Instructions for correctly rebilling Utilization Review (UR) claim denials are found in Section 2.5.4: UTILIZATION REVIEW AND ASSOCIATED CLAIM RESUBMISSION of the Ohio Department of Medicaid (ODM) Hospital Billing Guidelines, available online at:

https://medicaid.ohio.gov/RESOURCES/Publications/ODM-Guidance

**Step 1:** Log into the MITS Provider Portal and click on Institutional Claims (see below):

**Step 2:** Submit a new claim with the required UR corrections and include either Condition Code C3 or the most recent ICN for the recouped claim (below). Enter the ICN starting with “56” (the claim recouped by ODM) in the “Supporting Data for Delayed Submission/Resubmission” field.

Note: Either Condition Code C3 or the ICN of the UR-recouped (denied) claim are required to bypass timely filing edits. Claims rebilled without one of these fields will not bypass timely-filing edits; the claim will deny. (ODM will not waive timely filing limits.)
To Enter Condition Code C3 (partial approval):

To report the denied ICN starting with “S6” go to “Supporting Data for Delayed Submission/Resubmission,” select “Utilization/TPL Vendor Approved Resubmission” as the Reason, and enter the 56 ICN:
**Important Notes:**

1. **Adjustment Reason Code (ARC or EOB) 8008** permits the provider to correct and resubmit the UR denied claim for the same type of bill (inpatient or outpatient) within **180 days** of the recouped “56” claim. (OAC 5160-1-19 (D)(2)(ii); ODM will not waive timely filing limits after 180 days.)

2. **ARC 8010** is assigned when the payment is recouped for UR-denied claims and the provider is **never allowed to resubmit** the claim for this consumer and dates of service.

3. **ARC 8012** permits the provider to resubmit the UR-denied inpatient claim as an outpatient claim within **60 days** of the recouped “56” claim. Adjustments to overpaid claims must be submitted within 60 days. (OAC 5160-1-19(F)(2); ODM will not waive timely filing limits after 60 days.
   
   a. The provider **must** correct the UR errors identified on the recouped claim and rebill outpatient services-only. Improperly rebilled claims will be denied.
   
   b. If the UR-denied inpatient claim contains multiple dates of service, the provider can bill for all out-patient services rendered on the first service date, but the provider can **only bill for laboratory and radiology services** rendered on dates of service **subsequent** to the first date of service. (Improperly rebilled claims will be denied.)

---

**Step 3:** To attach the UR denial letter, click on the dropdown box and select “Support Data For Claim” (see below); upload the UR denial letter (click “add an item”) from the utilization review entity, then click the Submit button. (Rebilled claims will deny without the UR denial letter.)
4. **Edits:** See Section 2.5.4 of the ODM Hospital Billing Guidelines for information regarding edits applied to improperly rebilled claims. Providers may submit a new claim again with the necessary corrections, provided that timely filing limits have not expired.

5. This guidance applies to **medical-surgical hospital claims-only.** See Section 2.5.4 of the ODM Hospital Billing Guidelines for instructions on rebilling UR-denied psychiatric hospital claims.