Ohio Administrative Code

Rule 3701-40-07 Reimbursement for hearing screening.

Effective: November 12, 2013

(A) The director shall reimburse providers for a maximum of one hearing screening per newborn or infant in accordance with this rule at a rate determined by the director if all the following criteria are met:

(1) The screening is performed before the newborn or infant is discharged by the provider;

(2) The parent, guardian, or custodian certifies with a signed statement that the family

(a) Is financially unable to pay for the screening;

(b) Is not eligible for medicaid; and

(c) Does not have insurance coverage for the screening.

(3) The provider is not reimbursed by a third-party payer.

(B) The provider seeking reimbursement from the director for a hearing screening shall submit an invoice for reimbursement to the director no later than twelve months after the completion of the screening. The invoice shall contain at least the following information:

(1) The name and address of the provider of the screening;

(2) The name and Ohio license number of the audiologist performing or supervising the performance of the hearing screening or the name and license number of the physician performing or supervising the hearing screening;

(3) The date and nature of service provided and the amount of the charge for this service;

(4) The name and date of birth of the newborn or infant screened;

(5) The name and address of the newborn's or infant's parent, guardian, or custodian;

(6) A written statement signed by the newborn's or infant's parent, guardian, or custodian attesting to an inability to pay for the screening and explaining the circumstances and reasons why the individual is unable to pay;

(7) Documentation of compliance with paragraph (D) of this rule; and

(8) Signature of the billing agent.

(C) The provider shall:

(1) Submit claims for all third-party benefits, including medicaid, for which the newborn or infant may be eligible, which may provide payment for the screening;

(2) Make all reasonable efforts to assist the parent, guardian, or custodian of the newborn or infant who was screened to submit claims and appeal denials for third-party benefits; and

(3) Provide any information necessary for processing the claims.

(D) Claims for third-party benefits shall have been submitted no less than sixty days before a request for payment is submitted to the director under this rule.

(E) The director shall not make payment for the screening under this rule:

(1) If any payment is made by the medicaid program established by Chapter 5111. of the Revised Code; and

(2) If the newborn's or infant's parent, guardian, or custodian has applied for medicaid reimbusement; and

(a) The medicaid program has not denied payment for the screening; and

(b) The medicaid administrative appeals process has not been exhausted by the parent, guardian, or custodian.

(F) The director shall review the request for reimbursement and may request any additional information necessary for making a determination regarding reimbursement.

(1) The provider shall file any requested information with the director no later than forty-five calendar days after the date on the director's request for additional information.

(2) The director shall deny payment if the provider has failed to comply with the requirements established by this rule or if the criteria for payment prescribed by paragraph (B) of this rule have not been met.

(G) Providers reimbursed by the director, medicaid or any third party payers for a hearing screening shall accept the amount paid by the director, medicaid or any third-party payers as payment in full and shall not seek payment from the parent, guardian, or custodian. This paragraph is not intended to prohibit the provider from collecting from the parent, guardian or custodian any applicable copayment or deductible when payment is made by a third party payer.

(H) The director shall send written notification to the provider of:

(1) A decision to deny reimbursement under this rule; and

(2) Procedures for reconsideration.

(I) The provider may submit a written request for reconsideration no later than thirty calendar days after the date on the notice of the proposed action and shall provide:

(1) A statement of the reasons why the provider believes that the proposed decision is incorrect or inappropriate; and

(2) Any written documentation, arguments, or other materials that the provider wishes to sumit in defense of the claim.

(J) For the purposes of reconsideration, the director may request from the provider additional relevant records of documentation within forty-five calendar days of receipt of the request for reconsideration or of additional information previously submitted under this paragraph. The provider shall file any requested information with the director no later than forty-five calendar days after the date on the request for additional information.

(K) Within forty-five calendar days after receipt of a request for reconsideration from the provider that complies with paragraph (G) of this rule and of all necessary additional information requested and timely filed under paragraph (H) of this rule, the director shall notify the provider who requested the reconsideration, in writing, of his decision on reconsideration. The director's decision rendered upon reconsideration shall be final.