in paragraph (E)(1) or (E)(2) of this rule have been met.

(2) Claims submitted or resubmitted that require manual pricing or special handling by ODJFS.

(D) Omission of the provider identifier, improper placement of the provider identifier, or an invalid provider identifier on a submitted claim may result in a rejection of the claim.

(E) Claims must be received by ODJFS within three hundred sixty-five days of the actual date the service was provided, unless the provisions in paragraph (E)(1) or (E)(2) of this rule apply. In the case of inpatient services for hospital providers, initial claims must be received within three hundred sixty-five days from the date of discharge.

Except for the provision in (E)(1) or (E)(2) of this rule, initial claims received beyond the three hundred sixty-five day time limit will not be processed for payment by ODJFS. The date of receipt, for purposes of this rule, is the date ODJFS assigns a transaction control number.

(1) When the claim submittal is delayed due to the pendency of either an administrative hearing decision by 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 of the date of the administrative decision by ODJFS or eligibility determination by the CDJFS. Claims must be submitted under this provision with documentation from the CDJFS or authorized ODJFS personnel that verifies the date of service and the date of the hearing decision or eligibility determination, whichever applies. In no case shall a delay in processing eligibility information at the county level (as required in rule 5101:1-38-02 of the Administrative Code) be a basis for denial of payment under this provision.

(2) Claims submitted to ODJFS do not have to meet the timely filing limits of paragraph (E) of this rule when the claim cannot be submitted within three hundred sixty-five days due to the coordination of benefits with medicare and/or other third-party payers. The claim must be received by ODJFS within one hundred eighty days of medicare's and/or the third-party payers' payment date.

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

(F) Claims that are not completed fully or properly may be denied or rejected by ODJFS.

(G) Providers may resubmit claims that have been denied. Resubmitted claims that do not require attachments may be submitted electronically or on a paper claim if they are received by ODJFS within three hundred sixty-five days of the actual date the service was provided or one hundred eighty days from the date the claim was denied. Claims that are resubmitted that require attachments must be resubmitted on a paper claim form. Providers resubmitting claims for reconsideration must meet the following provisions:

(1) The original claim was submitted within three hundred sixty-five days of the actual date the service was provided unless the provisions in paragraph (E)(1) or (E)(2) of this rule apply.

(2) The resubmission must be within three hundred sixty-five days from the actual date of service or within one hundred eighty days from the date the claim was denied. ODJFS will not process a resubmitted claim if the claim is received more than seven hundred thirty days after the date of service or discharge

except as set forth in paragraph (E)(1) or (E)(2) of this rule.

- (3) A denied claim resubmitted within one hundred eighty days from the date the claim was denied, but greater than three hundred sixty-five days from the date of service, must be resubmitted on a paper claim form with a completed JFS 06653 form (rev. 7/2003) and any necessary attachments indicated in the JFS 06653 form instructions.
- (H) Claim status inquiries may be requested through either EDI "276/277 Health Care Claim Status Request and Response" transactions or telephone inquiries. Providers may request the EDI "276/277" transactions through an authorized trading partner in accordance with rule 5101:3-1-20.2 of the Administrative Code. Telephone inquiries regarding the status of claims are made using the ODJFS interactive voice response system. A four digit personal identification number is required to access protected health information.

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CERTIFIED ELECTRONICALLY

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Certification

05/11/2007

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Date

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