Ohio Administrative Code

Rule 5160-1-60.4 By-report procedures, services, and supplies.

Effective: July 1, 2018

(A) The term "by-report" identifies a covered procedure, service, or supply for which no single maximum payment amount has been established and for which payment is not determined by prior authorization. Claims for by-report procedures, services, and supplies are reviewed manually by the department or its designee. The purpose of the review is to determine whether the procedure code for the by-report procedure, service, or supply reported on the claim is the most appropriate and, if so, to establish a maximum payment amount for the procedure, service, or supply on a case-by-case basis. Information must be submitted on or with the claim (e.g., supporting documents such as operative reports, clinical assessments, or other medical records) to identify the particular by-report procedure, service, or supply.

(B) By-report procedures, services, and supplies are so indicated in the relevant rule in agency 5160 of the Administrative Code or in its associated payment schedule.

(C) A non-covered procedure, service, or supply that is reported on a claim with a by-report procedure code is non-covered.

(D) A claim for a by-report procedure, service, or supply will not be reviewed further and may be denied under either of the following conditions:

(1) Information submitted on or with the claim does not sufficiently identify the by-report procedure, service, or supply, and additional documentation requested by the reviewer is not supplied; or

(2) The procedure, service, or supply can be reported appropriately with a different procedure code for which a specific maximum payment amount has been established.

(E) When a claim has been denied because a different procedure code adequately describes a procedure, service, or supply, the provider may submit a new claim with the appropriate code. The new claim must not be submitted for by-report consideration.