AMERICAN PODIATRIC MEDICAL ASSOCIATION

STATE REFERENCE MANUAL

PART G – PROMPT PAYMENT LAWS JUNE 2015

OHIO

OHIO REVISED CODE
TITLE 39. INSURANCE
CHAPTER 39.01. SUPERINTENDENT OF INSURANCE

§ 3901.381. Processing of claims by third-party payers

(A) Except as provided in sections 3901.382, 3901.383, 3901.384, and 3901.386 of the Revised Code, a third-party payer shall process a claim for payment for health care services rendered by a provider to a beneficiary in accordance with this section.

(B)(1) Unless division (B)(2) or (3) of this section applies, when a third-party payer receives from a provider or beneficiary a claim on the standard claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code, the third-party payer shall pay or deny the claim not later than thirty days after receipt of the claim. When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.

(2)(a) Unless division (B)(3) of this section applies, when a provider or beneficiary has used the standard claim form, but the third-party payer determines that reasonable supporting documentation is needed to establish the third-party payer's responsibility to make payment, the third-party payer shall pay or deny the claim not later than forty-five days after receipt of the claim. Supporting documentation includes the verification of employer and beneficiary coverage under a benefits contract, confirmation of premium payment, medical information regarding the beneficiary and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. Not later than thirty days after receipt of the claim, the third-party payer shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, beneficiary, or third-party payer may request the third-party payer to provide the notice in writing, and the third-party payer shall then provide the notice in writing. If any of the supporting documentation is under the control of the beneficiary, the beneficiary shall provide the supporting documentation to the third-party payer. The number of days that elapse between the third-party payer's last request for supporting documentation within the thirty-day period and the third-party payer's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days for payment or denial of a claim. Except as provided in division (B)(2)(b) of this section, if the third-party payer requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.

(b) If a third-party payer determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a beneficiary's preexisting condition, which condition was unknown to the third-party payer and about which it was reasonable for the third-party payer to have no knowledge at the time of its initial request for documentation, and the third-party payer subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the third-party payer's compliance with the time period of not more than forty-five days.
(c) When a third-party payer denies a claim, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.
(d) If a third-party payer determines that supporting documentation related to medical information is routinely necessary to process a claim for payment of a particular health care service, the third-party payer shall establish a description of the supporting documentation that is routinely necessary and make the description available to providers in a readily accessible format.
Third-party payers and providers shall, in connection with a claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-9 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration.

(3) When a provider or beneficiary submits a claim by using the standard claim form prescribed in the superintendent's rules, but the information provided in the claim is materially deficient, the third-party payer shall notify the provider or beneficiary not later than fifteen days after receipt of the claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, the third-party payer shall proceed in accordance with division (B)(1) or (2) of this section.
It is not a violation of the notification time period of not more than fifteen days if a third-party payer fails to notify a provider or beneficiary of material deficiencies in the claim related to a diagnosis or treatment or the provider's identification. A third-party payer may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting documentation under division (B)(2) of this section, and payment or denial of the claim is subject to the time periods specified in that division.
(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a claim form was received by the third-party payer, both of the following apply:
(1) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by the third-party payer on the fifth business day after the day the claim was mailed, unless it can be proven otherwise.
(2) If the provider or a person acting on behalf of the provider submits a claim directly to a third-party payer electronically, there exists a rebuttable presumption that the claim was received by the third-party payer twenty-four hours after the claim was submitted, unless it can be proven otherwise.
(D) Nothing in this section requires a third-party payer to provide more than one notice to an employer whose premium for coverage of employees under a benefits contract has not been received by the third-party payer.
(E) Compliance with the provisions of division (B)(3) of this section shall be determined separately from compliance with the provisions of divisions (B)(1) and (2) of this section.
(F) A third party payer shall transmit electronically any payment with respect to claims that the third party payer receives electronically and pays to a contracted provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

3901.383 Contractual agreements for payments by third-party payers.
(A) A provider and a third-party payer may do either of the following:
(1) Enter into a contractual agreement under which time periods shorter than those set forth in section 3901.381 of the Revised Code are applicable to the third-party payer in paying a claim for any amount due for health care services rendered by the provider;
(2) Enter into a contractual agreement under which the timing of payments by the third-party payer is not directly related to the receipt of a claim form. The contractual arrangement may include periodic interim payment arrangements, capitation payment arrangements, or other periodic payment arrangements acceptable to the provider and the third-party payer. Under a capitation payment arrangement, the third-party payer shall begin paying the capitated amounts to the beneficiary's primary care provider not later than sixty days after the date the beneficiary

selects or is assigned to the provider. Under any other contractual periodic payment arrangement, the contractual agreement shall state, with specificity, the timing of payments by the third-party payer.
(B) Regardless of whether a third-party payer is exempted under division (D) of section 3901.3814 from sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code, a provider and the third-party payer, including a third-party payer that provides coverage under the medicaid program, shall not enter into a contractual arrangement under which time periods longer than those provided for in paragraph (c)(1) of 42 C.F.R. 447.46 are applicable to the third-party payer in paying a claim for any amount due for health care services rendered by the provider.
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§ 3901.384. Processing of claims not submitted in timely manner
(A) Subject to division (B) of this section, a third-party payer that requires timely submission of claims for payment for health care services shall process a claim that is not submitted in a timely manner if a claim for the same services was initially submitted to a different third-party payer or state or federal program that offers health care benefits and that payer or program has determined that it is not responsible for the cost of the health care services. When a claim is submitted later than one year after the last date of service for which reimbursement is sought under the claim, the third-party payer shall pay or deny the claim not later than ninety days after receipt of the claim or, alternatively, pursuant to the requirements of sections 3901.381 to 3901.388 of the Revised Code. The third-party payer must make an election to process such claims either within the ninety-day period or under section 3901.381 of the Revised Code. If the claim is denied, the third-party payer shall notify the provider and the beneficiary. The notice shall state, with specificity, why the third-party payer denied the claim.
(B) The third-party payer may refuse to process a claim submitted by a provider if the provider submits the claim later than forty-five days after receiving notice from the different third-party payer or a state or federal program that that payer or program is not responsible for the cost of the health care services, or if the provider does not submit the notice of denial from the different third-party payer or program with the claim. The failure of a provider to submit a notice of denial in accordance with this division shall not affect the terms of a benefits contract.
(C) For purposes of this section, both of the following apply:
(1) A determination that a third-party payer or state or federal program is not responsible for the cost of health care services includes a determination regarding coordination of benefits, preexisting health conditions, ineligibility for coverage at the time services were provided, subrogation provisions, and similar findings;
(2) State and federal programs that offer health care benefits include medicare, medicaid, workers' compensation, the civilian health and medical program of the uniformed services and other elements of the tricare program offered by the United States department of defense, and similar state or federal programs.
(D) Any provision of a contractual arrangement entered into between a third-party payer and a provider or beneficiary that is contrary to divisions (A) to (C) of this section is unenforceable.

3901.389 Computation of interest.

(A) Any third-party payer that fails to comply with section 3901.381 of the Revised Code, or any contractual payment arrangement entered into under section 3901.383 of the Revised Code, shall pay interest in accordance with this section.
(B) Interest shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with section 3901.381 of the Revised Code or the contractual payment arrangement entered into under section 3901.383of the Revised Code, and the date payment is made. The interest rate for determining the amount of interest due shall be equal to an annual percentage rate of eighteen per cent.
(C) For purposes of this section, if a dispute exists between a provider and a third-party payer as to the day a payment was made by the third-party payer, both of the following apply:
(1) If the third-party payer or a person acting on behalf of the third-party payer submits a payment directly to a provider by mail and retains a record of the day the payment was mailed, there exists a rebuttable presumption that the payment was made five business days before the day the payment was received by the provider, unless it can be proven otherwise.
(2) If the third-party payer or a person acting on behalf of the third-party payer submits a payment directly to a provider electronically, there exists a rebuttable presumption that the payment was made twenty-four hours before the date the payment was received by the provider, unless it can be proven otherwise.
(D) Interest due in accordance with this section shall be paid directly to the provider at the time payment of the claim is made and shall not be used to reduce benefits or payments otherwise payable under a benefits contract.

3901.3814 Exceptions to provisions.

Sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code do not apply to the following:
(A) Policies offering coverage that is regulated under Chapters 3935. and 3937. of the Revised Code;
(B) An employer's self-insurance plan and any of its administrators, as defined in section 3959.01 of the Revised Code, to the extent that federal law supersedes, preempts, prohibits, or otherwise precludes the application of any provisions of those sections to the plan and its administrators;
(C) A third-party payer for coverage provided under the medicare advantage program operated under Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended;
(D) A third-party payer for coverage provided under the Medicaid program , except that if a federal waiver applied for under section 5167.25 of the Revised Code is granted or the Medicaid director determines that this provision can be implemented without a waiver, sections 3901.38 and 3901.381 to 3901.3813 of the Revised Code apply to claims submitted electronically or non-electronically that are made with respect to coverage of Medicaid recipients by health insuring corporations licensed under Chapter 1751. of the Revised Code, instead of the prompt payment requirements of 42 C.F.R. 447.46;
(E) A third-party payer for coverage provided under the tricare program offered by the United States department of defense.