# Office of Benefits

# Hospital Billing Guidelines

Revised 2/1/2017

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# NEW CHANGES FOR 2/1/2017

Underlined text indicates new language.

- Language was updated throughout the document to clarify existing content.
- Effective January 1, 2016, all outpatient hospital claims submitted to ODM are expected to be in date of service order with the RCC in ascending order within each service date. (Refer to Section 1.2)
- Effective October 1, 2015, pre-certification is no longer required for surgical procedures, however, pre-certification is still required for psychiatric admissions. (Refer to Section 2.1.1)
- Effective January 1, 2016, new ARCs were implemented to indicate the reason for a recoupment that resulted from a utilization review. (Refer to Section 2.1.3)
- Effective for services rendered on or after January 1, 2016, upon utilization review of Medicaid inpatient hospital services, physician payments for services associated with the recouped payment that resulted from utilization review may be recovered as well. (Refer to Section 2.1.3)
- New Section 2.1.4 provides guidance regarding third-party liability resubmissions. (Refer to Section 2.1.4)
- Language was added to clarify reimbursement for abortion services. (Refer to Section 2.4.1)
- Language was added regarding the Consent for Sterilization Form. (Refer to Section 2.4.2)
- ODM recommends that an Acknowledgement of Hysterectomy Information Form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. (Refer to Section 2.4.3)
- Payment methodology table for transplant services on or before June 30, 2013 was moved from section 2.5 to Appendix J. (Refer to Section J.1)
- An example for a partial eligibility stay was added. (Refer to Section 2.6)
- Due to the Sunset of the Family Planning Services benefit plan on December 31, 2015, a person seeking family planning services will not be charged a non-emergency co-payment. (Formerly in Section 2.7)
- Language in section 2.8.1, "Effective January 1, 2014, the outlier multiplier was updated to 90% from 95%." was deleted as all claims submitted to ODM are now subject to an outlier multiplier of 90%. (Refer to Section 2.8.1)
- Former section 2.8.2 (Outlier payments – Services provided on or before 6/30/13) was moved to Appendix J. (Refer to Section J.2)
- Language was added to clarify third party liability. (Refer to Section 2.9)
- Language was added to clarify how claims should be submitted to ODM when Medicare Part A exhausts during an inpatient admission or Medicare becomes effective during an inpatient admission. (Refer to Section 2.9.1)
- Language was added to clarify how claims should be submitted to ODM when Medicaid is primary with Medicare Part B only. (Refer to Section 2.9.2)
- Language was added to clarify how claims with third party liability are reimbursed. (Refer to Section 2.9.4)
- Language was added to provide billing guidance in cases where there are outpatient services within three days of the admission date and the patient also changes Medicaid coverage on the same day as the admission. (Refer to Section 2.13)
- Billing guidance for LARCs was updated. (Refer to Section 2.15)
- Former Section 2.16 (Special unlisted dental surgery) was moved to Appendix J. (Refer to

Section J.3)

- New Section 2.16 contains information regarding the three calendar day roll-in and requirement to submit a HCPCS J-code or Q-code with RCC 25X and/or 636. (Refer to Section 2.16)
- New Section 2.19 provides information regarding non-cooperative patients. (Refer to Section 2.19)
- New Section 2.20 provides information regarding national drug codes. (Refer to Section 2.20)
- New Section 3.1.1 provides guidance on ICD-9 vs ICD-10 adjustments. (Refer to Section 3.1.1)
- New Section 3.3.1 provides information regarding ordering, referring, or prescribing providers. (Refer to Section 3.3.1)
- Language was added to provide clarifying language around Type of Bills XX7 and XX8. (Refer to Appendix A)
- A note was added to require Occurrence Code 55 to be reported with Discharge Status 20 to indicate the patient's date of death. (Refer to Appendix D)
- Language was revised regarding Condition Code C3. (Refer to Appendix E)
- Language was added to clarify reporting criteria for covered and non-covered days. (Refer to Appendix G)
- The revenue center code for consultation and education was corrected from 0693 to 0694. (Refer to Appendix I)
- A column was added to Appendix I to indicate whether the RCC requires a HCPCS or CPT code to be submitted on the same detail line. (Refer to Appendix I)
- Coverage determinations were made regarding new RCCs 815 (effective 1/1/2017) and 826 (effective 7/1/2017). (Refer to Appendix I)

# 1. HOSPITAL BILLING OVERVIEW

The Ohio Department of Medicaid (ODM) Hospital Billing Guidelines contain basic billing information for Ohio Medicaid hospital providers regarding inpatient and outpatient claims. It is intended to be a supplemental guide to assist providers with specific Medicaid policy from a billing perspective when submitting a claim electronically or through the web portal.

ODM Hospital Billing Guidelines are based on rules of the Ohio Administrative Code (OAC). Effective July 1, 2015, ODM is no longer publishing transmittal letters or utilizing eManuals, including the Ohio Department of Job and Family Services (ODJFS) Legal Policy Central Calendar.

Stakeholders who want to receive notification when ODM original or final files a rule package may visit the Ohio Joint Committee on Agency Rule Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by rule number or department.

Stakeholders can subscribe to receive notification when a clearance or business impact analysis (BIA) is posted for public comment on the Ohio Business Gateway here: http://business.ohio.gov/reform/enotify/subscription.aspx

OAC rules are available at Lawriter at http://codes.ohio.gov/oac/5160-2

Per OAC rule 5160-1-19, all claims must be submitted to ODM through one of the following formats:

(1) Electronic Data Interchange (EDI) in accordance with standards established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996; or
(2) The Medicaid Information Technology System (MITS) web portal.

Providers submitting claims electronically to ODM must use the most current version of the EDI 837 Institutional (I) format. The official EDI standards for all EDI transactions are developed and maintained by the Accredited Standards Committee (ASC) X12. The ODM 837I Companion Guide has been created as a supplemental guide and can be accessed through the ODM website at:

http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx

Many of the code sets used within the EDI 837I standards are set by the National Uniform Billing Committee (NUBC) for the UB-04 claim form. A complete document containing all current UB-04 billing codes may be accessed at the NUBC website:

http://www.nubc.org/

For additional information, please contact the Interactive Voice Response System (IVR) at 1-800-686-1516, or visit the Ohio Department of Medicaid website:

http://www.medicaid.ohio.gov

## 1.1 INSTRUCTIONS FOR HOSPITAL PROVIDERS

NOTE: This guide is structured using the UB-04 claim form layout, but claims are required to be submitted through EDI or the MITS web-portal.

| Form Locator # | Field | Required |
|---|---|---|
| **1** | Billing Provider Name, Address and Telephone Number | IP, OP |
| **2** | Billing Provider's Designated Pay-to Name and Address<br>(The address listed here will not be recognized. Payment will be sent to the address listed on the provider application.) | |
| **3a** | Patient Control Number | IP, OP |
| **3b** | Medical/Health Record Number | |
| **4** | Type of Bill<br>(See Appendix A for additional notes regarding Bill Type use for Ohio Medicaid.) | IP, OP |
| **5** | Federal Tax Number | IP, OP |
| **6** | Statement Covers Period<br>The span of service dates included on this particular claim. The 'from date' is the earliest date of service on the claim and it may not match the 'admission date'.<br>(For Medicare crossover claims this should match the "from date" and "through date" as it appears on the Medicare remittance advice.) | IP, OP |
| **7** | Reserved for Assignment by the NUBC | |
| **8a** | Patient Identifier | |
| **8b** | Patient Name<br>(Name must correspond to the name on the Medical Assistance I.D. card. No punctuation or abbreviation may be used.) | IP, OP |
| **9** | Patient Address | IP, OP |
| **10** | Patient Birth Date<br>(An unknown birth date is not acceptable.) | IP, OP |
| **11** | Patient Sex<br>(An unknown sex is not acceptable.) | IP, OP |
| **12** | Admission/Start of Care Date<br>This is the date the inpatient admission is ordered. | IP |
| **13** | Admission Hour | IP |
| **14** | Priority (Type) of Admission or Visit<br>(See Appendix B for additional notes regarding Priority (Type) of Visit code use for Ohio Medicaid.) | IP, OP |
| **15** | Point of Origin for Admission or Visit<br>(See Appendix C for additional notes regarding Point of Origin for Admission code use for Ohio Medicaid.) | IP, OP |

| Form Locator # | Field | Required |
|---|---|---|
| **16** | Discharge Hour<br>(This includes claims with a Frequency Code of 1, 4 and 7 when the replacement is for a prior final claim.) | IP |
| **17** | Patient Discharge Status<br>(See Appendix D for additional notes regarding Patient Discharge Status code use for Ohio Medicaid.) | IP, OP |
| **18-28** | Condition Codes<br>(See Appendix E for additional notes regarding Condition Code use for Ohio Medicaid. Form Locator 81 for additional codes will not be used.) | |
| **29** | Accident State | |
| **30** | Reserved for Assignment by the NUBC | |
| **31-34** | Occurrence Codes and Dates<br>(See Appendix F for additional notes regarding Occurrence Codes for Ohio Medicaid. Form Locator 81 for additional codes will not be recognized.) | |
| **35-36** | Occurrence Span Codes and Dates | |
| **37** | Reserved for Assignment by the NUBC | |
| **38** | Responsible Party Name and Address (Claim Address) | |
| **39-41** | Value Codes and Amounts<br>(See Appendix G for additional notes regarding Value Code use for Ohio Medicaid. Form Locator 81 for additional codes will not be recognized) | |
| **42** | Revenue Code<br>(See Appendix I for a listing of covered revenue codes. The Medicaid program will reimburse private room rates only under the following conditions: a.) When a private room is medically necessary; b.) When a hospital has no semi-private room; c.) When the patient chooses a private room and agrees, in advance in writing, to pay the difference between the private and semi-private rates. When submitting a bill to Medicaid with a private room revenue center code (RCC), either condition code 39 (medical necessity), value code 31 (patient liability-patient chooses private room and agrees to pay room differential), or value code 02 (hospital has no semi-private rooms) must be present or the claim will be denied. If value code 31 is used, the charges related to the private and semi-private room differential must appear in Form Locator 48 (Non-Covered Charges).) | IP, OP |
| **43** | Revenue Description<br>(If the revenue center code (RCC) in Form Locator 42 indicates room and board, enter the daily rate in Form Locator 44 and the number of days in Form Locator 46. The number of units for room and board for covered and non-covered days must be reported on separate lines in the claim details and need to match the header level covered and non-covered.) | |
| **44** | HCPCS/Accommodation Rates/HIPPS Rate Codes<br>(For most outpatient services, a Current Procedural Terminology (CPT) code must be reported. Services requiring CPT coding are detailed in Appendix B of OAC rule 5160-2-21.) | |
| **45** | Service Date | OP |

| Form Locator # | Field | Required |
|---|---|---|
| **46** | Service Units<br>(See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board.) | IP, OP |
| **47** | Total Charges<br>The total amount of charges related to the revenue code and/or CPT/ HCPCS code, include both covered and non-covered charges.<br>(See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board.)<br>The difference between Total Charges and Non-Covered Charges would be the Total Medicaid Covered Charges. The Total Medicaid Covered Charges are used for outlier calculations. | IP, OP |
| **48** | Non-Covered Charges<br>(See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board. Any charges that should be reported as non-covered should be listed here.)<br>The difference between Total Charges and Non-Covered Charges would be the Total Medicaid Covered Charges. The Total Medicaid Covered Charges are used for outlier calculations. | |
| **49** | Reserved for assignment by the NUBC | |
| **50** | Payer Name | IP, OP |
| **51** | Health Plan Identification Number | IP, OP |
| **52** | Release of Information Certification Indicator | IP, OP |
| **53** | Assignment of Benefits Certification Indicator | IP, OP |
| **54** | Prior Payments – Payer | |
| **55** | Estimated Amount Due | |
| **56** | National Provider Identifier – Billing Provider<br>(See Appendix H for additional notes regarding NPI use for Ohio Medicaid.) | |
| **57** | Other (Billing) Provider Identifier<br>(Can be used to report the Ohio Medicaid legacy number.) | |
| **58** | Insured's Name | IP, OP |
| **59** | Patient's Relationship to Insured | IP, OP |
| **60** | Insured's Unique Identifier<br>(Enter the patient's twelve (12) digit billing number exactly as it appears on the Medical Assistance I.D. card.) | IP, OP |
| **61** | Insured's Group Name | |
| **62** | Insured's Group Number | |
| **63** | Authorization Code/Referral Number | |
| **64** | Document Control Number (DCN) | |
| **65** | Employer Name (of the Insured) | |
| **66** | Diagnosis and Procedure Code Qualifier (ICD Revision Indicator)<br>(Qualifier Code "9" or "0" is required on all claims.) | IP, OP |
| **67** | Principal Diagnosis Code and Present on Admission Indicator | IP, OP |
| **67 A-Q** | Other Diagnosis Codes | |
| **68** | Reserved for Assignment by the NUBC | |

| Form Locator # | Field | Required |
|---|---|---|
| **69** | Admitting Diagnosis Code<br>(Required on 011X and 012X) | IP |
| **70 a-c** | Patient's Reason for Visit<br>(Required on Type of Bill 013X, 078X, and 085X when: (1) Form Locator 14 codes 1, 2, or 5 are reported; AND (2) Revenue codes 045X, 0516, or 0762 are reported on Form Locator 42.) | OP |
| **71** | Prospective Payment System (PPS) Code | |
| **72 a-c** | External Cause of Injury (ECI) Code and Present on Admission Indicator | |
| **73** | Reserved for Assignment by the NUBC | |
| **74** | Principal Procedure Code and Date | |
| **74 a-e** | Other Procedure Codes and Dates | |
| **75** | Reserved for Assignment by the NUBC | |
| **76** | Attending Provider Name and Identifiers | |
| **77** | Operating Physician Name and Identifiers | |
| **78-79** | Other Provider Name and Identifiers | |
| **80** | Remarks Field<br>(For all emergency department visits determined to be non-emergent enter COPAY_NEMR (note: _ indicates space).) | |
| **81** | Code – Code Field<br>(This field will not be used.) | |

## 1.2 REQUIREMENT TO BILL IN SERVICE DATE ORDER

Effective January 1, 2016, ODM expects all outpatient hospital claims billed to ODM (or adjusted) on or after January 1, 2016 to be billed with the details in service date order and the RCC in ascending order within each service date. This requirement applies to every outpatient hospital claim (bill types 131 and 135 on the UB-04 and 837i) that is billed to ODM regardless of mode of submission (portal or EDI). This new requirement does not apply to inpatient claims or any claim billed on a CMS 1500. This requirement also does not apply when Medicare is the primary payer, but does apply to any other outpatient claims where Medicaid is the secondary or tertiary payer.

Per this new requirement, details on each individual outpatient claim must be billed in service date order, and the RCC must be billed in ascending order within each date of service on the claim.

For example:

1/1/2016-RCC 250

1/1/2016-RCC 300

1/1/2016-RCC 324

1/5/2016-RCC 250

1/5/2016-RCC 300

Explanation of benefits (EOB)/edit 912 was implemented in MITS to deny any outpatient hospital claim where details are not billed in service date order and whose RCCs are not in ascending order. Official documentation of this change can be found in our Hospital Handbook Transmittal Letter (HHTL) No. 3352-16-01. The HHTL is located on the ODM website at the following link: http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx Click on 'Medicaid Policy' and the link to the HHTL is under the 'Hospital' heading.

# 2. SPECIAL CASES BILLING INSTRUCTIONS

## 2.1 PRE-CERTIFICATION, PRIOR AUTHORIZATION REQUIREMENTS, AND UTILIZATION REVIEW

These are two different types of authorization hospitals may be required to obtain – pre-certification and prior authorization. The pre-certification requirement is for all psychiatric admissions. The prior authorization (PA) requirement is for procedures that are normally considered non-covered in accordance with OAC rule 5160-2-03, and must be reviewed for medical necessity (except transplants, these are covered but still require prior authorization).

Pre-certification and prior authorization is not required when Medicare is the primary payer.

ODM contracts with a utilization review vendor, Permedion, that reviews all submitted pre-certification and PA requests on behalf of the Department.

Effective August 2, 2011, all pre-certification and prior authorization requests (except transplants) must be submitted through the ODM MITS Web Portal. The pre-certification/PA number is issued by MITS and must be submitted on the claim for the services for which the number was rendered.

### 2.1.1 PRE-CERTIFICATION

Specifications related to pre-certification are defined in OAC rule 5160-2-40. Providers are required to get pre-certification on psychiatric admissions.

Pre-certification requirements for surgical procedure were discontinued effective 10/1/2015.

Psychiatric Admissions

For psychiatric admissions, if the diagnosis related group (DRG) assigned to the claim is DRG 750 to 760 and admitting International Classification of Diseases, 10th Revision (ICD-10) diagnosis code is F0150-F99, G4700, G479, H9325, Q900-Q902, Q909-Q917, Q933-Q935, Q937, Q9388-Q9389, Q939, Q992, R37, R4181, R41840-R41841, R41843-R41844, R440, R442-R443, R450-R457, R4581-R4582 R45850-R45851, R4586-R4587, R4589, R4681, R4689, R480-R482, R488-R489, R54, Z72810-Z72811, Z87890 or Z9183, the admission requires pre-certification.

The pre-certification must be obtained prior to the admission or within two business days of the admission. For psychiatric admissions, pre-certification is required for all payers, unless Medicare is the primary payer. If Medicaid eligibility was pending at the time of psychiatric admission, or if Medicaid eligibility was granted retrospectively, the hospital will need to submit a pre-certification

request through the ODM MITS Web Portal to request a retrospective pre-certification number. The hospital should provide proof or reasonable assurance that eligibility was checked at the time of admission, so that their request may be processed in accordance with OAC guidelines.

If a person is admitted for medical reasons but after admission and medical evaluation, it is determined the reason for the care was psychiatric in nature, pre-certification is not required. The admitting diagnosis codes on these claims will indicate an acute medical condition rather than a psychiatric condition, so the claim will process without pre-certification.

### 2.1.2 Prior Authorization

There is not a published list of services that require prior authorization for inpatient procedures, but OAC rule 5160-2-03 describes the types of services that would require prior authorization. Examples of services that would require prior authorization include investigational/experimental procedures, plastic surgery, and organ transplants (except kidney). Prior authorization will be granted if a service that is typically not covered is proven to be medically necessary for a consumer. Per OAC rule 5160-1-11, Ohio Medicaid covered services will be reimbursed when rendered by out-of-state providers if the provider location for the medically necessary service is in a bordering state. Prior authorization is required for services rendered in states non-contiguous to Ohio. In addition, Appendix C of OAC rule 5160-2-21 identifies outpatient surgical procedures that require prior authorization with a PA indicator next to the CPT code. More information regarding Medicaid's prior authorization policy can be found in OAC rule 5160-1-31.

Procedures that require prior authorization are never exempt from prior authorization, so a retrospective review for PA can be requested. A claim submitted with a procedure code that requires a PA will never pay without an approved authorization.

Transplant prior authorizations must be obtained through the appropriate consortium:

Ohio Solid Organ Transplantation Consortium

1-614-504-5705

Ohio Hematopoietic Stem Cell Transplant Consortium

1-440-585-0759

Once the applicable transplant consortium has approved the PA request, the information is entered into MITS and an approval letter is generated to the hospital and the consumer. Hospitals may also log into MITS to check for transplant approvals and authorization numbers.

### 2.1.3 Utilization Review and Associated Claim Resubmission

Per OAC rule 5160-02-07.13, on behalf of ODM, a medical review entity performs utilization review for Medicaid inpatient and outpatient services (both acute and psych) regardless of the payment methodology used for reimbursement of those services. During the course of its analyses, the medical review entity may request information or records from the hospital and may conduct on-site medical record reviews.

Upon retrospective review, the medical review agency may determine billing errors, the wrong procedure code was used, or that the location of service was not medically necessary, but the services rendered were medically necessary. In the instance where the inpatient setting was not medically necessary, the hospital may bill Medicaid on an outpatient basis for those medically necessary services rendered on the date of admission in accordance with OAC rule 5160-2-21. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed on the outpatient claim.

1) Payments for inpatient acute stays that have been recouped due to utilization review will include adjustment reason codes (ARC), which will indicate the reason for the recoupment.

    a. ARC 8008 permits the provider to resubmit the claim for the same Type of Bill within 180 days of the voided claim. If a voided claim is assigned ARC 8008, the provider must submit the new claim, along with the letter from the utilization review entity, and include Condition Code C3 and/or the ICN of the voided claim. The new claim must be submitted within 180 days of the voided date of the original claim (the date the payment was taken back by ODM) to allow for the timely filing edits to be bypassed. If the provider fails to resubmit the claim in accordance with the criteria set forth in ARC 8008, audit 5045 (UR-DENY CLAIM WHEN 180 DAY FILING LIMIT EXCEEDED) will post to deny the claim. Do not use the 6653 form or process when resubmitting the claim. When resubmitting the claim through the MITS web portal, click on the dropdown box and select "support data for claim", then upload your attachment and click on the submit button.

    b. If a voided claim is assigned ARC 8010, the provider is never allowed to resubmit the claim for this consumer for these dates of service. If a provider attempts to resubmit a claim after the original paid claim is voided, audit 5042 (UR-DENY NEW DAY CLAIM IF HIST PAID CLAIM ADJ TO $0) or audit 5043 (UR-DENY ADJ CLAIM IF HIST PAID CLAIM ADJ TO $0) will post to deny the claim.

    c. ARC 8012 permits the provider to resubmit the claim as an outpatient claim within 60 days of the voided claim. If a voided claim is assigned ARC 8012, the provider must submit the new outpatient claim, along with the letter from the utilization review entity, and include Condition Code C3 and/or the ICN of the voided claim. The new outpatient claim must be submitted within 60 days from the voided date of the original claim (the date the payment was taken back by ODM) to allow for the timely filing edits to be bypassed. If the voided claim contains multiple dates of service, the provider can bill for all services rendered on the date of admission, but the provider can only bill for laboratory and radiology services rendered on dates of

service subsequent to the date of admission. If the provider fails to resubmit the claim in accordance with the criteria set forth in ARC 8012, audit 5044 (UR-DENY INPATIENT CLM IF RESUBMIT AS OUTPATIENT), audit 5046 (UR-DENY CLAIM WHEN 60 DAY FILING LIMIT EXCEEDED), or audit 5048 (UR-INVALID INPATIENT PROCEDURE/DOS COMB BILLED) will post to deny the claim. Do not use the 6653 form or process when resubmitting the claim. When resubmitting the claim through the MITS web portal, click on the dropdown box and select "support data for claim", then upload your attachment and click on the submit button.

NOTE: If the original claim was voided due to utilization review using ARC 8008 or 8012 but the provider failed to resubmit the claim with attachments, audit 5047 (UR-RESUBMITTED CLAIM WITH NO ATTACHMENTS) will post to deny the claim.

2) Payments for inpatient psych stays that have been recouped due to utilization review will NOT be assigned ARC 8008 or 8012. When resubmitting the claim after the payment recoupment, please include Condition Code C3 on the claim along with the following attachments:
   a. ODM 06653 Medical Claim Review Request Form
   b. Permedion Letter
   c. Remittance Advice indicating recoupment of payment

Effective for services rendered on or after January 1, 2016, per OAC rule 5160-2-07.13, upon utilization review of Medicaid inpatient hospital services, for those claims recouped for a technical denial (ARC 8010), ODM or its medical review entity may recover physician payments for services associated with the recouped inpatient claim payment that resulted from utilization review.

### 2.1.4 Utilization Review – Third Party Liability Post Payment Review

The Department has contracted with Health Management Systems, Inc. (HMS) to supplement its Medicaid third party liability (TPL) recovery activities. Following their claim review, HMS will issue a notice of its findings. Hospitals have 90 days from the date of the notice to:

1) Review its records;
2) Bill the respective commercial carrier, if it has not already done so; and
3) Forward documentation to HMS to either refute the impending recoupment action for every claim the commercial carrier denies or confirm receipt of payment from the third party to validate the impending recoupment.

Failure to respond to or provide proper justification for removing a claim from this initiative will result in the payment being recouped via the claims down adjustment process at the close of the cycle. In order to rebill the claim(s), providers must first seek authorization through HMS to validate the request. Providers who have repeatedly neglected to respond to recoupment cycles may be prevented from rebilling claims. The following documentation should be provided to HMS, when seeking to rebill the Department for refund or payment as secondary:

1) A copy of the cycle detail, highlighting the recipient name and date of service; and
2) A copy of the explanation of medical benefits (EOMB) letter from the third party, reflecting the status of the claim(s).

This information should sent, by fax, to the HMS Recoupment Team at (877) 256-1226 with the subject line "Refund" or "Payment as Secondary," whichever applies. Please note that the list of valid requests is sent to ODM for action on the last Friday of each month. The list of ICNs is then removed by ODM from the table and will be given a new ICM number that starts with the region code 56. This new ICN number will be on a remittance advice and is to be put on the claim in the Portal when reprocessing.

When submitting your new claim to the Department via the web portal, put the ICN number with the region n code 56 from your remittance advice in the supporting data for delayed resubmission field. When submitting via EDI, you must include the ICN number of the recoupment claim in the REF Segment P4. The claim will deny for timely filing if this is not included. After those steps are complete, follow the prompts until completion of your claim.

In the event you are still experience problems, complete the ODM 06653 form. In section 6 of this form ("Explanation of the Request"), put the statement "This is part of the HMS takeback process." Include the takeback EOMB/letter from HMS with the submission of the ODM 6653 form. When selecting the 'ATTACHMENTS' panel in the MITS Web Portal, locate the 'TYPE OF DOCUMENT' field and choose 'REFERRAL FORM (OHIO 6653)' from the dropdown menu. This will allow the provider's attachments to connect to the claim record, and suspend as designed for manual review.

For all claims, which includes hospital claims that are reviewed for another primary payer, HMS determines if a provider is allowed to resubmit a claim to the Department for payment. The following EOBs will be assigned accordingly, and will only allow claims to be resubmitted as indicated.

1) EOB 8200: TPL Contractor recovery because Medicare is primary. Provider is not able to adjust claim and must contact TPL Contractor.
2) EOB 8201: TPL Contractor recovery because a Commercial Insurance is primary. Provider is not able to adjust claim and must contact TPL Contractor.
3) EOB 8210: TPL Contractor take reversal – Provider is able to resubmit for Medicare Cost Sharing.
4) EOB 8211: TPL Contractor take reversal – Provider is able to resubmit for Commercial Insurance Cost Sharing.

NOTE: When a claim is allowed to be resubmitted, and EOB 8210 or 8211 has been assigned, the resubmitted claims MUST include the ICN of the recoupment claim in the REF Segment P4. The resubmitted claim will deny for timely filing if this is not included.

## 2.2 TRANSFER BILLING

Please refer to OAC rule 5160-2-65 for ODM requirements regarding transfer billing.

### 2.2.1 Transfer between Acute Care and Medicare Distinct Part Psychiatric Units

When a transfer occurs between an acute care unit and a Medicare-approved distinct part psychiatric unit within the same hospital, one of the following billing situations will occur:

1) The stay in the two units will be considered one admission for payment purposes if either of the following is true:

    - The DRGs for both episodes of care fall within the range of APR-DRGs 750 – 760 (psychiatric DRGs); or
    - The DRGs for both episodes of care fall outside the range of APR-DRGs 750 – 760 (non-psychiatric DRGs)

    In either of these situations, the hospital must combine the two episodes of care into one admit through discharge claim.

2) If the stay in the two units does not meet the criteria in the above paragraph, the two stays will be treated as two separate admissions for payment purposes and should be submitted as separate claims. A payment will be made for services rendered in the acute care section (APR-DRG 1 – 740 and 770 – 952) as well as for psychiatric services provided in the psychiatric distinct part unit (APR-DRG 750 – 760).

    Complete a separate claim for each stay according to the billing instructions except for the following:

    For the acute care stay:

    - Use Type of Bill 111
    - Enter the beginning and ending service dates to reflect the stay in the unit for the Statement Covers Period
    - Complete Patient Discharge Status as appropriate (example: use Patient Discharge Status 65 if leaving the acute care stay to be admitted to the psychiatric stay.)

    For the psychiatric stay:

    - Use Type of Bill 111
    - Enter the beginning and ending service dates to reflect the stay in the unit as the Statement Covers Period
        - The "from" date must equal the date of discharge on the acute care stay claim
    - Complete Patient Discharge Status as appropriate
    - Please note that a pre-certification is required for all psychiatric stays, regardless

of the patient's acute care stay.

### 2.2.2 MULTIPLE TRANSFERS BETWEEN ACUTE CARE AND MEDICARE DISTINCT PART PSYCHIATRIC UNITS

When a patient stay involves more than one transfer to or from a distinct part psychiatric unit, providers will need to combine the two separate stays of the same unit. In such cases, there are at least two separate episodes of care in either the acute or psychiatric unit, and possibly in both (e.g., 3 days in acute unit - 2 days in psychiatric unit - 2 days in acute unit). Using this example, the two separate stays in the acute unit can be combined into one claim, reporting the days in the psychiatric unit as non-covered days <u>and including the charges as both total and</u> non-covered.

Complete a separate claim for each stay according to the billing instructions except for the following:

For the acute care stay (using the example noted above):

- Use Type of Bill 111
- Enter the beginning and ending service dates to reflect both stays in the unit for the Statement Covers Period
- Covered days: 5
- Non-covered days: 2 <u>(while in psychiatric unit)</u>
- In the claim detail, report covered <u>days with associated charges on one line,</u> and non-covered days <u>(RCC 180) along with the associated</u> charges <u>included as total charges and non-covered charges</u> on a separate line.
- Complete Patient Discharge Status as appropriate

For the psychiatric stay:

- Use Type of Bill 111
- Enter the beginning and ending service dates to reflect the stay in the unit as the Statement Covers Period
  - The "from" date must equal the date of discharge on the acute care stay claim
- Complete Patient Discharge Status as appropriate

### 2.2.3 TRANSFERS BETWEEN ACUTE AND DISTINCT PART REHABILITATION UNITS

Medicaid does not recognize distinct part rehabilitation units as a separate unit of the hospital. A complete admit through discharge claim must be submitted to ODM when a patient is transferred between the acute care unit and rehabilitation unit within the same hospital. For hospitals that internally generate two claims for these stays, collapse them into one claim prior to submission to ODM.

## 2.3 INTERIM BILLING INSTRUCTIONS

According to OAC rule 5160-2-65, claims qualify for advance interim payment on the 30th day of a consecutive inpatient stay and at 30-day intervals thereafter. All claims for advance interim payment can be submitted via EDI or through the ODM MITS Web Portal.

To receive an interim payment, complete the claim for submission to Medicaid according to the following guidelines:

For hospitals paid under the prospective payment system (DRG):

- Use Type of Bill 112 or 113 (as defined by the NUBC)
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type
    - For 113 bill types, the admission date is not required to fall within the "Statement Covers Period" date span
- Covered days must be equal to or greater than 30 days
- Use Patient Status Code 30 (still patient)

Once the patient is discharged, all interim bills must be voided before the final admit through discharge bill can be submitted. The interim bills can be voided/reversed through an EDI transaction or through the ODM MITS Web Portal. The final bill must be a complete admit through discharge bill (111 bill type) reiterating all charges submitted on prior advance interim bills.

For hospitals that are exempt from DRG-based reimbursement:

- Use Type of Bill 112 or 113 (as defined by the NUBC)
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type
    - For 113 bill types, the admission date is not required to fall within the "Statement Covers Period" date span
- Covered days must be equal to or greater than 30 days
- Use Patient Status Code 30 (still patient)

As a final bill, DRG exempt providers are to submit a Type of Bill 114 with the remaining days and charges since the last interim bill (it would not have to be 30 days).

## 2.4 BILLING FOR SERVICES REQUIRING SPECIAL DOCUMENTATION

### 2.4.1 ABORTIONS

Please refer to OAC rule 5160-17-01 for ODM requirements regarding reimbursement of abortion procedures. The requirements of OAC rule 5160-17-01 apply only to those abortions, which are

induced, and not to those of a spontaneous nature which are normally otherwise defined as miscarriages.

Reimbursement for abortion services is restricted to the following circumstances:

1) Instances in which the mother suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself; or
2) Instances in which the pregnancy was the result of an act of rape; or
3) Instances in which the pregnancy was the result of an act of incest.

In cases of medical procedures, which include abortions, in which the life of the mother would be endangered if the fetus was carried to term, the Department must receive written certification from the physician attesting that the life of the mother would be endangered if the fetus was carried to term before any payment may be made. If space permits, the certification should be placed in the "Remarks" column of the claim. The certification can either be in typewritten or stamped form along with the physician's signature. All certifications must contain the address of the recipient.

The certification must be as follows:

> "I certify that, on the basis of my professional judgment, this service was necessary because the life of the mother would be endangered if the fetus were carried to term."

Invoices for abortion services subject to the above requirements must be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately. Reimbursement will not be made for hospital services, associated services, or laboratory tests if the abortion service is not eligible for reimbursement, regardless of whether or not the abortion itself is billed to the Department.

### 2.4.2 STERILIZATION

Please refer to OAC rule 5160-21-02.2 for ODM requirements regarding reimbursement of sterilization procedures. The OMB 0937-0166 Consent for Sterilization Form must be attached to all claims for sterilization procedures. The Consent for Sterilization Form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. In order for the sterilization services to be reimbursed, the date of the informed consent must occur at least 30 days, but not more than 180 days, prior to the date of the sterilization; this is not applicable in cases of premature delivery or emergency abdominal surgery. These claims can be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

### 2.4.3 HYSTERECTOMY SERVICES

Please refer to OAC rule 5160-21-02.2, which describes the requirements regarding reimbursement for hysterectomy services. All invoices submitted to the Department for hysterectomies (whether performed as a primary or secondary procedure) or for medical procedures directly related to such hysterectomies, must include a copy of the ODM 03199 Acknowledgement of Hysterectomy Information Form. A consent form must be completed when a recipient is eligible for both the Medicare and Medicaid programs and requires a hysterectomy. However, a hysterectomy consent form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. The completed consent form does not have to be submitted with the Medicare crossover claim, but must be forwarded separately to Medicaid as an attachment. If the claim is rejected by Medicare, submit a Medicaid claim with the Medicare rejection attached. In the "Provider Remarks" section of the invoice, enter the following: Consent form submitted (date submitted).

All hysterectomies (inpatient and outpatient) also require prior authorization. Prior authorization allows all providers the opportunity to submit a prior authorization request, even retrospectively. Please note that condition code "AN" will not bypass the prior authorization requirement.

All invoices for hysterectomies, along with an attached ODM 03199 Acknowledgement of Hysterectomy Information Form, can be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

## 2.5 TRANSPLANTS

Effective with the implementation of the APR-DRGs and in accordance with OAC rule 5160-2-65, all transplant services are subject to DRG prospective payment.

In order to receive reimbursement for organ acquisition charges, the charges must be reported using revenue center code "810 - Organ Acquisition, General Classification." Please note that kidney transplants are not subject to additional reimbursement for organ acquisition.

Prior Authorization for transplants must be requested directly from the appropriate consortium:

Ohio Solid Organ Transplantation Consortium
9200 Memorial Dr.
Plain City, Ohio 43064
Telephone: 614-504-5705
FAX: 614-504-5707

Ohio Hematopoietic Stem Cell Transplant Consortium
9500 Euclid Avenue, Desk R32

Cleveland, Ohio 44195
Telephone: 440-585-0759
FAX: 440-943-6877

Transplant claims can be submitted via EDI or through the ODM MITS Web Portal. The assigned prior authorization number must be included on the claim.

## 2.6 PARTIAL ELIGIBILITY

In the case of patients whose Medicaid eligibility does not cover the entire hospitalization, payment for the stay will be made on a per diem basis. However, the entire stay must be reflected in the Statement Covers Period. The covered and non-covered days must also be correctly completed to reflect the date span of the stay that is shown in Statement Covers Period/Dates of Service. Days the patient is not Medicaid eligible should be reported as non-covered.

Example for partial eligibility stay:

- Use Type of Bill 11X
- Enter the beginning and ending service dates to reflect the entire stay in the Statement Covers Period
- The date of discharge is never counted in covered or non-covered days
- Covered days: Number of days eligible
- Non-covered days: Number of days not eligible
- In the claim detail, report covered days with associated charges on one line, and on a separate line include non-covered days (RCC 180) along with the associated charges included as total charges and non-covered charges

Per diem payments are calculated by multiplying the hospital-specific base rate times the relative weight for the DRG, and dividing that value by the average length of stay for that DRG. Payment for the stay is the per diem amount times the number of days of the stay for which the patient was Medicaid eligible, plus applicable medical education (medical education times the DRG relative weight) and capital add-on amounts, not to exceed the DRG maximum. Partial eligibility cases may also qualify for additional payment in the form of outlier payments.

## 2.7 NON-EMERGENCY CO-PAY

Please refer to OAC rule 5160-2-21.1 for ODM requirements regarding reimbursement of non-emergency co-pay.

Effective for dates of service on or after January 1, 2006, Medicaid consumers are required to pay a co-payment equal to three dollars for non-emergency emergency department services, except as excluded in OAC rule 5160-1-09 as listed below.

Co-payments must not be charged if the consumer is:

- Under the age of 21, or
- In a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID), or
- Receiving emergency services, or
- A female who is pregnant or has post-partum coverage, or
- Receiving hospice care.

For non-emergency services sought in the emergency department (procedure codes 99281-99285), please indicate a $3.00 co-pay, which is assessed by adding the following in the remarks field on the claims, "COPAY_NEMR" (note: _ indicates space). The Department shall reimburse the emergency department claim the allowable Medicaid payment minus the applicable co-payment and any third party resources available to the patient.

## 2.8 OUTLIER PAYMENTS

### 2.8.1 SERVICES PROVIDED ON OR AFTER JULY 1, 2013

For services provided on or after July 1, 2013, the following outlier methodology applies, as described in rule 5160-2-65 of the OAC.

1) Calculate Claim Costs
    - Claim Cost = (Allowed Charges – RCC 810) * Hospital-Specific CCR
        - Allowed Charges = (Billed Charges – Non-Covered Charges)
        - CCR = Cost-to-Charge Ratio
2) Select Fixed Outlier Threshold
    - Trach DRGs (004 & 005), Neonate DRGs (580 - 639) $42,900.00
    - Hospitals in either the Major Teaching or Children's peer groups $54,400.00
    - All other DRGs/peer groups $68,000.00
        - A claim qualifies for only one threshold as determined in the order shown.
3) Conduct Outlier Qualification Test
    - Is Claim Cost > [(Hospital-Specific Base Rate * DRG/SOI Rel. Wgt. ) + Fixed (Outlier) Threshold]
    - If YES, claim qualifies for an outlier add-on payment
        - See #4 for outlier add-on payment calculation
        - See #5 for total claim payment calculation
    - If NO, calculate standard APR-DRG reimbursement
        - Standard APR-DRG reimbursement = #5 minus Outlier Add-On
    - SOI = Severity of Illness
4) Computation of Outlier Payment
    - Outlier Add-On Payment = [Cost of Case – ((Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + Fixed (Outlier) Threshold)] * <u>90%</u>
        - Cost of Case = [(Covered Charges – RCC 810) * Hospital-Specific CCR]
5) Total Claim Payment = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + (Medical

Education Add-On * DRG/SOI Rel. Wgt.) + Capital Add-On + Outlier Add-On (if applicable) + Non-Outlier Add-On (Organ Acquisition Costs or Charges, if applicable)

Please note:

1) Transfer/Partial Eligibility Pricing Calculation
   - Please refer to OAC rule 5160-2-65(N)(3) for ODM requirements regarding transfer pricing.
   - Please refer to OAC rule 5160-2-65(N)(4) for ODM requirements regarding partial eligibility pricing.
   - Per Diem calculation was updated to use Average Length of Stay (ALOS) instead of from Geometric Mean Length of Stay
   - Transfer Payment Logic: Transfers will be paid the lessor of the [Transfer Base or DRG Base] plus Capital Add-On, Medical Education Add-On and Outlier Add-On (if applicable)
     - A) Transfer Base = Transfer Per Diem * Covered Days
     - Transfer Per Diem = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) / DRG/SOI ALOS
     - B) DRG Base = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.)
     - C) Partial Eligibility Base = Transfer Per Diem * Number of Medicaid Eligible Days
   - Total Transfer Payment = Lessor of A or B + Capital Add-On, Medical Education Add-On & Outlier Add-On (if applicable)
   - Partial Eligibility Payment = Lessor of C or B + Capital Add-On, Medical Education Add-On & Outlier Add-On (if applicable)
2) Transplant Pricing Logic using RCC 810 (organ acquisition costs/charges) remains unchanged
   - Transplants with 100% Charge application for RCC 810: APR-DRG 1, 2, & 6 with SOIs
   - Transplants with 100% Cost application for RCC 810: APR-DRG 3 with SOIs

## 2.9 MEDICARE / THIRD PARTY LIABILITY

For claims where Medicare is primary, Medicaid reimbursement for hospital services covered by Medicare Part A and Part B will be equal to the lesser of:

1) The sum of the deductible, coinsurance, and co-payment amount as provided by Medicare; OR
2) The Medicaid maximum allowed amount, minus the total prior payment, not to equal less than $0.00.
3) If Medicare has already paid more than the Medicaid Maximum, Medicaid's payment will be $0.00.

Please refer to OAC rule 5160-2-25, Coordination of benefits: hospital services, for further details on how Medicaid will process claims with Medicare as the primary payer.

### 2.9.1 Medicare Part A Exhausted During Stay or Medicare Becomes Effective During Admission

For an inpatient stay, in which a patient's Medicare Part A exhausts during the stay and Medicaid becomes primary with Medicare Part B, OR Medicare Part A eligibility starts after an admission and Medicaid is primary with Part B before Part A eligibility starts.

In this situation, three claims will be submitted to Medicaid:

1) Medicare Part A cost sharing, Bill Type 111 (normal crossover claim)
   a. Using Medicare billing guidelines, Medicare Part A is billed first, and then the claim is submitted to Medicaid for cost sharing.
2) Medicare Part B cost sharing, Bill Type 121 (normal crossover claim)
   a. After Medicare Part A is exhausted, using Medicare billing guidelines, all covered services under Part B are submitted to Medicare Part B. The claim is then submitted to Medicaid for cost sharing.
3) Medicaid as primary for days Medicare Part A is exhausted or not eligible, Bill Type 111
   a. The Statement Covers Period/"Admit through discharge" is for the entire stay.
   b. Include Occurrence Code A3 with the Medicare Part A exhaust date.
   c. Covered days are the days in which Medicaid was primary.
   d. Non-covered days (RCC 180) should equal the days Medicare Part A was primary.
      i) At the detail level, any days listed as non-covered must have a separate line with matching units indicating total charges and listed again as non-covered charges. (Covered days would be billed as normal at the detail.)
   e. Any charges submitted to Medicare Part A or Part B, must be reported at the detail as non-covered charges OR they must be removed from the claim completely. (Except for charges reflecting non-covered days, these must be reported as mentioned above and cannot be removed from the claim.) You do not include any other payer information, and you do not include any other payments.
   f. Since Medicaid is primary, do not include any other payer information or any other payments. Do not include any payments received from Medicare Part A or Part B on this claim.

### 2.9.2 Medicaid Primary with Medicare Part B Only

For an inpatient stay, in which a patient has Medicaid primary and only has Medicare Part B. The patient could have had Medicare Part A but it exhausts prior to the inpatient stay.

In this situation, two claims may be submitted to Medicaid:

1) Medicare Part B Cost sharing, Bill Type 121 (normal crossover claim):
   a. Medicare Part B is billed first, and then the claim is submitted to Medicaid for cost sharing.
2) Medicaid as primary for all other charges, Bill Type 111:
   a. If Medicare Part A exhausted before the inpatient stay, please include Occurrence

Code A3 with the exhaust date.

b. Report all charges submitted to Medicare Part B as total charges and non-covered charges, OR remove the charges submitted to Medicare Part B from the Medicaid claim entirely (these charges were submitted to Medicare Part B on Bill Type 121).
c. Submit the claim to Medicaid as usual, according to the billing guidelines.
d. Since Medicaid is primary, do not include any other payer information or any other payments. If there is another payer besides Medicare Part B, then Medicaid is not primary. Do not include any payments received from Medicare Part B on this claim.

### 2.9.3 QMB Exhausts Medicare Part A

QMB members do not have Medicaid coverage; therefore, Medicaid has no payment liability until a 'QMB Beneficiary' is determined eligible for Medicaid.

### 2.9.4 Third Party Liability/Coordination of Benefits

For claims where another payer is primary, Medicaid's reimbursement for hospital services will be no more than the Medicaid Maximum. If the prior payer has already paid more than the Medicaid Maximum, Medicaid's payment will be $0.00. Please refer to OAC rule 5160-2-25 for further clarification regarding Medicaid reimbursement policies for hospital services subject to reimbursement from other payers.

## 2.10 Present on Admission Indicator

In accordance with federal regulations (42 CFR § 447.26), payment for provider-preventable conditions are prohibited. Therefore, the NUBC instructions require the collection of Present on Admission (POA) indicators on all claims for inpatient hospital services. Although Medicare exempts certain types of hospitals from POA reporting, OAC rule 5160-1-02 explicitly prohibits payment for hospital acquired conditions. As a result, ODM does not exempt any hospital from reporting POA indicators as the POA indicator is a crucial part of identifying hospital acquired conditions.

A non-reimbursable hospital condition can only be identified in one of two ways:

1) The POA indicator, or
2) The retrospective review process

In the case that a claim is missing a POA indicator and ODM reimburses the hospital for those services, the claim will be recouped during retrospective review as it lacked the POA indicator.

## 2.11 Inpatient Hospital Stay with Outpatient Services

Please refer to OAC rule 5160-2-02 for ODM requirements regarding reimbursement for outpatient services during an inpatient stay. Inpatient services include all covered services provided to patients during the course of their inpatient stay, whether furnished directly by the hospital or under arrangement, except for direct-care services provided by physicians, podiatrists, and dentists. If a patient receives outpatient services from another hospital before he/she is discharged from the inpatient stay, the inpatient hospital should submit an invoice that includes both inpatient and outpatient services. Although the inpatient hospital submits the claim, the outpatient hospital will be reimbursed by the inpatient hospital for those outpatient services.

If the outpatient hospital submits the claim separately to ODM before the inpatient hospital submits their claim, the inpatient claim will be deemed as a duplicate claim and will be denied payment. The inpatient hospital will need to work with the outpatient hospital to pay the outpatient visit and to have them void their paid claim for the outpatient service. The inpatient hospital should then resubmit the claim to ODM so that it includes inpatient and outpatient services.

## 2.12 NURSING FACILITY

Please refer to OAC rule 5160-3-16.4 for ODM requirements regarding nursing facility (NF) reimbursement.

### 2.12.1 HOSPITAL LEAVE DAYS

NFs may be paid for Hospital Leave Days at a reduced daily rate to reserve a bed for the resident who intends to return to that facility following a hospitalization. If a resident is in the NF for eight hours or more on the day they were transferred to the hospital or readmitted from the hospital, the NF is eligible for reimbursement at the full per diem rate instead of the Leave Day rate. Medicaid NF residents are eligible for up to 30 Leave Days per calendar year.

Claim Denials – Possible Duplicates:

When billed correctly, the Hospital and NF Leave Days billed in common will bypass the duplicate claim edit, except for HCBS Waiver consumers in a short-term NF stay.*

*Please note that MITS was not initially designed to cover Leave Days for HCBS Waiver Consumers in a NF for a short-term stay. Revisions to the applicable OAC rule and MITS are underway to allow for future coverage of such Hospital Leave Days. NFs must continue to bill all Hospital Leave Days with RCC 185 even though this code is not currently set to pay for Waiver Consumers. NFs must not bill Leave Days with RCC 160, as doing so will result in overpayment to the NF at 100% of the per diem rate and the corresponding hospital claim will deny.

NF Billing Scenarios:

Scenario 1: NF resident to Hospital for more than two days

A NF resident who is hospitalized on the 5th of January and returns to the NF on the 18th

1A) Resident in NF less than eight hours on date of transfer to hospital
Line 1) 01/01/2015 – 01/04/2015 Revenue Center Code (RCC) 101
*Line 2) 01/05/2015 – 01/17/2015 RCC 185 (hospital leave days)*
Line 3) 01/18/2015 – 01/31/2015 RCC 101

1B) Resident in NF for eight hours or more on date of transfer to hospital
Line 1) 01/01/2015 – 01/05/2015 RCC 101
*Line 2) 01/06/2015 – 01/17/2015 RCC 185 (hospital leave days)*
Line 3) 01/18/2015 – 01/31/2015 RCC 101

Scenarios 1A and 1B illustrate the difference in billing for a full day versus a Leave Day on the day of hospital admission. A full covered day may be billed (RCC 101) for the day the resident returns to the NF if they are in the NF for eight hours or more that day. Billing properly allows the duplicate edit to be bypassed so that both the NF and hospital can be paid appropriately for the covered days they bill in common.

Scenario 2: NF resident to Hospital for overnight stay

A NF resident who is hospitalized on the 13th of March and returns to the NF on the 14th

2A) Resident in NF less than eight hours on date of transfer to hospital
Line 1) 03/01/2015 – 03/12/2015 RCC 101
*Line 2) 03/13/2015 – 03/13/2015 RCC 185 (hospital leave day)*
Line 3) 03/14/2015 – 03/31/2015 RCC 101

2B) Resident in NF eight hours or more on date of transfer to hospital
Line 1) 03/01/2015 – 03/13/2015 RCC 101
Line 2) 03/14/2015 – 03/31/2015 RCC 101

Scenario 2B illustrates that the dates must be split into two different detail lines, even though no Leave Days are being billed. A full covered day may be billed (RCC 101) for the day the resident returns to the NF if they are in the NF for eight hours or more that day. Splitting the covered days into two different lines allows the duplicate edit to be bypassed so that both the NF and hospital can be paid appropriately for the covered days they bill in common.

Scenario 3: Waiver Consumer in NF for short-term stay to Hospital for more than two days: Consumer is hospitalized on the 5th of January and returns to the NF on the 18th.

3A) Waiver Consumer in NF less than eight hours on date of transfer to hospital

Line 1) 01/01/2015 – 01/04/2015 RCC 160
*Line 2) 01/05/2015 – 01/17/2015 RCC 185**
Line 3) 01/18/2015 – 01/31/2015 RCC 160

3B) Waiver Consumer in NF eight hours or more on date of transfer to hospital
Line 1) 01/01/2015 – 01/05/2015 RCC 160
*Line 2) 01/06/2015 – 01/17/2015 RCC 185**
Line 3) 01/18/2015 – 01/31/2015 RCC 160

Scenarios 3A and 3B illustrate the difference in billing for a full day versus a Leave Day on the day of hospital admission. RCC 160 must be billed instead of RCC 101 for HCBS Waiver consumers in a short-term NF stay (i.e., consumers with an active waiver span for DOS billed by NF). Hospital Leave Days must be billed with RCC 185.

Scenario 4: Waiver Consumer in NF for short-term stay to Hospital for an overnight stay: Consumer is hospitalized on the 13th of March and returns to the NF on the 14th

4A) Resident in NF less than eight hours on date of transfer to hospital
Line 1) 03/01/2015 – 03/12/2015 RCC 160
*Line 2) 03/13/2015 – 03/13/2015 RCC 185**
Line 3) 03/14/2015 – 03/31/2015 RCC 160

4B) Resident is in NF eight hours or more on date of transfer to hospital
Line 1) 03/01/2015 – 03/13/2015 RCC 160
Line 2) 03/14/2015 – 03/31/2015 RCC 160

Scenario 4B illustrates that the dates must be split into two different detail lines, even though no Leave Days are being billed. Splitting the covered days into two different lines allows the duplicate edit to be bypassed so that both the NF and hospital can be paid for the date of admission (3/13/2015). RCC 160 must be billed instead of RCC 101 for HCBS Waiver consumers in a short-term NF stay (i.e., consumers with an active waiver span for DOS billed by NF). Hospital Leave Days must be billed with RCC 185.

### 2.12.2 READMISSIONS TO A HOSPITAL

If a consumer is an inpatient in a hospital, is discharged, then subsequently re-admitted to the same hospital within a day, the hospital must collapse the two inpatient stays into one admit through discharge claim. The hospital must report one non-covered day at the header, and use Revenue Code 180 to report a non-covered day at the detail.

For example, if the consumer is hospitalized 1/1/2015 and is discharged to a NF on 1/5/2015, then re-admitted to the hospital on 1/6/2015, the hospital must report one non-covered day for

the first date of discharge (1/5/2015) at the header, and one non-covered day at the detail level, RCC 180.

If the hospital claim denies as a duplicate against the corresponding NF claim due to the overlapping date of service (1/5/2015 in this example), the hospital should contact Provider Assistance at 1-800-686-1516.

### 2.12.3 Nursing Facility Bundling

If a NF resident goes to an outpatient hospital and receives any of the services specified below, then the hospital should bill the NF for those specific services. Since ODM reimburses NFs by a per diem rate, the NFs are responsible for reimbursing the provider for these particular services. If the hospital bills ODM for any of these specific services, the claim will be denied. The hospital should remove the specific service codes from the claim and submit these charges to the NF. Once these specific codes are removed from the claim, then the claim can be resubmitted to ODM for payment for the other services provided on that day.

Specific therapy codes that are included in the NF per diem bundled rate (hospital must not bill ODM):

92502 92507 92508 92521 92522 92523 92524 92526
92551 92552 92555 92556 92557 92610 97001 97002
97003 97004 97010 97014 97016 97018 97022 97024
97026 97028 97032 97033 97034 97035 97036 97110
97112 97113 97116 97124 97140 97150 97530 97532
97533 97535 97542 97750 97760 97761 97762

Please note that custom wheelchairs, medically necessary wheelchair van and ambulance transportation, and oxygen (except emergency oxygen) are no longer bundled into the NF per diem rate.

## 2.13 Changes in Patient's Medicaid Coverage

Please refer to OAC rule 5160-26-02(D) for ODM requirements regarding payment responsibility for a patient whose Medicaid coverage changes during an inpatient hospital stay.

| Admit Plan | Enrollment Change | Responsible Plan* |
|---|---|---|
| FFS | FFS -> MCP | FFS |
| MCP | MCP -> FFS | MCP |
| $MCP_1$ | $MCP_1$ -> $MCP_2$ | $MCP_1$ |

** Responsible for the inpatient facility charges through the date of discharge. All other medically necessary services, i.e., Physicians & other Professionals, are the responsibility of the enrolled plan based on the date of service by the professional.*

*In the situation where there are outpatient services within three days of the admission date and the patient also changes Medicaid coverage on the same day as the admission, the outpatient services would not be bundled into the inpatient claim. Refer to Section 2.16.1 for additional details.*

## 2.14 MODIFIERS

Please refer to Appendix A to OAC rule 5160-2-21 for the list of modifiers that affect reimbursement in the outpatient hospital setting. All modifiers are accepted, but only the modifiers listed on Appendix A will affect reimbursement.

### 2.14.1 MODIFIER 50

Modifier 50 is an accepted modifier on hospital claims. However, it is informational only and will not affect reimbursement of the procedure or the claim.

When submitting a claim with multiple surgeries, submit the surgical CPT code on two separate detail lines on the claim. Per OAC rule 5160-2-21(F)(2)(b), ODM's payment logic for multiple surgeries is programmed to reimburse the highest paid surgery at 100% of the fee schedule amount and each additional surgery on the claim at 50% of the fee schedule amount. If the multiple surgical procedures are submitted on the same detail line, the multiple surgical procedure payment logic will not be applied to the claim. Please note that for all other procedures (ancillary, labs, etc.), multiple identical procedures must be submitted on one detail line with multiple units, otherwise that date of service will deny due to duplicate procedures.

### 2.14.2 MODIFIER 59

Modifier 59 is an accepted modifier on hospital claims. However, it is informational only, and will not affect reimbursement of the procedure or the claim.

### 2.14.3 MODIFIER 73

Modifier 73 should be used when a surgery is canceled prior to the administration of anesthesia.

### 2.14.4 MODIFIER 74

Modifier 74 should be used when a surgery is canceled after the administration of anesthesia.

## 2.15 LONG-ACTING REVERSIBLE CONTRACEPTIVES

Ohio Medicaid provides coverage for Long-Acting Reversible Contraceptives (LARCs) in the inpatient hospital setting immediately after a delivery or up to the time of the inpatient discharge for postpartum women, or at any time deemed medically necessary. LARC services are also covered by Ohio Medicaid when provided in an outpatient hospital or an independent professional setting. All claims for reimbursement of LARC services should follow correct coding conventions and be supported by the appropriate diagnosis and procedure codes.

### 2.15.1 INPATIENT HOSPITAL SETTING

When LARC services are provided in an inpatient hospital setting following a delivery, the hospital should use an ICD-10 delivery diagnosis code [or, for deliveries with inpatient discharge dates before October 1, 2015, an ICD-9 delivery diagnosis code] on the inpatient claim as well as the appropriate ICD-10/ICD-9 surgical procedure code to indicate an insertion of a contraceptive device. See the table below for the appropriate diagnostic and procedure codes needed to document that LARC services were provided. Per OAC rule 5160-2-65(E), for DRG hospitals, inpatient claims will process and pay in accordance with the All Patient Refined Diagnosis Related Group (APR-DRG) methodology. The cost of the device or drug implant is captured in the hospital's charges on the inpatient claim. No additional or separate payment will be made to the hospital for LARC inpatient services.

| **Long Acting Reversible Contraceptive (LARC)** | | | | |
|---|---|---|---|---|
| | ***Inpatient Hospital Setting*** | | | |
| | **ICD-9** | | **ICD-10** | |
| ***Insertion/Removal of:*** | ***Diagnostic*** | ***Procedural*** | ***Diagnostic*** | ***Procedural*** |
| **IUD** | V25.02, V25.11, V25.12, V25.13, V72.31, V25.42 | 69.7, 97.71 | Z30.013,Z30.014, Z30.018, Z30.019, Z30.430, Z30.432 (Encounter for Removal), Z30.433, Z01.411, Z01.419, Z30.431 (Encounter for routine checking of intrauterine contraceptive device) | 0UH97HZ, 0UH98HZ, 0UHC7HZ, 0UHC8HZ, 0UPD7HZ (Removal), 0UPD8HZ (Removal) |
| **Birth Control Implant** | V25.5, V25.02, V72.31, V25.43 | 99.23, 99.24, 86.09* | Z30.49 (Encounter for surveillance of other | 0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, |

| | | | contraceptives), Z30.013, Z30.017, Z30.018, Z30.019, Z01.411, Z01.419 | 0JHM0HZ, 0JHM3HZ, 0JHN0HZ, 0JHN3HZ |
|---|---|---|---|---|

** ICD-9 Procedural code 86.09 is a generic code that may be billed to capture insertion of a contraceptive implant.*

### 2.15.2 Physician Billing for LARC Services on a Professional Claim

For the LARC insertion procedure, the attending physician should bill Medicaid on a professional claim utilizing an appropriate ICD-10/ICD-9 diagnosis code and one of the CPT procedure codes listed in the table below. If the procedure is performed in a private physician's office and the practitioner supplies the IUD or other LARC, the practitioner may also bill for the device using the appropriate Healthcare Common Procedure Coding System (HCPCS) Level II procedure code listed below. Reimbursement for the drug/device will be made in accordance with the Medicaid Non-Institutional Maximum Payment Fee Schedule and the Provider Administered Pharmaceuticals Fee Schedule both of which are located under the Providers Tab on the Ohio Department of Medicaid's website (http://www.medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

| Long Acting Reversible Contraceptive (LARC) | |
|---|---|
| | ***Professional Billing*** |
| ***Insertion/Removal of:*** | **CPT/HCPCS** |
| **IUD** | 58300, 58301 (Removal), J7297, J7298, J7300, J7301, J7302 |
| **Birth Control Implant** | 11981, 11982 (Removal), 11983, J7307 |

Notes:

- *The diagnostic coding will vary, however, codes will usually be selected from the V25 series in ICD-9-CM or Z30 series in ICD-10-CM (Encounter for contraceptive management).*
- *Occasionally, ultrasound is needed to guide IUD insertion. It would be coded with CPT 76998 in an outpatient hospital or professional setting.*

### 2.15.3 Outpatient Hospital Setting

Ohio Medicaid will reimburse hospitals for the services associated with the insertion or implantation of a LARC device provided in an outpatient hospital setting in accordance with the Outpatient Hospital Fee Schedule, which is located under the Providers Tab on the ODM website. Any drugs, medical supplies (including the cost of the LARC) or routine ancillary services will be rolled into the surgical payment for reimbursement. The hospital would use the appropriate diagnostic and procedure codes listed below to capture the surgical procedure associated with the insertion of the LARC device:

| Long Acting Reversible Contraceptive (LARC) | | | |
|---|---|---|---|
| | Outpatient Hospital Setting | | |
| | ICD-9 | ICD-10 | CPT/HCPCS |
| *Insertion/Removal of:* | *Diagnostic* | *Diagnostic* | *Procedural* |
| **IUD** | V25.02, V25.11, V25.12, V25.13, V72.31, V25.42 | Z30.013, Z30.014, Z30.018, Z30.019, Z30.430, Z30.432 (Encounter for Removal), Z30.433, Z01.411, Z01.419, Z30.431 (Encounter for routine checking of intrauterine device) | 58300, 58301, J7297, J7298, J7300, J7301, J7302 |
| **Birth Control Implant** | V25.5, V25.02, V72.31, V25.43 | Z30.49 (Encounter for surveillance of other contraceptives), Z30.013, Z30.014 (Encounter for initial prescription of intrauterine contraceptive device), Z30.017, Z30.018, Z30.019, Z01.411, Z01.419 | 11981-11983, J7307 |

Hospitals may elect to independently bill the pharmaceutical or medical supply costs of the LARC in lieu of billing for the surgical procedure. In such cases, the provider would only bill for the LARC using RCC 636 with one of the valid J-codes listed above, and would not include any other procedures/services on the claim provided on the same date. Per OAC rule 5160-2-21(L), reimbursement for the independently billed drug/device are currently paid in accordance with the Provider-Administered Pharmaceuticals fee schedule.

## 2.16 BUDGET INITIATIVES EFFECTIVE JANUARY 1, 2016

### 2.16.1 THREE CALENDAR DAY ROLL-IN

Effective for admissions on or after January 1, 2016, per OAC rule 5160-2-02(B)(2), outpatient services provided within three calendar days prior to the date of admission will be covered as inpatient services; this includes emergency room and observation services. All outpatient services provided within three calendar days prior to the inpatient admission need to be included on the inpatient claim. The 'From Date' (statement covers period) should start with the first date of outpatient services and the 'Through Date' should be the date of discharge. The 'Admit Date' field should have the date the patient was admitted as an inpatient.

The only exception to the three calendar day roll-in policy is when a patient's Medicaid coverage changes on the date of an inpatient admission. All outpatient services provided within three calendar days prior to the inpatient admission should be submitted to the Medicaid plan (fee-for-service or managed care plan) that is responsible for the patient during those days. The inpatient claim should be submitted to the Medicaid plan (managed care plan or fee-for-service) that is responsible for the patient on the date of admission.

Claim Example (Medicaid primary for entire stay):

Dates outpatient services were rendered: 1/8 – 1/9

Dates of inpatient stay: 1/10 – 1/15

1. The Statement Covers Period/'Admit through Discharge' is for the entire stay. This should include the first date of outpatient services and the 'Through Date' should be the date of discharge.
    a. FDOS: 1/8
    b. TDOS: 1/15
2. The admission date is the date the patient was admitted as an inpatient.
    a. Admit Date: 1/10
3. Covered days are the inpatient days.
    a. Covered Days: 5 (the date of discharge is not included, so only count 1/10 – 1/14 as covered days. Outpatient visit days are not included.)
    b. Non-covered Days: 0
4. When reporting room accommodations at the detail, the units should equal the total days (covered + non-covered days) reported at the header. (Note: any days listed as non-covered must have a separate line with matching units indicating total charges and listed again as non-covered charges.)

### 2.16.2 RCC 25X and/or 636 with HCPCS J-Code or Q-Code

Please note that the Department is not updating how pharmaceuticals qualify for additional payment. Rather, the Department is updating its requirements for billing pharmaceuticals in the outpatient hospital setting.

There are only two instances in which pharmaceuticals qualify for additional payment: (1) The claim contains an IV therapy CPT code (96365, 96366, 96367, or 96368); (2) The claim does not contain dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services as defined in paragraphs (D) to (K) of OAC rule 5160-2-21 and therefore is considered independently billed as defined in paragraph (L) of OAC rule 5160-2-21.

Effective for dates of service on or after January 1, 2016, pharmaceuticals must be billed using RCC 25X and/or 636 with a provider-administered pharmaceutical HCPCS J-code or Q-code; those pharmaceutical line items will be paid in accordance with the Provider-Administered Pharmaceuticals fee schedule. Please note that the Provider-Administered Pharmaceuticals fee

schedule is only to be used for reimbursement rates of covered J-codes and Q-codes, not coverage policies of services in the outpatient hospital setting.

When an applicable HCPCS J-code or Q-code does not exist for the provider-administered pharmaceutical for the date of service or if the HCPCS J-code or Q-code is listed as "by report" on the Provider-Administered Pharmaceuticals fee schedule, then payment for those line items will be calculated by multiplying the charges on those line items by 60% of the hospital's outpatient cost-to-charge ratio. All HCPCS J-codes are covered in the outpatient hospital setting, but only provider-administered pharmaceutical HCPCS Q-codes are covered in the outpatient hospital setting. Please refer to Appendix I to OAC rule 5160-2-21 for a list of covered Q-codes in the outpatient hospital setting.

The Department recognizes that there may not be an applicable HCPCS J-code or Q-code for certain pharmaceuticals, which resulted in the option to submit RCC 25X without a HCPCS J-code or Q-code. However, the use of detailed billing (e.g., HCPCS J-code or Q-code) is required whenever applicable. If a detail line contains RCC 25X without a corresponding HCPCS J-code or Q-code then that claim may be targeted for retrospective review to determine whether an applicable HCPCS J-code or Q-code should have been submitted on the RCC 25X detail line.

Effective for dates of service on or after January 1, 2016, covered vaccine/toxoid CPT codes are reimbursable when submitted with RCC 25X or 636. Effective for dates of service on or after October 1, 2016, covered immune globulins, serum, and recombinant products CPT codes are reimbursable when submitted with RCC 25X or 636. Please refer to the outpatient ancillary services fee schedule (Appendix F to OAC rule 5160-2-21) for coverage and reimbursement rates for these codes.

## 2.17 National Correct Coding Initiative

Effective January 1, 2016, ODM will implement the edit and coding methodologies of the National Correct Coding Initiative (NCCI), which is a national program that consists of coding policies and edits. NCCI policies and edits are applied against claims for procedures/services performed by the same provider for the same consumer on the same date of service. The NCCI analyzes and edits claims based upon HCPCS/CPT codes reported by outpatient providers for procedures/services rendered to Medicaid consumers.

### 2.17.1 Edits

NCCI methodologies consists of two types of edits:

1) Procedure to Procedure (PTP): Edits that define pairs of HCPCS/CPT codes that should not be reported together. NCCI methodologies for this edit are applied to current and historical claims.

2) Medically Unlikely Edits (MUEs): Edits that define, for many HCPCS/CPT codes, the maximum number of units of service that are, under most circumstances, billable by the same provider, for the same consumer on the same date of service.

The following EOBs will be reported if a detail line on a claim has denied because of a PTP or MUE edit:

1) EOB 7222: The current procedure is denied based on an NCCI edit because this service is not payable with another service on the same claim for the same date of service.
2) EOB 7223: The current procedure is denied based on an NCCI edit because this service is not payable with another service on a history claim for the same date of service.
3) EOB 7224: A historical procedure for the same date of service would have been denied based on an NCCI edit because that service is not payable with this current service.
4) EOB 7227: The current procedure is denied based on an NCCI edit because the units of service exceed the medically unlikely limit per claim detail for the same date of service.

### 2.17.2 MODIFIERS

There are two Correct Coding Modifier Indicators (CCMI):

1) CCMI 0: The reported CPT codes should never be reported together by the same provider for the same consumer on the same date of service.
2) CCMI 1: The reported CPT codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers.

PTP edit files include a column which identifies whether the combination of CPT codes billed is allowed with a CCMI (O = not allowed, 1 = allowed, 9 = not applicable).

### 2.17.3 MODIFIER 59

Effective for claims with dates of service on or after January 1, 2016, the following modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported. NCCI will eventually require the use of these modifiers rather than modifier 59 with certain edits. The following modifiers may be utilized in lieu of modifier 59 whenever possible:

1) XE - "Separate Encounter: A service that is distinct because it occurred during a separate encounter." This modifier should only be used to describe separate encounters on the same date of service.
2) XS – "Separate Structure: A service that is distinct because it was performed on a separate organ/structure."
3) XP – "Separate Practitioner: A service that is distinct because it was performed by a different practitioner."
4) XU – "Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service."

### 2.17.4 MISCELLANEOUS

Billed detail claim lines with a unit-of-service value greater than the established MUE value for the HCPCS/CPT code OR a pair of HCPCS/CPT codes that should not be reported together will result in that detail line being denied for payment.

All currently active Medicaid PTP edits and MUEs, as well as information about the NCCI program are published on the Medicaid NCCI webpage at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/National-Correct-Coding-Initiative.html. These files are updated on a quarterly basis. The PTP edit files contain the effective date of every edit and the deletion date of prior edits. This information can be used to verify whether a particular PTP edit was valid on the date of service of the claim in question and whether use of a PTP-associated modifier would allow the claim to bypass the edit. The MUE edit files are applicable to claims processed in the current quarter and with dates of service in the current quarter. MUE edit files do not contain historical information.

It is important that providers access the Medicaid NCCI edit file at the above webpage and not the Medicare NCCI files on the CMS webpage. Medicaid NCCI edits are significantly different from Medicare NCCI edits.

## 2.18 PREGNANCY AND CHILD BIRTH DELIVERY

### 2.18.1 EARLY ELECTIVE DELIVERIES

Per OAC rule 5160-1-10, caesarean section, labor induction, or any delivery following labor induction is subject to the following criteria: (1) Gestational age of the fetus must be determined to be at least thirty-nine weeks or (2) If a delivery occurs prior to thirty-nine weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery. Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to thirty-nine weeks gestation that are not considered medically necessary are not eligible for payment.

### 2.18.2 GESTATIONAL AGE DIAGNOSIS CODES

ICD-10 has new diagnosis codes available that indicate the weeks of gestation of pregnancy. ODM will require that all claims for a delivery procedure (mother's claim, not child's claim) with a date of service (outpatient and professional), or date of discharge (institutional) on or after October 1, 2015 must include the weeks of gestation ICD-10 diagnosis code. This billing requirement will be effective with the ICD-10 compliance date of 10/1/2015.

The following table displays the ICD-10 diagnosis codes that must be present with a delivery procedure code beginning 10/1/2015. To allow providers six months to adjust to this ICD-10

billing requirement, the system logic to enforce this billing guidance will be set to post and pay starting 10/1/2015, and then set to deny for dates of service (outpatient and professional) or dates of discharge (institutional) on or after 2/1/2017.

| ICD-10 Diagnosis Codes | |
|---|---|
| Z3A.00 | Gestation not specified |
| Z3A.01 | Less than 8 weeks Gestation of Pregnancy |
| Z3A.08 | 8 weeks gestation of pregnancy |
| Z3A.09 | 9 weeks gestation of pregnancy |
| Z3A.10 | 10 weeks gestation of pregnancy |
| Z3A.11 | 11 weeks gestation of pregnancy |
| Z3A.12 | 12 weeks gestation of pregnancy |
| Z3A.13 | 13 weeks gestation of pregnancy |
| Z3A.14 | 14 weeks gestation of pregnancy |
| Z3A.15 | 15 weeks gestation of pregnancy |
| Z3A.16 | 16 weeks gestation of pregnancy |
| Z3A.17 | 17 weeks gestation of pregnancy |
| Z3A.18 | 18 weeks gestation of pregnancy |
| Z3A.19 | 19 weeks gestation of pregnancy |
| Z3A.20 | 20 weeks gestation of pregnancy |
| Z3A.21 | 21 weeks gestation of pregnancy |
| Z3A.22 | 22 Weeks gestation of pregnancy |
| Z3A.23 | 23 Weeks gestation of pregnancy |
| Z3A.24 | 24 Weeks gestation of pregnancy |
| Z3A.25 | 25 Weeks gestation of pregnancy |
| Z3A.26 | 26 Weeks gestation of pregnancy |
| Z3A.27 | 27 Weeks gestation of pregnancy |
| Z3A.28 | 28 Weeks gestation of pregnancy |
| Z3A.29 | 29 Weeks gestation of pregnancy |
| Z3A.30 | 30 Weeks gestation of pregnancy |
| Z3A.31 | 31 Weeks gestation of pregnancy |
| Z3A.32 | 32 Weeks gestation of pregnancy |
| Z3A.33 | 33 Weeks gestation of pregnancy |
| Z3A.34 | 34 Weeks gestation of pregnancy |
| Z3A.35 | 35 Weeks gestation of pregnancy |
| Z3A.36 | 36 Weeks gestation of pregnancy |

| ICD-10 Diagnosis Codes | |
|---|---|
| Z3A.37 | 37 Weeks gestation of pregnancy |
| Z3A.38 | 38 Weeks gestation of pregnancy |
| Z3A.39 | 39 Weeks gestation of pregnancy |
| Z3A.40 | 40 Weeks gestation of pregnancy |
| Z3A.41 | 41 Weeks gestation of pregnancy |
| Z3A.42 | 42 Weeks gestation of pregnancy |
| Z3A.49 | Greater than 42 weeks Gestation of Pregnancy |

This guidance applies to professional and outpatient claims when the following CPT codes are present on the claim:

| CPT Codes | |
|---|---|
| 59400 – 59410 | Vaginal Delivery, Antepartum and Postpartum Care |
| 59510 – 59515 | Cesarean Delivery |
| 59610 – 59622 | Delivery After Previous Cesarean Delivery |

This guidance applies to institutional claims when the following ICD-10 procedure codes are present on the claim:

| ICD-10 Procedure Codes | |
|---|---|
| 10D00Z0 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Classical |
| 10D00Z1 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Low Cervical |
| 10D00Z2 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Extraperitoneal |
| 10D07Z3 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Low Forceps |
| 10D07Z4 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Mid Forceps |
| 10D07Z5 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, High Forceps |
| 10D07Z6 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Vacuum |
| 10D07Z7 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Internal Version |
| 10D07Z8 | Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Other |
| 10E0XZZ | Obstetrics, Pregnancy, Delivery, Assisting the passage of products of conception from the genital canal, Products of Conception, External, No Device, No Qualifier |

## 2.19 Non-Cooperative Patients

Providers must bill third-party insurance companies prior to billing Medicaid. Providers who are attempting to work with “uncooperative” consumers also have the option to contact the administrative agency (County Department of Job and Family Services or CDJFS) and speak with the consumer's case worker about the consumer's lack of cooperation in regards to complying with requests regarding third party insurance. If the consumer’s caseworker is unresponsive to the provider’s request for assistance for a TPL issue, the provider may contact the caseworker’s supervisor to address the issue.

OAC rule 5160-1-13.1, Medicaid Consumer Liability, describes circumstances under which a provider may “bill" Ohio Medicaid consumers. In accordance with OAC rule 5160-1-13.1(C),

"Providers are not required to bill the Ohio department of medicaid (ODM) for medicaid-covered services rendered to eligible consumers. However, providers may not bill consumers in lieu of ODM unless:

1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODM for the covered service; and
2) The consumer agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and
3) The provider explains to the consumer that the service is a covered medicaid service and other medicaid providers may render the service at no cost to the consumer."

In addition, there are recent updates to OAC rules that may help encourage consumers to comply with the required requests from providers and third party payers.

1) OAC rule 5160:1-2-10, Medicaid: Conditions of Eligibility and Verifications
    a. OAC rule 5160:1-2-10(B)(7)(a): The consumer must cooperate with requests from a third-party insurance company to provide additional information that is required to authorize coverage or obtain benefits through the third party insurance company.
    b. OAC rule 5160:1-2-10(B)(7)(b): The consumer must cooperate with requests from a Medicaid provider, managed care plan, or a managed care plan's contracted provider to provide additional information that is required for the provider or plan to obtain payments from a third-party insurance company for Medicaid covered services.
2) OAC rule 5160:1-2-01, Medicaid: Administrative Agency Responsibilities
    a. If information needed to determine an individual's initial or continuing eligibility for a medical assistance program must be verified, but was not submitted with the application, the administrative agency must deny an application for medical assistance or terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verifications.

Providers may communicate with consumers about their responsibility to provide information that is required in order to maintain their eligibility in the medical assistance program, such as verifying third party coverage.

## 2.20 NATIONAL DRUG CODES

All outpatient claims with dates of service on or after January 1, 2017 that contain a pharmaceutical code must have the corresponding valid national drug code (NDC) submitted on the same detail line. Furthermore, a valid NDC must be submitted on any detail line that contains RCC 25X without a CPT/HCPCS code.

# 3. CLAIMS PROCESSING

## 3.1 ADJUSTMENTS TO PAID CLAIMS

If a provider feels that an improper assignment of a DRG has occurred through omission of information and/or submittal of incorrect claims data, an adjustment can be completed. Through the ODM MITS Web Portal, the paid claim can be voided so the corrected claim can be submitted; this process can also be submitted through EDI.

Information pertaining to electronic adjustments submitted via EDI 837 transactions can be found on the Department's EDI website:

http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx

### 3.1.1 ICD-9 VS ICD-10 ADJUSTMENTS

When adjusting a claim, the code set originally used to submit the claim will be the code set used when adjusting the claim. For example, if the claim was submitted using the ICD-9 code set and date of service/date of discharge was prior to 10/1/2015, the ICD-9 code set will be used for adjusting the claim. If the claim was submitted using the ICD-10 code set and date of service/date of discharge was on or after 10/1/2015, the ICD-10 code set will be used for adjusting the claim.

## 3.2 DENIED/PROBLEM CLAIMS

Denied or problem claims should be resubmitted to the Department through the ODM MITS Web Portal for reprocessing (indicate that the ODM 06653 Medical Claim Review Request Form is attached).

The following are some examples of when this process must be used:

- Denied claims for clinical editor rejections (age/diagnosis conflicts) – also attach a copy of the Medicaid remittance advice showing the denial. On the ODM 06653 Medical Claim Review Request Form, indicate why the diagnosis code in question is used.
- Medicare Crossover/TPL primary denials – also attach the primary payer's remittance advice for the denied claim, which will indicate the reason for the denial.
- Timely filing denials – also attach a copy of the remittance advice highlighting the claim in question as well as documentation to support timely filing as stated in OAC rule 5160-1-19.

## 3.3 PROVIDER ENROLLMENT

All provider enrollments must be initiated through the ODM MITS Web Portal. More information regarding provider enrollment may be found at: http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx.

### 3.3.1 Ordering, Referring, or Prescribing Providers

Per OAC rule 5160-1-17.9, ODM requires any ordering, referring or prescribing (ORP) providers to be screened and enrolled as participating providers with the Medicaid program. ODM cannot reimburse the eligible rendering provider for any healthcare service requiring a referral, order, or prescription from a physician or other healthcare professional unless the ORP provider is enrolled with Ohio Medicaid. If a claim fails to include the provider's National Provider Identifier (NPI) or the legal name of the physician or healthcare professional that ordered or prescribed the service, or referred the client for the service, Medicaid reimbursement will not be allowed. Providers can choose to enroll as a Medicaid ORP only provider, which allows the provider to order, refer, or prescribe services to Medicaid consumers, but the provider cannot submit a claim to ODM for reimbursement. Claims submitted to an Ohio Medicaid MCP are exempt from ORP requirements.

If a claim was denied because the ORP provider was not enrolled as a provider in the Ohio Medicaid program, the ORP provider is permitted to retroactively enroll up to 12 months prior to the date of enrollment. Retroactive enrollment is permitted under the condition that the enrolling provider is appropriately licensed and the enrollment complies with program integrity provisions established by ODM. Once the ORP provider is enrolled, the denied claim can be resubmitted by the billing provider for payment as long as the resubmission occurs within 365 days from the date of service.

When an existing Medicaid provider's contract is about to expire, ODM has an automated process that sends out letters warning providers of the approaching expirations, both 90 days and 30 days prior to the expiration date of the provider contract. If the provider fails to revalidate, the provider's agreement is terminated. If an ORP provider's contract is terminated for failure to revalidate the Medicaid provider contract prior to the expiration date, any claims submitted with that provider as the ORP for the inactive time period will be denied and cannot be backdated.

# APPENDIX A – TYPE OF BILL

Type of Bill should be used in accordance with the following guidelines.

INPATIENT - Medicaid

0110 Zero Pay Bill
0111 Hospital inpatient admit through discharge
0112 Hospital inpatient first interim bill
0113 Hospital inpatient continuing interim bill
0114 Hospital inpatient last interim bill (only allowable for DRG-exempt hospitals)
0115 Late charges (DRG hospitals will not be reimbursed for late charges)

NOTE: Hospitals subject to DRG payment may submit bill types 112 and 113 in 30 day cycles. However, before the final admit through discharge bill (0111) can be submitted, all interim bills must be voided. These transactions can be submitted EDI or through the ODM MITS Web Portal. These are not handled by the Department's Adjustment Unit.

INPATIENT - Medicare Part A (Medicare crossover claim)

011X Hospital inpatient admit through discharge

NOTE: If an inpatient claim has Medicare coverage for Part A services and Medicaid coverage for the Part A coinsurance and deductible, Medicaid can only be billed directly when the claim for the coinsurance and deductible has not automatically "crossed-over" from Medicare to Medicaid within 90 days of the hospital's receipt of the Medicare payment.

INPATIENT - Medicare Part B (Medicare crossover claim)

012X Hospital inpatient admit through discharge (Use only with Medicare Part B)

NOTE: If an inpatient claim has Medicare coverage for Part B services and Medicaid coverage for the Part B coinsurance and deductible, Medicaid can only be billed directly when the claim for the coinsurance and deductible has not automatically "crossed-over" from Medicare to Medicaid within 90 days of the hospital's receipt of the Medicare payment.

INPATIENT - Medicare HMO (Part C) Plan

011X Hospital Inpatient Admit Through Discharge

NOTE: Unlike traditional Medicare Part A and Part B, claims for patients enrolled in Medicare HMO plans do not automatically “cross-over” from Medicare to Medicaid. To bill Medicaid for the cost-sharing related to a Medicare HMO Claim, the provider must submit a claim directly to Medicaid.

OUTPATIENT - Medicaid

0131 Outpatient
0135 Outpatient late charge

NOTE: Only two late charge bills may be submitted per provider, per recipient, per date of service. Only laboratory, pregnancy services, and radiology services may be included on claims for late charges.

OUTPATIENT - Medicare Part B (Medicare crossover claim)

013X Outpatient

NOTE: If an outpatient claim has Medicare coverage for Part B services and Medicaid coverage for the Part B coinsurance and deductible, Medicaid can only be billed directly when the claim for the coinsurance and deductible has not automatically "crossed-over" from Medicare to Medicaid within 90 days of the hospital's receipt of the Medicare payment.

OUTPATIENT - Medicare HMO (Part C) Plan

013X Outpatient

NOTE: Unlike traditional Medicare Part A and Part B, claims for patients enrolled in Medicare HMO plans do not automatically “cross-over” from Medicare to Medicaid. To bill Medicaid for the cost-sharing related to a Medicare HMO Claim, the provider must submit a claim directly to Medicaid.

VOID and REPLACE OR VOID – Can only be submitted as an Electronic Data Interchange (EDI)claim

XXX7 Void and Replace a previously paid claim

XXX8 Void a previously paid claim

NOTE: Please see the NUBC and EDI guidelines for additional information on how to use these Type of Bills ending in ‘7’ or ‘8’. These cannot be used in the MITS Web Portal. The MITS Web

Portal has a 'void' option and an 'adjustment' option once a claim is selected. Therefore, use of Type of Bills XX7 or XX8 in the MITS Web Portal is unnecessary.

# APPENDIX B – PRIORITY (TYPE) OF VISIT

The Priority (Type) of Visit Codes should be used in accordance with the following guidelines.

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 1 | Emergency | Yes | Yes |
| 2 | Urgent | Yes | Yes |
| 3 | Elective | Yes | Yes |
| 4 | Newborn | Yes | Yes |
| 5 | Trauma Center | Yes | Yes |
| 9 | Information not available – use of this code will cause claim to deny | Not Allowed | Not Allowed |

## APPENDIX C – POINT OF ORIGIN FOR ADMISSION OR VISIT

Point of Origin for Admission or Visit Codes should be used in accordance with the following guidelines for Ohio Medicaid.

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 1 | Non-Health Care Facility Point of Origin | Yes | Not Applicable |
| 2 | Clinic or Physician's Office | Yes | Not Applicable |
| 4 | Transfer from a Hospital - excludes transfers from hospital inpatient in the same facility (will be considered a transfer claim for payment purposes) | Yes | Not Applicable |
| 5 | Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Assisted Living Facility (ALF) | Yes | Not Applicable |
| 6 | Transfer from Another Health Care Facility | Yes | Not Applicable |
| 8 | Court/Law Enforcement | Yes | Not Applicable |
| 9 | Information not Available – use of this code will result in denied claim | Not Allowed | Not Applicable |
| D | Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to Payer | Yes | Not Applicable |
| E | Transfer from Ambulatory Surgery Center | Yes | Not Applicable |
| F | Transfer from a Hospice Facility | Yes | Not Applicable |
| **Code** | **Code Structure for Newborn** | **IP** | **OP** |
| 5 | Born Inside this Hospital: use, as applicable, with Priority (Type) of Visit 4 (Newborn) | Yes | Required only if Priority (Type) of Visit = 4 |
| 6 | Born Outside of this Hospital: use, as applicable, with Priority (Type) of Visit 4 (Newborn) | Yes | Required only if Priority (Type) of Visit = 4 |

# APPENDIX D – PATIENT DISCHARGE STATUS

Patient Discharge Status Codes should be used in accordance with the following guidelines.

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 1 | Discharged to home or self-care (routine discharge) | Yes | Yes |
| 2 | Discharged/transferred to a short-term general hospital for inpatient care (will be considered a transfer claim for payment purposes) | Yes | Yes |
| 3 | Discharged/transferred to skilled nursing facility | Yes | Yes |
| 4 | Discharged/transferred to a facility that provides custodial or supportive care | Yes | Yes |
| 5 | Discharged/transferred to a Designated Cancer Center or Children's Hospital (will be considered a transfer claim for payment purposes) | Yes | Yes |
| 6 | Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care | Yes | Yes |
| 7 | Left against medical advice | Yes | Yes |
| 9 | Admitted as an inpatient to this hospital | Not Allowed | Yes |
| 20 | Expired<br>NOTE: Please report Occurrence Code 55 to report the patient's date of death. | Yes | Yes |
| 21 | Discharged/transferred to court/law enforcement | Yes | Yes |
| 30 | Still patient (when billing for inpatient services, use of this code with type of bill other than 112, 113, 122 or 123 will result in a denied claim) | Yes | Yes |
| 40 | Expired at home – use of this code will result in a denied claim | Not Allowed | Not Allowed |
| 41 | Expired in a medical facility – use of this code will result in a denied claim | Not Allowed | Not Allowed |
| 42 | Expired – place unknown – use of this code will result in a denied claim | Not Allowed | Not Allowed |
| 43 | Discharged/transferred to a federal health care facility | Yes | Yes |
| 50 | Hospice – home | Yes | Yes |
| 51 | Hospice – medical facility | Yes | Yes |

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 61 | Discharged/transferred to a hospital-based Medicare approved swing bed. Note: Use of this code will cause the claim to be processed as a discharge, rather than a transfer for payment purposes. | Yes | Yes |
| 62 | Discharged/transferred to an inpatient rehabilitation facility (will be considered a transfer claim for payment purposes)<br>**IMPORTANT NOTE:** Ohio Medicaid does not recognize distinct part rehabilitation units of a hospital as separate providers, therefore, one admit through discharge claim should be submitted to include the stay in both the medical unit and rehabilitation unit of the same hospital in these situations. Use this code only when discharging/transferring patient to a free-standing rehabilitation hospital. | Yes | Yes |
| 63 | Discharged/transferred to a Medicare Certified Long-Term Care Hospital (LTCH) (will be considered a transfer claim for payment purposes) | Yes | Yes |
| 64 | Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare | Yes | Yes |
| 65 | Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (will be considered a transfer claim for payment purposes) | Yes | Yes |
| 66 | Discharged/transferred to a Critical Access Hospital (CAH) (will be considered a transfer claim for payment purposes) | Yes | Yes |
| 69 | Discharged/transferred to a designated disaster alternative care site (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |
| 70 | Discharged/transferred to another type of health care institution not defined elsewhere in this Code List (will be considered a transfer claim for payment purposes) - See Code 95 for a discharge with a Planned Acute Care Hospital Inpatient Readmission | Yes | Yes |
| 81 | Discharged to home or self-care with a planned acute care hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 82 | Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |
| 83 | Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |
| 84 | Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |
| 85 | Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |
| 86 | Discharged/transferred to home under care of an organized home health service organization with a planned acute hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |
| 87 | Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |
| 88 | Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |
| 89 | Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care Hospital inpatient readmission (Effective 10/1/13) | Yes | Yes |
| 90 | Discharged/transferred to an Inpatient Readmission Facility (IRF) including rehabilitation distinct parts units of a hospital with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |
| 91 | Discharged/transferred to a Medicare Certified Long-Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 92 | Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission | Yes | Yes |
| 93 | Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |
| 94 | Discharged/transferred to a Critical Access Hospital (CAH) with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |
| 95 | Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13) | Yes | Yes |

# APPENDIX E – CONDITION CODES

Condition Codes should be used in accordance with the following guidelines.

**Please note**: NUBC condition codes not used by Medicaid for adjudication are not listed here, but will not cause claims to deny when correctly submitted.

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 2 | Condition Is Employment Related | Yes | Yes |
| 3 | Patient Covered By Insurance Not Reflected Here | Yes | Yes |
| 39 | Private Room Medically Necessary | Yes | No |
| 71 | Full Care In Dialysis Unit | Yes | Yes |
| 72 | Self-Care In Dialysis Unit | Yes | Yes |
| 73 | Self-Care Training | Yes | Yes |
| 74 | Home Dialysis | Yes | No |
| 75 | Home - 100% Reimbursement - Home Dialysis Using a Machine Purchased By Medicare Under The 100% Program | Yes | No |
| 76 | Back-Up In-Facility Dialysis (home dialysis patients) | Yes | No |
| 81 | C-sections or inductions performed at less than 39 weeks gestation for medical necessity (Effective 10/1/2013) | Yes | No |
| 82 | C-sections or inductions performed at less than 39 weeks gestation electively (Effective 10/1/2013) | Yes | No |
| 83 | C-sections or inductions performed at 39 weeks gestation or greater (Effective 10/1/2013) | Yes | No |
| A1 | HEALTHCHECK / (EPSDT) | Yes | Yes |
| A2 | Physically Handicapped Children's Program | Yes | Yes |
| A4 | Family Planning | Yes | Yes |
| AA | Abortion Due to Rape | Yes | Yes |
| AB | Abortion Performed Due to Incest | Yes | Yes |
| AC | Abortion Due to Serious Fetal Genetic Defect, Deformity, or Abnormality | Not Covered | Not Covered |
| AD | Abortion Performed Due to a Life Endangering Physical Condition Caused by, Arising from, or Exacerbated by the Pregnancy Itself | Yes | Yes |
| AE | Abortion Due to Physical Health of Mother that is not Life Endangering | Not Covered | Not Covered |

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| AF | Abortion Performed Due to Emotional/Psychological Health of the Mother | Not Covered | Not Covered |
| AG | Abortion Due to Social or Economic Reasons | Not Covered | Not Covered |
| AH | Elective Abortion | Not Covered | Not Covered |
| AI | Sterilization | Yes | Yes |
| AN | Preadmission Screening Not Required* | Yes | Yes |
| C3 | Partial Approval** | No | Yes |

* Use this condition code to report claims exempt from pre-certification when the services would otherwise require pre-certification.

** This code should be included on any claims that are permitted to be resubmitted after a retrospective review by the utilization review vendor.

## Appendix F – Occurrence Codes

Occurrence Codes should be used in accordance with the following guidelines for Ohio Medicaid.

**Please note**: Valid codes not used by Medicaid for adjudication are not listed here, but will not cause claims to deny when correctly submitted.

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 1 | Auto Accident | Yes | Yes |
| 2 | Auto Accident/No Fault Insurance Involved | Yes | Yes |
| 3 | Accident/Tort Liability | Yes | Yes |
| 4 | Accident/Employment Related | Yes | Yes |
| 5 | Accident/No Medical or Liability Coverage | Yes | Yes |
| 6 | Crime Victim | Yes | Yes |
| 10 | Last menstrual period. The date of the last menstrual period is applicable when the patient is being treated for a maternity related condition. Not required | Yes | Yes |
| 24 | Date of Insurance Denied | Yes | Yes |
| 25 | Date Benefits Terminated by Primary Payer | Yes | Yes |
| 42 | Date of Discharge: To be used when "Through" date in Form Locator 6 is not the actual discharge date and frequency code in Form Locator 4 is that of final bill (when the replacement is for a prior final claim). | Yes | No |
| 43 | Scheduled Date of Canceled Surgery (Outpatient only and must report modifier 73 or 74 with the canceled outpatient procedure.) | No | Yes |
| A3 | Benefits Exhausted - Payer A | Yes | Yes |
| B3 | Benefits Exhausted - Payer B | Yes | Yes |
| C3 | Benefits Exhausted - Payer C | Yes | Yes |

# APPENDIX G – VALUE CODES

Value Codes should be used in accordance with the following guidelines for Ohio Medicaid.

**Please note**: Valid codes not used by Medicaid for adjudication are not listed here but will not cause claims to deny when correctly submitted.

| Code | Description | Used in Medicaid Claims Adjudication | |
|---|---|---|---|
| | | IP | OP |
| 01 | Most common semi-private rate | Yes | Not Applicable |
| 02 | Hospital has no semi-private rooms (do not list dollar amounts) | Yes | Not Applicable |
| 06 | Medicare Part A Blood Deductible | Yes | Not Applicable |
| 23 | Recurring monthly income (Patient's monthly spend-down responsibility) | Yes | Yes |
| 31 | Patient Liability Amount (Required when a patient chooses a private room and agrees to pay the room differential. Differential must also be reported as non-covered charges for revenue code 011X) | Yes | Not Applicable |
| 54 | Newborn birth weight in grams (Required for all newborns as well as any neonates that group to DRG 385)<br><br>Please note: Providers should include decimal points when reporting birth weight. For example, if the birth weight is 1000 grams, then the provider should report 1000.00 along with value code 54. | Yes | Not Applicable |
| 80 | Covered Days | Yes | Not Applicable |
| 81 | Non-Covered Days | Yes | Not Applicable |
| 82 | Co-Insurance Days | Yes | Not Applicable |
| 83 | Lifetime Reserve Days | Yes | Not Applicable |

**IMPORTANT NOTES regarding Value Code use for Ohio Medicaid:**

**Medicaid Spend-Down**

Some persons are eligible for Medicaid only after they have incurred medical expenses that reduce their income (spend-down) to the Medicaid need standard. Persons eligible for Medicaid through spend-down are responsible for the medical expenses they incur. Medicaid cannot be billed for any unpaid spend-down amounts. The incurred spend-down amount reflected in Form Locator

39a-d, 40a-d, and 41a-d of the UB-04 will be deducted from the applicable Medicaid payment. If a third-party payment is made in addition to a collected spend-down amount and the third-party payment exceeds the applicable Medicaid payment amount, then the spend-down payment should be refunded to the recipient. If the third-party payment plus the spend-down exceed the applicable Medicaid payment, the spend-down amount in excess of the applicable Medicaid payment amount should be refunded.

**Reporting Covered and Non-Covered Days**

The days being reported as covered should only be the days Medicaid is responsible for payment during the Statement Covers Period (From and Through dates). Any days for which Medicaid is not responsible (i.e., person is ineligible) during the Statement Covers Period (From and Through dates), should be reported as non-covered days. These numbers will also need to be reported separately at the detail level. The number of covered days should also match the number of units and charges being reported for room and board. Non-covered days should have a separate line at the detail level for the matching of the number of units. Any charges related to the non-covered days would be reported under Total Charges and Non-Covered Charges. The discharge date should not be included as a non-covered day.

Effective for admissions on or after January 1, 2016, all outpatient services rendered within three days of an inpatient admission must be submitted on the inpatient claim. As a result, the covered days should reflect the number of days in which the patient was admitted and eligible for Medicaid fee-for-service coverage.

# APPENDIX H – NATIONAL PROVIDER IDENTIFIER (NPI) INFORMATION

In accordance with federal regulations (45 CFR § 162.404), all eligible health care providers are required to obtain a ten digit National Provider Identifier (NPI) from the National Plan and Provider Enumeration System. ODM will continue to maintain and assign the seven-digit Medicaid Legacy Provider Identifier upon enrollment.

**NPI and Claims Submission**

Providers must use the general acute care hospital NPI on all claims submitted directly to Medicaid, including claims where the consumer has Medicare coverage. Medicaid will deny claims submitted directly with NPIs other than the general acute care hospital NPI. However, on claims that automatically “cross-over” from Medicare, Medicaid will accept “secondary” NPIs associated with a psychiatric unit, rehabilitation unit, or renal dialysis services. Providers must report “secondary” NPIs to Medicaid in order to have them accepted on automatic “cross-over” claims from Medicare. They will then be mapped to the general acute care hospital NPI for payment purposes.

**Billing for Non-Hospital Services**

Hospital providers who obtained unique NPIs for non-hospital services such as ambulance, durable medical equipment (DME), or pharmacy (for take-home drugs) must also obtain unique Medicaid Legacy Provider Identifiers. Unique NPIs associated with non-hospital services will not be mapped to the general acute care hospital Medicaid Legacy Provider Identifier.

# APPENDIX I – COVERED AND NON-COVERED REVENUE CODES

**Revenue Codes and Descriptions**

**I/P = Inpatient** **C = Covered** **CPT/HCPCS**
**O/P = Outpatient** **N = Non-Covered** **Required?**

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| Health Insurance - PPS | 002 | 2 - | Skilled Nursing Facility PPS | N | N | |
| | | 3 - | Home Health PPS | N | N | |
| | | 4 - | Inpatient Rehabilitation Facility PPS | N | N | |
| All Inclusive Rate | 010 | 0 - | All-inclusive Room and Board Plus Ancillary | C | N | |
| | | 1 - | All-Inclusive Room and Board | N | N | |
| Room & Board - Private (Medical or General) | 011 | 0 - | General Classification | C | C | |
| | | 1 - | Medical/Surgical/Gyn | C | C | |
| | | 2 - | OB | C | C | |
| | | 3 - | Pediatric | C | C | |
| | | 4 - | Psychiatric | C | C | |
| | | 5 - | Hospice | N | N | |
| | | 6 - | Detoxification | C | C | |
| | | 7 - | Oncology | C | C | |
| | | 8 - | Rehabilitation | C | C | |
| | | 9 - | Other | C | C | |
| Note: See rule 5160-2-03 for coverage limitations pertaining to private rooms. | | | | | | |
| Room & Board - Semi-Private Two Bed (Medical or General) | 012 | 0 - | General Classification | C | C | |
| | | 1 - | Medical/Surgical/Gyn | C | C | |
| | | 2 - | OB | C | C | |
| | | 3 - | Pediatric | C | C | |
| | | 4 - | Psychiatric | C | C | |
| | | 5 - | Hospice | N | N | |
| | | 6 - | Detoxification | C | C | |
| | | 7 - | Oncology | C | C | |
| | | 8 - | Rehabilitation | C | C | |
| | | 9 - | Other | C | C | |
| Room & Board - Semi-Private - Three and Four Beds | 013 | 0 - | General Classification | C | C | |
| | | 1 - | Medical/Surgical/Gyn | C | C | |
| | | 2 - | OB | C | C | |
| | | 3 - | Pediatric | C | C | |
| | | 4 - | Psychiatric | C | C | |
| | | 5 - | Hospice | N | N | |
| | | 6 - | Detoxification | C | C | |
| | | 7 - | Oncology | C | C | |
| | | 8 - | Rehabilitation | C | C | |
| | | 9 - | Other | C | C | |

**Revenue Codes and Descriptions**

**I/P = Inpatient** **C = Covered** **CPT/HCPCS**
**O/P = Outpatient** **N = Non-Covered** **Required?**

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | |
|---|---|---|---|---|---|---|
| Room & Board - Private (Deluxe) | 014 | 0 - | General Classification | N | N | |
| | | 1 - | Medical/Surgical/Gyn | N | N | |
| | | 2 - | OB | N | N | |
| | | 3 - | Pediatric | N | N | |
| | | 4 - | Psychiatric | N | N | |
| | | 5 - | Hospice | N | N | |
| | | 6 - | Detoxification | N | N | |
| | | 7 - | Oncology | N | N | |
| | | 8 - | Rehabilitation | N | N | |
| | | 9 - | Other | N | N | |
| Room & Board - Ward (Medical or General) | 015 | 0 - | General Classification | C | C | |
| | | 1 - | Medical/Surgical/Gyn | C | C | |
| | | 2 - | OB | C | C | |
| | | 3 - | Pediatric | C | C | |
| | | 4 - | Psychiatric | C | C | |
| | | 5 - | Hospice | N | N | |
| | | 6 - | Detoxification | C | C | |
| | | 7 - | Oncology | C | C | |
| | | 8 - | Rehabilitation | C | C | |
| | | 9 - | Other | C | C | |
| Room & Board - Other | 016 | 0 - | General Classification | C | C | |
| | | 4 - | Sterile Environment | C | C | |
| | | 7 - | Self-Care | N | N | |
| | | 9 - | Other | C | C | |
| Nursery | 017 | 0 - | General Classification | C | C | |
| | | 1 - | Newborn - Level I | C | C | |
| | | 2 - | Newborn - Level II | C | N | |
| | | 3 - | Newborn - Level III | C | N | |
| | | 4 - | Newborn - Level IV | C | N | |
| | | 9 - | Other | C | C | |
| Note: Subcategory codes 1 through 4 are defined by the National Uniform Billing Committee. Please note that these definitions are different than those recognized by the Ohio Department of Health. | | | | | | |
| Leave of Absence | 018 | 0 - | General Classification | N | N | |
| | | 2 - | Patient Convenience | N | N | |
| | | 3 - | Therapeutic Leave | N | N | |
| | | 5 - | Hospitalization | N | N | |
| | | 9 - | Other Leave of Absence | N | N | |
| Subacute Care | 019 | 0 - | General Classification | N | N | |
| | | 1 - | Subacute Care - Level I | N | N | |
| | | 2 - | Subacute Care - Level II | N | N | |
| | | 3 - | Subacute Care - Level III | N | N | |

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 4 - | Subacute Care - Level IV | N | N | |
| | | 9 - | Other Subacute Care | N | N | |
| Intensive Care | 020 | 0 - | General Classification | C | N | |
| | | 1 - | Surgical | C | N | |
| | | 2 - | Medical | C | N | |
| | | 3 - | Pediatric | C | N | |
| | | 4 - | Psychiatric | C | N | |
| | | 6 - | Intermediate ICU | C | N | |
| | | 7 - | Burn Care | C | N | |
| | | 8 - | Trauma | C | N | |
| | | 9 - | Other Intensive Care | C | N | |
| Coronary Care | 021 | 0 - | General Classification | C | N | |
| | | 1 - | Myocardial Infarction | C | N | |
| | | 2 - | Pulmonary Care | C | N | |
| | | 3 - | Heart Transplant | C | N | |
| | | 4 - | Intermediate ICU | C | N | |
| | | 9 - | Other Coronary Care | C | N | |
| Special Charges | 022 | 0 - | General Classification | N | N | |
| | | 1 - | Admission Charge | N | N | |
| | | 2 - | Technical Support Charge | N | N | |
| | | 3 - | U.R. Service Charge | N | N | |
| | | 4 - | Late Discharge, Medically Nec. | N | N | |
| | | 9 - | Other Special Charges | N | N | |
| Incremental Nursing Charge Rate | 023 | 0 - | General Classification | C | N | |
| | | 1 - | Nursery | C | N | |
| | | 2 - | OB | C | N | |
| | | 3 - | ICU | C | N | |
| | | 4 - | CCU | C | N | |
| | | 5 - | Hospice | N | N | |
| | | 9 - | Other | C | N | |
| All Inclusive Ancillary | 024 | 0 - | General Classification | C | N | |
| | | 1 - | Basic | C | N | |
| | | 2 - | Comprehensive | C | N | |
| | | 3 - | Specialty | C | N | |
| | | 9 - | Other All Inclusive Ancillary | C | N | |
| Pharmacy (Also see 063X, an extension of 025X) | 025 | 0 - | General Classification | C | C | |
| | | 1 - | Generic Drugs | C | C | |
| | | 2 - | Non-Generic Drugs | C | C | |
| | | 3 - | Take Home Drugs | N | N | |
| | | 4 - | Drugs Incident to Other Diagnostic Services | C | C | |

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 5 - | Drugs Incident to Radiology | C | C | |
| | | 6 - | Experimental Drugs | N | N | |
| | | 7 - | Non-Prescription Drugs | C | N | |
| | | 8 - | IV Solution | C | C | |
| | | 9 - | Other Pharmacy | C | C | |
| IV Therapy | 026 | 0 - | General Classification | C | C | Y |
| | | 1 - | Infusion Pump | C | C | Y |
| | | 2 - | IV Therapy/Pharmacy | C | C | |
| | | 3 - | IV Therapy/Drug/Supply/Delivery | C | C | |
| | | 4 - | IV Therapy/Supplies | C | C | |
| | | 9 - | Other IV Therapy | C | C | Y |
| Medical/Surgical Supplies and Devices (Also see 062X, and extension of 027X) | 027 | 0 - | General Classification | C | C | |
| | | 1 - | Non Sterile Supply | C | C | |
| | | 2 - | Sterile Supply | C | C | |
| | | 3 - | Take Home Supplies | N | N | |
| | | 4 - | Prosthetic/Orthotic Devices | C | N | |
| | | 5 - | Pacemaker | C | C | |
| | | 6 - | Intraocular Lens | C | C | |
| | | 7 - | Oxygen-Take Home | N | N | |
| | | 8 - | Other Implant | C | C | |
| | | 9 - | Other Supplies/Devices | C | C | |
| Oncology | 028 | 0 - | General Classification | C | C | Y |
| | | 9 - | Other Oncology | C | C | Y |
| Durable Medical Equipment (Other than Rental) | 029 | 0 - | General Classification | N | N | |
| | | 1 - | Rental | C | N | |
| | | 2 - | Purchase of New DME | N | N | |
| | | 3 - | Purchase of Used DME | N | N | |
| | | 4 - | Supplies/Drugs for DME Effectiveness (HHA only) | N | N | |
| | | 9 - | Other Equipment | N | N | |
| Laboratory | 030 | 0 - | General Classification | C | C | Y |
| | | 1 - | Chemistry | C | C | Y |
| | | 2 - | Immunology | C | C | Y |
| | | 3 - | Renal Patient (home) | N | N | |
| | | 4 - | Non-routine Dialysis | C | C | Y |
| | | 5 - | Hematology | C | C | Y |
| | | 6 - | Bacteriology & Microbiology | C | C | Y |
| | | 7 - | Urology | C | C | Y |
| | | 9 - | Other Laboratory | C | C | Y |
| Laboratory Pathological | 031 | 0 - | General Classification | C | C | Y |

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 1 - | Cytology | C | C | Y |
| | | 2 - | Histology | C | C | Y |
| | | 4 - | Biopsy | C | C | Y |
| | | 9 - | Other Laboratory Pathological | C | C | Y |
| Radiology - Diagnostic | 032 | 0 - | General Classification | C | C | Y |
| | | 1 - | Angiocardiography | C | C | Y |
| | | 2 - | Arthrography | C | C | Y |
| | | 3 - | Arteriography | C | C | Y |
| | | 4 - | Chest X-ray | C | C | Y |
| | | 9 - | Other Radiology - Diagnostic | C | C | Y |
| Radiology - Therapeutic and/or Chemotherapy Administration | 033 | 0 - | General Classification | C | C | Y |
| | | 1 - | Chemotherapy Administration - Injected | C | C | Y |
| | | 2 - | Chemotherapy Admin. - Oral | C | C | Y |
| | | 3 - | Radiation Therapy | C | C | Y |
| | | 5 - | Chemotherapy Admin. - IV | C | C | Y |
| | | 9 - | Other Radiology - Therapeutic | C | C | Y |
| Nuclear Medicine | 034 | 0 - | General Classification | C | C | Y |
| | | 1 - | Diagnostic Procedures | C | C | Y |
| | | 2 - | Therapeutic Procedures | C | C | Y |
| | | 3 - | Diagnostic Radiopharmaceutical | C | C | |
| | | 4 - | Therapeutic Radiopharmaceutical | C | C | |
| | | 9 - | Other | C | C | Y |
| CT Scan | 035 | 0 - | General Classification | C | C | Y |
| | | 1 - | Head Scan | C | C | Y |
| | | 2 - | Body Scan | C | C | Y |
| | | 9 - | Other CT Scan | C | C | Y |
| Operating Room Services | 036 | 0 - | General Classification | C | C | Y |
| | | 1 - | Minor Surgery | C | C | Y |
| | | 2 - | Organ Transplant-Other Than Kidney | C | N | |
| | | 7 - | Kidney Transplant | C | N | |
| | | 9 - | Other Operating Room Services | C | C | Y |
| Anesthesia | 037 | 0 - | General Classification | C | C | Y |
| | | 1 - | Anesthesia Incident to Radiology | C | C | Y |
| | | 2 - | Anesthesia Incident to Other Diagnostic Services | C | C | Y |
| | | 4 - | Acupuncture | N | N | |
| | | 9 - | Other Anesthesia | C | C | Y |
| Blood | 038 | 0 - | General Classification | C | C | |

## Revenue Codes and Descriptions

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| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 1 - | Packed Blood Cells | C | C | |
| | | 2 - | Whole Blood | C | C | |
| | | 3 - | Plasma | C | C | |
| | | 4 - | Platelets | C | C | |
| | | 5 - | Leucocytes | C | C | |
| | | 6 - | Other Components | C | C | |
| | | 7 - | Other Derivatives (Cryoprecipitate) | C | C | |
| | | 9 - | Other Blood | C | C | |
| Blood and Blood Components Administration, Processing & Storage | 039 | 0 - | General Classification | C | C | |
| | | 1 - | Administration (Transfusions) | C | C | |
| | | 9 - | Other Processing and Storage | C | C | |
| Other Imaging Services | 040 | 0 - | General Classification | C | C | Y |
| | | 1 - | Diagnostic Mammography | C | C | Y |
| | | 2 - | Ultrasound | C | C | Y |
| | | 3 - | Screening Mammography | C | C | Y |
| | | 4 - | Positron Emission Tomography | C | C | Y |
| | | 9 - | Other Imaging Service | C | C | Y |
| Respiratory Services | 041 | 0 - | General Classification | C | C | Y |
| | | 2 - | Inhalation Services | C | C | Y |
| | | 3 - | Hyperbaric Oxygen Therapy | C | C | Y |
| | | 9 - | Other Respiratory Services | C | C | Y |
| Physical Therapy | 042 | 0 - | General Classification | C | C | Y |
| | | 1 - | Visit Charge | C | C | Y |
| | | 2 - | Hourly Charge | C | C | Y |
| | | 3 - | Group Rate | C | C | Y |
| | | 4 - | Evaluation or Re-evaluation | C | C | Y |
| | | 9 - | Other Physical Therapy | C | C | Y |
| Occupational Therapy | 043 | 0 - | General Classification | C | C | Y |
| | | 1 - | Visit Charge | C | C | Y |
| | | 2 - | Hourly Charge | C | C | Y |
| | | 3 - | Group Rate | C | C | Y |
| | | 4 - | Evaluation or Re-evaluation | C | C | Y |
| | | 9 - | Other Occupational Therapy | C | C | Y |
| Speech-Language Pathology | 044 | 0 - | General Classification | C | C | Y |
| | | 1 - | Visit Charge | C | C | Y |
| | | 2 - | Hourly Charge | C | C | Y |
| | | 3 - | Group Rate | C | C | Y |
| | | 4 - | Evaluation or Re-evaluation | C | C | Y |
| | | 9 - | Other Speech-Language Pathology | C | C | Y |

**Revenue Codes and Descriptions**

**I/P = Inpatient** | **C = Covered** | **CPT/HCPCS**
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| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| Emergency Room | 045 | 0 - | General Classification | C | C | Y |
| | | 1 - | EMTALA Emergency Medical Screening Services | C | C | Y |
| | | 2 - | ER Beyond EMTALA Screening Services | C | C | Y |
| | | 6 - | Urgent Care | C | C | Y |
| | | 9 - | Other Emergency Room | C | C | Y |
| Pulmonary Function | 046 | 0 - | General Classification | C | C | Y |
| | | 9 - | Other Pulmonary Function | C | C | Y |
| Audiology | 047 | 0 - | General Classification | C | C | Y |
| | | 1 - | Diagnostic | C | C | Y |
| | | 2 - | Treatment | C | C | Y |
| | | 9 - | Other Audiology | C | C | Y |
| Cardiology | 048 | 0 - | General Classification | C | C | Y |
| | | 1 - | Cardiac Cath Lab | C | C | Y |
| | | 2 - | Stress Test | C | C | Y |
| | | 3 - | Echocardiography | C | C | Y |
| | | 9 - | Other Cardiology | C | C | Y |
| Ambulatory Surgical Care | 049 | 0 - | General Classification | C | C | Y |
| | | 9 - | Other Ambulatory Surgical Care | C | C | Y |
| Outpatient Services | 050 | 0 - | General Classification | N | N | |
| | | 9 - | Other Outpatient Service | N | N | |
| Clinic | 051 | 0 - | General Classification | C | C | Y |
| | | 1 - | Chronic Pain Center | C | C | Y |
| | | 2 - | Dental Clinic* | C | C | Y |
| | | 3 - | Psychiatric Clinic | C | C | Y |
| | | 4 - | OB-GYN Clinic | C | C | Y |
| | | 5 - | Pediatric Clinic | C | C | Y |
| | | 6 - | Urgent Care Clinic | C | C | Y |
| | | 7 - | Family Practice Clinic | C | C | Y |
| | | 9 - | Other Clinic | C | C | Y |
| *Note: See rule 5160-2-03 for coverage limitations pertaining to dental services provided in a hospital facility. | | | | | | |
| Free-Standing Clinic | 052 | 0 - | General Classification | N | N | |
| | | 1 - | Rural Health-Clinic | N | N | |
| | | 2 - | Rural Health-Home | N | N | |
| | | 3 - | Family Practice Clinic | N | N | |
| | | 4 - | Visit by RHC/FQHC Practitioner - SNF (Covered by Part A) | N | N | |

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| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 5 - | Visit by RHC/FQHC Practitioner - SNF(not a Covered Part A Stay) or NF or ICF MR or Other Residential Facility | N | N | |
| | | 6 - | Urgent Care Clinic | N | N | |
| | | 7 - | Visiting Nurse Service(s)- in a Home Health Shortage Area | N | N | |
| | | 8 - | Visit by RHC/FQHC Practitioner to Other Site | N | N | |
| | | 9 - | Other Freestanding Clinic | N | N | |
| Osteopathic Services | 053 | 0 - | General Classification | C | C | Y |
| | | 1 - | Osteopathic Therapy | C | C | Y |
| | | 9 - | Other Osteopathic Services | C | C | Y |
| Ambulance | 054 | 0 - | General Classification | N | N | |
| | | 1 - | Supplies | N | N | |
| | | 2 - | Medical Transport | N | N | |
| | | 3 - | Heart Mobile | N | N | |
| | | 4 - | Oxygen | N | N | |
| | | 5 - | Air Ambulance | N | N | |
| | | 6 - | Neonatal Ambulance Service | N | N | |
| | | 7 - | Pharmacy | N | N | |
| | | 8 - | Telephone Transmission EKG | N | N | |
| | | 9 - | Other Ambulance | N | N | |
| Skilled Nursing | 055 | 0 - | General Classification | N | N | |
| | | 1 - | Visit Charge | N | N | |
| | | 2 - | Hourly Charge | N | N | |
| | | 9 - | Other Skilled Nursing | N | N | |
| Medical Social Services | 056 | 0 - | General Classification | N | N | |
| | | 1 - | Visit Charge | N | N | |
| | | 2 - | Hourly Charge | N | N | |
| | | 9 - | Other Medical Social Services | N | N | |
| Home Health - Home Health Aide | 057 | 0 - | General Classification | N | N | |
| | | 1 - | Visit Charge | N | N | |
| | | 2 - | Hourly Charge | N | N | |
| | | 9 - | Other Home Health Aide | N | N | |
| Home Health - Other Visits | 058 | 0 - | General Classification | N | N | |
| | | 1 - | Visit Charge | N | N | |
| | | 2 - | Hourly Charge | N | N | |
| | | 3 - | Assessment | N | N | |
| | | 9 - | Other Home Health Visit | N | N | |

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| Home Health - Units of Service | 059 | 0 - | General Classification | N | N | |
| Home Health - Oxygen | 060 | 0 - | General Classification | N | N | |
| | | 1 - | Oxygen - State/Equip/Supply/or Cont | N | N | |
| | | 2 - | Oxygen - State/Equip/Supply/ under 1 LPM | N | N | |
| | | 3 - | Oxygen - State/Equip/Over 4 LPM | N | N | |
| | | 4 - | Oxygen - Portable Add-on | N | N | |
| | | 9 - | Other Oxygen | N | N | |
| Magnetic Resonance Technology (MRT) | 061 | 0 - | General Classification | C | C | Y |
| | | 1 - | MRI - Brain (Including Brainstem) | C | C | Y |
| | | 2 - | MRI - Spinal Cord (Incl. Spine) | C | C | Y |
| | | 4 - | MRI - Other | C | C | Y |
| | | 5 - | MRA - Head and Neck | C | C | Y |
| | | 6 - | MRA - Lower Extremities | C | C | Y |
| | | 8 - | MRA - Other | C | C | Y |
| | | 9 - | Other MRT | C | C | Y |
| Medical/Surgical Supplies - Extension of 027X | 062 | 1 - | Supplies Incident to Radiology | C | C | |
| | | 2 - | Supplies Incident to Other Diagnostic Services | C | C | |
| | | 3 - | Surgical Dressings | C | C | |
| | | 4 - | FDA Investigational Devices | N | N | |
| Pharmacy - Extension of 025X | 063 | 1 - | Single Source Drug | N | N | |
| | | 2 - | Multiple Source Drug | N | N | |
| | | 3 - | Restrictive Prescription | N | N | |
| | | 4 - | Erythropoietin (EPO) Less Than 10,000 Units | C | C | |
| | | 5 - | Erythropoietin (EPO) 10,000 or More Units | C | C | |
| | | 6 - | Drugs Requiring Detailed Coding | N | C | Y |
| | | 7 - | Self-administrable Drugs | C | C | |
| Home IV Therapy Services | 064 | 0 - | General Classification | N | N | |
| | | 1 - | Nonroutine Nursing, Central Line | N | N | |
| | | 2 - | IV Site Care, Central Line | N | N | |
| | | 3 - | IV Start/Change, Peripheral Line | N | N | |
| | | 4 - | Nonroutine Nurs., Peripheral Line | N | N | |

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 5 - | Training, Patient/Caregiver, Central Line | N | N | |
| | | 6 - | Training, Disabled Patient, Central Line | N | N | |
| | | 7 - | Training, Patient/Caregiver, Peripheral Line | N | N | |
| | | 8 - | Training, Disabled Patient, Peripheral Line | N | N | |
| | | 9 - | Other IV Therapy Services | N | N | |
| Hospice Service | 065 | 0 - | General Classification | N | N | |
| | | 1 - | Routine Home Care | N | N | |
| | | 2 - | Continuous Home Care | N | N | |
| | | 5 - | Inpatient Respite Care | N | N | |
| | | 6 - | General IP Care (Non-respite) | N | N | |
| | | 7 - | Physician Services | N | N | |
| | | 8 - | Hospice Room & Board - Nursing Facility | N | N | |
| | | 9 - | Other Hospice Service | N | N | |
| Respite Care | 066 | 0 - | General Classification | N | N | |
| | | 1 - | Hourly Charge/Nursing | N | N | |
| | | 2 - | Hourly Charge/Aid/Homemaker/ Companion | N | N | |
| | | 3 - | Daily Respite Charge | N | N | |
| | | 9 - | Other Respite Charge | N | N | |
| Outpatient Special Residence Charge | 067 | 0 - | General Classification | N | N | |
| | | 1 - | Hospital Based | N | N | |
| | | 2 - | Contracted | N | N | |
| | | 9 - | Other Special Residence Charge | N | N | |
| Trauma Response (Charge for Trauma Team Activation) | 068 | 1 - | Level I | N | N | |
| | | 2 - | Level II | N | N | |
| | | 3 - | Level III | N | N | |
| | | 4 - | Level IV | N | N | |
| | | 9 - | Other Trauma Response | N | N | |
| Pre-Hospice/Palliative Care Services | 069 | 0- | General Classification | N | N | |
| | | 1- | Visit Charge | N | N | |
| | | 2- | Hourly Charge | N | N | |
| | | 3- | Evaluation | N | N | |
| | | 4- | Consultation and Education | N | N | |
| | | 5- | Inpatient Care | N | N | |
| | | 6- | Physician Services | N | N | |
| | | 7-8 | RESERVED | N | N | |

**Revenue Codes and Descriptions**

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| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 9- | Other Pre-Hospice/Palliative Care Services | N | N | |
| Cast Room | 070 | 0 - | General Classification | C | C | Y |
| Recovery Room | 071 | 0 - | General Classification | C | C | |
| Labor Room/Delivery | 072 | 0 - | General Classification | C | C | Y |
| | | 1 - | Labor | C | C | Y |
| | | 2 - | Delivery | C | C | Y |
| | | 3 - | Circumcision | C | C | Y |
| | | 4 - | Birthing Center | C | C | Y |
| | | 9 - | Other Labor Room/Delivery | C | C | Y |
| EKG/ECG (Electrocardiogram) | 073 | 0 - | General Classification | C | C | Y |
| | | 1 - | Holter Monitor | C | C | Y |
| | | 2 - | Telemetry | C | C | Y |
| | | 9 - | Other EKG/ECG | C | C | Y |
| EEG (Electroencephalogram) | 074 | 0 - | General Classification | C | C | Y |
| Gastro-Intestinal Services | 075 | 0 - | General Classification | C | C | Y |
| Treatment/Observation Room | 076 | 0 - | General Classification | C | C | Y |
| | | 1 - | Treatment Room | C | C | Y |
| | | 2 - | Observation Room | C | C | Y |
| | | 9 - | Other Treatment/Obs. Room | C | C | Y |
| Preventive Care Services | 077 | 0 - | General Classification | C | C | |
| | | 1 - | Vaccine Administration | C | C | |
| Telemedicine | 078 | 0 - | General Classification | N | N | |
| Extra-Corporeal Shock Wave Therapy | 079 | 0 - | General Classification | C | C | Y |
| Inpatient Renal Dialysis | 080 | 0 - | General Classification | C | N | |
| | | 1 - | Inpatient Hemodialysis | C | N | |
| | | 2 - | Inpatient Peritoneal (Non-CAPD) | C | N | |
| | | 3 - | Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD) | C | N | |
| | | 4 - | Inpatient Continuous Cycling Peritoneal Dialysis (CCPD) | C | N | |
| | | 9 - | Other Inpatient Dialysis | C | N | |
| Acquisition of Body Components | 081 | 0 - | General Classification | C | N | |
| | | 1 - | Living Donor | C | N | |
| | | 2 - | Cadaver Donor | C | N | |
| | | 3 - | Unknown Donor | N | N | |
| | | 4 - | Unsuccessful Organ Search Donor Bank Charges | N | N | |
| | | 5 - | Stem Cells - Allogeneic | C | C | Y |

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 9 - | Other Donor | C | N | |
| Note: Acquisition charges eligible for cost-related reimbursement, as described in rule 5160-2-65, should be reported using revenue code 0810. | | | | | | |
| Hemodialysis - Outpatient or Home | 082 | 0 - | General Classification | N | C | Y |
| | | 1 - | Hemodialysis/Composite or Other Rate | N | C | Y |
| | | 2 - | Home Supplies | N | N | |
| | | 3 - | Home Equipment | N | N | |
| | | 4 - | Maintenance/100% | N | N | |
| | | 5 - | Support Services | N | N | |
| | | 6 - | Hemodialysis – Shorter | N | C | Y |
| | | 9 - | Other Outpatient Hemodialysis | N | C | Y |
| Peritoneal Dialysis - Outpatient or Home | 083 | 0 - | General Classification | N | C | Y |
| | | 1 - | Peritoneal Dialysis/Composite or Other Rate | N | C | Y |
| | | 2 - | Home Supplies | N | N | |
| | | 3 - | Home Equipment | N | N | |
| | | 4 - | Maintenance/100% | N | N | |
| | | 5 - | Support Services | N | N | |
| | | 9 - | Other OP Peritoneal Dialysis | N | C | Y |
| Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home | 084 | 0 - | General Classification | N | C | Y |
| | | 1 - | CAPD/Composite or Other Rate | N | C | Y |
| | | 2 - | Home Supplies | N | N | |
| | | 3 - | Home Equipment | N | N | |
| | | 4 - | Maintenance 100% | N | N | |
| | | 5 - | Support Services | N | N | |
| | | 9 - | Other Outpatient CAPD | N | C | Y |
| Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home | 085 | 0 - | General Classification | N | C | Y |
| | | 1 - | CCPD/Composite or Other Rate | N | C | Y |
| | | 2 - | Home Supplies | N | N | |
| | | 3 - | Home Equipment | N | N | |
| | | 4 - | Maintenance 100% | N | N | |
| | | 5 - | Support Services | N | N | |
| | | 9 - | Other Outpatient CCPD | N | C | Y |
| Miscellaneous Dialysis | 088 | 0 - | General Classification | C | C | Y |
| | | 1 - | Ultrafiltration | C | C | Y |
| | | 2 - | Home Dialysis Aid Visit | N | N | |
| | | 9 - | Other Miscellaneous Dialysis | C | C | Y |
| Behavioral Health Treatments/Services (Also | 090 | 0 - | General Classification | C | C | Y |
| | | 1 - | Electroshock Treatment | N | N | |
| | | 2 - | Milieu Therapy | N | N | |

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| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| see 091X, an extension of 090X) | | 3 - | Play Therapy | N | N | |
| | | 4 - | Activity Therapy | N | N | |
| | | 5 - | IOP - Psychiatric | N | N | |
| | | 6 - | IOP - Chemical Dependency | N | N | |
| | | 7 - | Day Treatment | N | N | |
| Behavioral Health Treatments/Services - Extension of 090X | 091 | 1 - | Rehabilitation | N | C | Y |
| | | 2 - | Partial Hospitalization - Less Intensive | N | N | |
| | | 3 - | Partial Hospitalization - Intensive | N | N | |
| | | 4 - | Individual Therapy | C | C | Y |
| | | 5 - | Group Therapy | C | C | Y |
| | | 6 - | Family Therapy | C | C | Y |
| | | 7 - | Bio Feedback | N | N | |
| | | 8 - | Testing | C | C | Y |
| | | 9 - | Other Behavioral Health Treatment/Services | C | C | Y |
| Other Diagnostic Services | 092 | 0 - | General Classification | C | C | Y |
| | | 1 - | Peripheral Vascular Lab | C | C | Y |
| | | 2 - | Electromyogram | C | C | Y |
| | | 3 - | Pap Smear | C | C | Y |
| | | 4 - | Allergy Test | C | C | Y |
| | | 5 - | Pregnancy Test | C | C | Y |
| | | 9 - | Other Diagnostic Services | C | C | Y |
| Medical Rehabilitation Day Program | 093 | 1 - | Half Day | N | N | |
| | | 2 - | Full Day | N | N | |
| Other Therapeutic Services (Also see 095X, an extension of 094X) | 094 | 0 - | General Classification | C | C | Y |
| | | 1 - | Recreational Therapy | N | N | |
| | | 2 - | Education/Training | C | C | Y |
| | | 3 - | Cardiac Rehabilitation | C | C | Y |
| | | 4 - | Drug Rehabilitation | N | C | Y |
| | | 5 - | Alcohol Rehabilitation | N | C | Y |
| | | 6 - | Complex Medical Equipment - Routine | N | N | |
| | | 7 - | Complex Medical Equipment - Ancillary | N | N | |
| | | 9 - | Other Therapeutic Service | C | C | Y |
| Other Therapeutic Services - Ext. of 094X | 095 | 1 - | Athletic Training | N | N | |
| | | 2- | Kinesiotherapy | C | C | Y |
| | | 3- | Chemical Dependency (Drug and Alcohol) CHEMDEP | N | N | |
| | | 4-9 | RESERVED | N | N | |

## Revenue Codes and Descriptions

**I/P = Inpatient** | **C = Covered** | **CPT/HCPCS**
**O/P = Outpatient** | **N = Non-Covered** | **Required?**

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| Professional Fees (Also see 097X and 098X) | 096 | 0 - | General Classification | N | N | |
| | | 1 - | Psychiatric | N | N | |
| | | 2 - | Ophthalmology | N | N | |
| | | 3 - | Anesthesiologist (MD) | N | N | |
| | | 4 - | Anesthetist (CRNA) | N | N | |
| | | 9 - | Other Professional Fee | N | N | |
| Professional Fees (Extension of 096X) | 097 | 1 - | Laboratory | N | N | |
| | | 2 - | Radiology - Diagnostic | N | N | |
| | | 3 - | Radiology - Therapeutic | N | N | |
| | | 4 - | Radiology - Nuclear Medicine | N | N | |
| | | 5 - | Operating Room | N | N | |
| | | 6 - | Respiratory Therapy | N | N | |
| | | 7 - | Physical Therapy | N | N | |
| | | 8 - | Occupational Therapy | N | N | |
| | | 9 - | Speech Pathology | N | N | |
| Professional Fees (Extension of 096X and 097X) | 098 | 1 - | Emergency Room | N | N | |
| | | 2 - | Outpatient Services | N | N | |
| | | 3 - | Clinic | N | N | |
| | | 4 - | Medical Social Services | N | N | |
| | | 5 - | EKG | N | N | |
| | | 6 - | EEG | N | N | |
| | | 7 - | Hospital Visit | N | N | |
| | | 8 - | Consultation | N | N | |
| | | 9 - | Private Duty Nurse | N | N | |
| Patient Convenience Items | 099 | 0 - | General Classification | N | N | |
| | | 1 - | Cafeteria/Guest Tray | N | N | |
| | | 2 - | Private Linen Service | N | N | |
| | | 3 - | Telephone/Telegraph | N | N | |
| | | 4 - | TV/Radio | N | N | |
| | | 5 - | Nonpatient Room Rentals | N | N | |
| | | 6 - | Late Discharge Charge | N | N | |
| | | 7 - | Admission Kits | N | N | |
| | | 8 - | Beauty Shop/Barber | N | N | |
| | | 9 - | Other Patient Convenience Item | N | N | |
| Behavioral Health Accommodations | 100 | 0 - | General Classification | N | N | |
| | | 1 - | Res.Treatment - Psychiatric | N | N | |
| | | 2 - | Res. Treatment - Chem. Dep. | N | N | |
| | | 3 - | Supervised Living | N | N | |
| | | 4 - | Halfway House | N | N | |
| | | 5 - | Group Home | N | N | |
| Alternative Therapy Services | 210 | 0 - | General Classification | N | N | |

**I/P = Inpatient** **C = Covered** **CPT/HCPCS**
**O/P = Outpatient** **N = Non-Covered** **Required?**

| General Category | 1st Three Digits | 4th Digit | Detail Description | I/P | O/P | CPT/HCPCS Required? |
|---|---|---|---|---|---|---|
| | | 1 - | Acupuncture | N | N | |
| | | 2 - | Acupressure | N | N | |
| | | 3 - | Massage | N | N | |
| | | 4 - | Reflexology | N | N | |
| | | 5 - | Biofeedback | N | N | |
| | | 6 - | Hypnosis | N | N | |
| | | 9 - | Other Alternative Therapy | N | N | |
| Adult Care | 310 | 1 - | Adult Day Care, Medical and Social - Hourly | N | N | |
| | | 2 - | Adult Day Care, Social - Hourly | N | N | |
| | | 3 - | Adult Day Care, Medical and Social - Daily | N | N | |
| | | 4 - | Adult Day Care, Social - Daily | N | N | |
| | | 5 - | Adult Foster Care - Daily | N | N | |
| | | 9 - | Other Adult Care | N | N | |

# APPENDIX J – OUTDATED INFORMATION

## J.1 TRANSPLANTS ON OR BEFORE 6/30/13

The following table summarizes the payment methodology for transplant services performed on or before June 30, 2013:

| Transplant Service | Prior Authorization (PA) Required | Payment Method on or before 6/30/13 |
|---|---|---|
| Heart | Ohio Solid Organ Transplant Consortium and | DRG |
| | ODM PA Unit | |
| Liver | Ohio Solid Organ Transplant Consortium and | DRG |
| | ODM PA Unit | |
| Bone Marrow (Stem Cell) | Ohio Bone Marrow Transplantation Consortium and | DRG |
| | ODM PA Unit | |
| Single/Double Lung | Ohio Solid Organ Transplant Consortium and | DRG |
| | ODM PA Unit | |
| Kidney | No PA required | DRG |
| Heart/Lung | Ohio Solid Organ Transplant Consortium and | Cost-to-Charge Ratio |
| | ODM PA Unit | |
| Liver/Small Bowel | Ohio Solid Organ Transplant Consortium and | Cost-to-Charge Ratio |
| | ODM PA Unit | |
| Pancreas | Ohio Solid Organ Transplant Consortium and | Cost-to-Charge Ratio |
| | ODM PA Unit | |

## J.2 OUTLIER PAYMENTS – SERVICES PROVIDED ON OR BEFORE 6/30/13

For services provided on or before June 30, 2013 the following outlier methodology applies, as described in OAC rule 5160-2-07.9. Additional payments will be made for cases that qualify as cost outliers. Outlier payments are automatically calculated by the Department; therefore, no special billing is required by the provider. Claims for discharges that may qualify for outlier payment may be billed only after discharge, unless the claim also qualifies for interim payment.

A claim qualifies as a cost outlier if the total allowable claim charges exceed the charge high trim for the DRG.

1) Exceptional Cost Outlier Methodology - Before a claim is considered a cost outlier, it should be considered for exceptional cost outlier status.

The table below lists the exceptional cost outlier threshold for each calendar year.

| Calendar Year | Exceptional Cost Outlier Threshold |
|---|---|
| 2013 (to 6/30/13) | $642,176 |
| 2012 | $630,202 |
| 2011 | $608,303 |
| 2010 | $590,013 |
| 2009 | $579,580 |
| 2008 | $551,456 |
| 2007 | $531,268 |
| 2006 | $514,794 |
| 2005 | $493,098 |
| 2004 | $477,346 |

Claim cost is calculated by multiplying total allowable claim charges by the hospital-specific, inpatient cost-to-charge ratio. All DRGs at all Ohio prospective payment hospitals are eligible for payment under the exceptional cost outlier methodology.

Example:

| | |
|---|---|
| Total Allowable Claim Charges: | $650,000.00 |
| Hospital-Specific Inpatient Cost-to-Charge Ratio: | X .88 |
| Claim Cost: | =$572,000.00 |

If claim cost exceeds the threshold, the claim is paid at cost. If it does not exceed the threshold, the claim should be analyzed according to the other cost outlier methodologies.

2) Cost Outlier Methodology – This cost outlier methodology does not apply: (1) to hospitals identified by ODM as having high outlier experience coupled with high Medicaid volume, and (2) to DRGs 488 – 490 for hospitals identified as having an exceptionally high volume of HIV inpatient discharges. For these exceptions, see section C below.

   a. Compare total allowable claim charges to the DRG charge high trim (charge high trims can be found on the relative weight table on the ODM website). If the total allowable claim charges exceed the charge high trim, calculate the difference.
   b. Multiply the outlier charges, calculated in step one above, by the hospital-specific cost-to-charge ratio to determine the cost outlier payment.
   c. To calculate the claim's TOTAL DRG PAYMENT: Add the Cost Outlier Payment to the hospital's standard DRG payment (DRG Base Price + Medical Education Add-On +

Capital Add-On).

3) Cost Outlier Methodology – Use this methodology for: (1) hospitals identified by ODM as having high outlier experience coupled with high Medicaid volume, and (2) DRGs 488 – 490 for hospitals identified as having an exceptionally high volume of HIV inpatient discharges.

   a. Compare total allowable claim charges to the DRG charge high trim, same as above. If the total allowable claim charges exceed the charge high trim, calculate total claim cost by multiplying total allowable claim charges by the hospital-specific inpatient cost-to-charge ratio.
   b. Multiply total claim cost, calculated in step one above, by 85 percent to determine total reimbursement amount. This amount constitutes the total outlier and DRG final payment.

4) Day Outlier Methodology

Note: If a claim qualifies for cost outlier and day outlier, then payment is based on the cost outlier.

   a. Compare the number of covered days of the stay to the DRG day high trim (day high trims can be found on the relative weight table on the ODM website). If the total covered days exceed the day high trim, compute the difference.

Example:

| | |
|---|---|
| Number of Covered Days | 99 |
| Day High Trim | - 72 |
| Outlier Days | = 27 |

   b. Outlier days are reimbursed on a per diem basis. The per diem amount is calculated by dividing the DRG base price by the DRG geometric mean length of stay.

Example:

| | |
|---|---|
| Hospital Base Rate | $2,000.00 |
| Relative Weight | X 4.47598 |
| DRG Base Price | $8,951.96 |
| Geometric Mean Length of Stay | ÷ 10.4705 |
| Per Diem Amount | $854.97 |

   c. Multiply the number of outlier days by the per diem amount, calculated in step two above, to compute the day outlier cost.

Example:

| | |
|---|---|
| Outlier Days | 27 |

| | |
|---|---|
| Per Diem Amount | X $854.97 |
| Day Outlier Cost | $23,084.19 |

d. Multiply the day outlier cost, calculated in step three above, by 60 percent* to determine the day outlier payment.

Example:

| | |
|---|---|
| Day Outlier Cost | $23,084.19 |
| | X .60 |
| Day Outlier Payment | $13,850.51 |

* Multiply by 80 percent for DRGs 388 – 390 and 892 – 898.

* Multiply by 80 percent for hospitals identified by ODM as having high outlier experience coupled with high Medicaid volume.

* Multiply by 80 percent for DRGs 48 8 – 490 for hospitals identified as having an exceptionally high volume of HIV inpatient discharges.

5) Total DRG Payment Calculation: Add the Day Outlier Payment to the hospital's standard DRG payment (DRG Base Price + Medical Education Add-On + Capital Add-On)

## J.3 SPECIAL UNLISTED DENTAL SURGERY PRICING

Per OAC rule 5160-2-21(F)(2)(b)(iii), for hospitals that had a ratio of unlisted dental surgery services provided to patients with an intellectual disability diagnosis to total unlisted dental surgery services greater than the calendar year 2012 Ohio Medicaid fee-for-service mean ratio of unlisted dental surgery claims with an intellectual disability diagnosis to total unlisted dental surgery services plus three standard deviations and also had an average cost for unlisted dental surgery services provided to individuals with intellectual disabilities greater than the calendar year 2012 Ohio Medicaid fee-for-service mean cost for unlisted dental surgery services provided to individuals with an intellectual disability diagnosis: Claims billed with CPT code 41899 and an ICD-9 diagnosis code of 317, 318.0, 318.1, 318.2, or 319 or ICD-10 diagnosis code of F70, F71, F72, F73, F78, or F79 will be paid five thousand five hundred dollars per claim, for dates of service on or between January 1, 2014 and December 31, 2015.