

## 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):

**Institutional Claim:**

**BILLING INFORMATION**

ICN  
Claim Received Date  
Provider ID NPI  
\*Type Of Bill [ Search ]  
Claim Type  
\*Medicaid Billing Number  
\*Date of Birth  
Last Name  
First Name, MI  
\*Patient Account #  
Medical Record #  
\*Attending Physician #  
\*Last Name  
\*First Name, MI  
Operating Physician #  
Other Physician #  
\*ICD Version 10  
\*Patient Amount Paid \$0.00

**SERVICE INFORMATION**

\*Release of Information NOT ALLOWED TO RELEASE DATA  
\*From Date  
\*To Date  
Admission Date  
Admission Hour  
\*Admission Type  
Admit Source [ Search ]  
Discharge Hour  
\*Patient Status [ Search ]  
\*Covered Days 0  
Non Covered Days 0  
Coinsurance Days 0  
Lifetime Reserve Days  
Prior Authorization #/  
Precertification #  
TOTAL CHARGES  
Total Charges \$0.00  
Total Non Covered Charges \$0.00  
Total Covered Charges \$0.00  
Medicaid CoPay Amount \$0.00  
Note Reference Code  
Notes

Condition Inpatient Procedure Occurrence/Span Value

Sequence	Condition	Description
A		

delete add an item Select row above to update -or- click add an item button below.

\*Sequence 01 \*Condition C3 [ Search ]

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:

**Attachments**

Type of Document Transmission Type

A

Select row above to update -or- click add an item button below.

delete add an item

For attachments submitted via mail, not electronically attached, please send to the appropriate address. A button for printing a cover page and a button to view mailing addresses will appear after the claim has been submitted.

For documents transmitted via Upload, an upload button will appear after the claim has been submitted. Only file types of gif, tiff, bmp, jpg, ppt, pptx, doc, docx, xls, xlsx, pdf, txt, and mdi can be uploaded.

\*Type of Document SUPPORT DATA FOR CLAIM  
\*Transmission Type UPLOAD

Supporting Data for Delayed Submission / Resubmission  
DISCLAIMER: Documentation to justify utilization review. DELAYED SUBMISSION/RESUBMISSION for future audit purposes.

Previously Denied ICN or TCN 5620267123456 Reason UTILIZATION/TPL VENDOR APPROVED RESUBMISSION

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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.)

The screenshot displays the MITS system interface. At the top, there is a table for 'Condition' with columns for Sequence, Condition, and Description. Below this is a search area with fields for \*Sequence (01) and \*Condition (C3). The main area shows a list of document types under the 'Attachments' section. A dropdown menu is open, listing various document types. The 'SUPPORT DATA FOR CLAIM' option is highlighted in blue and circled in red. A blue arrow points to this option. Other options in the menu include Admission Summary, Certification, Dental Models, Diagnostic Report, Discharge Summary, Explanation of Benefits, Models, Nursing Notes, Operative Note, Physical Therapy Certification, Physical Therapy Notes, Physician Order, Prescription, Prosthetics or Orthotic Certification, Radiology Films, Radiology Reports, Referral Form (OHIO 6653), and Report of Tests and Analysis Report.

### 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.)

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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**.