

3701-43-09 Criteria and procedures for payment of providers.

- (A) The director shall pay providers for diagnostic services and for treatment services and goods furnished to recipients in accordance with this rule.
- (B) The director shall pay only for services or goods that have been authorized to be provided under the applicable provisions of this chapter.
- (C) A provider shall submit a request for payment on a form prescribed by the director and containing at least the name and identification number of the applicant or recipient to whom the services or goods were provided, the provider's identification number, a description of the goods or services provided and the amount of the charges for the goods or services. The request for payment shall be submitted so that it is received by the director no later than twelve months after the last date on which goods or services included in the request were furnished.
- (D) If the request for payment does not contain sufficient information for the director to determine whether payment may be made, the director shall deny the request. The director shall notify the provider within thirty days after receipt of a request for payment that the request has been denied and of any additional or corrected information necessary to process the request. Additional information may include, but is not limited to, reports, descriptions of the types or amounts of goods or services provided, the amount of charges for the goods or services and information concerning submission of claims for third-party benefits. The provider may resubmit the request for payment but shall not resubmit the request so that it is received by the director more than twenty-four months after the last date on which goods or services included in the request were furnished.
- (E) A provider shall submit claims for medicaid benefits and for all other third-party benefits which may provide payment for the services rendered or goods supplied and shall make all reasonable efforts to assist the recipient to whom the goods or services were provided and the recipient's parent, guardian or other legal representative to submit claims for third-party benefits and any information necessary for processing the claims. The claims for third-party benefits shall have been submitted no less than sixty days before a request for payment is submitted to the director under this rule.
 - (1) If any payment is made for the goods or services by the medicaid program, the director shall not make payment under this rule. If the recipient of the goods or services giving rise to the request for payment is a medicaid recipient at the time that the services or goods were furnished, the director shall not make payment under this rule until after the medicaid program has denied payment for the goods or services.
 - (2) If payment is received by the provider through third-party benefits, other than medicaid program benefits, for the goods or services, the director shall subtract the amount of the third-party benefits from the amount determined under paragraph (F) of this rule and shall pay the difference to the provider.
 - (3) If a provider receives payment from the medicaid program or through other third-party benefits of at least the amount determined under paragraph (F) of this rule from the program for goods or services authorized to be provided by the director under the applicable provisions of this chapter, the provider shall

not seek payment of any additional amount from the recipient, recipient's parent, guardian or other legal representative.

- (F) If the director determines that a request for payment meets the criteria prescribed by this rule, the director shall pay the provider within sixty days after receipt of all necessary information. Subject to paragraph (E)(2) of this rule, the director shall pay:
- (1) For inpatient hospital care, outpatient care and for all other medical assistance furnished by hospitals to recipients in accordance with reasonable cost principles for reimbursement under the medicare program established under Title XVIII of the Social Security Act, 79 Stat. 291 (1965), 42 U.S.C. 1395 (1965).
 - (2) Providers of good or services other than inpatient or outpatient hospital care in accordance with the fee schedules set forth in the operational manual.

The director shall notify the provider in writing of the amount paid and, if the amount paid is less than the charges, of the reconsideration procedure established by paragraph (B) of rule 3701-43-23 of the Administrative Code.
 - (3) For pharmaceuticals, the pharmaceutical shall be approved by the medicaid program and be necessary to treat an eligible condition as specified in rule 3701-43-17 of the Administrative Code. The director may deny approval for certain pharmaceuticals when the director determines that there are other therapeutic equivalents available within the drug class and on the basis of costs, medical efficacy, operational guidelines and other factors, the denial is determined to be in the best interest of the program.
- (G) The director shall deny payment if the provider fails to meet any of the deadlines established by this rule or if the request for payment does not meet the criteria for payment prescribed by this rule. The director shall notify the provider in writing of the denial of a request for payment and the reasons for denial of the request for payment within thirty days of:
- (1) Receipt of information verifying that the request for payment does not meet the criteria prescribed by this rule; or
 - (2) The provider's failure to comply with a deadline established by this rule.

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