4123-6-14 MCO bill submission to bureau.

(A) The bureau shall review all bills received from the MCO pursuant to paragraph (A)(1) of rule 4123-6-10 of the Administrative Code for payment eligibility. The bureau's review may include, but not be limited to, verification of the following:

(1) The services were delivered, rendered, or directly supervised by providers who meet bureau credentialing and licensing criteria;

(2) The bills conform to standard clinical editing criteria in effect on the billed date(s) of service, including but not limited to: the bureau's billing and reimbursement manual, the centers for medicare and medicaid services' healthcare common procedure coding system (HCPCS), and the national correct coding initiative (NCCI) guidelines.

The bureau shall electronically transfer funds to the MCO for allowed payments after receipt of a proper invoice and after a final adjudication permitting payment for the bill. Upon receipt of funds from the bureau, the MCO shall pay the provider within seven days or less. The MCO shall pay to providers at least the amount electronically transferred by the bureau to the MCO for reimbursement of provider services.

(B) A provider that bills an MCO for services in expectation of payment from the MCO is responsible for the accuracy of all billing data and information the provider transmits to the MCO. The MCO is responsible for the accuracy of translating billing data received from the provider and the accuracy of transmitting billing data to the bureau that results in payment to the MCO or to the provider.

Effective: 11/13/15
Prior Effective Dates: 2/16/96, 1/15/99, 2/1/10