UTILIZATION REVIEW AND ASSOCIATED CLAIM RESUBMISSION
MITS Rebilling Desk Aid

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.)

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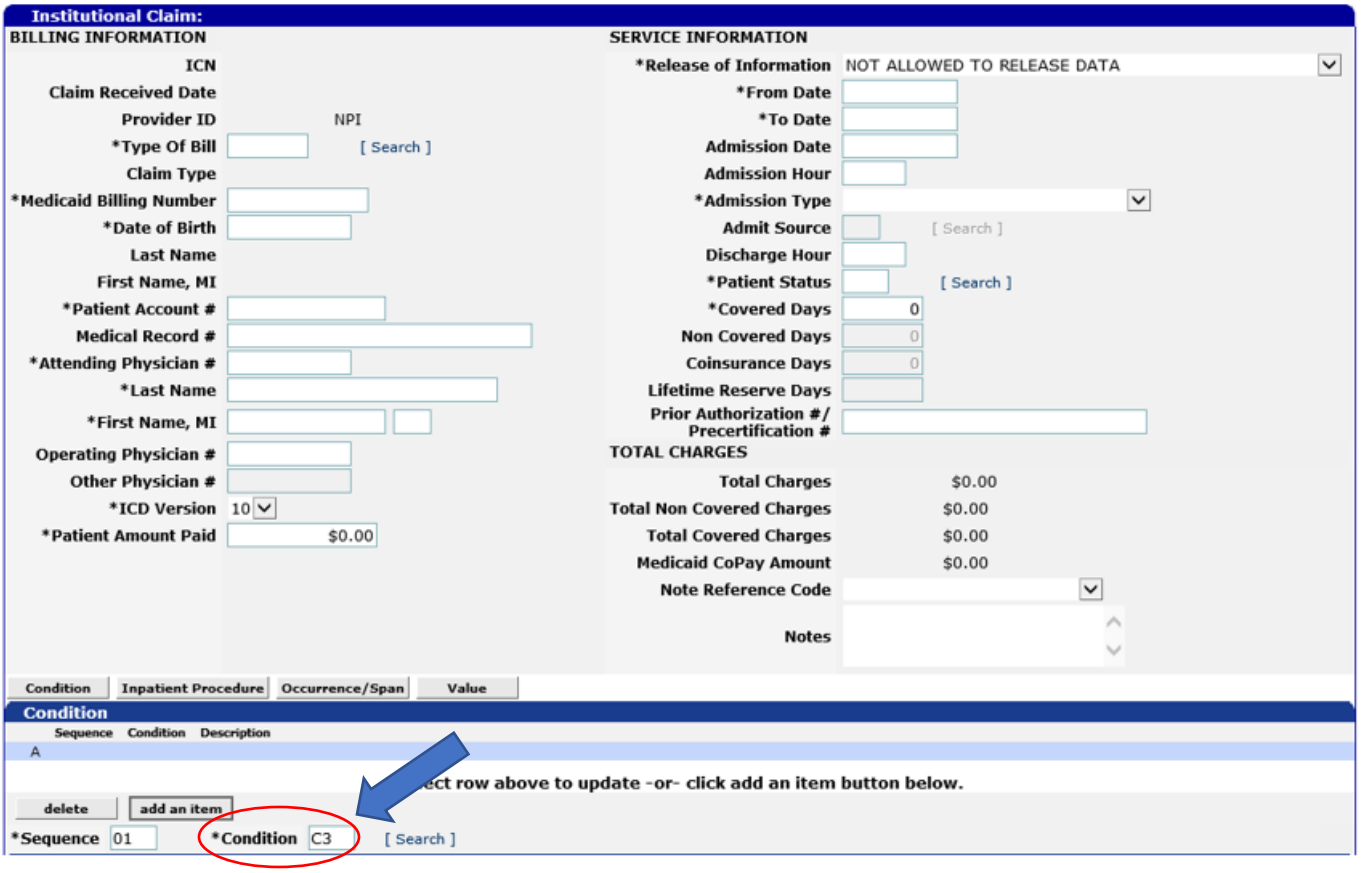
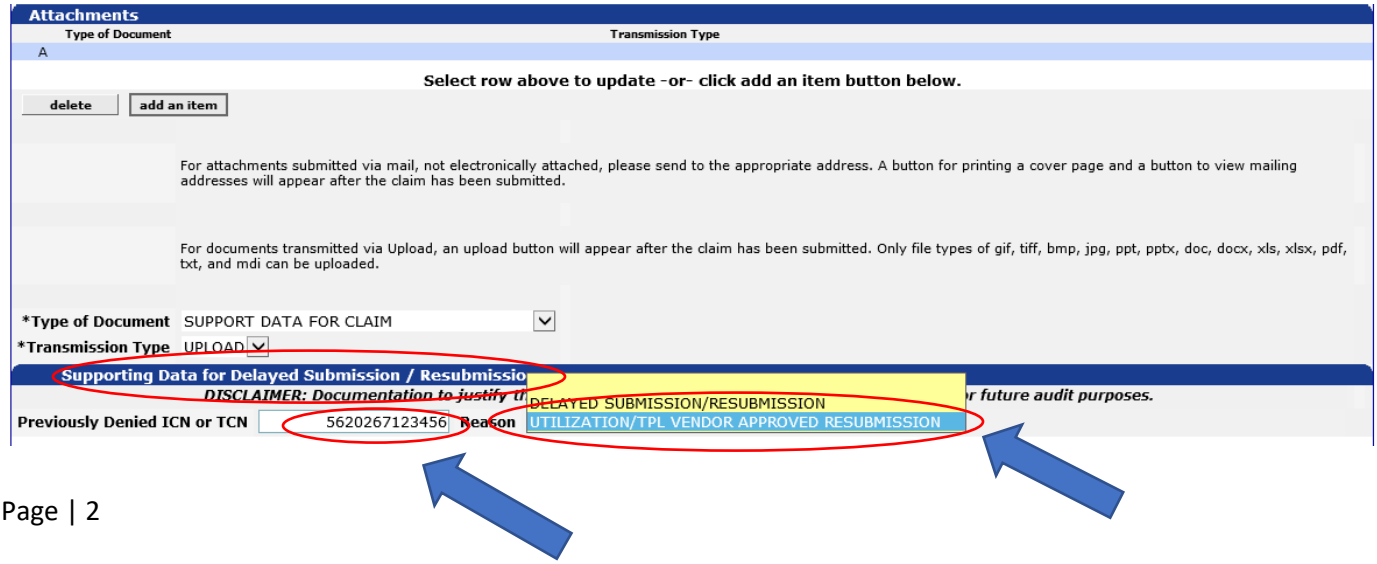
To Enter Condition Code C3 (partial approval):



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



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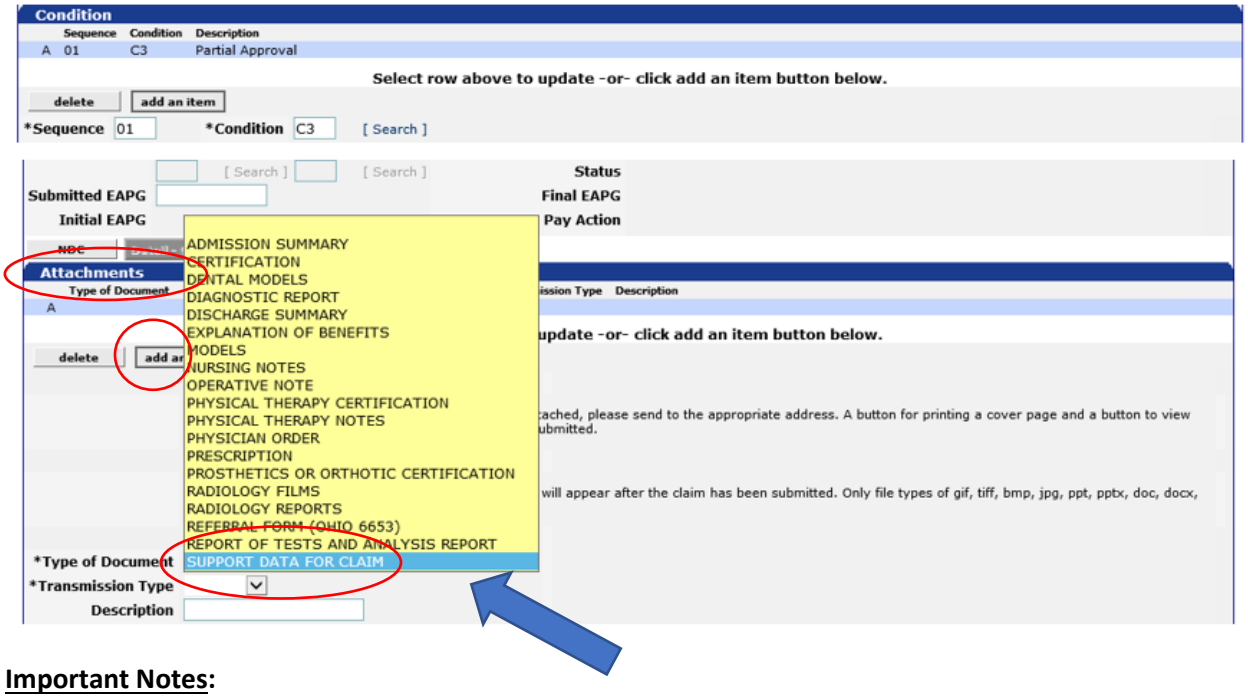
Step 3: To attach the UR denial letter, click on the dropdown box and select "Support Data For Claim" (see below); upload the UR denial letter (click "add an item") from the utilization review entity, then click the Submit button. (Rebilled claims will deny without the UR denial letter.)



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 out-patient 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.)

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**.