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Medicaid Handbook Transmittal Letters

MHTL 3355-11-01 (MITS-Related Changes to OAC Chapter 5101:3-8 Rules)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-11-01

July 28, 2011

TO: Eligible Providers of Advance Practice Nurse and Limited Practitioner Services
Medicaid Managed Care Plans
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: MITS-Related Changes to Rules in OAC Chapter 5101:3-8

The rules addressed in this transmittal letter are being amended for three reasons: (1) to comply with requirements of the five-year review process, (2) to update existing rule language, and (3) to support implementation of the Medicaid Information Technology System (MITS). MITS is Ohio Medicaid's new electronic claims submission interface and is scheduled to become operational on August 2, 2011, which is the effective date of these rules.

Rule Changes

Rule [5101:3-8-01](#), "Eligible providers of limited practitioner services," establishes provider enrollment criteria for chiropractors, physical therapists, occupational therapists, and psychologists.

Changes: Language in the rule has been updated.

Rule [5101:3-8-21](#), "Advance practice nurses: eligible Ohio Medicaid providers," establishes provider enrollment criteria for advance practice nurses (APNs).

Changes: Language in the rule has been updated. Citations of the statute from which the Ohio Board of Nursing derives its authority have been expanded to include Sections 4723.41 and 4723.42 of the Ohio Revised Code.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Office of Ohio Health Plans (Medicaid) may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

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Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

MHTL 3355-09-03 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-09-03

January 8, 2010

TO: All Eligible Advance Practice Nurse Providers
All Eligible Certified Registered Nurse Anesthetists
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

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Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

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- (3) Selecting "General Information for Medicaid Providers (Rules)";
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P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3355-09-02 (Updates to Advanced Practice Nursing Rules)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-09-02

January 8, 2010

TO: All Eligible Providers of Advanced Practice Nurse Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Updates to Advanced Practice Nursing Rules

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce changes to the rule addressing advanced practice nurse modifiers as a result of five year rule review.

Advanced practice nurses: modifiers: [Rule 5101:3-8-27](#)

All proposed changes to this rule are grammatical in nature or aid in the clarification of existing policy.

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- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3355-09-01 (Pregnancy Prevention/Contraceptive Management Services [Family Planning])

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-09-01

July 10, 2009

TO: All Eligible Advance Practice Nurse Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Pregnancy Prevention/Contraceptive Management Services (Family Planning)

This letter provides information regarding the rescission, amendment, and issuance of Ohio Administrative Code (OAC) rules related to pregnancy prevention and contraceptive management services ("family planning services").

Important elements of these rules include:

1. Family planning means preventing or delaying pregnancy.
2. Family planning services means pregnancy prevention/contraceptive management services.
3. Family planning services are not subject to a co-payment, regardless of gender.
4. Infertility services are not Medicaid covered.
5. Hysterectomies and voluntary sterilizations are Medicaid covered services.
6. Providers must include valid Medicaid-covered CPT and/or HCPCS procedure codes and a valid contraceptive management diagnosis code (V25.0 through V25.9) on claims for pregnancy prevention/contraception services.

OAC rule 5101:3-1-09 is titled "Medicaid co-payment program [except for Medicaid consumers enrolled in the Medicaid managed health care program]." This rule establishes co-payment requirements for Medicaid consumers. Paragraph (C)(5) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that these services are not subject to a co-payment, regardless of gender. This rule is also amended to update a rule reference and correct grammatical errors.

OAC rule 5101:3-4-02 is titled "Scope of coverage." This rule establishes the requirements of physician supervision of services provided by nonphysicians. Paragraph (D)(2)(d) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update rule references, improve sentence structure, delete an out of date reference to registered nurses, and include a reference to occupational therapists.

OAC rule 5101:3-4-07 is titled "Family planning services." This rule is rescinded and replaced with rules 5101:3-21-02, 5101:3-21-02.1, and 5101:3-21-02.2.

OAC rule 5101:3-4-13 is titled "Therapeutic injections (including trigger point injections) and prescribed drugs." This rule sets forth requirements related to Medicaid coverage of therapeutic injection services. Paragraph (A)(3)(a)(iii) of this rule is amended to clarify that infertility treatment services are not Medicaid covered.

OAC rule 5101:3-4-28 is titled "Noncovered services." This rule describes services that are not covered by Medicaid. Paragraphs (E) and (F) are removed to clarify that hysterectomies and voluntary sterilizations are Medicaid covered services. Paragraphs (G) and (H) are amended to clarify that infertility treatment services are not Medicaid covered. This rule is also amended to remove redundant language and to update a rule reference.

OAC rule 5101:3-4-34 is titled "Preventive medicine services." This rule defines preventive medicine as services that prevent disease, maintain good health, and proactively avoid disease, disability and death. This rule specifies which preventive medicine services are covered under the Ohio Medicaid program. Paragraph (B)(4) of this rule is amended to clarify that family planning services means pregnancy

prevention/contraceptive management services. This rule is also amended to update rule references and correct formatting errors.

OAC rule 5101:3-13-01.5 is titled "Fee-for-service ambulatory health care clinics (AHCCs): family planning clinics." This rule outlines requirements that apply to all fee-for-service family planning AHCCs. This rule is amended to clarify definitions in paragraph (A) and to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update a rule reference.

OAC rule 5101:3-21-01 is titled "Sterilization." This rule sets forth requirements regarding Medicaid coverage of permanent sterilization and hysterectomy procedures. This rule is rescinded and replaced with new rule 5101:3-21-02.2, "Medicaid covered reproductive health services: permanent contraception/sterilization services."

OAC rule 5101:3-21-01 is titled "Medicaid covered reproductive health services: preconception care services." This new rule describes Medicaid coverage of services that are provided for the primary purpose of achieving optimal outcome of future pregnancies.

OAC rule 5101:3-21-02 is titled "Medicaid covered reproductive health services: pregnancy prevention/contraception services overview." This new rule replaces, in part, rescinded rule 5101:3-4-07 and describes Medicaid coverage of services that are provided for the primary purpose of pregnancy prevention/contraceptive management.

OAC rule 5101:3-21-02.1 is titled "Medicaid covered reproductive health services: temporary pregnancy prevention/contraception services." This new rule replaces, in part, rescinded rule 5101:3-4-07 and describes Medicaid coverage of services provided for the primary purpose of temporary pregnancy prevention/contraceptive management.

OAC rule 5101:3-21-02.2 is titled "Medicaid covered reproductive health services: permanent contraception/sterilization services." This new rule replaces, in part, rescinded rule 5101:3-21-01 and in part, rescinded rule 5101:3-4-07. This new rule describes Medicaid coverage of services that are provided for the purpose of permanent pregnancy prevention/contraceptive management (sterilization).

OAC rule 5101:3-21-03 is titled "Medicaid covered reproductive health services: infertility services." This new rule describes Medicaid coverage of infertility services.

OAC rule 5101:3-29-01 is titled "Eligible providers." This rule describes Medicaid requirements pertaining to provider enrollment as an "outpatient health facility" (OHF). Paragraph (E) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that such services are considered preventive in nature. This rule is also amended to update a rule reference, correct spelling and grammatical errors, and incorporate terminology consistent with Chapter 5101:3-4 of the Administrative Code.

OAC rule 5101:3-29-04 is titled "Billable services." This rule specifies Medicaid requirements pertaining to services provided by outpatient health facilities. Paragraph (B) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and to clarify that such services are considered preventive in nature. This rule is also amended to restructure paragraph (B)(1)(c) and correct spelling and grammatical errors.

These rules do not include detailed information regarding Medicaid coverage of pharmacy, durable medical equipment, and laboratory services as they relate to pregnancy prevention/contraceptive management services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to these topics.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided in hospitals. Please refer to Chapter 5101:3-2 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to facility providers.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided under managed care. Please refer to Chapter 5101:3-26 of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to Medicaid managed care.

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Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

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MHTL 3355-08-03 (Fee Increases and Corresponding Policy Changes)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-08-03

July 15, 2008

To: Eligible Providers of Advanced Practice Nurse Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Fee Increases and Corresponding Policy Changes

EFFECTIVE JULY 1, 2008

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce changes to the Ohio Administrative Code (OAC) rule governing Medicaid reimbursement. Other supporting OAC rules have been updated to support the price changes reflected in the Medicaid Reimbursement rule 5101:3-1-60. The physician policy rules being amended include: 5101:3-4-12, 5101:3-4-08.1, and 5101:3-4-02.2.

Immunizations - 5101:3-4-12

The Department is pleased to announce that the vaccine administration rate is being increased. Effective for dates of service on and after July 1, 2008 (the targeted effective date), the vaccine administration rate for children's vaccine is being increased from \$5.00 to \$10.00 per vaccine.

This administration rate is paid to providers when a vaccine designated as "a free vaccine" in paragraph (A) of this rule is given to a child ages eighteen years of age or younger. The "free vaccines" are obtained from the Ohio Department of Health through the Vaccine for Children (VFC) Program. See paragraph (G) (2) of rule 5101:3-4-12 for more information.

Prenatal Visits - 5101:3-4-08.1

This rule is being amended to announce an increase in the Medicaid maximum for prenatal visit codes billed with the TH modifier. Codes 99201 through 99202 for new patient prenatal visits and codes 99212 and 99213 for established visits are being increased 3% to \$49.85. The new Medicaid maximums for other new and established visits codes and billed with the "TH modifier" to signify prenatal care can be found in rule 5101:3-1-60 of the Administrative Code.

Site Differential - 5101:3-4-02.2

Appendix A of the site differential rule has been amended to reflect that the site differential will apply to psychiatric services provided in a hospital setting (inpatient, outpatient, or emergency department) and consultation codes 99241 and 99242 have been added to Appendix A. When any of the codes listed in this appendix are provided in a hospital setting, the Department will pay the lesser of the provider's billed charge or 80% of the Medicaid maximum as set forth in appendix DD of the Medicaid reimbursement rule 5101:3-1-60 of the Administrative Code.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is

<http://emanuals.odjfs.state.oh.us/emanuals/>.

The full text of this rule amendment and the accompanying appendix DD to this rule can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Physical Therapy Services handbook.

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "APN services"; and,

(3) Selecting this MHTL number from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter and rules 5101:3-4-12, 5101:3-4-08.1, or 5101:3-4-02.2 completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3355-08-02 (Fee Increases and Corresponding Policy Changes)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-08-02

July 17, 2008

To: Eligible Providers of Advanced Practice Nurse Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Fee Increases and Corresponding Policy Changes

Effective July 1, 2008

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce changes to the Ohio Administrative Code (OAC) rule governing Medicaid reimbursement. Other supporting OAC rules have been updated to support the price changes reflected in the Medicaid reimbursement rule 5101:3-1-60.

Medicaid Reimbursement - Rule 5101:3-1-60

The Department is pleased to announce that the Medicaid maximums for certain codes will be increased as part of the Governor's biennial budget. An aggregate 3% increase is being implemented for claims with dates of service on or after July 1, 2008. The fee changes for all CPT codes can be found in Appendix DD to rule 5101:3-1-60 of the Ohio Administrative Code.

Information including Medicare prices and Relative Value Units (RVUs) for all CPT codes was used to evaluate the proposed fee changes. Under the proposed fee changes, the Medicaid maximum for codes are increased, left unchanged or reduced. The Medicaid maximums for some codes were reduced if they exceeded the 2007 Medicare fee.

Office visits were a primary focus of this aggregate increase. The Department is pleased to announce the following fee increases in this area:

Code	Current Medicaid Maximum	New Medicaid Maximum
New patient office visits		
99202	\$34.42	\$36.05
99203	\$48.01	\$53.48
99204	\$70.32	\$81.55
99205	\$87.97	\$102.47
Established patient office visits		
99212	\$24.74	\$24.75
99213	\$34.35	\$40.38
99214	\$52.57	\$61.24
99215	\$81.04	\$82.99

Preventive medicine was another area of emphasis in this targeted fee increase. The table below reflects the fee increases in this area:

Code	Current Medicaid Maximum	New Medicaid Maximum
New patient preventive medicine visit		
99381	\$50.70	\$59.07
99382	\$57.61	\$63.75
99383	\$57.51	\$62.84
99384	\$64.52	\$68.22
99385	\$61.21	\$68.22
Established patient preventive medicine visit		
99391	\$44.18	\$47.59
99392	\$51.12	\$52.97
99393	\$51.12	\$52.12
99395	\$55.66	\$56.62

To identify the fee changes for other codes, please refer to appendix DD of Ohio Administrative Code rule 5101:3-1-60.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule 5101:3-1-60 will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "APN"; and,
- (3) Selecting this MHTL number from the "Table of Contents" pull down menu.

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans
 Provider Services Section
 P.O. Box 1461
 Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3355-08-01 (Physician Policy Updates: New 2008 HCPCS Codes and Policy Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-08-01

March 21, 2008

To: All Eligible Providers of Advanced Practice Nurse Services
Directors, County Departments of Job and Family Services
Medical Assistant Coordinators

From: Helen E Jones-Kelley, Director

Subject: Physician Policy Updates: New 2008 HCPCS Codes and Policy Updates.

Effective March 30, 2008

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the adoption of the 2008 Healthcare Procedural Coding System (HCPCS) codes and 2008 Current Procedural Terminology (CPT) codes effective January 1, 2008 in order to maintain industry standards, which the Department is required to do under the Health Insurance Portability and Accountability Act (HIPPA), and to adopt any new policy changes resulting from these changes to eligible providers of physician services. These rules replace the emergency rules which were effective on December 31, 2007.

Medicaid Reimbursement: Rule 5101:3-1-60

Appendix DD to this rule is being proposed for permanent amendment to replace the emergency filing of this rule. All changes associated with the emergency file of this rule are located in the emergency MHTL 3336-07-04.

In addition, a proposed amendment to appendix DD of this rule is to update the J code prices for those codes that had an updated Average Sales Price (ASP) in the most recent Centers for Medicare and Medicaid Services' (CMS) ASP list.

Physician Visits: Rule 5101:3-4-06

This rule is being proposed for permanent amendment to replace the emergency filing of this rule. All changes associated with the emergency file of this rule are located in the emergency MHTL 3336-07-04.

In addition, a proposed amendment to this rule is the removal of CPT code 99431 from the list of CPT codes that will not be reimbursed on the same date of service as CPT code 99477 for the same recipient.

Therapeutic injections (including trigger point injections) and prescribed drugs: Rule 5101:3-4-13

This rule is proposed for permanent amendment to replace the emergency filing of this rule. All changes associated with the emergency file of this rule are located in the emergency MHTL 3336-07-04.

In addition, proposed amendments to this rule include updating paragraph (A) (3) (v) to delete miscellaneous CPT code 90799 because this code is no longer a valid code and add CPT code 90779 to the miscellaneous code list because this code replaced deleted CPT code 90799. Another amendment is an addition to paragraph (B) (2) to include the fact that a physician visit for a patient will not be separately reimbursed when performed on the same date of service as trigger point injection procedures.

Gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy and special dermatology services: Rule 5101:3-4-17

This rule is being proposed for permanent amendment to replace the emergency filing of this rule. All changes associated with the emergency file of this rule are located in the emergency MHTL 3336-07-04.

Surgery services: Rule 5101:3-4-22

Appendix A and appendix B to this rule are being proposed for permanent amendment to replace the emergency filing of this rule. All changes associated with the emergency file of this rule are located in the emergency MHTL 3336-07-04.

Office Incentive Program: Rule 5101:3-4-09

The office incentive program appendix that lists CPT codes subject to the office incentive program has been amended to remove discontinued CPT codes 32000, 45360, 54152, 85095, and 85102 from the appendix to this rule.

Web Page and Paper Distribution:

Rules 5101:3-1-60, 5101:3-4-06, Rule 5101:3-4-13, 5101:3-4-17, and 5101:3-4-22 are being proposed for permanent amendment. Rule 5101:3-4-09 is being proposed for amendment to update the valid surgery codes subject to the office incentive program. All of these changes have been posted to the Department's web site.

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "Advanced Practice Nurse Services"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

If you are maintaining a paper copy of the Physician Services handbook, please remove the outdated rules from your book (listed in the MHTL) and replace them with the amended rules.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter and rules 5101:3-4-06, 5101:3-4-09, 5101:3-4-13, 5101:3-4-17, and 5101:3-4-22 by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461
Toll Free Telephone Number 1-800-686-1516

MHTL 3355-07-04 (Advanced Practice Nurse Policy Updates: New 2008 HCPCS Codes and Policy Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-07-04

December 20, 2007

To: All Eligible Providers of Advanced Practice Nurse Services
Directors, County Departments of Job and Family Services
Medical Assistant Coordinators

From: Helen E Jones-Kelley, Director

Subject: Advanced Practice Nurse Policy Updates: New 2008 HCPCS Codes and Policy Updates and to Announce Revisions to Advanced Practice Nurses Policy.

Effective January 1, 2008

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is twofold: 1). to announce the implementation of the 2008 HCPCS codes (CPT and alphabetic) and to transmit any new policy changes resulting from these changes to eligible providers of physician services. 2). To announce revisions to the advanced practice nurse policy.

I. HCPCS 2008 Codes

On January 1, 2008 the Department will begin accepting the 2008 HCPCS codes effective for services on and after January 1, 2008. The Department will not accept the 2007 codes that have been obsoleted by the AMA for services rendered beyond December 31, 2007.

Physician Services Handbook Updates: Policy Updates

Rules 5101:3-4-06, 5101:3-4-13, 5101:3-4-17, and 5101:3-4-22 are to be filed on an emergency basis on December 29, 2007, and are to be proposed in January 2008 for permanent amendment. The following paragraphs summarize the significant rule changes that have been made effective for services provided on and after January 1, 2008. These changes have been posted to the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals/> in the Physician Services handbook. If you are maintaining a paper copy of the Physician Services handbook, please remove the outdated rules from your book (listed in the MHTL) and replace them with the amended rules.

Rule Changes Effective January 1, 2008

Physician Visits: Rule 5101:3-4-06

Paragraph (H) of this rule has been added to include the new physician visit code for initial hospital care for the evaluation and management of a neonate, twenty-eight days or less. This service requires intensive observation, frequent interventions and other intensive care services. Providers must bill CPT code 99477 to report the initial hospital care for the evaluation and management of a neonate, twenty eight days or less, that requires intensive observation, frequent interventions and other intensive care services. CPT code 99477 is a global twenty-four hour code and is billed once per admission and on the first day of care. CPT code 99477 will not be reimbursed when billed on the same date of service with CPT codes 99221 through 99223, 99295, and 99431. Subsequent inpatient hospital intensive care services provided to neonates are reported following CPT guidelines under the subsequent inpatient neonatal critical care code.

Therapeutic injections (including trigger point injections) and prescribed drugs: Rule 5101:3-4-13

Paragraph (A) (4) has been amended to expand the CPT code range for therapeutic, prophylactic, or diagnostic injections to 90765 to 90779.

Surgery services: Rule 5101:3-4-22

Appendix A to this rule has been updated to include the 2007 surgery codes that are considered bilateral surgery, multiple surgery, or assistant at surgery and whether pricing reductions for these codes apply. These revisions to appendix A of this rule are effective for claims submitted on or after January 1, 2007.

Appendix B to this rule has been updated to reflect the 2008 surgery codes that are considered bilateral surgery, multiple surgery, or assistant at surgery and whether pricing reductions for these codes apply. These revisions to appendix B of this rule are effective for claims submitted on or after January 1, 2008. Surgery codes that were deleted by the AMA were also discontinued in this appendix.

Note: There are new 2008 codes 58570-58573 for hysterectomies performed laparoscopically. Since the surgery results in sterilization, the requirements in the sterilization rule 5101:21-01 must be met including completion of the Consent to Hysterectomy form JFS 3199 to document that the provider has secured the recipient's consent to the procedure prior to the service being performed. All claims for hysterectomies must be billed on a paper claim and the consent form must be attached. Electronic claims will not be accepted.

Medicaid reimbursement: Rule 5101:3-1-60

Appendix DD of this rule lists all the new 2008 HCPCS codes and reflects whether Ohio Medicaid will be covering the new code. It also lists the Medicaid maximum for each covered service. Codes that were discontinued by the AMA were also discontinued in this appendix.

Appendices

The following appendices are being discontinued effective January 1, 2008. The information found in these appendices can be found in appendix DD of 5101:3-1-60 of the Ohio Administrative Code.

The payable surgical code information can be found in columns J and K in appendix DD.

The diagnostic and therapeutic codes requiring modifiers for billing can be found in column I in appendix DD.

The alphabetic and numeric listing of injection codes can be found in column C in appendix DD.

The radiology procedure code listing with professional and technical split indicators can be found in column I in appendix DD.

II. Advanced practice nurse policy updates

Effective January 1, 2008

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to rules governing APN services and to update existing policy as a result of five year rule review.

Advanced practice nurses - Rule 5101:3-8-20

This rule is being amended because of five year rule review. Changes include removing the reference to section 4723.55 of the Revised Code because that section was repealed, and adding a reference to section 4723.42 of the Revised Code because 4723.42 addresses the issuance of certificate of authority to practice as an advanced practice nurse.

Advanced practice nurses: eligible Ohio Medicaid providers - Rule 5101:3-8-21

This rule is being amended because of five year rule review. Changes include removing the eligibility criteria for advanced practice nurses employed by pilot programs since these pilot programs expired in January 2004.

Effective with dates of service on or after the effective date of this rule, a palliative care nurse practitioner and a psychiatric nurse practitioner certified by a national certifying organization approved by the Ohio Board of Nursing are eligible to become an Ohio Medicaid provider. A palliative care clinical nurse specialist, psychiatric clinical nurse specialist, acute care clinical nurse specialist, and pediatric clinical nurse specialist certified by a national certifying organization approved by the Ohio Board of Nursing are eligible to become an Ohio Medicaid provider.

Paragraph (C) has been updated to reference paragraphs within the rule that define eligibility requirements for certified nurse specialists and certified nurse practitioners.

The eligibility requirements for a certified nurse midwife have been updated. A certified nurse midwife can become an eligible Medicaid provider by receiving a certificate of authority to practice as a certified nurse midwife from the Ohio Board of Nursing. In order to receive this certificate, a certified nurse midwife must have completed an accredited course of study and be certified by either the American College of Nurse Midwives, the American Midwifery Certification Board, or the American College of Nurse Midwives Certification Council.

In paragraph (D) of this rule, the definition of a group practice has been updated to reference paragraph (C) of rule 5101:3-1-17 to meet national provider identifier (NPI) requirements. Another change applies to out-of-state advanced practice nurses who are eligible to be enrolled in the Ohio Medicaid program. Out-of-state advanced practice nurses do not have to possess a master's degree unless it is a requirement of the advanced practice nurse's state that holds jurisdiction. In order for an out-of-state advanced practice nurse to be eligible to provide services to Ohio Medicaid recipients, the advanced practice nurse must be licensed, certified, or authorized by the state in which the provider is located to practice as an advanced practice nurse, and must meet the provisions of rule 5101:3-1-11 addressing out-of-state coverage.

Advanced practice nurses practice arrangements and reimbursement - Rule 5101:3-8-22

This rule is being amended because of five year rule review. Changes include grammatical corrections and removing any references to section 4723.52 of the Revised Code because that section was repealed.

Advanced practice nurses: coverage and limitations - Rule 5101:3-8-23

This rule is being amended because of five year rule review. Changes include updating references to paragraphs in the teaching physician rule 5101:3-4-05 that are applicable to advanced practice nurses.

Effective with dates of service on or after the effective date of this rule, advanced practice nurses are eligible to bill the following evaluation and management codes: 99205, 99215, 99217 to 99220, 99241 to 99255, and 99291 to 99300. Emergency room visit codes 99284 and 99285 are covered if the advanced practice nurse is employed by or under contract with a physician, physician group, or hospital. Advanced practice nurses are eligible to bill for consultation services. Professional radiology or diagnostic or therapeutic services are covered when the services are performed by an advanced practice nurse if the services are provided within the advanced practice nurse's scope of practice.

The list of services that are not covered when performed by a certified nurse midwife except in unavoidable emergency situations has been updated as specified in section 4723.43 of the Revised Code.

Paragraph (D) (1), has been expanded to include two more rules that govern certified registered nurse anesthetists (5101:3-8-24 and 5101:3-8-25).

Eligible providers of certified registered nurse anesthetist (CRNA) services- Rule 5101:3-8-24

This rule is being amended because of five year rule review. Changes include updating the criteria for a CRNA group practice to be considered a professional group as specified in paragraph (C) of rule 5101:3-1-17 to meet national provider identifier requirements and updating the provisions for out-of-state CRNAs to participate in the Ohio Medicaid program as specified in 5101:3-1-11 addressing out-of-state coverage.

The requirements for a CRNA to receive a Medicaid legacy number have been added referencing the provisions of paragraph (B) or (C) of rule 5101-3-8-25 and national provider requirements specified in rule 5101:3-1-17.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider"
- (2) Selecting "Advanced Practice Nurse Services"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

JFS 03400 ODJFS Service Provider Update Request Form

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments (rules 5101:3-4-06, 5101:3-4-13, 5101:3-4-17, 5101:3-4-22, 5101:3-8-20, 5101:3-8-21, 5101:3-8-22, 5101:3-8-23, or 5101:3-8-24) by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3355-07-02 (Updates to Anesthesia Services)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-07-02

November 8, 2007

To: All Eligible Providers of Certified Registered Nurse Anesthetist Services or Anesthesiology Assistant Groups,
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Updates to Anesthesia Services

Effective November 20, 2007

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce policy changes to the rule regarding anesthesia services as a result of five year rule review.

Anesthesia services - Rule 5101:3-4-21

This rule is being amended because of five year rule review. The Department is removing anesthesia code 01995 from paragraph (B) (7) (a) since this code is no longer a valid anesthesia code.

The list of conditions under which the Department will reimburse a provider for two anesthesia procedures performed on the same patient on the same date of service has been updated to include a patient receiving anesthesia for a vaginal delivery of a newborn and anesthesia for a tubal ligation procedure meeting the requirements specified in rule 5101:3-21-01 of the Administrative Code.

The billing requirements for Medicaid crossover claims have been updated replacing the certified registered nurse anesthetist (CRNA) or anesthesiologist assistant's (AA's) provider number with their Medicaid legacy number on the crossover claim as the rendering provider and replacing the provider number of the employing provider with their Medicaid legacy number on the crossover claim as the "pay to" provider. The billing requirements for a CRNA employed by a physician or physician group practice have been updated requiring the CRNA's Medicaid legacy number and national provider identifier (NPI) number be listed on the claim as the rendering provider and Medicaid legacy number and NPI number of the employing physician or physician group practice be listed on the claim as the "pay to" provider.

Requesting Paper Updates:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms, and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "Advanced Practice Nurse Services"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form."

Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of this form.

Questions pertaining to this MHTL should be addressed to:

**Office of Ohio Health Plans
Provider Services Section**

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3355-07-01 (Updates to Certain Current Procedure Code and Immunizations)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-07-01

June 27, 2007

TO: All Eligible Providers of Advanced Practice Nursing (APN) Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Updates to certain current procedure code and immunizations

EFFECTIVE JULY 26, 2007

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing Medicaid reimbursement and immunizations.

The full text of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the APN Services handbook.

Medicaid Reimbursement - Rule 5101:3-1-60

This rule is being amended to make changes to appendix DD. The proposed changes to appendix DD are as follows:

- 1) Updating the professional technical split indicators (TC= technical component and 26= professional component) for codes that have a split, e.g. certain radiology codes, certain diagnostic and therapeutic codes, and some surgery codes to more closely align with Medicare's splits;
- 2) Updating J code prices for those J codes that had an updated Average Sales Price (ASP) in Centers for Medicare and Medicaid Services (CMS) most recent ASP listing;
- 3) Updating the prices for three immunization codes that will be covered for both adults and children;
- 4) Changing payment status of immunization codes for cholera and the poliovirus, since these vaccines are no longer offered in the United States;
- 5) Miscellaneous code changes including coverage decisions for codes listed in the CMS 2007 1st quarter update;
- 6) As a part of the 1st quarter 2007 update, J7319 was discontinued by CMS and Q4083 Q4084, Q4085, and Q4086 replaces this code;
- 7) Updating the Ambulatory Surgery Center (ASC) group indicator for eleven surgery codes covered in the ASC program; and
- 8) Adding the new Q codes which replace the J codes that have been discontinued in the July 1, 2007 HCPCS update released by CMS, since these codes are listed as carrier priced in the update these codes are all listed as by report.

EFFECTIVE JULY 25, 2007

Immunizations - Rule 5101:3-4-12

This rule is being amended to update the tables for immunizations covered for children and adults as a result of recommendations from the Centers for Disease Control (CDC), American Academy of Pediatrics (AAP), or Advisory Committee on Immunization Practices (ACIP). The poliovirus vaccine (90712) has been removed from the list of covered vaccines for children since this vaccine is no longer made available in the United States. The pneumococcal polysaccharide vaccine, 23 valent (90732) has been added to the table for immunizations covered under the Federal Vaccines for Children Program (VFC). The measles, mumps, and rubella virus vaccine (90707) and the varicella vaccine (90716) have been added to the table of active

immunizations for adults. The pneumococcal polysaccharide vaccine, valent 23 (90732), measles, mumps, and rubella virus vaccine (90707), and varicella vaccine (90716) have been added to the list of vaccines that are covered for either a child or an adult. If one of these three codes is billed for an individual eighteen years of age or younger, the department will pay a five dollar administration fee. For adults over eighteen years of age, these codes will be reimbursed at the lesser amount of the provider's billed charge or the Medicaid maximum.

Another amendment to this rule is changing the age requirement for the human papilloma virus (90649) from eleven to eighteen years of age to nine to eighteen years of age as a result of national immunization recommendations from the VFC program.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of updates to the immunization rule 5101:3-4-12, please complete the attached JFS 03400 and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3355-06-06 (APN Policy Updates: New 2007 HCPCS Codes and Policy Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3355-06-06

December 15, 2006

TO: All Eligible Providers of Advanced Practice Nurse (APN) Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: APN Policy Updates: New 2007 HCPCS Codes and Policy Updates

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2007 HCPCS codes (CPT and alphabetic) and to transmit any new policy changes resulting from these changes to eligible providers of APN services.

2007 Codes

On January 1, 2007 the Department began accepting the 2007 HCPCS codes effective for services on and after January 1, 2007. The Department will not accept the 2006 codes that have been obsoleted by the AMA for services rendered beyond December 31, 2006.

Advance Practice Nurse Services Handbook Updates: Policy Updates

Rule 5101:3-4-22 is to be filed on an emergency basis on December 29, 2006, and is to be proposed in January 2007 for permanent amendment. Rule 5101:3-4-12 has been refiled for an effective date of January 1, 2007. The following paragraphs summarize the significant rule changes that have been made effective for services provided on and after January 1, 2007. These changes have been posted to the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Advance Practice Nurse Services handbook. If you are maintaining a paper copy of the Advance Practice Nurse Services handbook, please remove these rules that have been amended from your book (listed in the MHTL) and replace them with the amended rules.

Rule Changes Effective December 29, 2006

Surgery services: Rule 5101:3-4-22

Appendix A to this rule has been updated to reflect the new surgery codes that are considered bilateral surgery, multiple surgery, or assistant at surgery and whether pricing reductions for these codes apply. These revisions to appendix A of this rule are effective for claims submitted on or after January 1, 2007. Surgery codes that were deleted by the AMA were also discontinued in this appendix.

Note: New 2007 codes 58541-58548 are for hysterectomies performed laparoscopically. Since the surgery results in sterilization, the requirements in the sterilization rule 5101:21-01 must be met including completion of the Consent to Hysterectomy form JFS 3199 to document that the provider has secured the recipient's consent to the procedure prior to the service being performed. All claims for hysterectomies must be billed on a paper claim and the consent form must be attached. Electronic claims will not be accepted.

Medicaid reimbursement: Rule 5101:3-1-60

Appendix DD of this rule lists all the new 2007 HCPCS codes and reflects whether Ohio Medicaid will be covering the new code. It also lists the Medicaid maximum for each covered service. Codes that were discontinued by the AMA were also discontinued in this appendix.

Rule Changes Effective January 1, 2007

Immunization services: Rule 5101:3-4-12

The list of immunizations covered for Medicaid children has been revised to add coverage of code 90649 for the Human Papilla Virus (HPV) vaccine effective for dates of service on and after January 1, 2007 for females ages eleven through eighteen. In an earlier rule filing the Department had stated that coverage would begin

November 1, 2006. However, the Ohio Department of Health (ODH), which administers the Vaccine for Children (VFC) program, notified the Department late in October that the vaccine would not be available free to providers in the VFC program as originally planned on November 1st. Therefore, the Department refiled this rule to make coverage of the vaccine available via the VFC program starting for dates of service on and after January 1, 2007 when ODH expects that its supply of the vaccine will be available. The Department will pay the \$5.00 administrative fee for the HPC vaccine when the vaccine is available free via the VFC program for dates of service on and after January 1, 2007.

Appendices Revised:

The following appendices have been updated as a result of the 2007 HCPCS code update:

Payable Surgical Procedure Codes (10000-69999)

Injection Codes

Valid Modifiers This appendix has been updated to list the 51 modifier in accordance with the specifications in rule 5101:3-4-22, the surgery rule.

Waived Laboratory Procedures This appendix has been deleted from the Advance Practice Nurse Services handbook. To determine whether a lab procedure is considered a waived test go to the CMS web site listing all waived codes at <http://www.cms.hhs.gov/>

Rule Changes Effective November 13, 2006

Non-covered services: 5101: 3-4-28

Rule 5101:3-4-28, "Non-covered services," was amended for five-year rule review. Paragraph C of this rule was removed. This paragraph listed exceptions to non-covered services that were of a preventive nature. Because the services listed are actually covered preventive services, the listing was removed from this non-covered rule to provide more clarity and listed in rule 5101:3-4-34 titled "Covered preventive medicine services."

Preventive medicine services: 5101:3-4-34

A new rule, 5101:3-4-34, "Covered preventive medicine services" was added to the Advance Practice Nurse Services handbook. In that rule, the preventive medicine services covered by Ohio Medicaid are listed and a clarification regarding screening colonoscopies is provided. Screening colonoscopies for individuals age fifty or older or for high-risk patients are covered. The term "high-risk" is defined in "The Guide to Medicare Preventive Services," which can be found at www.cms.hhs.gov. The policy states that a APN must perform the screening.

Rule Changes Effective March 29, 2007

Visits: Rule 5101:3-4-06

Paragraph (N)(1)(d) that addresses limits on outpatient visits has been amended to correct the visit codes that are counted as part of the twenty-four visit limit.

Reminders:

Bilateral surgery billing and claim processing: 5101:3-4-22

Effective for claims submitted on and after October 15, 2006, rule 5101:3-4-22, the surgery rule, contains an appendix that lists the surgery codes in the range of 10000- 69999 where bilateral pricing applies. For those surgery codes that are performed bilateral, considered bilateral and marked with an "X" in the appendix under the column "bilateral", providers must bill the department using the surgery code modified by a 50. The Medicaid maximum for bilateral procedure is 150% of the Medicaid maximum when the code is billed with the 50 modifier. If the procedure code is billed unmodified, the Department will not reimburse for the procedure code as a bilateral procedure.

If a bilateral surgery claim has been billed inappropriately to the Department, the lines billed inappropriate will not be paid. To receive reimbursement:

- 1) The provider must send to the Department, a completed JFS 06768 Claim Reversal Form to reverse the original claim transaction.

- 2) The provider must then re-bill for the bilateral surgery on one claim line with the 50 modifier following rule 5101:3-4-22. The provider should not submit the new claim until after the reversal transaction has been processed. Wait until after the reversal transaction has been processed and history weekend before resubmitting.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of the rules **5101:3-4-06, 5101:3-4-12, 5101:3-4-22, 5101: 3-4-28, 5101:3-4-34**, please complete the attached JFS 03400 form and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3355-06-05 (APN Policy Updates: Surgery, Immunizations and Other Rule Amendments for 5-year Rule Review)

Medicaid Handbook Transmittal Letter (MHTL) 3355-06-05

September 26, 2006

TO: All Eligible Providers of Advanced Practice Nurse Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: APN Policy Updates: Surgery, Immunizations and Other Rule Amendments for 5-year Rule Review

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce amendments being made to Ohio Administrative Code (OAC) Rules 5101:3-4-21.1, Anesthesia for neuraxial analgesia for obstetrical services, 5101:3-1-60, Medicaid reimbursement, 5101:3-4-12, Immunizations, and 5101:3-4-22, Surgical services.

Note: Rule 5101:3-4-21.1 is in a proposed status and is scheduled to become effective October 1, 2006 for dates of service on or after October 1, 2006. Rules 5101:3-1-60 and 5101:3-4-22 are in a proposed status and are scheduled to become effective October 15, 2006 for dates of service on or after October 15, 2006. Rule 5101:3-4-12 is in a proposed status and scheduled to be effective November 1, 2006 for dates of service on and after November 1, 2006. The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the APN Services handbook.

EFFECTIVE OCTOBER 1, 2006

Anesthesia for neuraxial analgesia for obstetrical services: 5101:3-4-21.1

Rule 5101:3-4-21.1 is being proposed for amendment because of the five-year rule review process. It provides information directly relating to specific CPT codes for anesthesia services described in the title of this rule. This rule has been amended to include the updated descriptions for the anesthesia procedure codes relating to neuraxial analgesia. There are no policy changes resulting from this review.

EFFECTIVE OCTOBER 15, 2006

Medicaid reimbursement: 5101:3-1-60

Amendments to this rule relative to APN services were updates to Appendix DD of the rule to include quarterly pricing updates from the Centers for Medicare and Medicaid Services on APN-administered J-drug codes prices.

Surgical services: 5101:3-4-22

This rule was amended to include a new appendix. Appendix A of this rule specifies which surgical procedures the Department considers to be bilateral, multiple surgeries, or whether an assistant at surgery is reimbursable. Procedure codes listed in appendix A are indicated with an "x" in the column that corresponds to whether bilateral, multiple surgery, or assistant at surgery price reductions apply.

Multiple surgeries:

Effective for claims submitted on and after October 15, 2006, surgical procedures marked by an "x" in the appendix in the column called "multiple surgery", will be subject to multiple surgery price reductions.

For multiple procedure pricing, a definition has been added to delineate which procedure will be considered the primary procedure. New language states that the primary procedure is considered to be the surgical procedure that has the highest Medicaid maximum listed in appendix DD of rule 5101:3-1-60 of the Ohio Administrative Code.

Surgical procedure codes that are not considered multiple surgery will be paid at the lesser of the billed charge or the Medicaid maximum regardless of whether the codes are submitted with another surgical procedure that had an "x" in the multiple surgery column of appendix A to the surgery rule.

The Department will begin to recognize the 51 modifier on codes that are considered multiple surgery. This modifier signifies a multiple procedure. However, usage of this modifier will not have an effect on the level of reimbursement. If a claim is submitted with the 51 modifier but the surgical code is not marked as multiple surgery in appendix A in the surgery rule, the claim with the 51 modifier will be denied.

Bilateral surgery:

For claims submitted on or after the effective date of this rule, bilateral surgery pricing will apply to procedures indicated with an "x" in the corresponding column for bilateral surgery in appendix A to the surgery rule.

Bilateral procedures should be billed to the Department using the appropriate code for the procedure modified by the modifier 50. For example, 6943350 would mean a tympanostomy was performed on both ears. Code 69433 billed without a modifier would mean the procedure was performed on one ear. If the procedure code is billed unmodified, the department will not reimburse for the procedure as a bilateral procedure.

The Medicaid maximum for bilateral procedures is one hundred fifty per cent of the Medicaid maximum allowed for the same procedures performed unilaterally.

Assistants at surgery:

For claims submitted on or after October 15, 2006, assistant at surgery pricing will apply to procedures indicated with an "x" in the corresponding column for assistant at surgery in appendix A to this rule.

For reimbursement, providers must bill the appropriate code for the primary surgical procedure modified by 80.

EFFECTIVE NOVEMBER 1, 2006

Immunizations: 5101:3-4-12

This rule has been amended to include a new vaccine that has been approved by the FDA and recommended by the Centers for Disease Control. The vaccine for the prevention of Human Papilloma Virus (HPV) has been added to the list of covered vaccines for children covered by the Vaccine for Children program administered by the Ohio Department of Health. This vaccine will be covered for female children ages 11-18. The code to be used for this vaccine is 90649.

Rule 5101:3-1-60 has also been amended to reflect that the Department will pay the \$5.00 administration fee for the HPV vaccine effective for dates of service on and after November 1, 2006.

REMINDER

Sterilization, Hysterectomy and Abortion Claims: 5101:3-21-01 and 5101:3-17-01

Before payment can be made for any sterilization, hysterectomy, or abortion for the primary or secondary procedure, or for medical procedures, including anesthesia directly related to the sterilization, hysterectomy, or abortion, a copy of the signed consent form must be included with the paper claim. Reimbursement will not be made for associated services when the signed consent form is not included with the claim. Paragraph (B) of rule 5101:3-21-01 specifies this requirement.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of rules 5101:3-4.21.1, 5101:3-4-22, and 5101:3-4-12, please complete the attached JFS 03400 form and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3355-06-04 (Healthchek [EPSDT] Policy/Rule Updates)

Medicaid Handbook Transmittal Letter (MHTL) 3355-06-04

June 30, 2006

TO: All Eligible Providers of Advanced Practice Nurse (APN) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Healthchek (EPSDT) Policy/Rule Updates

EFFECTIVE July 1, 2006

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing Healthchek (EPSDT) and to provide reminders regarding existing policy. Note: These rules are in a proposal status and are scheduled to be effective for dates of service on or after July 1, 2006.

Rules 5101:3-14-01, 5101:3-14-02, 5101:3-14-03, 5101:3-14-04, 5101:3-14-05 and 5101:3-14-09 of the Ohio Administrative Code (OAC) are amended to fulfill five year rule review requirements. Rule 5101:3-14-06 of the OAC is rescinded to fulfill five year rule review requirements. Context in the rescinded rule is incorporated into amended rules 5101:3-14-04 and 5101:3-14-05 of the OAC.

The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Advance Practice Nurse Services handbook. The Department encourages providers to visit the website and review the full text of the amended Healthchek (EPSDT) provider rules.

Key points of interest in the amended rules are:

- The titles of these rules are amended to more accurately describe the rule content and to be consistent with other rules within the same Chapter of the OAC
- Clarification of the components of screening visits
- Removing the term "assessment," as this term has many different interpretations
- Updated screening frequency (periodicity schedule) requirements to reference the American Academy of Pediatrics (AAP) website
- Clarification of the differentiation between screening and diagnosis/treatment (5101:3-14-03 is the screening rule, 5101:3-14-05 is the diagnosis/treatment rule)
- Inclusion of language to clarify that habilitation services are not covered under EPSDT and cannot be authorized under EPSDT

Rule 5101:3-14-01 of the OAC, entitled "Healthchek" otherwise known as early and periodic screening, diagnosis, and treatment program (EPSDT), is amended as part of the five-year rule review process. The title of this rule is amended to: "Healthchek: early and periodic screening, diagnosis, and treatment (EPSDT) services for individuals under age twenty-one." This title more accurately describes the rule content and is consistent with other rule titles within the same Chapter of the OAC. This rule outlines the general provisions that govern Healthchek, Ohio's early and periodic screening, diagnosis, and treatment program. This rule is amended to clarify existing policy. A key clarification in this rule is:

- Paragraph (B) is amended to clarify that the scope of services provided depends upon individual factors, including the findings of the Healthchek (EPSDT) screening or other covered medical services. Diagnosis and treatment services provided under Healthchek (EPSDT) are not limited to conditions identified in a Healthchek (EPSDT) screening visit.

Rule 5101:3-14-02 of the OAC, entitled Eligible providers of "Healthchek" (EPSDT) services, is amended as part of the five-year rule review process. The title of this rule is amended to: "Healthchek: eligible providers of

early and periodic screening, diagnosis, and treatment (EPSDT) services." This title more accurately describes the rule content and is consistent with other rule titles within the same Chapter of the OAC. This rule lists the eligible providers of Healthchek (EPSDT) services. Paragraph (A)(2) is added to state that advance practice nurses (APNs) may also provide Healthchek (EPSDT) screening services, in accordance with Chapter 5101:3-8 of the Administrative Code. This rule is amended to clarify existing policy.

Rule 5101:3-14-03 of the OAC, entitled Covered "Healthchek" (EPSDT) screening services, is amended as part of the five- year rule review process. The title of this rule is amended to: "Healthchek: early and periodic screening, diagnosis, and treatment (EPSDT) screening visits." This title more accurately describes the rule content and is consistent with other rule titles within the same Chapter of the OAC. This rule outlines the screening components that the Healthchek (EPSDT) provider shall complete as part of initial and periodic Healthchek (EPSDT) screening visits. Key points in this rule include:

- Reference is added to clarify that providers shall document an individual's refusal of component(s) of the EPSDT screening visit.
- A definition of "screening" is included in paragraph (A), stating: "For the purposes of Chapter 5101:3-14 of the Administrative Code, 'screening' is defined as the identification of individuals at risk of health problems. Results of a screening do not represent a diagnosis, but rather, indicate need for referral to an appropriate resource for additional evaluation, diagnosis, treatment, or other follow-up when concerns or questions remain as a result of the screening."
- The term "assessment" is no longer used, as many providers and other individuals consider "assessment" to mean evaluation and diagnosis. The language change is made to clarify the intent of the Healthchek screening visits.
- Reference to the screening frequency (periodicity schedule) is relocated to paragraph (B)(1) of this rule from the reimbursement rule (5101:3-14-04).
- Clarification is made in paragraph (B), referencing the referral requirements of the medicaid managed care program found in rule 5101:3-26-05.1 of the OAC.
- "Lea" is added as an example of a visual acuity test appropriate for individuals age three and older and "stereopsis test (e.g., random dot E)" is added as a vision screening service in paragraph (G)
- Clarification in paragraph (G)(2) that vision screening is considered part of the comprehensive Healthchek (EPSDT) visit and is not reimbursed separately.
- Clarification in paragraph (H)(1)(b) that when pure-tone equipment is not available for a hearing screening, providers are encouraged to refer children to another provider for a pure-tone test.
- Clarification in paragraph (J) that blood lead screening tests are covered whenever medically indicated and that children of any age may be screened for lead toxicity.
- Clarification in paragraph (J)(1)(c)(iii) that the erythrocyte protoporphyrin test is not acceptable as a blood lead screening test.
- Clarification in paragraph (K)(3)(c) that a wide variety of individuals should be screened for sickle cell or other hemoglobinopathies.
- Clarification in paragraph (L) that providers shall perform a dental screening as part of the basic examination component of each initial and periodic screening visit.
- Inclusion of paragraph (M)(3) to state that additional health education and counseling codes (e.g., 99401, 99402, 99403, 99404) will not be reimbursed on the same date of services as a Healthchek (EPSDT) visit code (e.g., 99381, 99382, 99383, 99384, 99385). References to additional reimbursement for health education and counseling that lasts thirty minutes or more is removed.
- Clarification in paragraph (N) that when the need for further evaluation is indicated, "the provider shall, without delay, make a referral for evaluation, diagnosis, and/or treatment. Evaluation,

diagnosis, and/or treatment may be provided at the time of the Healthchek (EPSDT) screening visit if the health care professional is qualified to provide the services."

Rule 5101:3-14-04 of the OAC, entitled Reimbursement of "Healthchek" (EPSDT) screening services and screening frequency, is amended as part of the five-year rule review process. The title of this rule is amended to: "Healthchek: reimbursement of early and periodic screening, diagnosis, and treatment (EPSDT) services." This title more accurately describes the rule content and is consistent with other rule titles within the same Chapter of the OAC. This rule outlines the general provisions that govern provider reimbursement for Healthchek (EPSDT) services. No policy changes are intended in the amended rule. This rule is amended to clarify existing policy. Key points in this rule include:

- Clarification that Healthchek (EPSDT) screening visits shall be billed using the appropriate preventive medicine services code reflecting a comprehensive preventive medicine evaluation and management, focusing on age and gender appropriate history, examination, anticipatory guidance, and risk factor reduction interventions.
- Clarification that laboratory specimens sent to an outside laboratory for analysis must be billed by the laboratory that actually performs the procedure.
- Reference to interperiodic examinations, vision, hearing and dental services is relocated to paragraph (B)(2) of this rule from rule 5101-3-14-06 of the OAC.
- Paragraph (B) lists the services that may be billed separately and on the same date as a Healthchek (EPSDT) screening visit.
- Inclusion of paragraph (C), clarifying that when a Medicaid recipient is enrolled in a Medicaid managed care program, prior authorization and claim submission requirements for Healthchek (EPSDT) are applicable, in accordance with rule 5101:3-26-05.1 of the OAC.

Rule 5101:3-14-05 of the OAC, entitled Vision, hearing, and dental services, is amended as part of the five-year rule review process. The title of this rule is amended to: "Healthchek: covered diagnostic and treatment services under early and periodic screening, diagnosis, and treatment (EPSDT)." This title more accurately describes the rule content and is consistent with other rule titles within the same Chapter of the OAC. This rule outlines requirements for the provision of evaluation, diagnostic, and treatment services under Healthchek (EPSDT). Key points in this rule include:

- Clarification that when a Healthchek (EPSDT) screening visit indicates the need for further evaluation of an individual's health, the provider shall make a referral for diagnosis and treatment without delay and follow-up to make sure that the individual receives a complete diagnostic evaluation.
- Clarification of the components of diagnostic and treatment services.
- Reference to interperiodic examinations, vision, hearing and dental services is relocated to paragraph (D) of this rule from rule 5101-3-14-06 of the OAC.
- Inclusion, in paragraph (E)(2), of language stating that diagnostic services provided beyond stated coverage and limitations (e.g., Physical therapy) are subject to prior authorization and provided in accordance with federal EPSDT requirements.
- Inclusion of language in paragraph (F) to clarify that certain services not usually covered by Medicaid may be available for Medicaid recipients who are in institutional settings or receiving HCBS waiver services: "Additional services not usually covered under the Medicaid program may be available in an institutional setting or through a home and community-based services (HCBS) waiver."
- Inclusion of language in paragraph (G) stating: "Habilitation services are not covered and are not authorized under EPSDT on Ohio Medicaid's state plan except when provided in an intermediate care facility for persons with mental retardation (ICF/MR). Habilitation services may also be provided to enrollees of ICF/MR based waivers if the habilitation services is a service covered by the waiver and if the service is medically necessary for the waiver enrollee." Habilitation services are neither covered nor authorized except when provided in an

intermediate care facility for persons with mental retardation (ICF-MR) or as part of an ICF/MR based waiver if the habilitation services are covered by the waiver and medically necessary for the waiver enrollee.

Rule **5101:3-14-06** of the OAC, entitled Interperiodic "Healthchek" (EPSDT) services, is rescinded as part of the five-year rule review process. This rescinded rule outlines the provisions that govern medically necessary diagnostic vision, hearing, and dental examinations in the Medicaid program. The content is incorporated into amended rules 5101:3-14-04 and 5101:3-14-05. No policy changes are intended.

Rule 5101:3-14-09 of the OAC, entitled Environmental assessments for elevated blood levels, is amended as part of the five-year rule review process. The title of this rule is amended to: "Healthchek: environmental investigation for elevated blood levels under early and periodic screening, diagnosis, and treatment services environmental investigation." This title more accurately describes the rule content and is consistent with other rule titles within the same Chapter of the OAC. This rule outlines the general provisions that govern Medicaid coverage of public health lead investigations performed by the Ohio Department of Health (ODH), in accordance with Section 3742 of the Revised Code. No policy changes are intended in the amended rule.

Web Page Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

At the "electronic manuals" web page, this MHTL, and any attachments, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Advance Practice Nurse Services Handbook."
- (3) From the drop-down menu entitled "Table of Contents" at the top of the page, scroll to and select the desired MHTL number.
- (4) Scroll through the MHTL to the desired rule number highlighted in blue and select the rule number.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of updates to the Healthchek (EPSDT) rules in Chapter 5101:3-14 of the OAC, please complete the attached JFS 03400 and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3355-06-03 (Advance Practice Nurse Policy Updates: 5101:3-1-60 and 5101:3-4-12)

Medicaid Handbook Transmittal Letter (MHTL) 3355-06-03

June 30, 2006

TO: All Eligible Providers of Advance Practice Nursing Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Advance Practice Nurse Policy Updates: 5101:3-1-60 and 5101:3-4-12

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce amendments being made to Ohio Administrative Code (OAC) Rules 5101:3-1-60, Medicaid reimbursement, and 5101:3-4-12, Immunizations.

Note: These rules are in a proposed status. Rules 5101:3-1-60 and 5101:3-4-12 are scheduled to become effective July 15, 2006 for dates of service on or after July 15, 2006. The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Advanced Practice Nurse Services handbook.

EFFECTIVE JULY 15, 2006

Medicaid reimbursement: 5101:3-1-60

The Medicaid reimbursement rule is being amended to reflect price changes for J codes and immunization codes, to add the new vaccine code for rotavirus, and to revise miscellaneous CPT or HCPCS codes. The changes can be found in appendix DD of the rule.

Immunizations: 5101:3-4-12

The immunization rule is being amended to add the vaccine code (90680) for rotavirus to the list of free vaccines for children. The national Advisory Committee on Immunization Practices (ACIP) recommendations specify that the rotavirus vaccine is medically indicated for infants age 6 weeks through 32 weeks.

Language has also been amended in paragraph (G)(1) to clarify how the Department sets the Medicaid maximum for covered vaccines for adults. Other language added or removed from the rule is for the purpose of clarification.

Edit for multiple unit billing:

It has come to the Department's attention that some providers are billing multiple units for a single evaluation and management CPT code, e.g., a hospital visit or an office visit. The Department's billing instructions, which can be found at <http://emanuals.odjfs.state.oh.us/emanuals>, specify that one unit should be billed in most cases (exceptions are anesthesia time, time-based codes, etc.). The Department will begin denying claims for codes in the range of 99201-99440 (excluding time-based codes and add-on codes) and 99050-99051 when multiple units are billed for a single code. When billing evaluation and management codes, providers must enter the CPT code for each evaluation and management service provided on a single line of the claim and must have only one unit for that service (e.g. a recipient has a three day hospital stay, the provider should bill code 99232, three times, on three different lines, showing each date of service on a single line of the claim). Please be advised that Ohio Medicaid does not accept billing for a span of care covering a range of dates on a single claim line of a professional claim. Claims containing evaluation and management codes with multiple units will be denied and providers will have to resubmit with only one unit per code. Should you have questions, please call Provider Network Management at 1-800-686-1516.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of rule 5101:3-4-12, please complete the attached JFS03400 form and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3355-06-02 (Ohio Medicaid Coverage of Fluoride Varnish Application by Non-Dental Providers)

Medicaid Handbook Transmittal Letter (MHTL) NO. 3355-06-02

July 14, 2006

To: All Eligible Providers of Advanced Practice Nurse (APN) Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Re: Ohio Medicaid coverage of fluoride varnish application by non-dental providers

The purpose of MHTL No. 3355-06-02 is to inform providers of APN services of the coverage and limitation of OAC rule 5101:3-4-33 Coverage of fluoride varnish by non-dental providers.

This new rule, effective July 1, 2006, authorizes Medicaid program coverage and separate reimbursement for eligible APN providers to perform fluoride treatment, within their scope of practice, through the application of fluoride varnish during the course of a well or sick child examination for children to age three when medically appropriate. Coverage of fluoride treatments by physician providers is limited to one application every one hundred eighty days.

Fluoride varnish can arrest demineralization and remineralize teeth damaged by the decay process. The application of fluoride varnish has three components each of which must be performed: oral assessment, varnish application and referral.

In addition to the oral assessment and varnish application, parents or guardians must be provided with information about the fluoride varnish procedure and proper oral health care for their child. If the child has obvious oral health problems and does not have a dental provider, he/she must be referred to a dentist or the county department of job and family services.

In order to be reimbursed for the professional services associated with the application of fluoride varnish, APN providers should follow their standard billing procedures and must submit CDT code D1203 topical application of fluoride (prophylaxis not included) - child with the appropriate APN modifier.

As a reminder, all services provided by APNs must be submitted with the appropriate APN modifier regardless of the work setting.

Valid APN modifiers are:

SA (nurse practitioner)

SB (nurse mid-wife)

UC (clinical nurse specialist)

Provider handbooks, billing instructions and other provider communications are available on the Department's electronic manual site at:

<http://emanuals.odjfs.state.oh.us/emanuals>

If you do not have internet access, you may request a paper copy of the new OAC rule 5101:3-4-33 Coverage of fluoride varnish by non-dental providers mentioned in this MHTL by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3355-06-01 (Advanced Practice Nurse Handbook Update: 2006 HCPCS Changes)

Medicaid Handbook Transmittal Letter (MHTL) 3355-06-01

January 23, 2006

TO: All Eligible Providers of Advanced Practice Nurse (APN) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: ADVANCED PRACTICE NURSE HANDBOOK UPDATE: 2006 HCPCS Changes

2006 HCPCS CODE AND POLICY CHANGES

EFFECTIVE JANUARY 1, 2006

- After hours care
- Confirmatory consultation codes
- Critical Care Services- low birth weight service codes
- Nursing Facility Services Codes
- Domiciliary, rest home, or home care plan oversight services
- Family Planning- contraceptive subdermal implants deleted
- Immunization code added
- Gastric restrictive procedures

EFFECTIVE APRIL 1, 2006

- Family planning
- Immunizations- new coverage of immunizations for children and adults

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2006 HCPCS codes (CPT and alphabetic) and to transmit any new policy changes resulting from these changes to eligible providers of APN services.

2006 Codes

Rules 5101:3-4-06, 5101:3-4-07, 5101:3-4-12, and 5101:3-4-28 are to be filed on an emergency basis on December 30, 2005, and are to be proposed in January 2006 for permanent amendment.

On January 1, 2006 the Department began accepting the 2006 HCPCS codes effective for services on and after January 1, 2006. The Department will not accept the 2005 codes that have been obsoleted by the AMA for services rendered beyond December 31, 2005.

Advanced Practice Nurse Book Updates: Policy Updates

The following paragraphs summarize the significant rule changes that have been made effective for services provided on and after January 1, 2006. These changes have been posted to the department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the physician book. If you are maintaining a paper copy of the new APN rule-based book, please remove these rules that have been amended from your book (listed in the MHTL) and replace them with the amended rules.

Rule Changes:

After Hours Care: Rule 5101:3-4-06

The Department has amended this portion of the rule because of the deletion of code 99052 and to emphasize new code 99050 should be billed if care is provided after hours in addition to basic services. Other codes for after hours services are not covered. These services are considered bundled in the payment for other services.

Confirmatory Consultations: Rule 5101:3-4-06

Codes for confirmatory consultations have been deleted from the CPT book. The amendment made to this rule reflects new language stating that for confirmatory consultations, providers are to bill an appropriate E/M service code for the setting and type of service.

Critical Care Services: Rule 5101:3-4-06

The change to this part of the rule reflects language in the new and revised codes for continuing intensive care for low birth weight infants. The CPT codes for low birth weight infants have changed from two to three categories. Low birth weight infants are now classified into the following categories: less than 1500 grams, 1500-2500 grams, and 2501-5000 grams.

Codes 99298, 99299, 99300 delineated under continuing intensive care services represent subsequent days of care and are reimbursable only once per calendar day per patient. These are considered global codes with the same services bundled as outlined under codes 99243-99246 under "inpatient neonatal and pediatric critical care services."

Nursing Facility Services: Rule 5101:3-4-06

All the codes under "Initial Nursing Facility Care" and "Subsequent Nursing Facility Care" have changed. The codes have been replaced with new 2006 codes that list minor differences in the key components that are required to bill the codes. In addition to this change a new category titled "Other Nursing Facility Services" was added. Code 99318 should be used to bill for an annual nursing facility assessment. This code is not reimbursable on the same day of service as the nursing facility service codes (99304-99316).

Domiciliary, Rest Home, or Home Care Plan Oversight Services: Rule 5101:3-4-06

This is a new section within the CPT book for 2006. The codes listed in this section of CPT are for care plan oversight services of patients in the home, domiciliary, or rest home under the individual supervision of a physician. Payment for these services are considered to be bundled and therefore are not covered by Ohio Medicaid.

Family Planning- contraceptive subdermal implants deleted: Rule 5101:3-4-07

The code A4260 (Norplant), has been deleted since the subdermal implant is no longer available in the United States. Paragraph H of rule 5101:3-4-07, containing this information has been stricken from the rule.

Immunizations: Rule 5101:3-4-12

A new vaccine code, 90714, preservative free tetanus diphtheria toxoids, has been added to the Vaccines for Children list based on national Advisory Committee on Immunization Practices (ACIP) recommendations. The new code will be valid for children age 7 or older.

In addition, code 90710 for measles, mumps, rubella, and varicella vaccine is being added to the Vaccine for Children's program based on national ACIP recommendations.

Gastric Restrictive Procedures: Rule 5101:3-4-28

Codes 43770 through 43774 and 43886 through 43888 have been added to the CPT. The new codes are for gastric restrictive procedure. Procedures for obesity are not typically covered by Medicaid and therefore they have been added to rule 5101:3-4-28, as non-covered services.

Appendices Revisions

The following appendices have been revised as a result of the 2006 HCPCS code update:

[**Payable Surgical Procedure Codes \(10000-69999\)**](#)

[**Injection Codes**](#)

[**Clinical Lab Procedures with Pathology Consultations**](#)

Waived Laboratory Procedures

RULE CHANGES EFFECTIVE FOR APRIL 1, 2006

Family Planning Visits: 5101:3-4-07

- The family planning rule will be proposed for amendment in January 2006 and will become effective on or about March 27, 2006. Under the family planning visits portion of the rule, language has been removed so that advanced practice nurses are not required to have orders from a supervising physician to provide services such as pap smears, vaginal smears, or cultures.
- Sexually transmitted infection testing has been added to laboratory services covered as family planning per recommendation of the Ohio Department of Public Health.
- The detailed listing of contraceptive devices/methods covered by the Department have been removed from the rule. For family planning services covered by Medicaid, providers should refer to rules 5101:3-1-60 or 5101:3-9 of the Ohio Administrative code. In addition to this change, the language under reimbursement for family planning pharmaceutical or medical supplies has been revised to allow for all providers with prescriptive authority under Ohio law to be reimbursed for pharmaceutical or medical supplies.

Immunization: Rule 5101:3-4-12

The immunization rule will be proposed for amendment in January 2006 and will become effective on or about March 27, 2006. The following codes will be added to the Vaccines for Children program per recommendation by the Ohio Department of Public Health: 1) 90633 Hepatitis A, 2 dose schedule, 2) 90634 Hepatitis A, 3 dose schedule, 3) 90660 intranasal influenza, and 4) 90710, measles, mumps, rubella, and varicella vaccine. Code 90714, preservative free tetanus diphtheria toxoids, and 90715 have been added to the list of covered immunizations for adults.

In paragraph G of rule 5101:3-4-12, the following codes have been added to the list of codes that will be covered for both adults and children (90633, 90634, 90660, 90710, 90714, 90715). When one of these vaccines is provided to a child age 18 or less, the Department will pay the \$5.00 administration fee since the vaccine will be obtained free through the VFC program. When the vaccine is provided to an adult, the vaccine will be reimbursed at the lesser of the provider's billed charge or the Medicaid maximum listed in rule 5101:3-1-60 of the Ohio Administrative Code.

Note: Some of these vaccines for adults will be considered by report and must be submitted on a paper claim and will be paid manually. Please provide a copy of the invoice reflecting your cost processed with your paper claim.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached JFS 03400 form and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3355-05-02 (APN and Anesthesiology Assistant Policy/Rule Updates)

Medicaid Handbook Transmittal Letter (MHTL) 3355-05-02

July 14, 2005

TO: All Eligible Providers of APN and Anesthesiology Assistant (AA) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: APN and Anesthesiology Assistant (AA) Policy/Rule Updates

- Additional immunization coverage
- Radiopharmaceutical diagnostic imaging agents
- Place of service codes
- Allergy coverage criteria
- Billing bilateral claims
- CRNA rule: rule review completed: no policy changes
- Price changes
- Anesthesiology assistant rule- five-year rule review

EFFECTIVE SEPTEMBER 1, 2005

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing APN and anesthesiology assistant (AA) services and to provide reminders regarding existing policy. Note: The rules relating to policy changes are in a proposal status and are scheduled to be effective for dates of service on or after September 1, 2005.

The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the APN book.

I. APN Policies

A. Immunization coverage additions - Rule 5101:3-4-12

Four additional vaccines will be covered for children under the federal Vaccines for Children (VFC) program. They are the preservative free influenza for ages 3 and above (code 90656), the meningococcal polysaccharide vaccine for children ages 2 -18 (code 90733), the meningococcal conjugate vaccine for children ages 11 - 18 (code 90734), and tetanus, diphtheria toxoids and acellular pertussis for children 7 years or old (code 90715).

The Department will restrict payment to the age categories specified for each vaccine code using the Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control (CDC) recommendations. The ACIP recommendations for the meningococcal vaccines can be found at http://www.cdc.gov/nip/vfc/acip_resolutions/0205mening-mpsv4.pdf.

The description for code 90700 in the VFC list was also amended to reflect the description in the CPT book that specifies that this vaccine is for individuals younger than seven years of age.

For adults over age 18, the preservative free influenza vaccine will also be covered (code 90656). The Hib vaccines (codes 90645, 90646, 90647, and 90648) and the meningococcal conjugate vaccine (code 90734) will also be covered for adults, but only if determined medically necessary by the department.

Previously, if providers gave the DTaP/Hib combination vaccine, they were required to bill both a DTaP (90700) and a Hib vaccination code (90645, 90646, 90647, or 90648). Now they should bill the DTaP/Hib combination code 90721.

All of these additional coverages are effective for dates of service September 1, 2005. This date is dependent on MIS work being completed. Should required MIS work be incomplete on September 1, the Department will notify providers via a remittance advice newsletter of the revised date.

B. Place of service codes - Rule 5101:3-4-02.2

Additional valid place of service codes are being added, but it is dependent on work that needs to be completed by the Department's Management Information Systems staff. The department will notify providers when the work is completed. The department's billing instructions will be updated to include the new HIPAA compliant place of service codes when the MIS work has been completed.

C. Allergy coverage criteria - Rule 5101:3-4-19

The following paragraphs describe new policy relating to allergy services.

A complete medical and immunological history and physical examination must be done prior to performing diagnostic testing. The testing must be performed based on the medical and immunologic history and physical examination that documents that the antigen being used for the testing exists within a reasonable probability of exposure in the patient's environment. This must be documented in the patient's medical record. The allergy testing must be limited to the minimal number of tests medically necessary to reach a diagnosis.

Effective for dates of service on or after September 1, 2005, CPT codes 86005 and 95078 are not covered because they are not medically necessary. Ophthalmic mucous membrane tests and direct nasal mucous membrane tests are allowed only when skin testing cannot test allergens. Ingestion challenge tests (95075) are allowed once per patient encounter regardless of the number of items tested and include the evaluation of the patient's response to the test items.

For allergen immunotherapy, the patient's medical record must document that allergen immunotherapy was determined by appropriate diagnostic procedures coordinated with clinical judgment and knowledge of the natural history of allergic diseases. Documentation must be made available to the Department upon request. Allergen immunotherapy will not be covered for the following antigens: newsprint, tobacco smoke, dandelion, orris root, phenol, formalin, alcohol, sugar, yeast, grain mill dust goldenrod, pyrethrum, marigold, soybean dust, honeysuckle, wool, fiberglass, green tea, or chalk since they are not considered medically necessary.

Effective for dates of service on or after September 1, 2005, CPT codes 95120 through 95134 are also not covered because they represent complete services and providers are required to use component billing. Clarification of component billing and how to component bill is outlined in the rule. These changes are consistent with current Medicare policy.

Please review rule 5101:3-4-19 for a complete understanding of this policy.

D. Billing with the bilateral modifier - Rule 5101:3-4-22

This is an important reminder about bilateral procedure billing. Bilateral procedures must be billed using the code for the procedure modified by the modifier 50. For example, 6943650 means that a tympanostomy was performed on both ears. Code 69436 billed without a modifier means the procedure was performed on one ear. The Department will pay the lesser of the provider's billed charge or 150% of the Medicaid maximum for the procedure when it is performed bilaterally.

A bilateral procedure code should never be billed twice (either two lines on the same claim or on two different claims), once with the 50 modifier and once without a modifier. Billings of this nature will be delayed. The Department is in the process of implementing systems logic that will begin denying bilateral services that are billed twice since this is not the appropriate billing method.

Note: To facilitate billing of bilateral procedures, the department has updated its claims system to accept the 50 bilateral modifier for any surgical code identified by CMS as bilateral. Therefore, claims billed with the bilateral modifier should not deny.

E. CRNAs - 5101:3-8-25

This rule was amended as part of the 5 year rule review process. The only changes made to the rule were to correct grammar and an outdated rule reference and modifier reference.

F. Price changes 5101:3-1-60

The prices for certain codes have been adjusted if Medicaid's price was above Medicare's price. These price changes are for certain J codes, some immunization codes, and selected surgical and radiology codes.

II. Anesthesiology Assistant Policy 5101:3-8-26

The anesthesia assistant rule was reviewed as part of the five year rule review process. This rule is rescinded and reissued to clarify existing policy and correct references to the Ohio Revised Code and code modifier. No policy changes are intended in the new rule.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of updates to the physician rules (with the exception of rule 5101:3-1-60, please complete the attached JFS 03400 and either mail it or fax it to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3355-05-01 (APN Handbook Update: 2005 HCPCS Changes)

Medicaid Handbook Transmittal Letter (MHTL) 3355-05-01

December 17, 2004

TO: All Eligible Providers of APN Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: APN Handbook Update: 2005 HCPCS Changes

2005 HCPCS CODE AND POLICY CHANGES

EFFECTIVE JANUARY 1, 2005

- Critical care visits
- New anatomical laboratory codes
- Risperadol Consta
- Revised appendices
- Other Changes - rule reviews
- Reminder - gynecological exams
- Reminder - lead testing requests

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2005 HCPCS codes (CPT and alphabetic) and to transmit any new policy changes resulting from these changes to eligible providers of APN services. These changes are based on the emergency filing of these rules that will be effective on or around January 1, 2005.

2005 HCPCS Code Changes

On January 1, 2005, the Department began accepting the 2005 HCPCS codes effective for services on and after January 1, 2005. The Department will not accept the 2004 codes that have been obsoleted by the AMA for services rendered beyond December 31, 2004.

APN Book Updates: Policy Updates

The following paragraphs summarize the significant rule changes that have been made effective for services provided on and after January 1, 2005. These changes have been posted to the department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> in the APN book. If you are maintaining a paper copy of the new APN rule-based book, please remove these rules that have been amended from your book (listed in this MHTL) and replace them with the amended rules.

Rule Changes:

Critical Care Visits: 5101:3-4-06

Please note the change in the description for the pediatric and neonatal critical care codes 99293 through 99296. The descriptions of these codes were revised to change the definition of a critically ill infant to 29 days through 24 months of age from 31 days up through 24 months of age and the definition of a critically ill neonate to 28 days of age or less from 30 days of age or less.

New anatomical laboratory codes:

There are new anatomical lab codes added by the AMA for 2005: They are 88187, 88188, 88189, 88360, 88367, and 88368. These codes will be added to the anatomical lab code table now found under the section called "billing and coding aids." Please use modifier 26 when billing for the professional component.

Risperadol Consta

Procedure code S0163 for Risperdal Consta 12.5 mg will be deleted effective 1/1/05. J2794 will replace S0163, but will be measured in 0.5 mg units. This represents the lowest common denominator of possible billing units. The Medicaid maximum for each unit billed for this code is \$4.64. Multiple units may be billed based upon the appropriate dosage being administered. Bill the number of units necessary to cover the dosage given. For example, if 12.5 mg were administered, the units billed would be 25 and the maximum payment would be \$116.00. If 20 mg were administered, the units billed would be 40 and the maximum payment would be \$185.60.

Appendices Revisions

The following appendices have been revised as a result of the 2005 HCPCS code update or as a result of HIPAA code/modifier changes:

[Payable Surgical Procedure Codes \(10000-69999\)](#)

[Injection Codes](#)

[Clinical Lab Procedures with Pathology Consultations](#)

[Waived Laboratory Procedures](#)

Other Changes:

Rule Reviews: Rules 5101:3-4-17 *and* 5101:3-21-01

Rule 5101:3-17-01 entitled Abortions and Rule 5101:3-21-01 entitled Sterilization are being amended as part of the five year rule review process. Both rules contain grammatical revisions that are not substantive. The Sterilization rule contains the following new sentence in paragraph (A)(5): "The individual must also be permitted to have a witness of his/her choice present when consent is made." This sentence was added so that Ohio's rule matches federal statute.

Reminders:

Gynecologic Exams: Rule 5101:3-4-28

The only time Medicaid covers preventive medicine visits is for a "routine pelvic exam, pap smears and breast exam," which are not for the purpose of family planning. The appropriate evaluation and management (E/M) office visit code should be billed for this service and not the family planning office visit codes.

Lead Testing: Rule 5101:3-14-03

The Department would like to remind providers of the mandatory lead testing requirements for all 12 and 24 month old Medicaid eligible children. All 12 and 24 month old Medicaid children must have a blood lead screening as stated in the EPSDT rule 5101:3-14-03 paragraph (H). Children between the ages of 36 and 72 months of age also must have a blood lead screening test if they have not been previously screened for lead poisoning. Also under paragraph (H) of rule 5101:3-14-03 is the definition of what constitutes a lead toxicity screening. Only a lead blood test must be used when performing a lead toxicity screening. A Risk Assessment Questionnaire is not an acceptable substitute for the blood lead toxicity screening.

All Medicaid children are considered "at risk" for lead poisoning. Although lead toxicity screening is required under EPSDT/Healthchek, all Medicaid age applicable children (see definition in paragraph 1 above) should be tested regardless of the reason for the visit.

The Ohio Department of Health (ODH), Lead Poisoning Prevention program also promotes lead screening. The ODH rule 3701:30-02 identifies the responsibility of a primary health care provider to provide a lead test to "at risk" children. ODH rule 3701:30-01 defines a child "at risk" of lead poisoning and includes a child who is Medicaid eligible. To locate a copy of this ODH rule go to;

http://www.odh.ohio.gov/Rules/Final/Chap30/FR30_1st.htm or call John Belt, Lead Poisoning Prevention Program Supervisor (ODH) at 614-728-9454

For up to date Medicaid testing information go to the following website:

<http://ifs.ohio.gov/ohp/bhpp/lpplpt/providerlead.stm> or call Donna Bush at 614-466-6420.

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached JFS 03400 form and either mail it or fax it to the address on the form.

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In-state toll free telephone number 1-800-686-1516

MHTL 3355-04-02 (APN Policy/Rule Updates)

Medicaid Handbook Transmittal Letter (MHTL) 3355-04-02

August 9, 2004

TO: All Eligible Providers of Advanced Practice Nurse (APN) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: APN Policy/Rule Updates

- New immunization code
- Injection code update
- Use of APN modifiers - reminder
- HealthChek (EPSDT) referrals
- Bilateral modifier correction

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules which govern APN services. Please note that the rules relating to policy changes for immunizations and pulmonary services are in a proposed status but are scheduled to be effective for dates of service on and after October 1, 2004 while the changes relating to miscellaneous injection codes will be effective November 15, 2004. The other policy topics are reminders regarding existing policy.

The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the physician book.

I. Immunization code addition - Rule 5101:3-4-12

Preservative free influenza vaccine

Effective for dates of service on and after October 1, 2004, the Department will cover the preservative free influenza vaccine, code 90655, through the Vaccine for Children's (VFC) program operated by the Ohio Department of Health. The Vaccine for Children's program will issue the preservative free influenza vaccine for children less than twenty-four months of age. The Department (ODJFS) will reimburse \$5.00 for the administration fee for this vaccine when the vaccine code is billed.

If the child is between ages twenty-four months and thirty-six months, reimbursement for the administration of the influenza vaccine is available for the influenza vaccine with preservative if the code 90657 is billed.

II. Injection code update - Rule 5101:3-4-13

Effective for date of service October 1, 2004, the Department has adjusted its Medicaid maximum for certain J codes. These changes can be found in appendix DD of rule 5101:3-1-60 in the legal services section of the Department's web site. This action was taken so that Medicaid would not be paying more than Medicare for these services.

Effective for dates of service on and after November 15, 2004, there will be a change to the codes to use when there is no code available for a generic drug or the dosage is lower than the code available. If there is no code available for the generic drug name or the dosage is lower than the code available, use the most appropriate miscellaneous code listed below.

When billing one of these codes, the national drug code (NDC) number, name of the drug/injectable, and the dosage must be provided in the remarks column of the billing invoice; all three items must be included in the remarks column (item 19 on the CMS 1500 claim form) for payment determination. The unit field on the claim form must indicate a unit of one. Under no circumstances should more than one miscellaneous code be used for the same drug on the same date of service.

If your organization submits electronic claims (either NSF tape or EDI 837 P transactions), all claims submitted with a miscellaneous code, e.g. J3490, J8999, 90799, must be submitted on a paper claim form.

The following are miscellaneous codes that should only be used if there is not a specific code available:

J3490, J3535, J3590, J7599, J7699, J7799, J8499, J8999, J9999, 90799.

III. Use of APN modifiers - 5101:3-8-27

This is a reminder that effective for dates of service on and after October 1, 2003, all services provided by APNs must be submitted with a the appropriate APN modifier. This requirement is in OAC rule 5101:3-8-27. The valid modifiers are:

SA= Nurse practitioner

SB= Nurse mid-wife

UC= Clinical nurse specialist

Modifiers should be used for APNs working in any setting, e.g. a physician's office, independently, etc.

The Department realizes that there was a systems problem initially (in October 2003) when the APN modifier was submitted as a second or third modifier. Policy staff has been assured by our MMIS department that this has been fixed, so please record the APN modifier on all claim submissions (paper claims, NSF format or 837 P transactions) when an APN provides the service.

IV. HealthChek (EPSDT) Referrals - Rule 5101:3-14-04

It is important for the Department to report to the federal government all EPSDT referrals. OAC rule 5101:3-14-04 describes reimbursement for HealthChek (EPSDT) screening services. To accurately report Ohio's EPSDT activity, the Department needs your help.

When billing for an EPSDT visit (preventive medicine codes 99381-99385 and 99391-99395) and an EPSDT referral is made for other services during that visit (e.g. referral to a dentist), follow the applicable instructions listed below:

- 1) On a paper claim, please enter the "R" indicator in item 24h.
- 2) For any NSF tape claims, record the "R" indicator in field F.O. -22.0.
- 3) If billing EDI using the 837 P transaction, please follow the instructions in the Department's companion guide on our web site and complete the appropriate fields in loop 2300 using the EPSDT referral segment (on page 89 of the 837 P companion guide). In the 2400 loop, complete the SV111 field (see page 151 of the 837 P companion guide).

For 837 P transactions, your trading partner can access the ODJFS companion guide for 837 P transactions at <http://hipaa.oh.gov/odjfs/pdfs/837A1Pro-post-a.pdf>. To obtain instructions on the EPSDT referral loop. Also, the ODJFS EDI support unit can assist your trading partner at 614-387-1212. Trading partners can email them at MMIS-EDI_support@odjfs.state.oh.us.

The Department realizes that some providers submitted paper claims with the "R" for dates of service on and after October 16, 2003, and the "R" was not accepted. The Department wishes to apologize. However, it is important that providers follow these instructions now and report all referrals in the future.

V. Bilateral modifier - Rule 5101:3-4-22

In MHTL 3336-0401 dated December 31, 2003, there was a typographic error that erroneously indicated that the bilateral modifier was 51. The correct modifier for bilateral services is 50.

VI. Requesting paper updates

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached JFS 03400 form and either mail or fax the form to the address on the form.

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In-state toll free telephone number 1-800-686-1516

MHTL 3355-04-01 (APN Handbook Update: 2004 HCPCS Changes)

Medicaid Handbook Transmittal Letter (MHTL) 3355-04-01

December 31, 2003

TO: All Eligible Providers of APN Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: APN Handbook Update: 2004 HCPCS Changes

2004 HCPCS CODE AND POLICY CHANGES

EFFECTIVE JANUARY 1, 2004

- Consultations- clarification
- Visits performed in conjunction with surgical procedures- follow-up day revisions
- Immunizations code deleted
- Scope of coverage: supervision requirements
- Use of new family planning exam codes
- Bilateral modifier added to codes
- Care coordination code limit
- Revised appendices

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2004 HCPCS codes (CPT and alphabetic) and to transmit any new policy changes resulting from these changes to eligible providers of APN services.

2004 Codes

On January 1, 2004, the Department began accepting the 2004 HCPCS codes effective for services on and after January 1, 2004. The Department will not accept the 2003 codes that have been obsoleted by the AMA for services rendered beyond December 31, 2003.

APN Book Updates: Policy Updates

The following paragraphs summarize the significant rule changes that have been made effective for services provided on and after January 1, 2004. These changes have been posted to the department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> in the APN book. If you are maintaining a paper copy of the new APN rule-based book, please remove these rules that have been amended from your book (listed in this MHTL) and replace them with the amended rules.

Rule Changes:

Consultations: *Rule 5101:3-4-06*

The Department has amended this rule to clarify that in order to bill a consultation code, the person requesting the consultation must be a health care professional who is eligible to bill the Department for physician services. When a teacher, social worker, or other non-physician (excluding an APN) requests a physician to evaluate a patient, these evaluations are not reimbursable as a consultation.

Visits performed in conjunction with surgical procedures- follow-up days: *Rule 5101:3-4-06*

In the 2004 CPT book, the starred designation was removed from surgical codes. Therefore, the Department has removed the asterisk from most surgical codes as well. The Department will continue the asterisk

designation in appendix DD of rule 5101:3-1-60 for a limited number of procedures, e.g. venipuncture procedures.

For those procedures where the asterisk was removed, for all claims received on and after January 1, 2004, a follow-up visit will no longer be allowed. However, since a payment for an E/M visit will no longer be made, the Department has adjusted the price of some of these codes.

For the venipuncture procedures which will continue to have an asterisk in rule 5101:3-1-60, a visit on the same day as surgery will be allowed only if it is customary for the physician to charge a visit to all patients.

These changes can be seen in the appendix entitled Payable Surgical Procedure Codes.

Immunizations: **Rule 5101:3-4-12**

Code 90659 for the influenza, whole virus will no longer be covered since the code was deleted from CPT. To report, use code 90658 for adults or children 3 years of age and above or 90657 for children, ages 6-35 months.

Scope of coverage: supervision requirements: **Rule 5101:3-4-02**

Services provided by non-physicians who have their own provider category/type (e.g. clinical psychologists, advanced practice nurses, and physical therapists) and are employed by or under contract with a physician's office are not subject to the physician supervision provisions described in this rule. However, a physician's office may not act simply as a billing agent for a non-physician such as a clinical psychologist. The conditions described in paragraph (C) (1) of this rule must be met in order for the services of a non-physician such as clinical psychologist to be covered as a physician service. The non-physicians listed in this paragraph are restricted to the coverage provisions and limitations for their respective provider type.

For non-physicians who have their own provider type:

Patients' records do not have to be reviewed and countersigned by the supervising physician.

The general supervision requirements do not apply to providers with their own Medicaid provider type.

For the services of these non-physicians to be considered a physician service, the service must meet the following requirements (in paragraph (C) (1) of rule 5101:3-4-02):

The non-physician must be a part-time, full-time or leased employee of the supervising physician, physician group practice, or of the legal entity that employs the physician, or the non-physician must be an independent contractor engaged by the physician through a written agreement; and

If the non-physician is a leased employee or independent contractor, the physician or legal entity exercises control over the actions taken by the non physician personnel with regard to the rendering of medical services to the same extent as the physician would exercise if the leased employee or contractor was an employee of the physician or legal entity.

Note that chiropractic services are not covered for adults in any setting effective for services rendered on and after January 1, 2004

Use of new codes for family planning exam- clarification

Effective for dates of service on and after October 1, 2003, the Department deleted the code X1453 since it was not HIPAA compliant. This code was replaced by 2 codes S0610 for a gynecological exam for family planning for a new patient and S0612 for a gynecological exam for family planning for an established patient. Please remember to bill these codes when a gynecological exam for family planning purposes is provided. Please do not bill an office visit code when a gynecological exam is for the purpose of family planning.

Bilateral modifiers added:

The bilateral modifier 51 has been added to hundreds of surgical codes. Please bill the 51 modifier when the code is considered bilateral as instructed in rule 5101:3-4-22, the surgery rule.

Care Coordination Code Limit Clarification

It has come to our attention that providers billing for care coordination services (H1002) for pregnancy-related services every 28 days have had claims denied with the explanation that " the service can be billed only once

every 30 days". This system rejection is incorrect. Staff has requested a correction. However, since it is not clear when this system error will be corrected, please re-bill care coordination (H1002) for a date which is greater than 30 days after the last date care coordination services were provided. Since services provided as part of care coordination are provided over the course of a month (not on an exact day), this re-bill will not be in conflict with Medicaid policy. Please review the requirements of care coordination services listed in the pregnancy-related services rule 5101:3-4-10 to verify that you are providing all of the services required as part of this service before billing the code.

Appendices Revisions

The following appendices have been revised as a result of the 2004 HCPCS code update:

Payable Surgical Procedure Codes (10000-69999)

Injection Codes

Valid Modifiers

Valid Alpha HCPCS Codes

Requesting Paper Updates:

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached JFS 03400 form(s) and either mail them or fax them to the address on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-1516

MHTL 3355-03-04 (New APN Services Policy Book)

Medicaid Handbook Transmittal Letter (MHTL) 3355-03-04

December 15, 2003

TO: Eligible Providers of APN Services
Directors, County Department of Job and Family Services

FROM: Thomas J. Hayes, Director

SUBJECT: New APN Services Policy Book

The Department wishes to announce that the program policies for APNs participating in the Medicaid program have a new look effective January 1, 2004. Providers accessing the program policies on the Department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> will no longer see a handbook style format, e.g. APN.1101 Visits. The policies are now linked to the Ohio Administrative Code (OAC) rules that are the legal basis for those policies. For example, the policy governing "allergy services" is a direct link to OAC 5101:3-4-19, and the policy governing "eligible providers of APN services" is linked to OAC 5101:3-8-21. We encourage providers to navigate the new APN book and become familiar with the organization and location of the APN rules and other policy information.

ODJFS would like to stress that these are not new rules or policy. All of this information was in our APN handbook previously but was in a different format. The new APN handbook on dynaweb is a rule-based format. Each of the chapters contained in this book contain the rules relating to the chapter title. Any information that is not in a rule will be located in the appendix called Billing and Coding Aids.

The new APN book will be divided into the following sections:

Medicaid Handbook Transmittal Letters (MHTL)

Medical Assistance Letters (MAL)

Alphabetic site index

Chapter 1: General Information for APNs

Chapter 2: APN Reimbursement

Chapter 3: Utilization Review

Chapter 4: APN Coverage and Reimbursement Policies

Additional APN Information

Medicaid Forms for APNs

Billing and Coding Aids for APNs

Appendices

The alphabetic index to the APN book will show all topics alphabetically. From this alphabetic index, the provider can double click on the specific topic of interest.

The Department will continue to announce policy/rule changes using a Medicaid Handbook Transmittal Letter (MHTL). In addition, all of the MHTLs that have been issued in the past will still be posted to the web site so APNs can access them for historical information.

Chapter 1 titled "General Information for APN Providers" contains rules that are related to general topics such as eligibility for both nurse practitioners, clinical nurse specialists, and CRNAs.

Chapter 2 titled "APN Reimbursement" contains the general reimbursement rule, 5101:3-1-60 as well as other reimbursement rules such as non-covered services, by-report provisions, direct and general supervision requirements, etc.

Chapter 3 titled "Utilization Review of APN Services" contains preadmission certification provisions and prior authorization rules.

Chapter 4 called "APN Coverage and Reimbursement" contains all of the rules governing coverage of APN services. It lists each rule by rule title. For example, the rule governing APN coverage and limitations is first. This rule links to many physician rules which state, in detail, coverage for specific services including but not limited to allergy, anesthesia, and others. This section contains many rules including five (5) rules devoted to HealthChek also known as Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services that are an integral part of the APN program.

The next section is called Additional APN Information. It contains Medicaid forms, billing and coding aids for APNs, and appendices that are already in the current APN handbook.

The section titled "Medicaid Forms" contains forms that APNs' offices may use such as the Prenatal Risk Assessment Form.

The section called "Billing and Coding Aids for APNs" is new. This section includes information that was previously contained in various sections of the current APN handbook that is not in OAC rules. For example, under "HealthChek-(EPSDT) services there are billing codes and billing instructions for EPSDT services. Both of these documents were previously in the section APN.1105 called "HealthChek (EPSDT) Services" of the APN handbook.

A second example of information in the new section called "Billing and Coding Aides" can be found under "laboratory services". Under this section providers can access a listing of clinical laboratory codes, a listing of anatomical laboratory codes, a listing of waived, PPMP, and radiology codes subject to CLIA requirements.

The last section contains appendices that were previously in the APN handbook. The only change is that the name of each appendix is listed and no longer starts with APN.

It should be stressed that all of the information formerly contained in the APN handbook is still in this rule-based collection. Only the format has changed.

Requesting paper updates

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached ODJFS Health Plan Provider Update Request form (JFS 03400) and either mail it or fax it to the address or phone number provided on the form.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In state toll free telephone number 1-800-686-6108

Out-of-state telephone number 614-728-3288

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-10-02](#) is maintained in the General Information e-book.

MHTL 3334-09-02 (Discontinuing the DMA Program and the Rescission of OAC Rule 5101:3-23-01)

Medicaid Handbook Transmittal Letter (MHTL) No. [3334-09-02](#) is maintained in the General Information e-book.

MHTL 3336-10-01 (Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule)

Medicaid Handbook Transmittal Letter (MHTL) No. [3336-10-01](#) is maintained in the Physician Services e-book.

Medical Assistance Letters

MAL 583 (Medicaid Pharmacy Coverage for Dual Eligibles Effective January 1, 2013)

Medical Assistance Letter (MAL) [583](#) is maintained in the Pharmacy Services e-book.

MAL 582 (Pharmacy Program Changes Effective October 1, 2012)

Medical Assistance Letter (MAL) [582](#) is maintained in the Pharmacy Services e-book.

MAL 569 (Changes to the Medicaid Preferred Drug List Effective October 1, 2010)

Medical Assistance Letter (MAL) [569](#) is maintained in the Pharmacy Services e-book.

MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)

Medical Assistance Letter No [561](#) is maintained in the Pharmacy Services e-book.

MAL 550 (Changes to the Fee-For-Service Pharmacy Program Effective October 1, 2008)

Medical Assistance Letter No [550](#) is maintained in the Pharmacy Services e-book.

MAL 546 (March 20, 2008 - Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms)

Medical Assistance Letter No [546](#) is maintained in the Pharmacy Services e-book.

MAL 529 (Information Providers Must Know about NPI in Order to Get Paid)

Medical Assistance Letter (MAL) 529

June 7, 2007

To: Group Advanced Practice Nurses
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform providers enrolled and billing as Advanced Practice Nurse (APN) group practices in the Ohio Medicaid program that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for group practices is a unique, ten-digit, entity type 2 identifier received from the National Plan and Provider Enumeration System (NPPES). This MAL also provides information on applying for your NPI, disclosing your NPI to ODJFS, and using your NPI when submitting claims to ODJFS.

APN group practices will also be required to use the unique (entity type 1) NPI numbers for each individual APN providing/rendering services for the group practice on claims* submitted to ODJFS if the individual APN has been issued an individual Medicaid legacy number. The group practice should work with the individual APNs in the group to determine if the group will obtain the individual APN numbers from NPPES for the practice's APNs or the individual APNs will independently obtain their own individual APN numbers from NPPES and then share the numbers with the group practice. For every Ohio Medicaid provider/billing number you currently have and use today for your Medicaid business, your practice must have a corresponding, unique NPI number.

After receiving the APN group NPI and the individual APN NPI numbers and until January 1, 2008, all APN group practices conducting business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their group NPI number and their current group Medicaid provider number (now referred to as the Medicaid legacy number or the Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL. In addition, they must submit both the individual APN's NPI number and the corresponding individual Medicaid legacy number in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers. Until January 1, 2008, claims received by ODJFS from APN group practices will continue to be accepted and processed if the claims contain a valid Medicaid legacy number or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields. Prior to January 1, 2008, claims **submitted without** an Ohio Medicaid legacy number (i.e., claims submitted only with an NPI number) in the required provider fields will be rejected or denied.*

APN claims submitted to ODJFS on or after January 1, 2008 will be rejected and/or denied if the group and/or individual NPI number is not in the required field(s) on the claim. APN claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

APNs and APN group practices must:

- enumerate through NPPES,
- receive their NPI, and
- disclose their NPI to ODJFS immediately.

APNs and APN group practices must be ready to submit both their NPI(s) and Medicaid legacy numbers on claims.*

* See special instructions for paper and tape claims (below in this MAL).

I. How do I get an NPI?

APN group practices can receive an (entity type 2) NPI number for the APN group practice and an individual (entity type 1) APN provider number for each APN in the group practice by submitting an application to NPES. To obtain a National Provider Identifier, providers should contact NPES directly at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

When you apply for your APN group practice NPI, ODJFS encourages you to submit the following information with your NPI application: Ohio Medicare legacy (PIN/UPIN) number, Ohio Medicaid legacy number, taxonomy number, and employer identification number (EIN). It is also very important to make it clear on the NPI application when you are applying for an NPI for the group practice and when you are applying for an individual NPI for one of the APNs in your practice.

If you are applying for a group NPI, check the box on the NPI application for "an organization that renders health care." Please submit as the primary taxonomy for the group practice either the taxonomy number **193400000X** (if you are a single specialty practice) or the taxonomy number **193200000X** (if you are a multi-specialty practice). Other APN taxonomy numbers may be given as secondary taxonomy numbers to further describe the practice and the type of specialty services provided by the practice.

If you are applying for an NPI for an individual APN in the group (i.e., an entity type 1 NPI), check the box on the NPI application for "an individual who provides health care." Please submit as the primary taxonomy number for the individual APN the taxonomy code that best describes the APN's specialty. You may submit more than one APN taxonomy number.

A listing of taxonomy codes for APNs can be found at <http://www.wpc-edi.com/codes/taxonomy>.

II. How do I bill ODJFS using the NPI?

If your practice received this MAL, at least once during the last twelve months you/your practice submitted claim(s) as a group practice.

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist your practice in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The NPI (entity type 2) assigned to the group practice must be sent with the XX qualifier in the NM108 and the group (entity type 2) NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the Medicaid legacy provider number assigned to the group practice must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the group Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The rendering provider loop (2310B loop) must also be completed and contain information about the individual APN who rendered the service. Group APN practices must submit the (entity type 1) NPI assigned to the individual APN that provided the service in the NM109 of 2310B with the qualifier value of XX in the NM108 of the 2310B loop and submit the Medicaid legacy number assigned to the individual APN in the REF02 of the 2310B loop with a 1D qualifier in the REF01 of the 2310B loop. When a group practice submits claims, the pay to numbers should always belong to the group and the rendering provider number must always be a valid individual APN or other valid individual practitioner that can provide Ohio Medicaid covered services under an APN group practice. Only one individual (entity type 1) NPI number can be associated with a (unique) individual Ohio Medicaid legacy number. An

individual APN's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another APN or another individual, group or organizational entity.

Instructions for submitting NPI on claims for an APN group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: <http://ifs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing on Paper Claims or by Tape

* *Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the **new** CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the **old** CMS 1500).

Providers submitting the old CMS 1500 must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old CMS 1500 will cause the claim to reject or may cause the claim to pay inappropriately.

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

III. Is the APN group practice required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires APNs and APN group practices to obtain NPI numbers, to use their NPI on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that APN in a standard transaction, including transactions sent to and received from any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

IV. Is the APN group practice required to share with ODJFS the NPI numbers assigned to the group and the individual APNs that practice in the group?

Yes, the group practice must disclose the NPI number assigned to the group to ODJFS. The group practice must also disclose the NPI numbers assigned to each individual APN that practices in the group to ODJFS, unless the individual APN has independently disclosed his or her individual NPI number to ODJFS.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://ifs.ohio.gov/OHP/providers/npi.stm>.

V. Is the group practice required to share the NPI numbers assigned to the group practice or assigned to the individual APNs in the group with other entities?

Yes, APNs and APN group practices must disclose their NPI, when requested, to any entity that needs the NPI to identify that APN/APN group practice in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans, and any other provider that needs to identify the APN on transactions.

Pharmacies will need the appropriate individual NPI to submit as the prescribing provider on pharmacy claims; hospitals and long term care facilities (LTCF) may need your NPI to submit as a provider on hospital and LTCF claims; durable medical equipment (DME) suppliers will need your NPI to submit as the ordering provider on DME claims. You are required to share the appropriate NPI with them.

VI. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

VII. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

VIII. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
The Provider Services Section
P.O. Box 1461
Columbus, Ohio 43216-1461**

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://ifs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 528 (Information Providers Must Know about NPI in Order to Get Paid)

Medical Assistance Letter (MAL) 528

June 7, 2007

To: Individual APNs, Anesthesia Assistants and Incorporated Individual APN Practices
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform individual Advanced Practice Nurses (APNs), Anesthesia Assistants and incorporated individual APN practices that are enrolled as providers in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for APNs and Anesthesia Assistants is a unique, ten-digit, entity type 1 identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008, APNs that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their individual NPI number and their current individual Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

APNs and Anesthesia Assistants MUST enumerate through NPPES, disclose their NPIs to ODJFS and bill using both the NPI and Medicaid legacy identifiers. This MAL provides direction to providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

APN claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.* APN claims submitted to ODJFS on or after January 1, 2008 will be denied if the APN's NPI number is not in the required field(s) on the claim. APN claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* See special instructions for paper and tape claims (below in this MAL).

I. How do I get an NPI?

Individual APNs can receive an NPI number by personally submitting an NPI application to NPPES. Or, you may arrange for your employing health care entity or place of practice to obtain an individual provider number for you. To obtain an NPI, providers should contact NPPES directly at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

When you apply for your individual NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,
- taxonomy number,
- social security number, and/or

- IRS individual tax identification number (TIN).

It is also important that you make it clear that you are applying for an NPI for an individual APN (i.e., an entity type 1 NPI) by checking the box on the NPI application for "an individual who provides health care." A listing of taxonomy codes for APNs can be found at

<http://www.wpc-edi.com/codes/taxonomy>.

II. How must my NPI relate to my Medicaid legacy number?

If your practice received this MAL, you/your practice submitted claim(s) as an individual APN or as an incorporated individual APN practice to ODJFS at least once during the last twelve months. When APNs are doing business with ODJFS as an individual APN or as an individual incorporated APN practice, ODJFS currently only issues an individual APN Medicaid legacy number and expects the billing provider, pay to provider, and rendering provider to be the same provider (the individual APN).

Services rendered by other practitioners employed by or under contract with the APN or APN's incorporated individual practice should be billed under the APN's NPI and/or the APN's Medicaid legacy number (when both numbers are required). This directive applies as soon as an APN receives their NPI number and remains in effect after January 1, 2008.

APNs must submit only the individual (entity type 1) NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as an individual APN. Only one NPI number can be associated with your individual Ohio Medicaid legacy number. An individual APN's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another APN.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for APNs who do business with ODJFS as individual APNs or as incorporated individual APN practices who have not obtained a group (entity 2 type) NPI. If you do business with ODJFS only as a member of a group practice or other provider-based practice, use the appropriate billing instructions as contained in MAL 529.

Instructions for submitting the NPI by an individual APN are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at:

<http://ifs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The APN's NPI must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the APN's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The EDI standard does not require the rendering provider loop to be completed if the rendering provider is the same as the pay to provider. For individual practices participating in Medicaid, the rendering and pay to provider are always the same. Do not send NPI information in the NM108 and NM109 nor the Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (2310B or 2430B respectively).

Billing on Paper Claims or by Tape

* *Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the new CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the old CMS 1500).

Providers using the old CMS 1500 must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old CMS 1500 will cause the claim to reject or may cause the claim to pay inappropriately.

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

IV. If my sole proprietary APN practice (practices owned by one APN) is incorporated, do I use my individual NPI number?

Although this is not currently allowed under the Ohio Medicaid program, many other health plans allow sole proprietary practices to be a group practice (of one member). The NPI provisions allow any sole proprietary practice that is incorporated to obtain an entity type 2 (group/organization) NPI and, if the sole proprietary practice is not incorporated, the practice is not eligible for a group/organization (entity type 2) NPI. When the sole proprietary practice is entitled to obtain an entity type 2 NPI, the NPI provisions require the individual APN that owns the practice and each APN employed by or under contract with the practice to also obtain an individual (entity 1) APN NPI number.

You may obtain your group (entity type 2) NPI number from NPPES as instructed in Section I of this MAL. It is important that you make it clear that you are seeking the group NPI by checking the box for "an organization that renders health care." Please submit as the primary taxonomy for the group practice either the taxonomy number **193400000X** (if you are a single specialty practice) or the taxonomy number **193200000X** (if you are a multi-specialty practice).

If your practice is an incorporated individual practice that has received, or plans to receive, an entity type 2 (group/organization) NPI, you may not submit that (entity type 2) NPI number on a claim to ODJFS until you have been issued a corresponding group Medicaid legacy number by ODJFS. Once you have received your (entity type 2) NPI for your practice, you may request a group Medicaid legacy number from ODJFS by contacting the Provider Enrollment Unit at P.O. Box 1461 Columbus, Ohio 43216-1461 or by phone at 1-800-686-1516.

Until you receive your group Medicaid legacy number from ODJFS, you must continue to bill as instructed in Section III of this MAL using only your individual NPI and Medicaid legacy number. Once you receive your group Medicaid legacy number you must bill in accordance with the instructions contained in MAL 529.

V. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires APNs to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that APN in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

VI. Am I required to share my NPI number with ODJFS?

Yes, the APN must disclose to ODJFS the NPI number that has been assigned to the APN. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site:

<http://ifs.ohio.gov/OHP/providers/npi.stm>.

VII. Am I required to share my NPI with other entities?

Yes, as stated in Section V above, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the APN in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

Pharmacies will need your NPI to submit as the prescribing provider on claims; hospitals and long term care facilities (LTCF) may need your NPI to submit as a provider on hospital and LTCF claims; durable medical equipment (DME) suppliers will need your NPI to submit as the ordering provider on claims. You are required to share your NPI with them.

VIII. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

IX. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

X. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://jfs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516)

Medical Assistance Letter No [522](#) is maintained in the General Information e-book.

MAL 516 (November 9, 2006 - Employee Education About False Claims Recovery)

Medical Assistance Letter No [516](#) is maintained in the General Information e-book.

MAL 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation)

Medical Assistance Letter No [473](#) is maintained in the Pharmacy Services e-book.

MAL 460 (December 18, 2003 - Consumer Co-Payments for Prescription Medication Requiring Prior Authorization)

Medical Assistance Letter No 460 is maintained in the Pharmacy Services e-book.

MAL 456 (September 15, 2003 - Preferred Drug List [PDL] Information)

Medical Assistance Letter No [456](#) is maintained in the Pharmacy Services e-book.

MAL 450-A (July 28, 2003 - Prenatal Care Reimbursement- Important Billing Change)

Medical Assistance Letter No [450-A](#) is maintained in the Physician Services Handbook.

MAL 450 (June 26, 2003 - Prenatal Care Reimbursement - Billing Changes Effective July 1, 2003)

Medical Assistance Letter No [450](#) is maintained in the Physician Services Handbook.

MAL 447 (March 6, 2003 - Preferred Drug List (PDL) Information)

Medical Assistance Letter No [447](#) is maintained in the Physician Services Handbook.

MAL 437(Billing Anesthesia for Missed or Spontaneous Abortions and Miscarriages)

Medical Assistance Letter (MAL) No. 437

October 25, 2002

TO: All Providers of Anesthesia Services
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Billing Anesthesia for Missed or Spontaneous Abortions and Miscarriages

BILLING CHANGE EFFECTIVE IMMEDIATELY

The purpose of this Medical Assistance Letter (MAL) is to clarify which code should be billed to the Department for services related to anesthesia for missed or spontaneous abortions and miscarriages.

The Current Procedure Terminology (CPT) book for 2002 produced a new anesthesia code specific to abortion procedures (01964, abortion procedures). If this code is billed for anesthesia services related to missed or spontaneous abortions or miscarriages, the claim will deny since an abortion consent form must be submitted. Until the American Medical Association (AMA) develops codes that recognize the difference between a legal abortion and a missed/spontaneous abortion or miscarriage, the following billing procedures apply:

- To bill for anesthesia services related to missed or spontaneous abortions and miscarriages, use code 00940, anesthesia for vaginal procedures.
- To bill for anesthesia services related to a legal abortion, use code 01964, abortion procedure. Legal abortions must meet all requirements of the Ohio Administrative Code (OAC) rule 5101:3-17-01. An Abortion Consent Form, ODJFS Form 3197, must be submitted certifying that the abortion meets the criteria for a legal abortion.

Any claims that have been submitted to the Department in 2002 using code 01964 that have not paid should be resubmitted observing the billing procedures outlined in this MAL.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-state toll free telephone number 1-800-686-6108
Out-of-state telephone number 1-614-728-3288

MAL 388 (Revisions to the Immunization Policy)

Medical Assistance Letter (MAL) No. 388

September 11, 2000

TO: All Providers of Advanced Practice Nurse Services
Directors, County Departments of Human Services
Directors, District Offices

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Revisions to the Immunization Policy

ADVANCED PRACTICE NURSE SERVICES

POLICY UPDATE

EFFECTIVE OCTOBER 1, 2000

The purpose of this Medical Assistance Letter (MAL) is to announce changes to the Department's policy addressing immunization services which will be effective for services provided on or after October 1, 2000.

Coverage of the Pneumococcal Vaccine:

- Effective for services provided on and after October 1, 2000, pending availability of the vaccine, the Department will begin covering Prevnar, the pneumococcal vaccine for children (CPT code 90669) through the Vaccine for Children (VFC) program. The vaccine will be available free through the Ohio Department of Health. The Department will pay a \$5.00 administrative fee.

Changes in Billing for the Influenza Vaccine:

To be more in line with CPT coding provisions while preserving the ability of the Department to track the number of vaccines given under the VFC program, the Department will be implementing the following billing changes:

- Effective October 1, 2000, the Department will begin covering 90657 Influenza, Split Vaccine, for children six months to thirty-five months of age. This vaccine is free through the VFC program so the Department pays a \$5.00 administrative fee to providers.
- Providers should bill 90658 for the Influenza, Split Vaccine, for children three years through eighteen years of age. This vaccine is also free through the VFC program so the Department pays a \$5.00 administrative fee to providers.
- For adults (over age 18), bill W0658 for the Influenza, Split Vaccine. This vaccine is not a VFC free vaccine so a fee-for-service payment is made for this vaccine.
- Use 90659 for the Influenza, Whole Virus and 90660 for Influenza, Intranasal. This vaccine is not a VFC free vaccine so a fee-for-service payment is made for this vaccine.

Coverage for Hepatitis A Vaccine:

- The Department will cover CPT codes 90633 and 90634 for the Hepatitis A vaccine on a case-by-case basis if medical necessity for this vaccine is substantiated. These codes should be billed as by report services.

Questions pertaining to this MAL should be addressed to:

The Ohio Department of Jobs and Family Services

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-State

1-800-686-6108 (toll free) or

(614) 728-3288

Out of State

(614) 728-3288

Chapter 1 - General Information for Advanced Practice Nurses

5160-3-19 Relationship of other Covered Medicaid Services to Nursing Facilities (NFS) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Services

***Formerly* 5101:3-3-19 Relationship of other Covered Medicaid Services to Nursing Facilities (NFS) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Services**

OAC rule [5160-3-19](#) is maintained in the Long Term Care Manual, located in the Ohio Health Plans - Provider collection.

5160-4-05 Teaching Physician Services

***Formerly* 5101: 3-4-05 Teaching Physician Services**

OAC rule [5160-4-05](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

MHTL 3355-07-04

Effective Date: January 1, 2008

Most Current Prior Effective Date: June 1, 2002

- (A) All the definitions set forth in rule 4723-08-01 of the Administrative Code ~~shall also~~ apply to rules 5101:3-8-20 to 5101:3-8-23 of the Administrative Code unless otherwise indicated.
- (B) Definitions.
- (1) "Fee-for-service clinics" ~~shall be defined as those~~ are clinics that are eligible and bill the department as ambulatory health clinics in accordance with Chapter 5101:3-13 of the Administrative Code.
 - (2) "Cost-based clinics" ~~shall be defined as those~~ are clinics that are eligible and bill the department as a rural health clinic (RHC), a federally qualified health center (FQHC), or an Ohio outpatient health facility (OHF) in accordance with Chapters 5101:3-16, 5101:3-28 and 5101:3-29 of the Administrative Code, respectively.
 - (3) "Advanced practice nurse" ~~shall be defined~~ for the purpose of rules 5101:3-8-21 to 5101:3-8-23 of the Administrative Code ~~as:~~ is a registered nurse who holds a certificate of authority issued by the board of nursing to practice as a certified nurse practitioner, clinical nurse specialist, or certified nurse midwife in accordance with section 4723.42 of the Revised Code and meets the criteria set forth in rule **5101:3-8-21** of the Administrative Code.
 - ~~(a) A registered nurse who holds a notice of approval issued by the board of nursing to practice as an advanced practice nurse in accordance with section 4723.55 of the Revised Code and meets the criteria set forth in paragraph (A) of rule 5101:3-8-21 of the Administrative Code; or~~
 - ~~(b) A registered nurse who holds a certificate of authority issued by the board of nursing to practice as a certified nurse practitioner, clinical nurse specialist, or certified nurse midwife in accordance with Chapter 4723. of the Revised Code and meets the criteria set forth in paragraph (B) of rule 5101:3-8-21 of the Administrative Code.~~

Effective: 01/01/2008

R.C. 119.032 review dates: 05/15/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/07/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 4723.41 to 4723.50

Prior Effective Dates: 3/1/94 (Emer), 5/12/94, 6/1/02

MHTL 3355-11-01

Effective Date: August 2, 2011

Most Current Prior Effective Date: January 1, 2008

- (A) A certified nurse practitioner approved under section 4723.42 of the Revised Code is eligible to become an Ohio medicaid provider as an individual nurse practitioner upon the execution of an Ohio medicaid provider agreement if both of the following are met:
- (1) The certified nurse practitioner holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code.
 - (2) The certified nurse practitioner is certified by a national certifying organization approved by the Ohio board of nursing as at least one of the following:
 - (a) An adult nurse practitioner;
 - (b) A family nurse practitioner;
 - (c) A pediatric nurse practitioner;
 - (d) An obstetrical-gynecological/women's health care nurse practitioner;
 - (e) A neonatal nurse practitioner;
 - (f) A gerontological nurse practitioner;
 - (g) An acute care nurse practitioner;
 - (h) A psychiatric nurse practitioner; or
 - (i) A palliative care nurse practitioner.
- (B) A clinical nurse specialist approved under section 4723.42 of the Revised Code is eligible to become an Ohio medicaid provider as an individual clinical nurse specialist upon execution of an Ohio medicaid provider agreement if both of the following are met:
- (1) The clinical nurse specialist holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code.
 - (2) The clinical nurse specialist is certified by a national certifying organization approved by the Ohio board of nursing as at least one of the following:
 - (a) An oncology clinical nurse specialist;
 - (b) A clinical nurse specialist in adult health;
 - (c) A gerontological clinical nurse specialist;
 - (d) A psychiatric clinical nurse specialist;
 - (e) A palliative care nurse specialist;
 - (f) An acute care clinical nurse specialist; or
 - (g) A pediatric clinical nurse specialist.
- (C) Clinical nurse specialists and certified nurse practitioners not meeting the criteria in paragraph (A)(1) and (A)(2), or (B)(1) and (B)(2), of this rule, as applicable, are not eligible for enrollment as a provider in the medicaid program.
- (D) A certified nurse midwife approved under section 4723.42 of the Revised Code is eligible to become an Ohio medicaid provider as an individual nurse midwife upon execution of an Ohio medicaid provider agreement if all of the following are met:

- (1) The certified nurse midwife holds a valid certificate of authority issued by the Ohio board of nursing in accordance with section 4723.42 of the Revised Code.
 - (2) The certified nurse midwife has completed an accredited course of study.
 - (3) The certified nurse midwife is certified by the American college of nurse-midwives, the American midwifery certification board, or the American college of nurse midwives certification council.
- (E) An advanced practice nurse group is eligible to enroll in the medicaid program if it meets the criteria as a professional medical group as defined in paragraph (C) of rule 5101:3-1-17 of the Administrative Code.
- (F) Advanced practice nurses enrolled in the medicaid program may be members of any physician group practice enrolled in the Ohio medicaid program.
- (G) Out-of-state advanced practice nurses providing services to Ohio medicaid recipients must be licensed, certified, or authorized as required by the state in which the recipient is located at the time the service is provided. In addition, out-of-state advanced practice nurses must meet the provisions of rule [5101:3-1-11](#) of the Administrative Code addressing out-of-state coverage.
- (H) Any advanced practice nurse practicing in Ohio who applies to become a medicaid provider ~~for the first time after January 1, 2003, must possess a master's degree in nursing~~ must be authorized by the Ohio board of nursing to practice as an advanced practice nurse in accordance with sections 4723.41 and 4723.42 of the Revised Code.

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/06/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 3/1/94 (Emer), 5/12/94, 5/1/97, 6/1/02, 1/1/08

[MHTL 3355-07-04](#)

Effective Date: January 1, 2008

Most Current Prior Effective Date: [June 1, 2002](#)

- (A) Any certified registered nurse anesthetist (CRNA) who holds a current, valid certificate of authority issued under, and in accordance with, Ohio law entitling the holder to practice as a nurse anesthetist is eligible to participate in Ohio's medicaid program and provide covered CRNA services upon the execution of the Ohio medicaid provider agreement.
- (B) A CRNA group practice ~~is a practice comprised solely of two or more CRNAs enrolled under the medicaid program~~ must meet the criteria as a professional group practice as defined in paragraph (C) of rule [5101:3-1-17](#) of the Administrative Code and is organized for the purpose of providing CRNA services.
- (C) A CRNA who is licensed or holds a current certificate, or similar document under another state's law entitling the holder to practice as a nurse anesthetist, is eligible to participate in Ohio's medicaid program and provide covered CRNA services as long as the following are met:
- (1) The services are rendered to eligible Ohio recipients in the state in which the CRNA is authorized to practice; ~~and~~
 - (2) The provider of CRNA services has a currently valid provider agreement with the department; and
 - (3) The provisions in rule [5101:3-1-11](#) of the Administrative Code addressing out-of-state coverage are met.
- (D) ~~Although anyone meeting~~ A CRNA that meets the criteria set forth in paragraphs (A) to (C)(2) of this rule is entitled to receive an Ohio medicaid ~~provider~~ legacy number; CRNA services may be billed if the following conditions are met: ~~under a CRNA's individual or group practice provider number only if paragraph (B) of rule 5101:3-8-25 of the Administrative Code applies.~~
- (1) The provisions of paragraph (B) or (C) of rule 5101:3-8-25 of the Administrative Code are met; and
 - (2) The provisions outlined in rule 5101:3-1-17 of the Administrative Code are met.

Effective: 01/01/2008

R.C. 119.032 review dates: 05/15/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/07/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 4723.41 to 4723.50

Prior Effective Dates: 3/30/95, 6/1/02

Chapter 2 - APN Reimbursement

5160-1-01 **Medicaid: Medical Necessity**

***Formerly* 5101:3-1-01** **Medicaid: Medical Necessity**

OAC rule [5160-1-01](#) is maintained in the General Information eManual, located in the Ohio Health Plans - Provider collection.

5160-1-60 Medicaid Reimbursement

***Formerly* 5101:3-1-60 Medicaid Reimbursement**

OAC rule [5160-1-60](#) is maintained in the General Information eManual, located in the Ohio Health Plans - Provider collection.

5160-4-02 **Scope of Coverage**

***Formerly* 5101:3-4-02** **Scope of Coverage**

OAC rule [5160-4-02](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-02.1 "By-Report" Services

***Formerly* 5101:3-4-02.1 "By-Report" Services**

OAC rule [5160-4-02.1](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-02.2 Site Differential Payments and Place of Service

***Formerly* 5101:3-4-02.2 Site Differential Payments and Place of Service**

OAC rule [5160-4-02.2](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-28 Noncovered Services

***Formerly* 5101:3-4-28 Noncovered Services**

OAC rule [5160-4-28](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

MHTL 3355-07-04

Effective Date: January 1, 2008

Most Current Prior Effective Date: June 1, 2002

- (A) Advanced practice nurses enrolled in the Ohio medicaid program may practice in a variety of practice or employment arrangements as specified in the nurse's standard care arrangement in accordance with section 4723.431 ~~or section 4723.52~~ of the Revised Code. Whether an advanced practice nurse or a group of advanced practice nurses is entitled to direct reimbursement under the Ohio medicaid program is dependent entirely on the practice or employment arrangement of the advanced practice nurse or group.
- (B) Practice arrangements.
- (1) Independent practice.
- An "advanced practice nurse" is considered to be in an independent practice if the medical services rendered to a patient are the responsibility of an advanced practice nurse who is in solo practice or a member of an advanced practice nurse group practice and the practice is free of the fiscal, administrative, and professional control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, a long term care facility, or any other medicaid provider. "Free of professional control" does not mean that the advanced practice nurse practices in the absence of a standard care arrangement. Each advanced practice nurse, including those in independent practice as defined in this rule, must maintain a standard care arrangement as required by section ~~4723.52 or~~ 4723.431 of the Revised Code.
- (2) Provider-based practice.
- An "advanced practice nurse" is considered to be in a provider-based practice if the advanced practice nurse is under the fiscal, administrative and professional control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, a long term care facility, or any other medicaid provider through an employment, a contractual, or any other legally binding arrangement. Advanced practice nursing services provided in provider-based practices are considered incidental to the employing or contractual provider (i.e., as physician services if provided in a physician-based practice, as clinic services if provided in a clinic-based practice, as hospital services if provided in a hospital-based practice, etc.).
- (C) Reimbursement.
- (1) Services provided by advanced practice nurses are subject to the site differential payments set forth in rule 5101:3-4-02.2 of the Administrative code and the office incentive payments set forth in rule 5101:3-4-09 of the Administrative Code.
- (a) The total reimbursement for services and procedures subject to the site differential payment is either the provider's billed charge or the reimbursement rate established in paragraphs (C)(3) and (C)(4) of this rule multiplied by the site differential percentage rate, whichever is less.
- (b) The total reimbursement for services and procedures subject to the office incentive payment is either the provider's billed charges or the reimbursement rate established in paragraphs (C)(3) and (C)(4) of this rule plus the incentive payment rate, whichever is less.
- (2) Separate reimbursement is not available for any service included in the global payment of another service (e.g., evaluation and management services provided for post-operative care), whether the global payment was made directly to the advanced practice nurse or to another medicaid provider.

- (3) Only advanced practice nurses who practice in an independent practice arrangement are eligible to bill and receive direct reimbursement under the Ohio medicaid program. For independent practices, reimbursement is the lesser of the provider's billed charge or one of the following:
- (a) Eighty-five per cent of the medicaid maximum when services are provided in a hospital setting; or
 - (b) One hundred per cent of the medicaid maximum when services are provided in a nonhospital setting.
- (4) Services provided by advanced practice nurses in provider-based practices are reimbursable only to the employing or contracting provider.
- (a) For individual physician-based practices, group physician-based practices, fee-for-service clinic-based practices, or hospital-based practices, reimbursement for advanced practice nursing services is the lesser of the provider's billed charge or one of the following:
 - (i) Eighty-five per cent of the medicaid maximum when services are provided by an **APN advanced practice nurse** in the following places of service: inpatient hospital, outpatient hospital, or hospital emergency department; or
 - (ii) One hundred per cent of the medicaid maximum when services are provided by an **APN advanced practice nurse** in any nonhospital place or service.
 - (b) For RHC-based, FQHC-based and OHF-based practices, reimbursement for advanced practice nursing services is the medicaid maximum set forth in Chapters 5101:3-16, 5101:3-28, and 5101:3-29 of the Administrative Code, respectively.
 - (c) For all other nonhospital, provider-based practices, reimbursement for advanced practice nursing services is bundled into the payment for that provider type and is the maximum allowed under the medicaid program for the services rendered by that provider type (e.g., services provided by a nurse practitioner employed by a home health agency would be bundled into the payment for a home health service).
 - (d) When services incident to advanced practice nurse services are provided by an individual who is not an advanced practice nurse in an office or clinic setting, the services rendered must be within the scope of licensure (if licensure is required) of the individual who is not an advanced practice nurse or a service for which the individual is legally authorized to provide under Ohio law and documented in the patient's medical records.
 - (i) The services rendered by the individual who is not an advanced practice nurse must be rendered under the direct supervision of the advanced practice nurse. The records must be reviewed and countersigned by the supervising advanced practice nurse.
 - (ii) "Direct supervision" in the advanced practice nurse's office or clinic setting means that the advanced practice nurse must be present in the office suite throughout the time the individual who is not an advanced practice nurse is providing the service and immediately available to provide assistance and direction throughout the time the individual who is not an advanced practice nurse is performing services. Direct supervision does not mean the advanced practice nurse must be in the same room while the individual who is not an advanced practice nurse is providing services. The availability of the **APN advanced practice nurse** by telephone or the presence of the **APN advanced practice nurse** somewhere in the institution does not constitute availability.
 - (iii) All of the provisions relating to direct supervision described in rule [5101:3-4-02](#) of the Administrative Code must be met.
- (5) Hospital-based advanced practice nurses.

- (a) For hospital-based practices, separate reimbursement is available to hospitals for professional services provided by advanced practice nurses only if the requirements set forth in paragraph (C)(5)(c) of this rule are met. Reimbursement for professional services provided by hospital-based advanced practice nurses is in accordance with paragraph (C)(4)(a) of this rule. In addition, certain services are subject to the site differential payment in accordance with paragraph (C)(1) of this rule.
- (b) Services provided by advanced practice nurses ~~which that~~ include teaching, research, administration, supervision of professional and/or technical personnel, supervision of nursing and advanced practice nursing students, service on hospital committees, and other hospital-based activities ~~which that~~ are of benefit to patients, generally ~~or~~ do not meet all of the requirements set forth in paragraph (C)(5)(c) of this rule:
 - (i) ~~Are Such services are~~ reimbursable only as hospital services and are bundled into the hospital's inpatient or outpatient facility payment in accordance with Chapter 5101:3-2 of the Administrative Code; and
 - (ii) The portion of the expenses associated with the provision of the type of services identified in paragraph (C)(5)(b) of this rule by an advanced practice nurse, may be included on the hospital cost report.
- (c) Reimbursement for services rendered directly to, and for the benefit of, individual patients by advanced practice nurses who are employed by or under contract with a hospital is separately reimbursable to the hospital on a fee-for-service basis as advanced practice nursing services (i.e., in addition to the inpatient or outpatient hospital facility payment) if the following requirements are met:
 - (i) The services are personally furnished for an individual patient by an advanced practice nurse who is currently enrolled as an Ohio medicaid provider;
 - (ii) The services contribute directly to the diagnosis or treatment of an individual patient;
 - (iii) The services ordinarily require performance by a physician or an advanced practice nurse;
 - (iv) The services are not the type of services routinely performed by registered nurses or other hospital-employed nonphysicians;
 - (v) For services identified in paragraphs (C)(5)(c)(i) to (C)(5)(c)(iv) of this rule, documentation must exist ~~which that~~ demonstrates the advanced practice nurse's involvement in the service rendered. A countersignature alone in the records is not considered sufficient documentation of advanced practice nursing services.
 - (vi) The portion of the expenses associated with the provision of the type of services identified in paragraphs (C)(5)(c)(i) to (C)(5)(c)(iv) of this rule by advanced practice nurses are excluded from the hospital cost report.
- (6) In an institutional setting, advanced practice nurses will only be reimbursed by the medicaid program for the services ~~which that~~ have been personally rendered by the advanced practice nurse.

Effective: 01/01/2008

R.C. 119.032 review dates: 05/15/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

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Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 4723.41 to 4723.50

Prior Effective Dates: 9/24/83, 4/1/88, 5/15/89, 3/1/94 (Emer), 5/12/94, 5/1/97, 6/1/02

5160-8-27 **Advanced Practice Nurses: Modifiers**

Formerly 5101:3-8-27 **Advanced Practice Nurses: Modifiers**

MHTL 3355-09-02

Effective Date: January 1, 2010

Most Current Prior Effective Date: October 1, 2003

Effective for services provided on ~~and~~ or after October 1, 2003, when billing for any service provided by an advanced practice nurse (APN), whether the APN is in independent practice or a provider-based practice as described in rule **5101:3-8-22** of the Administrative Code, all services ~~provided by an APN~~ must be billed with ~~a~~ the appropriate modifier to denote the type of APN ~~which~~ that provided the service:

- (A) Bill the modifier "SA" e.g. 99201SA, if the APN is a nurse practitioner;
- (B) Bill the modifier "SB" e.g. 99201SB, if the APN is a nurse mid-wife; or
- (C) Bill the modifier "UC" e.g. 99201UC if the APN is a clinical nurse specialist.

Effective: 01/01/2010

R.C. 119.032 review dates: 05/13/2009 and 01/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 12/18/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 10/1/2003

Chapter 3 - Utilization Review

5160-1-31 Prior Authorization [Except for Services Provided through Medicaid Contracting Managed Care Plans (MCPs)]

***Formerly* 5101:3-1-31** Prior Authorization [Except for Services Provided through Medicaid Contracting Managed Care Plans (MCPs)]

OAC rule [5160-1-31](#) is maintained in the ODJFS OAC.

5160-2-40 **Pre-Certification Review**

***Formerly* 5101:3-2-40** **Pre-Certification Review**

OAC rule [5160-2-40](#) is maintained in the Hospital Services e-book.

Chapter 4 - APN Coverage and Reimbursement

5160-4-06 Physician Visits

***Formerly* 5101:3-4-06 Physician Visits**

OAC rule [5160-4-06](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-06.1 Physician Attendance During Patient Transport

***Formerly* 5101:3-4-06.1 Physician Attendance During Patient Transport**

OAC rule [5160-4-06.1](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-07 **Family Planning Services**

***Formerly* 5101:3-4-07** **Family Planning Services**

OAC rule [5160-4-07](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-08 **Covered Obstetrical Services**

***Formerly* 5101:3-4-08** **Covered Obstetrical Services**

OAC rule [5160-4-08](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-08.1 Payment for Prenatal Visits

***Formerly* 5101:3-4-08.1 Payment for Prenatal Visits**

OAC rule [5160-4-08.1](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-09 Office Incentive Program

***Formerly* 5101:3-4-09 Office Incentive Program**

OAC rule [5160-4-09](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-10 Pregnancy Related Services

***Formerly* 5101:3-4-10 Pregnancy Related Services**

OAC rule [5160-4-10](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-12 Immunizations

***Formerly* 5101:3-4-12 Immunizations**

OAC rule [5160-4-12](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-13 Therapeutic Injections and Prescribed Drugs

***Formerly* 5101:3-4-13 Therapeutic Injections and Prescribed Drugs**

OAC rule [5160-4-13](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-17 Gastroenterology, Otorhinolaryngology, Endocrinology, Neurology, Photodynamic Therapy and Special Dermatology Services

***Formerly* 5101:3-4-17 Gastroenterology, Otorhinolaryngology, Endocrinology, Neurology, Photodynamic Therapy and Special Dermatology Services**

OAC rule [5160-4-17](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-19 Allergy Services

***Formerly* 5101:3-4-19 Allergy Services**

OAC rule [5160-4-19](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-21 Anesthesia Services

***Formerly* 5101:3-4-21 Anesthesia Services**

OAC rule [5160-4-21](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-21.1 Anesthesia for Neuraxial Analgesia for Obstetrical Services

***Formerly* 5101:3-4-21.1 Anesthesia for Neuraxial Analgesia for Obstetrical Services**

OAC rule [5160-4-21.1](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-21.2 Anesthesia Conversion Factors

***Formerly* 5101:3-4-21.2 Anesthesia Conversion Factors**

OAC rule [5160-4-21.2](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-22 Surgical Services

***Formerly* 5101:3-4-22 Surgical Services**

OAC rule [5160-4-22](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-25 Laboratory and Radiology Services

***Formerly* 5101:3-4-25 Laboratory and Radiology Services**

OAC rule [5160-4-25](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-28 Noncovered Services

***Formerly* 5101:3-4-28 Noncovered Services**

OAC rule [5160-4-28](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-29 Services Provided for the Diagnosis and Treatment of Mental and Emotional Disorders

***Formerly* 5101:3-4-29 Services Provided for the Diagnosis and Treatment of Mental and Emotional Disorders**

OAC rule [5160-4-29](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-4-34 **Preventive Medicine Services**

***Formerly* 5101:3-4-34** **Preventive Medicine Services**

OAC rule [5160-4-34](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

MHTL 3355-07-04

Effective Date: January 1, 2008

Most current prior effective date: June 1, 2002

- (A) The coverage of services provided by advanced practice nurses shall be limited only to the extent that the condition of the patient and/or the limited scope of practice of an advanced practice nurse as it is recognized under Ohio law warrants the intervention and/or care of a physician in a capacity other than one of advisory, collaborating, or for the purposes of prescribing pharmaceuticals or medical devices when the advanced practice nurse lacks prescriptive authority.
- (B) Chapter 5101:3-14 of the Administrative Code and all the rules set forth in Chapter 5101:3-4 of the Administrative Code that pertain to services a physician is legally authorized to perform under Ohio law shall apply to advanced practice nurses except, the term "physician" as it is defined in rule **5101:3-4-01** of the Administrative Code shall be replaced with the term "advanced practice nurse" as it is defined in rule 5101:3-8-21 of the Administrative Code.
- (C) In addition to being subject to the applicable rules set forth in Chapter 5101:3-4 of the Administrative Code, advanced practice nurses are subject to the following coverage and limitations:
- (1) For services provided in a teaching setting for advanced practice nurses, paragraphs (A) to ~~(D)(1) and (D)(2), (E)(1) and (F) and (E)(2)~~ in rule **5101:3-4-05** of the Administrative Code shall apply except the term "physician" in this rule shall be replaced by the term "advanced practice nurse" and the term "resident, intern, or fellow" shall be replaced by the term "individual in training for an advanced practice nursing certification."
 - (2) Under no circumstances will an advanced practice nurse be eligible to bill or be reimbursed for the following evaluation and management CPT ~~codes code: 99205, 99215, 99217 to 99220, 99223, 99241 to 99275, 99291 to 99298, 99284, and 99285.~~
 - (3) Consultations performed by an advanced practice nurse are covered.
 - ~~(3) Consultations performed by an advanced practice nurse are not covered.~~
 - (4) Except when precluded by Ohio law, inpatient hospital evaluation and management services are covered only if the advanced practice nurse is acting in the capacity of the patient's "primary treating provider" for the day and no physician is acting concurrently as the primary treating provider, and billing for evaluation and management services. For purposes of this rule, "primary treating provider" is a physician or advanced practice nurse who is responsible for managing the patient's inpatient hospital care for that day. "Primary treating provider" does not include a sub-specialist ~~physician provider~~ who may be treating the patient concurrently for specialty care, ~~i.e. (e.g. a nephrologist).~~
 - (5) Antepartum services may be provided by advanced practice nurses who are certified in an advanced practice nurse specialty that is qualified to perform antepartum services.
 - (6) "Covered nurse midwifery services" are defined as those services ~~which~~ that constitute the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically. Only advanced practice nurses who are certified nurse midwives may perform and bill for deliveries. In addition, the following services are noncovered when performed by nurse midwives, except in unavoidable, emergency situations:
 - (a) Management of an acute obstetric emergency; including any obstetric operation;
 - (b) Version or delivery of breech or face presentation; and
 - (c) Use of forceps;

- (7) Therapeutic injections, prescribed drugs, diagnostic and therapeutic services, laboratory services, and radiology services are covered as an advanced practice nursing service only if the service was ordered and/or prescribed by a physician, an advanced practice nurse, or any other provider who has the authority to order and/or prescribe the services under, and in accordance with, Ohio law.
- (8) With the exception of those laboratory procedures listed as physician-performed microscopy procedures (PPMP), laboratory services that require performance by a pathologist or a physician who is regarded as a specialist in pathological or hematological medicine (e.g., physician professional services associated with the gross or microscopic examination of surgical pathology tissues), are not covered if they are performed by an advanced practice nurse. ~~(e.g., physician professional services associated with the gross or microscopic examination of surgical pathology tissues).~~
- (9) Professional radiology or diagnostic and therapeutic services are covered by an advanced practice nurse if the advanced practice nurse is within his or her scope of practice.
- ~~(9) Professional radiology or diagnostic and therapeutic services that require performance by a physician who is regarded as a specialist in the disciplines of medicine specific to the provision of certain radiology, cardiology, neurology or other diagnostic and therapeutic services which are comprised entirely or in part of a professional component are not covered if performed by an advanced practice nurse.~~
- (10) If a physician and an APN advanced practice nurse provide the same covered service, (e.g. any evaluation and management service), or participate in the provision of a global/all-inclusive service ~~which~~that involves multiple visits on the same or different days, only one provider is entitled to reimbursement for the service.
- (a) Unless otherwise agreed upon by the two providers, the physician or the employing provider of the physician shall be the provider entitled to reimbursement if the condition of the patient and/or the limited scope of practice of an APN advanced practice nurse warrants the intervention and/or care of a physician in a capacity other than one of advisory, collaborating, or for the purpose of prescribing pharmaceuticals, medical devices, or other diagnostic and therapeutic services when the APN advanced practice nurse lacks the prescriptive authority required.
- (b) Separate reimbursement is not available for the physician's supervision of or collaboration with an APN advanced practice nurse. Any cost associated with the supervisory role of a physician is the responsibility of the APN advanced practice nurse or APN advanced practice nurse group if the APN advanced practice nurse is in an independent practice arrangement, or the responsibility of the employing provider if the APN advanced practice nurse is in a provider-based practice arrangement.

(D) The following services are noncovered:

- (1) Emergency room visit codes 99284 and 99285 are not covered if billed by an advanced practice nurse who is in an independent practice as defined in rule 5101:3-8-22 of the Administrative Code.
- ~~(1)~~(2) All services exceeding the policies and limitations defined in Chapters 5101:3-1, 5101:3-4 and 5101:3-14 of the Administrative Code and rules 5101:3-8-20 to ~~5101:3-8-23~~ and 5101:3-8-25 of the Administrative Code;
- ~~(2)~~(3) All services exceeding the scope of practice of an advanced practice nurse under, and in accordance with, Ohio law;
- ~~(3)~~(4) Any service exceeding the scope of practice of an advanced practice nurse as defined in the standard care arrangement;
- ~~(4)~~ Any service failing to be provided in accordance with the criteria and protocols set forth by the Ohio law for advanced practice nurses;

- (5) Services determined by the department as not medically necessary as defined in rule [5101:3-1-01](#) of the Administrative Code or that are duplicative in respect to a service provided concurrently by a physician or other valid medicaid provider;
- (6) Assistant-at-surgery services;
- (7) Services of residents, interns, and fellows provided in a teaching setting supervised by an advanced practice nurse; and
- (8) All services itemized as noncovered in rule [5101:3-4-28](#) of the Administrative Code.

Effective: 01/01/2008

R.C. 119.032 review dates: 05/15/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/07/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 4723.41 to 4723.50

Prior Effective Dates: 9/24/83, 3/1/94 (Emer), 5/12/94, 5/1/97, 6/1/02

5160-8-25 Coverage, Limitations, and Reimbursement of Anesthesia Services Provided by Certified Registered Nurse Anesthesists (CRNAs) CRNAs

***Formerly* 5101:3-8-25 Coverage, Limitations, and Reimbursement of Anesthesia Services Provided by Certified Registered Nurse Anesthesists (CRNAs) CRNAs**

MHTL 3355-05-02

Effective Date: September 1, 2005

- (A) The department will reimburse a CRNA for general, regional or supplementation of local anesthesia services (monitored anesthesia care as described in paragraph (I) of rule 5101:3-4-21 of the Administrative Code) provided during a surgical or diagnostic procedure. Anesthesia services include the basic preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluid and/or blood products incident to the anesthesia or surgery, and the usual monitoring procedures. Anesthesia services include ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry as usual monitoring procedures. Unusual monitoring procedures (e.g., intra-arterial, central venous, and swan-ganz) are not included and may be separately billed and reimbursed as long as the performance of these services are not limited by Ohio law.
- (B) A CRNA is considered to be self-employed if the CRNA is in a solo practice and the practice is free of the fiscal, administrative, and professional control of a CRNA group practice, an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, or any other medicaid provider type.
- (C) An independent CRNA group practice is a practice ~~comprised~~composed solely of two or more CRNAs enrolled under the medicaid program and the practice is free of the fiscal, administrative, and professional control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, or any other medicaid provider.
- (D) Reimbursement for anesthesia services provided by a CRNA may be made directly to a CRNA provider type only if the services were provided by a self-employed CRNA or by a CRNA employed by an independent CRNA group practice.
- (E) A CRNA's provider number may be listed on a medicaid invoice under the following circumstances only:
- (1) When a claim is being submitted for anesthesia services provided by a CRNA who either is self-employed or a member of an independent CRNA group practice;
 - (2) When a crossover ("F-type") claim is being submitted, in accordance with paragraph (G)(2) of this rule, for medicare ~~coinsurance~~ co-insurance and deductible payments;
 - (3) When a claim is being submitted, in accordance with paragraph (H)(2) of this rule, for anesthesia services that were provided by a non-medically directed physician-employed CRNA; or
 - (4) When a claim is being submitted in accordance with paragraph (H)(1) ~~(4)~~ of this rule, for anesthesia services that were provided by a medically-directed or medically-supervised physician-employed CRNA.
- (F) A CRNA is considered to be:
- (1) "Medically directed" if anesthesia services are provided with a physician who meets all of the conditions set forth in paragraph (C) of rule 5101:3-4-21 of the Administrative Code;
 - (2) "Nonmedically directed" if anesthesia services are provided without a physician who meets all of the conditions set forth in paragraph (C) of rule 5101:3-4-21 of the Administrative Code; and
 - (3) "Medically supervised" if anesthesia services are provided with a physician who meets all of the conditions set forth in paragraph (C) (4) of rule 5101:3-4-21 of the Administrative Code.
- (G) Separate reimbursement will be made for the medicare coinsurance and deductible amounts due for medicare covered CRNA services provided to a patient who is dually eligible for medicare and

medicaid, even if direct reimbursement would not be allowable if the anesthesia services are provided to a patient covered only under the medicaid program (e.g, hospital-employed CRNA services, physician-employed CRNA services, etc.).

- (1) The ~~coinsurance~~ co-insurance and deductible payments should normally be made through the automatic crossover mechanism.
- (2) If the claims did not get paid through the automatic crossover mechanism, the provider must submit a medicaid crossover "F-type 6780" claim, in accordance with the crossover billing instructions except that the CRNA's provider number must be submitted as the rendering provider and the employing provider number must be submitted as the pay to provider.

(H) The following CRNA reimbursement policies apply when services are provided to medicaid patients who are not also covered under medicare.

- (1) Reimbursement of anesthesia services provided by a ~~medically-directed~~ medically directed or ~~medically-supervised~~ medically supervised physician-employed CRNA.

When anesthesia services are provided by a CRNA who is under the employment of an individual or group physician practice and medical direction was provided by a physician in the practice, reimbursement for the services of the CRNA and the directing physician is paid to the employing physician or physician group practice as described in ~~paragraphs (D)(2)(a)(i) and (D)(2)(a)(ii)~~ paragraph (H)(3)(b)(ii) of rule 5101:3-4-21 of the Administrative Code. For reimbursement, the physician who provided the medical direction would be listed as the rendering provider and the ~~CPT code for the major surgical procedure modified by the modifier AB must be billed~~ appropriate modifier indicating medical direction listed in paragraph (D)(1) of rule 5101:3-4-21 of the Administrative Code must be billed.

- (2) Reimbursement of anesthesia services provided by a ~~nonmedically~~ non-medically directed and non-medically supervised physician-employed CRNA.

- (a) When anesthesia services are provided by a CRNA who is under the employment of an individual or group physician practice and medical direction was not provided by a physician in the practice, reimbursement for the services of the CRNA is reimbursable only to the employing physician or physician group practice.

- (b) For reimbursement:

- (i) The provider number of the employing individual physician practice or the employing physician group practice must be listed in the group practice space on the invoice;
- (ii) The provider number of the CRNA must be listed in the rendering provider space on the invoice; and
- (iii) The appropriate ~~CPT~~ anesthesia code must be modified with the QZ modifier.

- (3) Reimbursement of anesthesia services provided by hospital-employed CRNAs.

Direct reimbursement is not available for anesthesia services provided by a hospital employed CRNA. The reimbursement for the services provided by the CRNA is bundled into the facility payment made to the hospital. When a physician provides medical direction to a CRNA who is employed by the hospital, only the physician who provided the medical direction to the CRNA is entitled to reimbursement on a fee-for-service basis.

- (4) Reimbursement of anesthesia services provided by self-employed CRNAs or CRNAs who are members of an independent CRNA group practice.

- (a) Direct reimbursement for anesthesia services provided by a self-employed CRNA or a CRNA who is a member of an independent CRNA group practice is available whether or not the CRNA is medically directed by a physician.

- (b) When a physician provides medical direction or medical supervision to a CRNA who is self-employed or a member of an independent CRNA group practice, reimbursement for

the medical direction of the CRNA is also available to the physician and must be billed in accordance with rule 5101:3-4-21 of the Administrative Code.

- (c) Reimbursement is not available for supervision services provided by a physician when the physician does not meet the conditions set forth in paragraph (C) of rule 5101:3-4-21 of the Administrative Code.
 - (d) The CRNA or CRNA group practice must bill the ~~CPT~~ code for the appropriate anesthesia code modified by either the QX or QZ modifier and report the total anesthesia time in minutes.
 - (i) If the CRNA was medically directed or medically supervised, the procedure code must be modified with the QX modifier.
 - (ii) If the CRNA was not medically directed, the procedure code must be modified with the QZ modifier.
 - (e) The policies contained in paragraphs (B), (D)(3), (E), (F) and (G) of rule 5101:3-4-21 of the Administrative Code also apply when anesthesia services are provided and billed by CRNAs.
- (l) When a CRNA provides supervision and personal direction to a student nurse anesthetist involved in the provision of anesthesia services, reimbursement for the services of the CRNA is available in accordance with paragraph (G) of this rule. Reimbursement for the services of the student nurse anesthetist is bundled into the reimbursement made to the facility or hospital.

Effective Date: 09/01/2005

R.C. 119.032 review dates: 06/06/2005

Certification: CERTIFIED ELECTRONICALLY

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 3/30/95, 5/1/01

MHTL 3355-05-02

Effective Date: September 1, 2005

Most Current Prior Effective Date: May 1, 2001

(A) Definitions.

- (1) "Anesthesiologist assistant (AA) group practice" is two or more AAs organized for the purpose of providing AA services.
- (2) "Anesthesiologist assistant" (AA) is an individual recognized under Chapter 4760. of the Revised Code as an AA.
- (3) "Anesthesiologist-employed AA" is an AA employed by an anesthesiologist.
- (4) "Hospital-employed AA" is an AA employed by a hospital.
- (5) "Independent AA group practice" is two or more AAs organized for the purpose of providing AA services and free of the fiscal and administrative control of an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, or any other medicaid provider.
- (6) "Self-employed AA" is an AA in a solo practice that is free of the fiscal and administrative control of an independent AA group practice, an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic, or any other medicaid provider type.
- (7) "Medical direction" means, in accordance with paragraph (C)(3)(a) of rule 5101:3-4-21 of the Administrative Code, that a physician who meets the requirement set forth in paragraph (C)(1) of rule 5101:2-4-21 of the Administrative Code utilizes the assistance of an AA in the performance of anesthesia services.

(B) Eligible providers.

- (1) Any AA who holds a current valid certificate of registration issued by the state medical board may request an Ohio medicaid provider number.
- (2) Any AA group practice whose members hold current valid certificates of registration issued by the state medical board may request an Ohio medicaid provider number.
- (3) Only self-employed AAs and members of independent AA group practices may submit medicaid claims for direct reimbursement under their individual or AA group practice provider numbers.
- (4) The department will directly reimburse an AA for anesthesia services only if the services were provided by the self-employed AA or member of the independent AA group practice.

(C) Coverage and limitations.

- (1) The department will reimburse for general, regional, or supplementation of local anesthesia services of an AA, as described in rule 5101:3-4-21 of the Administrative Code, only when an AA is under the direct supervision and in the immediate presence of an anesthesiologist, in accordance with Chapter 4760. of the Revised Code.
- (2) The department will not reimburse any medicaid provider for services not provided in accordance with state and local laws.
- (3) Medicaid claims for services provided by an AA must include the appropriate anesthesia code modified by the QX modifier, indicating that the anesthesia services were provided under appropriate medical direction, and report the total anesthesia time in minutes.
- (4) Self-employed AAs and independent AA group practices.

- (a) Self-employed AAs and independent AA group practices may submit medicaid claims for direct reimbursement under their individual or group practice medicaid provider numbers only for services they provided as a self-employed AA or member of an independent AA group practice.
- (b) The policies contained in paragraphs (B), (D)(3), (E), (F), and (G) of rule 5101:3-4-21 of the Administrative Code apply to self-employed AAs and members of independent AA group practices who provide anesthesia services and submit medicaid claims for direct reimbursement.
- (c) Reimbursement for the medical direction of the AA is available to the anesthesiologist providing the medical direction and must be billed in accordance with rule 5101:3-4-21 of the Administrative Code.

(5) Anesthesiologist-employed AAs.

- (a) The department will reimburse the employing anesthesiologist or anesthesia group practice in accordance with rule 5101:3-4-21 of the Administrative Code for services of an AA and the directing anesthesiologist when anesthesia services are provided by an AA who is under the employment of an individual or group physician practice and medical direction was provided by an anesthesiologist in the practice.

(6) Hospital-employed AAs.

- (a) The department will not directly reimburse for anesthesia services provided by a hospital-employed AA. The department bundles reimbursement for the services provided by the AA into the facility payment made to the hospital.
- (b) The department will reimburse the anesthesiologist who provided medical direction to the AA when the anesthesiologist provides medical direction to a hospital-employed AA.

(D) Separate reimbursement will be made for the medicare coinsurance and deductible amounts due for medicare covered AA services provided to a patient who is dually eligible for medicare and medicaid, even if direct reimbursement would not be allowable if the anesthesia services are provided to a patient covered only under the medicaid program (e.g, hospital-employed AA services, etc.).

- (1) The coinsurance and deductible payments should be made through the automatic medicare crossover process in accordance with rule 5101:3-1-05 of the Administrative Code.
- (2) If claims are not paid through the automatic medicare crossover process, the provider must submit a medicaid crossover claim, in accordance with the crossover billing instructions.

Replaces: 5101:3-8-26

Effective Date: 09/01/2005

R.C. 119.032 review dates:

Certification: CERTIFIED ELECTRONICALLY

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 05/01/2001

5160-8-27 **Advanced Practice Nurses: Modifiers**

***Formerly* 5101:3-8-27** **Advanced Practice Nurses: Modifiers**

OAC rule [5160-8-27](#) is located in the Advanced Practice Nurses book.

5160-11-03 Laboratory Services: Coverage and Limitations

***Formerly* 5101:3-11-03 Laboratory Services: Coverage and Limitations**

OAC rule [5160-11-03](#) is maintained in the Laboratory Services Manual, located in the Ohio Health Plans - Provider collection.

5160-14-01 HEALTHCHEK Otherwise Known as Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

***Formerly* 5101:3-14-01 HEALTHCHEK Otherwise Known as Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)**

OAC rule [5160-14-01](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-14-02 **Eligible Providers of HEALTHCHEK (EPSDT) Services**

***Formerly* 5101:3-14-02** **Eligible Providers of HEALTHCHEK (EPSDT) Services**

OAC rule [5160-14-02](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-14-03 Covered HEALTHCHEK (EPSDT) Screening Services

***Formerly* 5101:3-14-03** Covered HEALTHCHEK (EPSDT) Screening Services

OAC rule [5160-14-03](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-14-04 Reimbursement of "HealthChek" (EPSDT) Screening Services and Screening Frequencies

***Formerly* 5101:3-14-04 Reimbursement of "HealthChek" (EPSDT) Screening Services and Screening Frequencies**

OAC rule [5160-14-04](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

5160-14-05 **Vision, Hearing, and Dental Services**

***Formerly* 5101:3-14-05** **Vision, Hearing, and Dental Services**

OAC rule [5160-14-05](#) is maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Advanced Practice Nurse Medicaid Forms

Prenatal Risk Assessment Form (JFS 03535)

<http://www.odjfs.state.oh.us/forms/findform.asp?formnum=03535>

Billing/Coding Aides for APNs

Allergy Services/ Billing

Percutaneous tests, intracutaneous tests, photo patch tests and patch or application tests are reimbursed on a per test basis. When billing, the provider must specify the number of tests performed in the unit's column/block on the invoice.

- For example, if 12 patch tests were performed, CPT code 95044 be entered in block 24.D on the HCFA 1500 and a 12 would be entered in the corresponding block 24.G.

Anesthesia Services

For dates of service on and after January 1, 2000 to April 30, 2001, the following fees were effective for anesthesiology services: for anesthesia services less than or equal to 60 minutes the maximum payment will be \$84.32 plus \$0.80 per minute; and for anesthesia services greater than 60 minutes the maximum payment will be \$149.20 plus \$0.80 per minute over sixty minutes.

For anesthesia services performed on or after January 1, 1997, the maximum reimbursement for anesthesia services less than or equal to 60 minutes will be \$58.15 plus \$.55 per minute and for anesthesia services greater than 60 minutes will be \$102.88 plus \$.55 per minute over 60 minutes.

HealthChek- EPSDT Services (billing instructions)

HEALTHCHEK Screening Service Codes

The codes for billing HEALTHCHEK (EPSDT) screening services may be found in the "Physicians' Current Procedural Terminology (CPT)," under preventive medicine services. The new patient codes, 99381 through 99385, may be used for patients who have not received any professional services from the provider within the past three years. The established patient codes, 99391 through 99395, must be used for patients who have received professional services from the physician within the past three years.

Effective for dates of service specified below, to comply with federal reporting requirements, provide the following information when billing the department based on the date of service and type of claim submission:

- (1) For dates of service prior to October 1, 2003 or the effective date of electronic data interchange transactions. e.g.(the 837 professional transaction), indicate that the service is part of the HealthChek (EPSDT) program by putting either:
 - (a) An "E" in item 24h on the paper claim form or in the same block on an electronic claim. "E" means that HealthChek (EPSDT) services were provided and no follow up services were required; or
 - (b) "An "R" in item 24h on the paper claim form or in the same block on an electronic claim. An "R" means that HealthChek (EPSDT) services were provided and follow up is required and a referral was made.

- (2) For dates of service October 1, 2003 and after or the effective date of electronic data interchange transactions. e.g.(the 837 professional transaction) and based on the type of claim submission, follow these instructions:
 - (a) When billing electronically using the 837 professional claim transaction, use the EPSDT referral feature in the 2300 claim information loop to indicate that an EPSDT referral was made. Put a "Y" in the Yes/No condition or response code data element to indicate that a referral was made and complete the condition indicator data element in the EPSDT referral feature area.
 - (b) If billing on a paper claim form, complete tem 24h on the paper claim form. Put an "E" if HealthChek services were provided and no follow up services were required. Put an "R" if HealthChek services were provided and follow-up was made and a referral given.
 - (c) Do not use the modifiers NF, FR, FA, or FC since they are not H.I.P.A.A. compliant.

Laboratory Services

Laboratory services- Clinical and anatomical pathology listing

Laboratory services are divided into 2 categories: clinical and anatomical pathology services. The department determines which procedures are considered clinical and which are considered anatomical pathology services.

Clinical Lab Codes

Clinical Services:

G0026	85130-86063	89050-89060
Q0111-Q0115	86140-87999	89125
80048-80090	88130-88155	89160-89399
80100-80440	88164-88167	
81000-85048	88230-88299	

Anatomical Lab Codes

Anatomical pathology laboratory services

80500-80502	88172-88199
85060-85097	88300-88399
86077-86079	89100-89105
88104-88108	89130-89141
88160-88162	

Waived PPMP and Radiology Codes

Laboratory tests considered "waived, provider-performed microscopy (PPMP), and radiology tests that are subject to CLIA requirements" can be found in the appendix titled [Waived Laboratory Procedure Categories](#).

Therapeutic Drugs and Injections

The appendix titled [Injection Codes](#) (J0000 to J9999) is a numeric and alphabetic listing of the J codes for injections.

Visits

Visits: Follow-up Days

The appendix titled [Payable Procedure Codes](#) (10000 to 69999) shows follow-up days for surgical codes.

Visits: Visits on the Same Day as Surgery

Codes with an asterisk beside them indicate that the day of surgery is not included in the minimum follow-up period and the number of follow-up days is equal to zero. This is listed in the appendix titled [Payable Procedure Codes](#) (10000 to 69999)

Advanced Practice Nurse Appendices

[Payable Surgical Procedure Codes](#)

[Guidelines for Health Supervision of Obstetrical Patients](#)

Alphabetic Listing of Injection Codes

The [Alphabetic Listing of Injection Codes](#) are maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Numeric Listing of Injection Codes

The [Numeric Listing of Injection Codes](#) are maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Office and Clinic Surgery Incentive Program

The [Office and Clinic Surgery Incentive Program](#) are maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Waived Laboratory Procedure Categories

A current list of waived or PPMP lab tests can be found on the CMS web site at <http://www.cms.hhs.gov/CLIA/>

Clinical Laboratory Procedure Codes Allowing Separate Reimbursement for Interpretive Consultations

The [Clinical Laboratory Procedure Codes Allowing Separate Reimbursement for Interpretive Consultations](#) are maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Lead Poisoning Table

Interpretation and Follow-up Activities for Children with Elevated Blood Lead Levels (BLL)

Chart adapted from "Screening Young Children for Lead Poisoning" Centers for Disease Control and Prevention (CDC 1997) in accordance with Ohio Department of Health Guidelines

Blood Lead Level (micrograms /dl)	Perform diagnostic test on venous blood within:	Perform follow-up test within:	Comprehensive follow-up services according to diagnostic BLL*
<10	Not indicated	Not indicated	Retest in 1 year. No additional action necessary unless exposure sources change.
10-14	3 months	3 months	Provide family lead education and follow-up testing. Refer for social services, if necessary
15-19	3 months	2 months	Provide family lead education, and follow-up testing. Refer to local health department for environmental investigation and lead hazard control. Refer for social services, if necessary. If BLLs persist (i.e., 2 venous BLLs in this range at least 2 months apart) or increase, proceed according to actions for BLLs 20-44**
20-44	1 month-1week (The higher the screening BLL, the more urgent the need for a diagnostic test)	***	Provide coordination of care (case management), clinical management, in addition to environmental investigation and lead hazard control. **
45-59	48 hours	***	Within 48 hours, begin coordination of care (case management), clinical management, environmental investigation, and lead hazard control**
60-69	24 hours	***	Within 24 hours, begin coordination of care (case management), clinical management, environmental investigation, and lead hazard control**
70 or higher	Immediately as an emergency lab test	***	Hospitalize child and begin medical treatment immediately. Begin coordination of care (case management), clinical management, environmental investigation, and lead hazard control immediately**

KEY

* A diagnostic BLL is the first venous BLL obtained within 6 months of an elevated screening BLL.

** Environmental investigations are initiated by the state or local health departments for all confirmed blood tests of 15 microgram/dl and above

*** Children with BLLs greater than or equal to 20 micrograms/dl should receive clinical management, which includes follow-up testing.

* A diagnostic BLL is the first venous BLL obtained within 6 months of an elevated screening BLL.

** Environmental investigations are initiated by the state or local health departments for all confirmed blood tests of 15 microgram/dl and above

*** Children with BLLs greater than or equal to 20 micrograms/dl should receive clinical management, which includes follow-up testing.

For further clarification of this table please contact Icilda Stevens-Dickerson, Program Supervisor at 614-728-9454 at the Ohio Department of Health Childhood Lead Poisoning Prevention Program, or you may obtain more information at http://www.odh.ohio.gov/odhPrograms/cfhs/lead_ch/leadch1.aspx

[List of Valid APN Modifiers](#)

Valid Alpha HCPCS Codes Excluding Injection Codes and DME Codes

The [Valid Alpha HCPCS Codes Excluding Injection Codes and DME Codes](#) are maintained in the Physician Services Manual, located in the Ohio Health Plans - Provider collection.

Codes Billable With Multiple Units Per Line Item

The following procedure codes may be billed with multiple units per line item.

When billing for multiple units per date of service, list the code once on the claim and bill the appropriate number of units. Do not list the code more than once on the claim.

CODE	PROCEDURE
11101	Biopsy of skin, each separate/additional lesion
*13102	Repair trunk, each added 5 cm or less
15001	Skin graft add-on
15101	Skin split graft procedure
15121	Skin split graft procedure
15201	Skin full graft procedure
15221	Skin full graft procedure
15241	Skin full graft procedure
15261	Skin full graft procedure
15351	Skin homograft add-on
15401	Skin heterograft add-on
17003	Destruction benign lesions, second to 14 lesions, each
63082	Removal of vertebral body
63086	Removal of vertebral body
63088	Removal of vertebral body
63091	Removal of vertebral body
64778	Added digit nerve surgery
64832	Repair additional nerve
64837	Repair additional nerve
64859	Suture of each additional major peripheral nerve
64901	Nerve graft, each additional nerve; single strand
90781	IV infusion for therapy/diagnosis, administered by physician or under direct supervision of physician; each additional hour, up to eight (8) hours
*	Indicates new 2000 CPT codes

Archived MHTLs

MHTL 3355-03-03

Medicaid Handbook Transmittal Letter (MHTL) 3355-03-03

July 23,2003

TO: All Providers of Advanced Practice Nurse Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: APN Handbook Update: Policy/Code Changes Relating to H.I.P.A.A.

H.I.P.A.A. CODE AND POLICY CHANGES

EFFECTIVE OCTOBER 1, 2003

- Modifiers for advanced practice nurse services.
- Code changes for casting materials and supply codes

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to provide notice of modifier and policy changes relating to H.I.P.A.A. for the policy areas listed above. The rules relating to these policies are in a proposed status but are scheduled to be effective for services provided on and after October 1, 2003. Providers should continue to use the current local level codes for services provided prior to October 1, 2003.

Health Insurance Portability and Accountability Act (H.I.P.P.A.)

To learn more about H.I.P.P.A. changes in ODJFS, please check the following web site address: <http://www.state.oh.us/odjfs/ohp/hipaa.stm>. The department has posted a code crosswalk for physician services that shows the current local level code (X-Z codes) used by the department, the new H.I.P.P.A. compliant code and its effective date, and the rule number that contains more detailed information about the change. The web address for this crosswalk document is <http://www.state.oh.us/odjfs/ohp/hipaa.stm>. The physician handbook located on the department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> contains the detailed information about the code changes also.

Handbook and Policy Update:

I. Billing for Advanced Practice Nurse Services

Effective for services provided on and after October 1, 2003, when billing for any service provided by an advanced practice nurse (APN), whether the APN is in independent practice or a provider-based practice (which includes an individual physician practice, a physician group practice, a hospital, a fee-for-service clinic, a cost-based clinic or a long term care facility) as described in rule 5101:3-8-22 of the Administrative Code, all services provided by an APN must be billed with a modifier to denote the type of APN which provided the service:

- Bill the modifier "SA" e.g. 99201SA, if the APN is a nurse practitioner;
- Bill the modifier "SB" e.g. 99201SB, if the APN is a nurse mid-wife; or
- Bill the modifier "UC" e.g. 99201UC if the APN is a clinical nurse specialist.

II. New range of Q-codes for casting materials and supply

Effective for services provided on and after October 1, 2003, local level code X9070 for casting materials and supply codes will not be HIPAA compliant and will no longer be a reimbursable service. To bill for casting supplies use HCPCS codes Q4001 to Q4048.

- Codes A4580 and A4590 for cast supplies will not be covered as of October 1, 2003. The cost for the cast supplies are bundled into the payment for the new Q-code.

III. Review of past Medicaid changes due to HIPAA compliancy

Throughout the past year, there have been many significant changes to Medicaid policy due to HIPAA regulations. These changes have ranged across many programs and many MHTL's. The following is a listing of affected program areas and the appropriate MHTL and/or website that contain the information. Please review any information that may pertain to you.

Please note that this list does not reflect all the information contained in the MHTL's, but rather the specific changes due to HIPAA compliancy issues.

MHTL 3355-02-04 (dated November 8, 2002)

- Discontinuation of immunization local level W-codes as of July 1, 2003.
- Discontinuation of EPSDT modifiers NF, FR, FA and FC as of October 16, 2003 plus important billing instructions for dates of service prior and after October 1, 2003.

MHTL 3355-02-05 (dated December 6, 2002)

- Discontinuation of ante partum local level code 59420 as of July 1, 2003. New billing instructions on billing for ante partum visits using E and M codes and the modifier TH as of July 1, 2003. See MAL 450 for more details on billing E and M codes with the TH modifier.
- Discontinuation of modifiers IF and IV as of July 1, 2003 used in conjunction with ante partum visits.
- Discontinuation of pregnancy related local level X-codes as of July 1, 2003 with cross-walk to new pregnancy related codes.
- Discontinuation of home visit travel local level code X5500 as of July 1, 2003.

MHTL 3355-03-01 (dated March 5, 2003)

Discontinuation of family planning local level X-codes as of October 1, 2003. Additional family planning billing instructions and the introduction of modifiers FP (for physicians) and SA and SB (for nurse practitioners). Family planning crosswalk from old to new family planning codes.

MHTL 3355-03-02 (dated May 13, 2003)

- Discontinuation of newborn care local level code X9380 as of July 1, 2003.
- Discontinuation of modifier VC for non-routine post operative visits as of July 1, 2003.
- Updates to Appendix G of the APN handbook for the List of Valid APN Modifiers.
- Updates to Appendix H of the APN handbook for List of Valid Alpha HCPCS codes.

To view a crosswalk spreadsheet of discontinued codes to HIPAA compliant codes, please visit our website at . This website also contains the list of HIPAA compliant modifiers and those modifiers that will be discontinued.

Copies of these MHTL's are at . Scroll down the list under ODJFS Ohio Health Plans Provider e-Collection and click on the link titled Advanced Practice Nurse.

Paper copies of the handbook updates will not be automatically sent out to providers per the ODJFS Paper Transmittal Reduction initiative. Handbook updates will be available online at Paper copies may be requested from ODJFS by filling out the attached ODJFS 03400 paper request form and sending it to the appropriate address or fax number given on the form.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-03-02

Medicaid Handbook Transmittal Letter (MHTL) 3355-03-02

May 13, 2003

TO: All Providers of Advanced Practice Nursing Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: APN Handbook Update For 2003 HCPCS Changes

2003 HCPCS HANDBOOK UPDATE

- **Clarification of use of acronym CPT and HCPCS**
- **Update on newborn care services**
- **Update on non-routine postoperative visits**
- **New website detailing local level code crosswalk to HIPAA compliant alpha or numeric codes**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2003 HCPCS (including CPT and alpha-numeric) codes and policies relating to those code changes.

The amended rules and updated sections of the advanced practice nurse handbook will be available on the Department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> by July of 2003. A consolidated APN handbook will be posted to the department's web site at <http://www.state.oh.us/odjfs/lpc/mtl>

2003 HCPCS Codes

On July 1, 2003, the Department will begin accepting the 2003 HCPCS codes effective for services rendered on and after that date. Since this notice is being sent well in advance of the effective date of July 1, 2003, there will not be the normal three-month transition period from old codes to new codes. For dates of service on and after July 1, 2003, the 2002 codes will no longer be accepted or reimbursed.

Advance Practice Nurse (APN) Services Handbook Update

The following is a summary of the significant policy and/or handbook changes that have been made effective for dates of service on and after July 1, 2003. Please review the bolded, bulleted headlines below and read those sections that pertain to the services you particular practice provides. This MHTL and all changes made to the consolidated Chapter 3355 will be available on the Internet in July of 2003 at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>.

Policy Changes and Clarifications

Clarification on use of the CPT and HCPCS acronym - APN.1101

"CPT" as used in the Ohio Medicaid Provider Handbook, Chapter 3355 for Advanced Practice Nurse Services, refers to the January 2003 edition of the current procedural terminology (CPT) book for services beginning July 1, 2003.

"HCPCS" as used in the Ohio Medicaid Provider Handbook, Chapter 3355 for Advanced Practice Nurse Services, refers to the January 2003 edition of the healthcare common procedure coding system (HCPCS) book for services beginning July 1, 2003.

Newborn Care

Local level code X9380 for the pre-delivery visit to a pediatrician/primary care provider for the establishment of a patient relationship with the APN is not HIPAA compliant and will no longer be reimbursed for dates of service on and after July 1, 2003. For reimbursement for this service, the APN must bill the appropriate evaluation and management code.

Non-routine Post Operative Visits

Revisions to non-routine postoperative visits have been made. Effective with dates of service on and after July 1, 2003, modifier VC has been deleted (due to HIPAA compliancy) and language for the modifier 24 has been revised to the meaning in the 2003 edition of the CPT book.

- An advanced practice nurse may be reimbursed for visits provided during the minimum surgical follow-up period only if the visit was provided after the day of surgery and the visit was provided for the diagnosis and/or treatment of a symptom illness or condition that was unrelated to the surgical procedure (previously) performed.
- Modifier **24** is defined as the unrelated evaluation and management service performed by the same advanced practice nurse during a postoperative period.

New website detailing local level code crosswalk to HIPAA compliant alpha or numeric codes

- A new document titled "Crosswalk from local level code to H.I.P.A.A. compliant code" detailing these changes can be found at <http://www.state.oh.us/odjfs/ohp/hipaacomcds.stm> . You will need Acrobat Adobe Reader to view and/or print this document.

Appendices

The following appendices have been revised as a result of the implementation of the 2003 HCPCS update:

- APN.1150 Payable Surgical Procedure Codes (10000-69999)
- APN.1153 Injection Codes (J0000 to J9999)
- APN.1156 List of Valid APN Modifiers
- APN.1157 List of Valid Alpha HCPCS codes

Appendix G (APN.1156.) List of Valid APN Modifiers

Due to the Health Insurance Portability and Accountability Act of 1996 (H.I.P.A.A.), many of the current modifiers will not be valid once H.I.P.A.A. regulations become effective. Appendix G shows the list of modifiers that will and will not be effective on and after July 1, 2003 and also a listing of modifiers that will and will not be effective on and after October 1, 2003.

Appendix H (APN.1157.) List of Valid Alpha HCPCS Codes

Again, due to H.I.P.A.A., many local level codes will not be compliant. Appendix H shows the list of codes that will be current and also codes that will no longer be effective for dates of service on and after July 1, 2003 and a list of codes no longer effective for dates of service on and after October 1, 2003.

Please visit our website detailing crosswalks from non-compliant codes to compliant HCPCS/CPT codes at <http://www.state.oh.us/odjfs/ohp/hipaacomcds.stm>

Requesting updates to this manual

If you wish to request a paper copy of the updated sections of the physician manual because you do not have access to the Internet, please complete the attached ODJFS Health Plan Provider Update Request Form and either mail or fax it to the address or phone number provided on the form. Please remember to indicate in the Information Request box all handbook sections needed. For example, if you only require a paper copy of this MHTL and section APN.1101.11 for Newborn Care, you need to indicate in the Information Request box APN.1101.11 and MHTL 3355-03-02. Also use this box to request appendix sections.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-03-01

Medicaid Handbook Transmittal Letter (MHTL) 3355-03-01

March 5, 2003

TO: All Providers of Advanced Practice Nurse Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Advance Practice Nurse (APN) Handbook Update: Policy/Code Changes Relating to H.I.P.A.A.

H.I.P.A.A. CODE AND POLICY CHANGES

EFFECTIVE OCTOBER 1, 2003

- **Family planning code update**
- **Immunization update**
- **HealthChek (EPSDT) update**
- **New 2003 CPT codes**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to provide an advance notice of code, modifier and policy changes relating to H.I.P.A.A. for the policy areas listed above. The rules relating to these policies are in a proposed status but are scheduled to be effective for services provided on and after October 1, 2003. Providers should continue to use the current local level codes for services provided prior to October 1, 2003.

Health Insurance Portability and Accountability Act (H.I.P.P.A.)

To learn more about H.I.P.P.A. changes in ODJFS, please check the following web site address: <http://www.state.oh.us/odjfs/ohp/hipaa.stm>. The department has posted a code crosswalk for APN services that shows the current local level code (X-Z codes) used by the department, the new H.I.P.P.A. compliant code and its effective date, and the rule number that contains more detailed information about the change. The APN handbook located on the department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> contains the detailed information about the code changes also.

Handbook and Policy Update:

Family planning billing after October 1, 2003 - APN.1102.7 H.I.P.P.A Code changes

Providers should continue to use the current local level X codes for family planning services provided prior to October 1, 2003.

Effective for services provided on and after October 1, 2003, the following provisions must be followed when a claim is submitted for family planning services:

- Providers must bill a family planning diagnosis code:
- V25 - V25.9 indicating an encounter for contraceptive management or
- V26 - V26.9 indicating an encounter for procreative management.
- For family planning services billed as APN services, providers must bill the "FP" modifier to indicate that services are provided as part of family planning.
- Services provided by a nurse practitioner or a nurse mid-wife must be billed with modifiers to indicate the provider that rendered the service:
- Use the "SA" modifier to indicate that a nurse practitioner rendered the service in collaboration with a physician; or

- Use the "SB" modifier to indicate that a nurse mid-wife provided the service.

Family planning visit codes - APN.1102.2 H.I.P.P.A Code changes

- For reimbursement of family planning visits, providers may bill one of the H.I.P.A.A. compliant codes listed below in the crosswalk from the current local level code to the new code:

Local level code (use for services prior to 10/1/03)	Description of current code	New code for services on and after 10/1/03	Description of new code
X1450	Minimal family planning visit	99211	Office visit not requiring MD presence
X1451	Family planning counseling by non- physician	H1011	Non-medical family planning education visit
X1452	Examination not performed by a physician	S0610 or	New patient gyn. exam- Must bill with SA or SB modifier
		S0612	Established patient gyn. exam-Must bill with SA or SB modifier
X1453	Examination performed by physician	S0610 or	New patient gyn. exam.
		S0612	Established patient gyn. exam

Other family planning codes - APN.1102.5 H.I.P.P.A Code changes

For a crosswalk of other X codes for family planning to the new H.I.P.A.A. compliant code, consult the document "Crosswalk from local level code to H.I.P.A.A. compliant code" which can be found at <http://www.state.oh.us/odjfs/ohp/hipaa.stm>.

New Vaccine for Children (VFC) Immunization Code - APN.1104.1

- Effective March 23, 2003 the Department and the Ohio Department of Health will add a new vaccine to the VFC program. The new vaccine code 90723 combines a number of existing vaccines into a single shot including diphtheria, tetanus toxoids, acellular pertussis, hepatitis B, and polio virus.
- Please note a correction to an earlier statement in MHTL 3355-02-04. Effective July 1, 2003 the local level code W0706 for adult rubella virus is being discontinued. The department is not crosswalking it to a CPT code since ODH has advised that a vaccine for rubella virus is no longer given as a stand-alone virus.

V. HealthChek (EPDST) billing - APN.1105.3 - H.I.P.A.A.

- In MHTL 3336-02-04 dated November 8, 2002, the department announced a number of changes to HealthChek billing relating to H.I.P.A.A. including local level modifiers being discontinued, use of the EPSDT referral loop in the 837 Professional transaction, and other billing changes. These changes should be implemented for dates of service on and after October 1, 2003, not October 16, 2003 as specified in the November 8, 2002 MHTL.

2003 Codes

- The department will begin accepting the new CPT codes for 2003 for dates of service on and after July 1, 2003. The new codes will not be retroactive for services provided prior to July 1, 2003.
- Codes that have been discontinued by the AMA for 2003 will no longer be accepted by the department for dates of service on and after July 1, 2003. Providers should bill the new 2003 code that replaces the older code for dates of service on and after July 1, 2003.

Requesting updates to this manual

If you wish to request a paper copy of the updated sections of this manual because you do not have access to the Internet, please complete the boxes below and fax the next page to: ODJFS Warehouse Service at 614-728- 7724. If you do not have fax capability,

you may mail the form to:

Warehouse Services

2098 Integrity Drive North

Columbus, OH 43209-2747

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-02-05

Medicaid Handbook Transmittal Letter (MHTL) 3355-02-05

December 6, 2002

TO: All Providers of Advanced Practice Nursing (APN) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: APN Handbook Update- Policy/Code Changes Relating to H.I.P.A.A. - Obstetrical Services

POLICY UPDATE: H.I.P.A.A. CODE CHANGES - OBSTETRICAL SERVICES

- **Billing antepartum visits**
- **Delivery and post-partum care services**
- **Discontinuing the IF and IV modifier for antepartum services**
- **Prenatal risk assessment form**
- **Pregnancy-related services code changes**
- **General information policy changes: Medical necessity, physician delegation in LTC facilities, prior authorization**
- **Reminder: Delay in addition of new 2003 CPT/HCPCS codes**
- **Reminder: Paper distribution of policies and handbooks ending**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rule which govern APN services which pertain to obstetrical and pregnancy-related services. Please note that the rules relating to the proposed policy changes addressing obstetrical and pregnancy-related services are in a proposed status but are scheduled to be effective July 1, 2003. This is an advanced notice of the changes. Providers should continue to use the current local level codes for services for dates of service prior to July 1, 2003.

I. Billing for antepartum visits - APN.1103.2 H.I.P.A.A. code change

- Providers should continue to use the local level code 59420 to bill for antepartum visits for dates of service prior to July 1, 2003.
- Effective for dates of service on and after **July 1, 2003**, the code local level 59420 for an antepartum visit will be discontinued since it is not H.I.P.A.A. compliant. When billing for an antepartum visit, select the evaluation and management code (office visit code) appropriate for the type of visit documented in the patient's record and modify it by the H.I.P.A.A. compliant modifier "TH" to signify "obstetrical services, prenatal or post-partum" (e.g. 99213TH). When billing an E/M code for an antepartum visit, providers must specify a diagnosis code to signify pregnancy such as V22 for supervision of a normal pregnancy, V23 for supervision of a high-risk pregnancy, or V28 for antenatal screening.
- Note: The Department does not recognize the global antepartum visit codes 59425 or 59426. Ohio Revised Code 5111.09 requires that the Department report the actual number of antepartum visits provided to Medicaid-eligible women to the state legislature each year. Therefore, it is not possible for the Department to meet this reporting obligation and adopt the global visit codes.
- Effective for dates of service on and after **July 1, 2003**, the Department will be discontinuing the IF and IV modifiers which are not H.I.P.A.A. compliant. These modifiers allowed an enhanced payment for an antepartum visits during the first trimester or after the first trimester and before 36-weeks of gestation. Therefore, to avoid a claim denial, do not bill for an antepartum visit with the IF or a IV modifier on or after July 1, 2003.

II. Delivery and post partum care - APN.1103.3

The Department wishes to clarify its policy and interpretation, for Medicaid billing purposes, of the delivery and post partum care CPT codes:

- Under the Medicaid program, the provision of postpartum care rendered prior to discharge from the inpatient hospital, outpatient hospital or birthing center (i.e. the delivering institution) is considered incidental to the delivery services and/or postpartum service and should not be a factor when selecting the delivery only codes or the delivery codes bundled with the postpartum care services.
- For the reimbursement of the delivery only codes, the provider or provider group must render, at a minimum, the delivery service.
- For reimbursement of the delivery and postpartum care codes, the provider or provider group practice must render, at a minimum, both the delivery and at least one evaluation and management service four to six weeks post-delivery.
- For the reimbursement of the postpartum care only code, the provider or provider group practice must render, at a minimum, at least one evaluation and management service four to six weeks post surgery.
- The Department has further defined "provider" for the following groupings of delivery and post partum CPT codes as the same rendering provider or any provider in the same provider group:
- For delivery and postpartum services provided to patients for which a vaginal or Cesarean delivery after a previous Cesarean delivery (VBAC) was not attempted.

(The table below contains delivery and post partum CPT codes)

Delivery and post partum CPT codes	
Code	Code Description
59409	For a vaginal delivery when <u>outpatient</u> postpartum care is provided by another provider <u>or provider group</u> .
59410	For a vaginal delivery when <u>outpatient</u> postpartum care is provided by the same provider <u>or provider group</u> .
59514	For a Cesarean section when <u>outpatient</u> postpartum care is provided by another provider <u>or provider group</u> .
59515	For a Cesarean section when <u>outpatient</u> postpartum care is provided by the same provider <u>or provider group</u> .

- For delivery and postpartum services to patients for which a VBAC was attempted.

(The table below contains delivery and post partum CPT codes)

Delivery and post partum CPT codes	
Code	Code Description
59612	For a vaginal delivery only, after previous Cesarean delivery (with or without episiotomy and/or forceps) when outpatient postpartum care is provided by another provider or provider group.
59614	For a vaginal delivery only, after previous Cesarean delivery (with or without episiotomy and/or forceps) when outpatient postpartum care is provided by the

	same provider or provider group .
59620	Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery when <u>outpatient</u> postpartum care is provided by another provider <u>or provider group</u> .
59622	Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery when <u>outpatient</u> postpartum care is provided by the same provider <u>or provider group</u> .

- For the reimbursement of codes 59410, 59430, 59515, 59614 or 59622, the provider must, at a minimum, render an evaluation and management service four to six weeks post-delivery.

III. Prenatal Risk Assessment Form - APN.1103.1

- In order to bill for the prenatal at-risk assessment code X5400, the provider must complete the Prenatal Risk Assessment form specific to the obstetrical patient. A copy of the PRS form should be placed in the patient's record to serve as documentation that the service was provided. Providers must submit a copy of the PRA form to the patient's residential county of ODJFS since the county staff can assist the patient to obtain needed services.
- The code for a prenatal at-risk assessment for dates of service on and after **July 1, 2003** will be H1000.
- Continue to use the existing local level code X5400 for services provided prior to July 1, 2003.

IV. Pregnancy-related services - APN.1103.2 - H.I.P.A.A. code changes

- Providers should continue to use the local level X codes noted in the far left-hand column of the table on the next page for services provided prior to July 1, 2003.
- Effective for dates of service on and after **July 1, 2003**, the Department will be discontinuing the X codes for pregnancy-related services and using a combination of H codes issued by the Centers for Medicare and Medicaid for pregnancy-related services and certain S codes.
- To bill for pregnancy-related services provided on and after July 1, 2003, with the exception of the pre-delivery visit to a pediatrician or other primary care provider, follow the billing instructions listed in this paragraph:
 - (a) Bill the appropriate code(s) specified in this rule with the modifier "TH" to indicate that obstetrical services, prenatal or post-partum were provided.
 - (b) Bill the appropriate diagnosis code to indicate that the diagnosis is for antepartum care either V22, V23, or V28.
- Use the following table to identify the appropriate code to bill for dates of service on and after July 1, 2003:

Code prior to 7/1/03:	New Code 7/1/03 and after:	New description:
X5431	H1002	Care Coordination
X5412	(see S codes below)	<u>Group</u> prenatal at-risk education
	S9436	Childbirth preparation/Lamaze classes, non-physician provider
	S9437	Childbirth refresher classes, non-

		physician provider
	S9452	Nutrition classes for pregnant women, non-physician provider
	S9444	Baby parenting classes provided to pregnancy women, non-physician provider
	S9447	Infant safety classes provider to pregnancy women, non-physician provider
X5411	H1003	<u>Individual</u> prenatal at-risk education
X5432	H1001	Antepartum management (formerly called high-risk patient monitoring)
X5422	S9470	Medical nutrition therapy counseling provided by a dietician
X5422	Use appropriate E/M visit code	For medical nutrition counseling provided by a physician
X5400	H1000	Pre-natal risk assessment

- It is important to note that for each different group prenatal at-risk education class, e.g. for childbirth preparation/Lamaze class, the unit of service is limited to one per pregnancy. Each code is priced for the entire session of childbirth classes whether the session consists of one class or 3 different classes.
- Note that there are now a variety of group classes which are specific to the type of classes. The types include: Childbirth preparation/Lamaze, childbirth refreshes class, nutrition classes for pregnant women, baby parenting, and infant safety.
- The code for home visit travel X5500 has been discontinued since it is not H.I.P.A.A.-compliant.
- For a pre-delivery visit to a pediatrician or other primary care provider, the provider should bill the most appropriate office visit (E and M)code.
- For nutrition interventions provided by a APN, bill the appropriate evaluation and management (visit) code. For nutrition interventions for pregnant women provided by a dietician, the dietician must be employed by or under contract with an eligible Medicaid provider in order for the physician practice to bill the code S9470. In both situations, the "TH" modifier must be billed to reflect that the nutrition services are for prenatal at-risk education purposes and the patient must have a diagnosis of either V22, V23, or V28.
- Pregnancy-related services may be provided at the provider's practice site or in the patient's home.

V. Changes to general rules for all providers

- A number of rules in Chapter 1 of Medicaid's rules (5101:3-1) have been updated as part of 5-year rule review. A new handbook (Chapter 3334) describing these rule changes will be issued shortly. Below is a summary of a few of these Chapter 1 rules which currently reside in the APN handbook.
- Medical necessity - APN.1003.1
- Please review this section of the handbook. Two new provisions have been added to the provisions which must be met for a service to be considered medically necessary:
- Be the lowest cost alternative that effectively addresses and treats the medical problem; and

- Meet general principles regarding reimbursement for medicaid covered services found in rule 5101:3-1-02 of the Administrative Code.
- Services provided to residents of long-term care facility - APN.1003.4
- The paragraph addressing physician delegation of tasks has been revised.
- Prior Authorization - APN.1004
- This section has been updated to reflect current procedures.

VI. Reminder: Delay in implementation of new 2003 CPT/HCPCS codes

The Department will **not** be conducting the 2003 update of HCPCS codes by January 1, 2003. Instead, the Department will be working to assure a smooth transition to the standard code sets and transactions required under the Health Insurance Portability and Accountability Act (H.I.P.A.A.). The Department will add the new codes for 2003 later in 2003. We will notify providers in advance of the date the Department decides to make the new 2003 codes effective.

VII. Reminder: Paper distribution of policies and handbooks ending

Notice - Paper Distribution Changes

Notice

Paper Distribution Changes

The Ohio Department of Job and Family Services (ODJFS) is converting to an electronic publication of policies which are currently provided on paper. Providers will receive ONLY paper copies of the cover letters that transmit policies, MHTLs and MALs. Instead of rules or handbooks being attached, providers will be directed to the website, <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>

Sometime in 2003, ODJFS plans to no longer send paper copies of the cover letters, MHTLs and MALs or handbooks announcing policy changes. Providers will be notified of the date at a later time. Providers may access the web site listed above for policy changes.

If you do not have access to the Internet, see the last page of this MHTL to request a paper copy of this information.

- To obtain a copy of this new obstetrical policy reflected in PHY.1003, please go to the department's handbook and rule web site address at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>. Once there, click on the "APN services" book and then click on APN.1103 to view and/or print this new policy.
- A new consolidated APN handbook containing all APN policies as of this date is also available at the above-listed web site address. The consolidated APN handbook contains sections APN.1000 describing general policies applicable to APNs and APN.1100 containing all covered services and associated limitations. Related appendices to the handbook can be viewed and printed individually from the web site by clicking on each individual appendix.

VIII. Requesting updates to the APN manual

- If you wish to request a paper copy of the updated sections of the APN manual because you do not have access to the Internet, please complete the boxes below and fax this page to: ODJFS Warehouse Information 614-728- 7724. If you do not have fax capability, you may mail the form to:

Warehouse Services
 2098 Integrity Drive North
 Columbus, OH 43209-2747

[Click here to print the order form for MHTL 3355-02-05.](#)

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-02-04

Medicaid Handbook Transmittal Letter (MHTL) 3355-02-04

November 8, 2002

TO: All Providers of Advanced Practice Nursing Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: APN Handbook Update- Policy/Code Changes

POLICY UPDATE: HCPCS AND H.I.P.A.A. CODE CHANGES

ELECTRONIC DISTRIBUTION OF HANDBOOK UPDATES

- **Delay in addition of new 2003 HCPCS codes**
- **Change in distribution of policy information**
- **How to access the web to review policy changes**
- **Immune globulin codes including RhoD - APN.1104**
- **Immunization codes- APN.1104.**
- **HealthChek (EPSDT) screening frequencies- APN. 1105**
- **Billing for HealthChek Services- APN.1105**
- **Therapeutic injection language revisions- APN.1106**
- **ZP modifier and other lab revisions - APN1110**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules which govern APN services. Please note that the rules relating to these proposed policy changes are in a proposed status but are scheduled to be effective for services provided on or after the date specified in each section of this MHTL.

I. 2003 HCPCS Code Update

The Department will **not** be conducting the 2003 update of HCPCS codes by January 1, 2003. Instead, the Department will be working to assure a smooth transition to the standard code sets and transactions required under the Health Insurance Portability and Accountability Act (H.I.P.A.A.). The Department will add the new codes for 2003 later in 2003. We will notify providers in advance of the date the Department decides to make the new 2003 codes effective.

II. *** Change in Distribution of Policy Information *******

Notice

Paper Distribution Ending

Effective immediately the Ohio Department of Job and Family Services (ODJFS) is converting to an electronic publication of policies which are currently provided on paper. Through December of this year providers will receive **ONLY** paper copies of the cover letters that transmit policies, MHTLs and MALs and all policy changes. Instead of rules or handbooks being attached, providers will be directed to the website, <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>

In January of 2003 ODJFS plans to no longer send paper copies of the cover letters, MHTLs and MALs or handbooks announcing policy changes.

Providers may access the web site listed above for all policy changes.

If a provider does not have access to the Internet, see the last page of this MHTL to request a paper copy of this information.

III. How to Access the Web to Review Policy Changes

Go to <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/>. Select "Ohio Health Plans" on the left frame to find all Ohio Medicaid materials. On the right-hand frame, click on the appropriate document, e.g. "Physician services" or "billing instructions". The table of contents for the physician handbook will appear on the left e.g. Medicaid handbook transmittal letters, PHY.1100 Covered services and limitations, appendices, etc. Click on PHY.1100 covered services to find different physician policies e.g. PHY.1103 obstetrical services, PHY.1104 immunizations, etc.

IV. Policy Changes:

Immune globulin code changes - APN.1104.3

Effective for dates of service on and after **January 1, 2003**, use immune globulin codes in the range of 90281 through 90396 for immune globulin services administered through the intramuscular or subcutaneous route. Otherwise, use an injection code (J code) for other immune globulin services. The following provisions apply to specific types of immune globulin services:

- For botulinum antitoxin, bill code 90287 if the antitoxin is for non-cosmetic purposes. Code 90288 for botulism immune globulin, human for intravenous use is no longer recognized by the department. Providers may be reimbursed for this service by billing the appropriate J code for this service.
- For cytomegalovirus immune globulin, human for intravenous use, bill 90291 per ml in the unit field. The injection code J1565 is no longer recognized by the Department for this service.
- For respiratory syncytial virus immune globulin for intra-muscular use, bill code 90378. Code 90379 for intravenous use will no longer be recognized by the Department. Providers may be reimbursed by billing the appropriate J injection code for this service.
- For Rho(D) immune globulin codes 90384 for the Rho(D) immune globulin, human, full dose for intramuscular use and 90385 for the Rho(D) immune globulin, human, mini-dose for intramuscular use, bill one vial in the units field for each dose provided. Injection code J2790 will no longer be recognized by the Department for this service. For RhoD for intravenous use, bill the appropriate injection code. Code 90386 will no longer be recognized by the Department.
- Note: The department has discontinued the "by report" status of the following immune globulin codes: 90291, 90378, 90384, and 90385. These codes are now priced and will pay automatically.
- Codes 90281 will be covered by the Department when bill per ml. in the units field.. Code 90399 will not be recognized by the Department.

Immunization codes changes - APN.1104.7. H.I.P.A.A. code changes

In preparation for H.I.P.A.A., the Department is discontinuing the following local level codes for immunizations for nondesignated vaccines for adults and will begin using the CPT codes for the vaccine effective for dates of service on and after **July 1, 2003**:

Old code:	Description	New Code
W0703	Tetanus, adult , nineteen years or older	90703
W0706	Rubella virus, adult, nineteen years or older	90706
W0718	Tetanus and diphtheria toxoids, adult	90718
W0658	Influenza, split vaccine, adult, 19 years or	90658

	older	
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Effective for dates of services on and after **July 1, 2003**, codes 90703, 90706, 90718, and 90658 will be reimbursed at the lesser of the provider's billed charge or the Medicaid maximum for these vaccines provided to adults over eighteen. For individuals eighteen years or younger, the Department will continue to reimburse \$5.00 for an administration fee for these vaccines since the vaccines can be obtained free through the VFC program administered by the Ohio Department of Health for children.

HealthChek (EPSDT) screening frequency - APN.1105.3

The Department has revised its recommendations regarding the frequency of HealthChek screenings. The Department will follow the recommendations for preventive pediatric health care developed by the Committee on Practice and Ambulatory Medicine of the American Academy of Pediatrics. These recommendations can be found on the web site of the American Academy of Pediatrics at <http://www.aap.org/policy/re9939.html>

HealthChek (EPSDT) billing - APN.1105.3 H.I.P.A.A. modifier changes

Modifier changes

Effective for dates of service **October 16, 2003 (or H.I.P.A.A. implementation date)**, the modifiers NF, FR, FA, and FC have been discontinued since they are not H.I.P.A.A. compliant.

- For dates of service prior to **October 16, 2003 (or H.I.P.A.A. implementation date)**, indicate the service is part of the HealthChek (EPSDT) program on the claim by putting either:
 - An "E" in item 24h on the paper claim form or in the same block on an electronic claim. "E" means that HealthChek (EPSDT) services were provided and no follow up services were required; or
 - "An "R" in item 24h on the paper claim form or in the same block on an electronic claim. An "R" means that HealthChek (EPSDT) services were provided and follow up is required and a referral was made.
 - Note: The Department's system is not yet programmed to accept the R in item 24h. We will notify providers when this system change has been finalized.
- For dates of service **October 16, 2003 and after (or H.I.P.A.A. implementation date)** and based on the type of claim submission, follow these instructions:
 - When billing electronically, using the 837 professional claim transaction:
 - Use the EPSDT referral feature in the 2300 claim information loop to indicate that an EPSDT referral was made. Put a "Y" in the Yes/No condition or response code data element to indicate that a referral was made and complete the condition indicator data element in the EPSDT referral feature area.
- If billing on a paper claim form, follow the instructions provided in this MHTL for completing item 24h on the paper claim form

Therapeutic injections - APN.1106.1

- Conditions for reimbursement.

Provisions specific to vitamin B-12, interferon, lupron depot, depo provera have been deleted. Instead, the Department is stating a general provision for all injections that reimbursement will be limited to only those injections/drugs that:

 - a. Have an FDA approved indication; or
 - b. Are considered by accepted standards of medical practice as specific or effective treatment for the particular condition for which they are given.
- Reimbursement for therapeutic injections or other pharmaceuticals administered during an office visit.

Effective **January 1, 2003** codes 90782 through 90788 are reimbursable if the conditions described in this paragraph are met. Reimbursement for therapeutic, prophylactic or diagnostic

injections ranging from code 90782 to 90788 will be made only when billed with an injection code (J code) and no other service is rendered by the same provider on that day. Reimbursement is considered bundled into the payment made for an evaluation and management service (visit) or other physician service billed on the same date by the same provider. Codes in the range 90782 to 90788 are not valid for place of service inpatient hospital, outpatient hospital or emergency room.

Price adjustments for Q codes and certain J codes

Effective **December 15, 2002**, the Department lowered its price for Q codes for EPO injections and certain J codes since we were paying more than Medicare for these services.

Laboratory code changes - APN.1110

- For dates of service beginning on **February 1, 2003**, local level code W0021 for neonatal diagnostic screening kits will no longer be reimbursed by the Department. Neonatal diagnostic screening kits may be obtained from the Ohio Department of Health (ODH).
- For dates of service beginning on July 1, 2002, local level codes X9354 and X9356 for evocative/suppression testing will no longer be reimbursed by the Department. To bill for these services, bill the appropriate evaluation and management code.

V. Requesting updates to the manual

If you wish to request a paper copy of the updated sections of the manual because you do not have access to the Internet, please complete the boxes below and fax the last page to: ODJFS Warehouse Information 614-728- 7724. If you do not have fax capability, you may mail the form to:

Warehouse Services

2098 Integrity Drive North

Columbus, OH 43209-2747

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-02-03

Medicaid Handbook Transmittal Letter (MHTL) 3355-02-03

July 18, 2002

TO: All Providers of Advanced Practice Nurse (APN) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: Advanced Practice Nurse Handbook Update- Anesthesia

EFFECTIVE SEPTEMBER 1, 2002

Anesthesia Conversion Factor

Other Anesthesia Changes

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules 5101:3-4-21 and 5101:3-4-21.2 which govern anesthesia services. Updated handbook pages are attached. Please note that the rules relating to these proposed policy changes are in a proposed status but are scheduled to be effective for services provided on or after September 1, 2002.

Please do not remove the old pages and replace them with these pages since the length of the material has changed the page numbering of this handbook. Instead simply read the new MHTL information and retain it for reference. A new handbook will be issued in January of 2003.

The amended rules and updated section of the advanced practice nurse handbook will be available on the Department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/> in August of 2002.

Policy Changes:

I. Anesthesia Conversion Factor for Medically-directed Services

Effective for dates of service on and after September 1, 2002, the conversion factor for modifiers QK, QX, and QY (medically-directed services) has been changed to \$16.26 (see APN.1108.9 paragraph (A)(6)(b)). This action was taken since state law prohibits the Department from paying more than Medicare for any service.

II. Other Anesthesia Changes

The definition of time unit has been revised to acknowledge that "time unit" for neuraxial analgesia for obstetrical services is different than the definition of time unit for other anesthesia services. The definition of time unit for neuraxial analgesia for obstetrical services is "time begins when the neuraxial labor analgesic is inserted and continues through delivery". Time for obstetrical anesthesia is the lower of actual time from insertion through delivery or a maximum of four hours.

The Department added a definition for "medical direction" and "medical supervision" which are:

- "Medical direction" is when a physician meets the requirement that the physician is acting exclusively as an anesthetist and is not also acting as the surgeon or assistant surgeon and the physician utilizes the assistance of a CRNA, resident, intern, or fellow in the performance of the services listed in section APN.1108.8 and is involved in no more than four anesthesia cases.
- "Medical supervision" is when the physician meets the requirement that the physician is acting exclusively as an anesthetist and is not also acting as the surgeon or assistant surgeon, performs a preanesthesia examination and evaluation, and prescribes the anesthesia plan as specified in section APN.1108.8 (B) and the anesthesiologist is involved in furnishing services for more than four concurrent procedures or is performing other services while directing the concurrent procedures.

Clarifying language was added to section APN.1108.41 (C)(1) and (C)(2) which addresses billing of claims for a CRNA when they are employed by a physician. This section now reads,

- One claim must be submitted when no medical direction or supervision was provided by the physician/anesthesiologist; or
- Two claims must be submitted when the physician/anesthesiologist meeting the requirements in section APN.1108.8 (B) provides medical direction or medical supervision to the CRNA.

III. Changes to the outline of the Advanced Practice Nurse (APN) Handbook, section APN.1108, have been made for easier referencing.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-02-02

Medicaid Handbook Transmittal Letter (MHTL) 3355-02-02

April 3, 2002

TO: All Providers of Advanced Practice Nurse (APN) Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: ADVANCED PRACTICE NURSE HANDBOOK UPDATE

ELIGIBLE APN PROVIDERS AND COVERAGE REVISIONS

EFFECTIVE JUNE 1, 2002

- Expansion of Eligible APN Providers
- Clarification of Reimbursement Provisions
- Billing for Visit (E/M) CPT codes
- Prescribing Drugs

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing eligible APN providers and coverage of services. Amended APN rules and updated handbook pages are attached. New information is noted by a vertical line to the left of the new language. Please note that the rules relating to these proposed policy changes are in a proposed status but are scheduled to be effective for services provided on or after June 1, 2002.

Please do not remove the old pages and replace them with these pages since the length of the material has changed the page numbering of this handbook. Instead simply read the new MHTL information and retain it for reference. A new handbook will be issued in January of 2003.

The amended rules and updated APN handbook will be available on the Department's web site at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/> in May of 2002*.

** The hardcopy erroneously states the date as May of 2003, however the electronic version has been updated to reflect the correct date.*

Policy Changes:

I. Eligible APN Providers

- The Department has expanded its policy regarding the specialty types of nurse practitioners who can bill the Department for covered services. Effective June 1, 2002 the following nurse practitioner specialities have been added to the list of nurse practitioners not employed by a pilot program who are eligible to become an Ohio Medicaid provider:
 - Gerontological nurse practitioners;
 - Neonatal nurse practitioners; and
 - Acute care nurse practitioners.
- Acute care nurse practitioners who are employed by a pilot program are now eligible to enroll as an Ohio Medicaid provider.
- Effective June 1, 2002, certain clinical nurse specialists (CNS) are eligible to enroll as an Ohio Medicaid provider if the CNS is:
 - Approved under section 4723.42 of the Revised Code (i.e. not employed by one of the pilot programs);
 - Holds a valid certificate of authority issued by the Ohio Board of Nursing; and

- Certified by a national certifying organization approved by the Ohio Board of Nursing as
 - An oncology clinical nurse specialist;
 - A medical-surgical clinical nurse specialist; or
 - A gerontological clinical nurse specialist.
- A revision has been made to the Department's policy regarding professional associations organized under sections 1785.01 to 1785.08 of the Revised Code. Effective June 1, 2002 an association must be comprised solely of two or more nurse practitioners, two or more nurse midwives, or two or more CRNAs in order to bill the Department for covered services.
- Medicaid APN rules have been amended to clarify that the provisions relative to approved pilot programs expire when the pilot programs expire in January of 2004.
- Any APN who applies to become a Medicaid provider for the first time after January 1, 2003 must possess a Master's degree in Nursing.

II. Coverage and limitations

- The Department wishes to clarify several existing coverage policies:
- Reimbursement is not available for an APN service including visit (evaluation and management) codes if a physician is billing for the same service or for a visit on the same day for the same patient. Specifically, if an APN and a physician provide the same covered service, e.g. any E/M service, or participate in the provisions of a global/all-inclusive service which includes multiple visits on the same or different days, one provider is entitled to reimbursement for the service.
- Except when precluded by Ohio law, inpatient hospital E/M services are covered only if the APN is acting in the capacity of the patient's "primary treating provider" for the day and no physician is acting concurrently as the "primary treating provider" for that day, and billing for the E/M service is in the capacity of "primary treating provider". For purposes of this rule, "primary treating provider" is a physician or APN who is responsible for managing the patient's inpatient hospital care for that day. "Primary treating provider" does not include a sub-specialist physician who may be treating the patient concurrently for specialty care such as a nephrologist.
- The Department has expanded the evaluation and management codes / visit codes which APNS are allowed to bill and be reimbursed for.
- Effective for dates of service on or after June 1, 2002 the Department will now allow APNs to bill for the following evaluation and management codes / visit codes which were previously prohibited by rule if it is within the APN's scope of practice to deliver these services:
 - 99222 Initial hospital care mid-level code
 - 99233 Highest level subsequent hospital care code
 - 99283 Midlevel emergency room visit
 - 99313 Highest level subsequent nursing facility care
 - 99323 Highest level new patient rest home code
 - 99333 Highest level established patient rest home code
 - 99343-45 Three highest level home visit codes
 - 99440 Newborn resuscitation (if performed by a neonatal nurse practitioner completing course(s) in neonatal resuscitation offer by American Heart Association of Academy of Pediatrics)
 - The Department also allows APNs to bill for patient transport evaluation and management / visit codes 99289 and 99290.
- However, the Department will continue its policy of not allowing APNs to be reimbursed for the following evaluation and management codes / visit codes:
 - 99205 Highest level new patient office visit
 - 99215 Highest level established patient office visit
 - 99217-20 Observation care

- 99223 Highest level initial hospital visit
- 99241-75 Consultations
- 99291-99298 Critical care and neonatal intensive care
- 99284-85 Highest level ER visits
- APNs may bill for prescribed drugs if the drug(s) was prescribed by an APN who has the authority to order and/or prescribe drugs under, and in accordance with Ohio law.
- APNs who may be teaching residents are not eligible to bill the Department for services provided by the resident. Services of a resident, intern, or fellow provided in a teaching setting and supervised by an APN are not covered by the Department.
- The Department is continuing its policy regarding assistant-at-surgery. Assisting at surgery is not reimbursable when provided by an APN.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

Attachments

OAC 5101:3-8-20 Advanced practice nurses.

OAC 5101:3-8-21 Advanced practice nurses participating in the pilot programs: eligible Ohio Medicaid providers.

OAC 5101:3-8-22 Advanced practice nurses: practice arrangements and reimbursement.

OAC 5101:3-8-23 Advanced practice nurses: coverage and limitations.

OAC 5101:3-8-24 Eligible providers of certified registered nurse anesthetist (CRNA) services.

MHTL 3355-02-01

Medicaid Handbook Transmittal Letter (MHTL) 3355-02-01

January 8, 2002

TO: All Providers of Advanced Practice Nurse Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas Hayes, Director

SUBJECT: HANDBOOK UPDATE FOR 2002 HCPCS CHANGES

2002 HCPCS HANDBOOK UPDATE

- **Update: Most commonly asked questions about Medicaid**
- **H.I.P.A.A.**
- **Prenatal care billing**
- **Anesthesia services for obstetrical care**
- **Exceptions to noncovered services**
- **Appendices**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2002 HCPCS (including CPT and alpha-numeric) codes and to transmit a new consolidated Chapter 3355 of the Ohio Medicaid Provider Handbook to providers of APN services.

2002 HCPCS Codes

On January 1, 2002, the Department began accepting the 2002 HCPCS codes effective for services rendered on and after that date. To give providers time to make the transition to the 2001 HCPCS codes, the Department will continue to accept the 2000 codes for services rendered through March 31, 2002. Providers may choose to bill either the 2000 codes or the 2001 codes during the transition period from January 1, 2002 to March 31, 2002. Beginning April 1, 2002, the 2001 codes will no longer be accepted to report services provided on and after that date.

APN Services Handbook Update

The following is a summary of the significant policy and/or handbook changes that have been made effective for January 1, 2002 and are incorporated into the attached consolidated Chapter 3355 of the Provider Handbook. Please review the bolded, bulleted headlines listed below and read those sections of the handbook that pertain to the services your particular practice provides. You will find a black line in the left-hand margin of applicable pages indicating changes made. This MHTL and all changes made to the consolidated Chapter 3355 will be available on the web in January, 2002 at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/>

Most Commonly Asked Questions Update

This section is now entitled "Top Fifteen Questions". The Department has added answers to five commonly asked questions noted as questions 11-15. These questions address issues including Medicare/Medicaid claim issues, "zero-pay" notations on a remittance advice, H.I.P.A.A. and provider address changes. Please review these new questions and answers.

Health Insurance Portability and Accountability Act (H.I.P.A.A)

To learn more about H.I.P.A.A., there has been a web site created by Ohio's statewide H.I.P.A.A. committee. Please check the following web site address for educational materials including an awareness brochure: <http://www.state.oh.us/hipaa/educationalmaterials.htm> (the hardcopy erroneously cites this URL as <http://www.state.oh.us.hipaa/educationalmaterials.htm>)

Policy Clarifications/ Changes:

Obstetrical Services- APN.1103

- This section has not been updated. However, please note that Medicaid has not adopted the new H codes (H1000-H1005 (*the hardcopy erroneously cites this code as H10005*)) for prenatal care at risk services at this time. Please continue to use the X codes listed in this section to bill for prenatal services

Policy Update: Anesthesia Services- APN.1108 (APN.1108(J))

- This new policy, effective January 1, 2002, applies to obstetrical care anesthesia procedures including:
 - 01967 Neuraxial analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or necessary placement of an epidural anesthesia during labor);
 - 01968 Cesarean delivery following neuraxial labor analgesia/anesthesia (Use in conjunction with code 01967)
 - 01969 Cesarean hysterectomy following neuraxial labor analgesia/anesthesia (Use in conjunction with code 01967)
- All of the provisions for anesthesia services specified in section PHY.1115 of the physician handbook apply to anesthesia services for the obstetrical anesthesia, except for:
 - Paragraph (B) (3) which defines "time unit";
 - Paragraph (C) (2) which defines the conditions for reimbursement of other anesthesia services;
 - Paragraph (C) (4) which discusses supervision of four concurrent procedures and
 - Paragraph (D) (3) which defines anesthesia time.
- In the case of anesthesia for obstetrical services for neuraxial analgesia "time unit" shall be defined as "time begins when the neuraxial labor analgesic is inserted and continues through delivery". Time for obstetrical anesthesia is the lower of actual time from insertion through delivery or a maximum of four hours. The maximum applies to anesthesia service relating to obstetrical care.
- The department will reimburse for neuraxial analgesia for obstetrical services if the following conditions are met:

For each patient, the physician, must:

 - Perform or approve a pre-anesthesia examination and evaluation for labor analgesia performed by a qualified anesthesia provider;
 - Prescribe or approve an anesthesia plan;
 - Personally participate in all critical portions of the procedure, including placement of the epidural or other regional technique;
 - Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
 - Periodically monitor the course of anesthesia/analgesia administration or ensures that a qualified anesthesia provider performs the monitoring;
 - Remain readily available for immediate diagnosis and treatment of emergencies as required by Ohio statute; and
 - Provide indicated post anesthesia care.

If medical supervision is provided for neuraxial analgesia and the AD modifier is billed, the physician must be involved in the pre-procedure anesthesia services.

Medical supervision applies to labor analgesia services when:

- The anesthesiologist is supervising more than four concurrent surgical anesthesia procedures while supervising a critical portion, e.g. epidural placement of a labor analgesia technique;
- The anesthesiologist is supervising more than four epidural placements at the same time; or
- The anesthesiologist is not in the obstetrical suite while supervising the critical portion of the neuraxial technique.
- For medically-supervised labor analgesia services, the anesthesiologist is not required to personally participate in all critical portions of the procedure.
- In the event that anesthesia for surgery is required during the course of a labor analgesic technique, i.e. cesarean section, the provisions for regular anesthesia outlined in section PHY.1115 apply.

Non-covered Service- APN.1112 (APN.1112.1(G))

- In this section, there is a statement that services of a preventive nature such as routine laboratory procedures and annual physical checkups are not covered. However, there is an extensive listing of preventive services which are exceptions to this policy. The following services have been added to this list of preventive services which are covered by Ohio Medicaid:
- Glaucoma screening is covered as a vision service as described in Chapter 5101: 3-06 of the Administrative Code; and
- Screening colonoscopies are covered once every two years for high-risk patients.
- Please note that the G codes added by Medicare for these services were not adopted by Ohio Medicaid. Providers should bill the CPT codes relevant to these services.

Appendices:

The following appendices have been revised as a result of the implementation of the 2002 HCPCS updates:

APN.1150 Payable Surgical Procedure Codes (10000-69999)

APN.1153 Injection Codes (Alpha and Numeric)

APN.1155 Lead Poisoning Table- Interpretation of Blood Test Results

APN.1156 Valid Modifiers

APN.1157 Valid Alpha HCPCS Codes

Appendix D (APN.1153) Injection Codes

The format of this appendix has been revised. Previously some J codes were listed by both the brand and generic product name. To simplify the listing and to follow the HCPCS definition, all products are now listed alphabetically by the generic name. To determine the generic name of a brand name product, refer to a medical drug reference or the product itself.

Appendix F (APN.1155) Lead Poisoning Table

This appendix has been updated to include a new CDC chart adapted from "Screening Young Children for Lead Poisoning" and is in accordance with Ohio Department of Health lead screening guidelines.

Appendix G (APN.1156) Valid Modifiers

This appendix has been updated to include the modifiers for anesthesia services. These modifiers include:

QX CRNA with medical direction by a physician

QZ CRNA without medical direction by a physician.

Note: The physician anesthesia modifiers AA , AB, AC, AE were discontinued effective for dates of service May 1, 2001.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-01-03

Medicaid Handbook Transmittal Letter (MHTL) 3355-01-03

June 4, 2001

TO: All Providers of Advanced Practice Nurse Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Greg L. Moody, Director

SUBJECT: Advanced Practice Nurse Handbook Update

HEALTHCHEK (EPSDT) AND LABORATORY SERVICES

HANDBOOK UPDATE

EFFECTIVE AUGUST 1, 2001

- **HEALTHCHEK (EPSDT) Services**
- **Specimen collection**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing laboratory and HEALTHCHECK (EPSDT) services. Updated handbook pages are attached. New information is noted by a vertical line to the left of the new language.

Please do not remove the old pages and replace them with these pages since the length of the material has changed the page numbering of this handbook. Instead simply read the new information in this MHTL and retain it for reference. A new handbook will be issued in January of 2002.

HEALTHCHEK (EPSDT) Services- APN.1105.2:

A clarification has been made in the area of pap smears for adolescent females (section (I) (4)). Pap smears are recommend for adolescent females (age 16 or older). If the child is sexually active, the adolescent should be tested regardless of age.

In the area of dental assessments (section (J)), dental examinations for diagnostic and preventive dental services are not required but are covered for children of any age. In addition, the Department wishes to clarify its policy on dental sealants for permanent second molars. Dental sealants for permanent second molars, are covered for individuals under age eighteen.

Laboratory Services - APN.1110.1:

A new code has been recognized for specimen collection. It is 36540 and is defined as "collection of blood specimen from partially or completely implantable venous access device". In addition, the code P9605, venipuncture for a homebound or nursing home patient is no longer a covered service.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-01-02

Medicaid Handbook Transmittal Letter (MHTL) 3355-01-02

March 1, 2001

TO: All Providers of CRNA Services
Directors, County Departments of Human Services
Directors, District Offices

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Revisions to the Anesthesia Policy

CRNA SERVICES

ANESTHESIA POLICY UPDATE

EFFECTIVE MAY 1, 2001

- CPT anesthesia coding
- New modifiers
- Billing for a physician-employed, medically-directed CRNA
- Need for CRNAs to have Medicaid provider numbers
- Monitored anesthesia care
- Reimbursement using RVU-based pricing
- Definition of a CRNA group practice

The purpose of this transmittal letter is to give CRNA providers of anesthesia services advance notice of changes to the Department's policy addressing anesthesia services. Anesthesia services policy changes will be effective for services provided on or after **May 1, 2001**.

A revised handbook section APN1108 entitled "Anesthesia/ CRNA Services" is attached. Please replace the old APN1108 section with the new APN1108 section. Please note that the pages in this new section are not numbered since the new APN1108 is longer than the old section.

Policy Changes:

- The Department will be adopting **anesthesia** CPT coding for dates on service on or after May 1, 2001. Surgical codes should no longer be billed for anesthesia services provided on or after May 1, 2001.
- To bill for professional anesthesia services, the CRNA must bill the appropriate CPT anesthesia code using the modifier which best describes the service which was provided and report the actual anesthesia time in minutes. The following anesthesia modifiers should be used by CRNAs:
 - *QX CRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist.
 - QZ CRNA without medical direction by physician.
- * The CRNA performing the service must obtain a Medicaid provider number if they do not already have one and bill using the instructions provided below.)
- If a teaching anesthesiologist is continuously involved in a single procedure with one resident or with one student CRNA, the teaching anesthesiologist may bill the modifier "AA". In this instance, the teaching anesthesiologist must document in the medical record that he or she was present during all critical portions of the procedure including induction and emergence.

- Services of a CRNA employed by a physician will continue to be paid to the employing physician. Services of a self-employed CRNA or a CRNA who is a member of an independent CRNA group practice will continue to be reimbursed directly to the CRNA or CRNA group practice.
- When a physician practice employs a CRNA and there is medical direction provided by the physician but the CRNA performs the anesthesia, two claims must be submitted:

One claim must be submitted for the medical direction provided by the physician using modifier "QY" listing the physician as the rendering provider;

A second claim must be submitted for the services provided by the CRNA indicating that medical direction was given. The modifier "QX" must be used and the CRNA must be listed as the rendering provider on the claim and the physician must be listed as the "pay to" provider on the claim.

- **Any CRNAs currently employed by a physician or physician group practice , must obtain their own Medicaid provider number (if they do not already have their own Medicaid provider number) in order to comply with the billing practices described in this MHTL. To obtain an application, please call the provider enrollment unit in provider network management section at the phone number listed on the last page of this MHTL.**
- **If a CRNA works for multiple physician groups, the CRNA should verify that each of the physician group practices he/she is affiliated with is listed and linked to his/her Medicaid provider number as the "pay to" provider on his/her Medicaid provider record. Please call Provider Enrollment for further instructions.**
- Services of a hospital-employed CRNA are considered part of facility payment made to the hospital.
- The Department recognizes services for monitored anesthesia care (MAC) which is a combination of local anesthesia and certain anxiolytic and analgesic medications. All of the conditions for reimbursement currently in effect for general anesthesia will apply to MAC.
- Reimbursement for anesthesia services for dates of service on or after May 1, 2001 will be the lesser of the actual charge or the anesthesia amount determined by RVU-based pricing specific to anesthesia using the following formula:

The formula for calculating anesthesia payments is the base unit value and the time unit value multiplied by the appropriate conversion factor.

"Anesthesia time" is the actual number of anesthesia minutes reported on the claim.

"Base unit" means the value for each anesthesia code that reflects all activities other than anesthesia time. Anesthesia activities include usual pre-operative and post-operative visits, the administration of fluids or blood incident to anesthesia care, and basic monitoring services.

"Base unit value" means the value for a base unit for each anesthesia CPT code. These values are taken from the 2000 American Society of Anesthesiologists' Relative Value Guide;

"Time unit" mean the continuous actual presence of the physician (or of the medically directed resident or medically-directed CRNA) and start when he/she begins to prepare the patient for anesthesia and ends when the anesthesiologist (or medically directed CRNA) is no longer in personal attendance. "Time unit" is the actual anesthesia time as reported on the claim; and

"Time unit value" is a systems-calculated value and means one unit for each fifteen minutes of reported anesthesia time rounded to the nearest tenth (ie. $50/15 = 3.3333$ rounds to 3.3)

Anesthesia conversion factors are as follows:

For modifier "QZ" the conversion factor is \$15.28; and

For modifiers "QX", the conversion factor is 50% of \$16.98 which is \$8.49.

Medicaid is forbidden by state law to pay more than Medicare for specific services. Therefore, to bring Medicaid anesthesia reimbursement in line with Medicare's reimbursement for medically-directed anesthesia, modifiers including "QX", will be reimbursed at fifty percent (50%) of the conversion factor specified for "QX" (\$16.98) which is \$8.49.

Anesthesia codes 01995 and 01996 will be paid based on the base units specified in the Relative Value Guide. No calculation for time is allowable for these codes.

If there is not a base unit listed in the Relative Value Guide for an anesthesia code and the anesthesia code is not listed in the current CPT manual, the anesthesia service will not be considered a covered service.

- Effective for purposes of Medicaid billing, an independent CRNA group practice must consist solely of two or more CRNAs enrolled under the Medicaid program.

Questions pertaining to this MAL should be addressed to:

The Ohio Department of Jobs and Family Services

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-State

1-800-686-6108 (toll free)

or

(614) 728-3288

Out of State (614) 728-3288

MHTL 3355-01-01

Medicaid Handbook Transmittal Letter (MHTL) 3355-01-01

January 23, 2001

TO: All Providers of Advanced Practice Nurse Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Handbook Update for 2001 HCPCS Changes

2001 HCPCS HANDBOOK UPDATE

- **Immunization Code Revisions**
- **Clarification of an "APN visit"**
- **Appendices**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2001 HCPCS (including CPT and alpha-numeric) codes and to transmit a new consolidated Chapter 3355 of the Ohio Medicaid Provider Handbook to providers of APN services.

2001 HCPCS Codes

On January 1, 2001, the Department began accepting the 2001 HCPCS codes effective for services rendered on and after that date. To give providers time to make the transition to the 2001 HCPCS codes, the Department will continue to accept the 2000 codes for services rendered through March 31, 2001. Providers may choose to bill either the 2000 codes or the 2001 codes during the transition period from January 1, 2001 to March 31, 2001. Beginning April 1, 2001, the 2000 codes will no longer be accepted to report services provided on and after that date.

APN Services Handbook Update

The following is a summary of the significant policy and/or handbook changes that have been made effective for January 1, 2001 and are incorporated into the attached consolidated Chapter 3355 of the Provider Handbook. Please review the bolded, bulleted headlines listed below and read those sections of the handbook that pertain to the services your particular practice provides. You will find black lines in the left-hand margin of applicable pages indicating changes made. This MHTL and all changes made to the consolidated Chapter 3355 will be available on CD-ROM in February, 2001.

Policy Clarifications/ Changes:

- **Clarification of the definition of an APN visit - APN.1101**

The Department wishes to remind providers that an evaluation and management code (APN visit) is reimbursable only when there is a face-to-face encounter by an APN with a patient for the purpose of medically evaluating or managing the patient. The only exception is CPT code 99211 which does not require the presence of an APN for this code to be billed. This is not a change in policy.

- **Immunization Code Changes and Coverage - APN.1104**

The following vaccine CPT codes have had language revisions in the most recent edition of the CPT book. These language revisions have been incorporated into the immunization section of the APN handbook. The codes include:

Vaccine for Children Program:

90669 Pneumococcal conjugate, polyvalent vaccine, children under five years of age

90702 DT, diphtheria and tetanus toxoids, individuals younger than seven years of age

90718 Td, Tetanus and diphtheria toxoids absorbed, for individuals seven years or older

90744 Hepatitis B vaccine; pediatric/adolescent dosage (three dose schedule)

Other non-designated vaccines:

90732 Pneumococcal polysaccharide vaccine, 23-valent, adult or immuno-suppressed patient

Note that CPT codes 90669, 90702, and 90718 has been revised to include age restrictions. The Department will be implementing edits to reimburse only for vaccines for children within these age restrictions.

The following vaccine is a new vaccine which will be covered by the Department as a non-designated vaccine:

90740 Hepatitis B dialysis or immuno-suppressed patient (3 dose schedule)

Note that 2 new vaccine codes, 90723 and 90743 will not be reimbursable by the Department. It is our understanding that the vaccine for DtaP-HepB-IPV (code 90723) is not yet licensed by the FDA and not available in the United States. Regarding code 90743(Hepatitis B, adolescent, (2 dose schedule)), the Ohio Department of Health has decided not to cover this code through the VFC program since the same vaccine is available at a less expensive price by providing the Hepatitis B vaccine via 90744, the 3 dose schedule.

Should you have questions about the changes in the Vaccines for Children program, please call the Ohio Department of Health at 614-752-1361.

Appendices:

- **Valid Modifiers - APN.1156 Appendix G**

A new modifier has been added and should be used when services are performed by a student APN in training under the direction of a teaching APN. This new modifier is to be used with the new teaching APN policy described in MHTL 3355-00-04 effective

January 1, 2001. The new modifier is :

GC Services performed in part by a student APN under the direction of a teaching APN.

- **Valid Alpha HCPCS Codes - APN.1157 - Appendix H**

A new code, W0658, has been added to bill for the influenza, split vaccine for individuals who are older than 18 years of age.

- The following appendices have been revised as a result of the implementation of the 2001 HCPCS updates:

APN.1150 Payable Surgical Procedure Codes (10000-69999)

APN.1153 Injection Codes

APN.1156 Valid Modifiers

APN.1157 Valid Alpha HCPCS Codes

APN.1158 Codes Billable with Multiple Units per Line Item

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-00-04

Medicaid Handbook Transmittal Letter (MHTL) 3355-00-04

November 8, 2000

TO: All Providers of Advanced Practice Nurse Services
Directors, County Departments of Human Services
Directors, District Offices

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Advanced Practice Nurse Services Handbook Update

ADVANCED PRACTICE NURSE SERVICES HANDBOOK UPDATE

EFFECTIVE JANUARY 1, 2001

- **Other providers of APN services**
- **Direct supervision**
- **By-report services**
- **Services provided in a teaching setting**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to update the handbook with several changes to the handbook resulting from the Department's review of the rules governing the physician services program. Revised handbook pages are attached. New information is noted by a vertical line to the left of the new language.

Please do not remove the old pages and replace them with these new pages since the length of the new material may, in some instances, have changes the page numbers of the document. Instead, simply read the new information noted by the vertical line to the left of the new language and retain this MHTL. A new handbook will be issued in January of 2001 and will include all of this new material.

Section 1000 Introduction - APN.1000

Other providers of APN Services - APN.1002.5

Federally-qualified health centers (FQHCs) were added to the list of "eligible APN providers".

General Coverage of Services- Direct Supervision - APN.1003.2

Please review carefully the attached handbook pages which detail the changes made in this section.

The definition of "direct supervision" has been revised. Clarifying language was added to the definition of "direct supervision" to indicate that the APN must be "present in the office suite" throughout the time the nonphysician is providing the service. Also the definition was expanded to clarify that "availability of the APN by telephone or the presence of the APN somewhere in the institution does not constitute direct supervision".

Paragraph (A) now entitled "Services provided under direct supervision" has been added to specify the conditions which must be met for services provided under direct supervision to be covered:

- The nonphysician personnel involved in performing the service must meet the following requirements:
The nonphysician must be a part-time, full-time or leased employee of the supervising APN, APN group practice, or of the legal entity that employs the APN or the nonphysician must be an independent contractor engaged by the APN through a legal agreement; and
If the nonphysician is a leased employee or independent contractor, the APN or legal entity exercises control over the actions taken by the nonphysician personnel with regard to the rendering of medical services to the same extent as the APN would exercise if the leased employee or contractor was an employee of the APN or legal entity.
- The service must represent an expense to the APN or legal entity;

- The APN must provide direct, personal supervision of the service as defined in this section of the handbook;
- The service must be furnished in connection with a covered APN service which was billed to the department. Therefore, the patient must be one who has been seen by the APN; and
- There must have been a personal professional service furnished by the APN to initiate the course of treatment on which the service being performed is an incidental part. In addition, there must be subsequent services by the APN of a frequency that reflects his/her continuing participation in the management of the course of treatment.

Services provided in a Teaching Setting - APN.1003.3

The Department has revised its policy regarding services provided in a teaching setting and has adopted a policy similar to Medicare's teaching physician policy. Please carefully read the attached handbook pages addressing this new policy.

The following paragraphs highlight certain components of this policy:

- Payment will be made for the services of a teaching APN only if the teaching APN is present for all key portions of the procedure and must be immediately available to provide services during the entire procedure. During the surgery which are not key portions, the teaching APN must be immediately available to return to the procedure. He/she must not be involved in another procedure from which he/she cannot return. Procedures include surgery, minor procedures, endoscopies, deliveries, and time-based codes.
- For evaluation and management services, the documentation guidelines for E/M services published by the AMA in the CPT book must be the basis for selection of the most appropriate level of E/M service. The teaching APN must personally document his/her presence and participation in the service in the medical records as described on pages 9-10 of the APN handbook.
- Please review section (E) of the handbook which addresses documentation in more detail. For a teaching APN to be eligible for reimbursement, the patient's medical record must document that the requirements for reimbursement as detailed in this section of the APN handbook are met. These conditions include:

The medical record must document that the requirements for reimbursement listed in sections (B) through (D) are met;

In the case of evaluation and management services, the teaching APN must personally document his/her participation in the service in the patient's medical record; and

When the requirements for reimbursement require that the teaching APN personally perform the service or be present when a APN student performs the service, the department will assume these conditions are met if:

The notes in the patient's record are personally written or dictated by and signed by the teaching APN; or

The notes written by APN student or nursing staff state that the teaching APN either personally provided the service or was present during the performing of the service.

By Report Services - APN.1003.5

This paragraph is amended to clarify that any attachments submitted with a claim must meet the requirements set forth in the general coverage chapter (5101:3-01) of the provider handbook.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-State

1-800-686-6108 (toll free) or (614) 728-3288

Out of State

(614) 728-3288

MHTL 3355-00-03

Medicaid Handbook Transmittal Letter (MHTL) 3355-00-03

October 11, 2000

TO: All Providers of Advanced Practice Nurse (APN) Services
Directors, County Departments of Human Services
Directors, District Offices

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: APN Services Handbook Update

ADVANCED PRACTICE NURSE SERVICES HANDBOOK UPDATE

EFFECTIVE JANUARY 1, 2001

- **Immunizations (10/1/01 effective date)**
- **Therapeutic injections and prescribed drugs**
- **Allergy services**
- **Office surgery incentive program**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to update the handbook with several changes to the handbook resulting from the Department's review of the rules governing the physician services program. Revised APN services handbook pages are attached. New information is noted by a vertical line to the left of the new language.

I. Section 1100 Covered Services and Associated Limitations:

- **Immunizations - APN.1104**

MAL # 388 describes the revisions to the Department's immunization coverage. Attached are handbook pages which reflect the new coverage which was effective for services on and after October 1, 2000.

- **Therapeutic Injections and Prescribed Drugs - APN.1106**

APN.1106.1 section is re-named to clarify that this section pertains to therapeutic injections or other pharmaceuticals administered during an office visit. Paragraph (C) (2) of this section is revised to indicate for which conditions interferon is covered.

Section APN.1106.2 is re-named to clarify that it pertains to prescribed drugs for take-home use. Section (A) of APN 1106.2 is revised to refer dispensing APNS to the instructions for suppliers of pharmacy services for the prior authorization process administered by Medicaid's contractor for pharmacy services, First Health.

- **Allergy Services - APN.1107**

Paragraph (D) entitled "Insect venoms in multiple dose vials or preparations" is being amended to clarify that if a provider bills CPT codes 95115 or 95117 for venom, the correct quantity (units of service) billed must be one.

II. Appendices:

- **Office Surgery Incentive Program - Appendix E- APN.1154**

This appendix was revised to add the following codes which are eligible for the office incentive payment: 11200, 25246, 25337, 27095, 28108, 28124, 28126, 28153, 28230, 28232, 28234, 28270, 28272, 45330, 50205, 50394, 58560, 58562, 58805, 69105, X1454, and X1455.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

In-State

1-800-686-6108 (toll free)

or

(614) 728-3288

Out of State

(614) 728-3288

MHTL 3355-00-02

Medicaid Handbook Transmittal Letter (MHTL) 3355-00-02

February 29, 2000

TO: All Providers of Advance Practice Nurse (APN) Services
Directors, County Department of Human Services
Medical Assistance Coordinators

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Modifications to Section APN.1150 (Appendix A) of the APN Handbook

It has come to our attention that CPT codes are listed in Appendix A (APN.1150) which are not covered services. However, the Department's reimbursement rule (OAC 5101:3-1-60) and the non-covered services rule (OAC 5101:3-4-28) correctly reflect that these codes are not and have never been covered services. Listed below are the affected codes. Since new provider handbooks were just issued, we suggest that providers review their copy of Appendix A and strike out these codes to accurately reflect that they are not payable. Codes which should be deleted from Appendix A are:

Procedure Codes To Be DELETED	Description of DELETED Codes
11719	Trimming of nondystrophic nails, any number
11920	Correct skin color defects
11921	Correct skin color defects
11922	Correct skin color defects
11970	Replace tissue expander
15775	Hair transplant punch grafts
15776	Hair transplant punch grafts
15780	Abrasion treatment of skin
15781	Abrasion treatment of skin
15782	Abrasion treatment of skin
15783	Abrasion treatment of skin
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
15810	Salabrasion

15811	Salabrasion
15819	Plastic surgery, neck
15820	Revision of lower eyelid
15821	Revision of lower eyelid
15822	Revision of upper eyelid
15823	Revision of upper eyelid
15824	Removal of forehead wrinkles
15825	Removal of neck wrinkles
15826	Removal of brow wrinkles
15828	Removal of face wrinkles
15829	Removal of skin wrinkles
15831	Excise excessive skin tissue
15832	Excise excessive skin tissue
15833	Excise excessive skin tissue
15834	Excise excessive skin tissue
15835	Excise excessive skin tissue
15836	Excise excessive skin tissue
15837	Excise excessive skin tissue
15838	Excise excessive skin tissue
15839	Excise excessive skin tissue
15850	Removal sutures under anesthesia
15876	Suction assisted lipectomy
15877	Suction assisted lipectomy
15878	Suction assisted lipectomy
15879	Suction assisted lipectomy
17380	Hair removal by electrolysis
19316	Suspension of breast
19324	Enlarge breast
19325	Enlarge breast with implant

19355	Correct inverted nipple(s)
19380	Revise breast reconstruction
19396	Design custom breast implant
21110	Interdental fixation
21497	Interdental wiring
32491	Removal of lung
32850	Donor pneumonectomy
33930	Removal of donor heart/lung
33940	Removal of donor heart
36468	Injection(s);spider veins
36469	Injection(s);spider veins
41820	Excision, gum, each quadrant
41828	Excision of gum lesion
41830	Removal of gum tissue
41870	Gum graft
41872	Repair gum
41874	Repair tooth socket
43842	Gastroplasty for obesity
43843	Gastroplasty for obesity
43846	Gastric bypass for obesity
43847	Gastric bypass for obesity
43848	Revision of gastric bypass for obesity
47133	Removal of donor liver
48550	Donor pancreatectomy
50300	Removal of donor kidney
55870	Electroejaculation
55970	Sex transformation, m to f
55980	Sex transformation, f to m
58321	Artificial insemination

58322	Artificial insemination
58323	Sperm washing
58340	Inject for uterus/tube x-ray
58345	Reopen fallopian tube
58350	Reopen fallopian tube
58750	Repair oviduct(s)
58752	Revise ovarian tube(s)
58760	Remove tubal obstruction
58770	Create new tubal opening
58970	Retrieval of oocyte
58974	Transfer of embryo
58976	Transfer of embryo
59618	Attempted VBAC delivery
59400	Obstetrical care
59425	Antepartum care only
59426	Antepartum care only
59510	Cesarean delivery
65760	Revision of cornea
65765	Revision of cornea
65767	Corneal tissue transplant
65771	Radial keratotomy
69090	Pierce earlobes

Note: The corrected Appendix A will be available on the latest edition of the handbook on CD-ROM available in March of 2000.

Questions pertaining to this MHTL should be addressed to:

The Provider Relations Section

P.O. Box 1461

Columbus, OH 43266-0161

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MHTL 3355-00-01

Medicaid Handbook Transmittal Letter (MHTL) 3355-00-01

February 2,2000

TO: All Providers of Advanced Practice Nurse Services
Directors, County Department of Human Services
Medical Assistance Coordinators

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: Handbook Update for 2000 HCPCS Changes

2000 HCPCS HANDBOOK UPDATE

- **Lead Poisoning Screening**
- **Immunization Code Changes**
- **Prostrate Screening Coverage**
- **Non-Covered Services**
- **Anesthesia Services Rates**
- **Reminder: Evaluation and Management Billing**
- **New Addresses for Hard Copy Claim Submissions**

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the implementation of the 2000 HCPCS (including CPT and alpha-numeric) codes and to transmit a new consolidated Chapter 3336 of the Ohio Medicaid Provider Handbook to providers of physician services.

2000 HCPCS Codes

On January 1, 2000, the Department began accepting the 2000 HCPCS codes effective for services rendered on and after that date. To give providers time to make the transition to the 2000 HCPCS codes, the Department will continue to accept the 1999 codes for services rendered through March 31, 2000. Providers may choose to bill either the 1999 codes or the 2000 codes during the transition period from January 1, 2000 to March 31, 2000. Beginning April 1, 2000, the 1999 codes will no longer be accepted to report services provided on and after that date.

Advanced Practice Nurse Services Handbook Update

The following is a summary of the significant policy and/or handbook changes that have been made effective for January 1, 2000 and are incorporated into the attached consolidated Chapter 3355 of the Provider Handbook. Please review the bolded, bulleted headlines listed below and read those sections of the handbook that pertain to the services your particular practice provides. You will find black lines in the left-hand margin of applicable pages indicating changes made. This MHTL and all changes made to the consolidated Chapter 3336 will be available on CD-ROM in February, 2000.

Policy Changes:

- **Lead Poisoning Screening - HEALTHCHEK APN.1105**
HCFA/CDC considers all children at risk for lead poisoning. All children must receive a blood lead screening test at one year and two years of age. Children between the ages of three and six years of age must receive a screening lead blood test if they have not been previously screened for lead poisoning. A lead blood test must be used when screening.
- **Immunization Code Changes and Coverage - APN.1104**
- Providers should use code 90744 **Hepatitis B** vaccine for vaccines provided to children ages eighteen and under. Code 90745 was deleted in the 2000 CPT book.

- The Department has added code 90747, **Hepatitis B** vaccine, for dialysis or immunosuppressed patients effective January 1, 2000.
- The Department discontinued its coverage of the **Rotavirus** vaccine (90680) effective July 28, 1999 due to concerns expressed by the CDC.
- The VFC program administered by the Ohio Department of Health(ODH) no longer offers vaccines for **DTP**, CPT code 90701 and 90720 (**DTP-Hib**) since the ACIP has indicated that these vaccines are no longer the vaccines of choice and will become obsolete. Therefore effective April 1, 2000, the Department will no longer reimburse for the administration of these vaccines. Provider may bill 90700 (DtaP) and the appropriate HIB vaccine (90645-48).
- Vaccines for **Mumps** (90704) **Measles** (90705) and **Rubella** (90706) have been replaced by code 90707, Measles, Mumps, and rubella virus vaccine effective January 1, 2000. Codes 90708 (Measles, rubella) and 90709 (Rubella, mumps) have been deleted since these vaccines are not manufactured anymore.
- The description for code 90658, **Influenza** has been modified to clarify that it should be used to bill for the influenza vaccine for all children regardless of age.
- Effective July 1, 2000 the Department will discontinue code 90712, **Poliovirus** vaccine, live, for oral use. ODH has advised the Department that this vaccine will not be available through the VFC program when its current supply is exhausted. Use code 90713, Poliovirus vaccine, inactivated.
- Should you have questions about the changes in the Vaccines for Children program, please call the Ohio Department of Health at (614) 752-1361.

- **Prostate Screening Coverage - APN.1112**

The Department began coverage of prostate screening tests when medically indicated by the patient's physician and according to generally-accepted standards of practice. Use the appropriate CPT code (84153-54, 86316) for billing purposes.

- **Non-covered Services - APN. 1112**

The Department will not reimburse for services related to assisted suicide.

- **Anesthesia services- APN. 1108**

For dates of service beginning January 1, 2000 the following fees will be effective for anesthesiology services: for anesthesia services less than or equal to 60 minutes the maximum payment will be \$84.32 plus \$0.80 per minute; and for anesthesia services greater than 60 minutes the maximum payment will be \$149.20 plus \$0.80 per minute over sixty minutes. The Department will implement anesthesia CPT coding and RVU-based pricing for anesthesia services in calendar year 2000; the date of implementation has not yet been determined. Additional information regarding RVU-based payments for anesthesia services will be forthcoming.

- **Evaluation and Management Billing - APN.1101**

Advanced practice nurses are not eligible to bill or to be reimbursed for the following evaluation and management CPT codes:

- 99205, 99215, 99217-99220, 99222, 99223, 99233, 99241 to 99275,
- 99291 to 99297, 99313, 99323, 99333, 99434, 99353, and 99440.

This is not a new policy but a clarification of an existing policy. Please refer to section APN.1101.

Appendices:

- **CDC Risk Assessment Questionnaire- formerly APN. 1156- Appendix G**

This appendix has been deleted since the CDC now requires a blood screening test to screen children rather than a risk-assessment. Please note that the numbering of appendices subsequent to this appendix has been adjusted accordingly.

The following appendices have been revised as a result of the implementation of the 2000 HCPCS updates:

APN.1150 Payable Surgical Procedure Codes (10000-69999)

APN.1153 Injection Codes

CDC Risk Assessment Questionnaire - **has been deleted**

APN.1157 Valid Alpha HCPCS Codes

- **Address Changes for Hard Copy Claim Submissions**

- Effective immediately, the address for submission of hard copy HCFA 1500 claims has changed to:

Ohio Department of Human Services

P. O. Box 7965

Akron, OH 44306

- Effective immediately, the new address for submission of hard copy 6780 forms is:

Ohio Department of Human Services

P. O. Box 182243

Columbus, OH 43218-2243

Billing Instructions:

The Billing Instructions in this new handbook have been revised to include references to information that is contained in Chapter 3334, General Information. While there are three new sections, there are no policy changes relating to these sections. The following are the three **new** sections:

BIN.1201 Claims Submission Information

BIN.1208 Prompt Payment and Interest Provisions

BIN.1300 Third Party Billing Information

The instructions for the Claim Credit Reversal form ODHS 6768 have also been added to this version of the billing instructions. Other changes include moving the Allowed Charge Source section from the appendix into the text section BIN.1202.1 and moving the Adjustment Reason Codes from the appendix to the text section BIN.1204.

Questions pertaining to this MHTL should be addressed to:

The Provider Relations Section

P.O. Box 1461

Columbus, OH 43266-0161

In-state toll free telephone number 1-800-686-6108

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