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Please send comments to ePubs_updates@jfs.ohio.gov
Alphabetic Index of Physician Policies

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TO:            Eligible Medicaid Providers of Physicians Services  
             Chief Executive Officers, Managed Care Plans  
FROM:         John B. McCarthy, Director of Medical Assistance  
SUBJECT:      Primary Care Physician Rate Increase - Announcement of Self Attestation Grace Period  

In accordance with the Patient Protection and Affordable Care Act (ACA), certain primary care physicians will soon be eligible to receive increased Medicaid payments for primary care services provided to Medicaid eligible individuals. The federal government will fully finance the difference between the state Medicaid payment rate and the current year Medicare rate during these two years.

As was communicated on December 21, 2012, physicians MUST REQUEST the reimbursement by self-attesting that they are an eligible provider by applying through the MITS portal on Ohio Medicaid’s website. In order to register, applying physicians MUST have a current MITS account with an active login and PIN. Providers can apply beginning on January 1, 2013.

Given what is likely to be a high volume of providers applying beginning January 1, 2013, the Office of Medical Assistance will allow a 14-day grace period for registration through the MITS portal. Verification of attestation will begin in mid-January. Providers will receive an email stating whether they have been approved or denied for the reimbursement increase. For physicians who self-attest on January 1, 2013 through January 13, 2013, the effective date of the approval will be January 1, 2013. For self-attestations received after January 13, 2013, the effective date of the increase will be the date of self-attestation.

Physicians can access the MITS portal here:

Physicians who do not have a MITS account can sign up for one at:

If additional assistance is needed regarding signing up for a MITS account, please call the Medicaid Provider Call Center at 1-800-686-1516.
MHTL 3336-12-02 (Physician Assistants as Medicaid Providers)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-12-02

July 3, 2012

TO: Eligible Medicaid Providers of Physician Services
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: Michael B. Colbert, Director

SUBJECT: Physician Assistants as Medicaid Providers

Summary

Rule 5101:3-4-03 "Physician Assistants" has been amended to adopt the changes House Bill 153 requires for physician assistants. This rule is effective July 1, 2012.

Rule Changes

Change: This rule was amended to allow physician assistants to enter into a provider agreement with Medicaid. There are now two options for submitting a physician assistant's Medicaid claim: either (1) the physician assistant who provided the service or (2) the physician, group practice, clinic, or other health care facility that employs or contracts with the physician assistant may submit the claim. For hospital-employed physician assistants, only the employing hospital may submit claims for the physician assistant's professional services, using the physician assistant's NPI as the rendering provider. Reimbursement for services provided by a hospital-employed physician assistant will be described in paragraph (C)(5) of this rule.

The effective date of this change is July 1, 2012.

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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Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Summary
In its Medicaid State Plan, each state may treat services provided by optometrists in one of two ways: (1) It may include them as physician services, coverage of which is mandatory. (2) It may choose to cover them, or decline to cover them, as a separate group of services. Ohio has been covering these services separately as optometrist services. It will now cover them as physician services. This change in classification will enable optometrists to benefit from certain provisions of the American Recovery and Reinvestment Act of 2009 that establish incentive payments for the adoption and meaningful use of certified electronic health record (EHR) technology.

Rule Changes
Rule 5101:3-4-01, "Eligible providers of physician services," defines the term physician, lists those eligible Medicaid providers that can be providers of physician services, and sets forth certain reimbursement requirements and restrictions.

Change: This rule is being rescinded and replaced simultaneously by a new rule 5101:3-4-01, "Physicians and other eligible providers of physician services," in which the list of providers of physician services has been expanded to include optometrists and the entire text has been reorganized and streamlined. In other respects, the content of the rule remains substantively unchanged.

The effective date of this change is January 1, 2012.

Access to Rules and Related Material
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**Additional Information**

Questions pertaining to this letter should be addressed to:

- 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 3336-11-06 (Coverage and Reimbursement Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-11-06

December 28, 2011

TO: Eligible Providers of Physician Services
    - Chief Executive Officers, Managed Care Plans (MCPs)
    - Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Coverage and Reimbursement Updates

Summary

The rules addressed in this transmittal letter are being filed to comply with Amended Substitute HB 153, the Patient Protection and Affordable Care Act, and a mandate from the Centers for Medicare and Medicaid Services (CMS). The rules are being amended to delineate coverage of medical nutritional therapy, obesity screening and counseling, and tobacco cessation counseling and treatment. In addition, the reimbursement rates of 105 Healthcare Common Procedure Coding System (HCPCS) codes are also being reduced to the 2011 Medicare Physician Fee Schedule rate.

Rule Changes

Rule 5101:3-1-60, "Medicaid Reimbursement," sets forth the fee-for-service reimbursement for all professional providers.

Changes: Six new HCPCS codes have been added to cover tobacco cessation counseling, classes and treatment and medical nutrition therapy. Reimbursement rates for 105 HCPCS codes have been reduced to the 2011 Medicare Physician Fee Schedule rate, the Medicaid reimbursement ceiling for professional claims.

Rule 5101:3-4-34, "Preventive medicine services," describes covered preventive medicine services.

Changes: This rule is being amended to describe coverage of obesity screening and counseling, medical nutritional therapy, and tobacco cessation counseling, classes and treatment.

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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1. Select the 'Ohio Health Plans - Provider' folder.
2. Select the appropriate service provider type or handbook.
3. Select the desired document type.
4. Select the desired item from the 'Table of Contents' pull-down menu.

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

1. Select the 'Ohio Health Plans - Provider' folder.
2. Select 'General Information for Medicaid Providers'.
3. Select 'General Information for Medicaid Providers (Rules)'.

...
Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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Additional Information

Questions pertaining to this letter should be addressed to:

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 3336-11-05 (Limited Family Planning Benefit Policy and Clarification of Existing Family Planning Policy)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-11-05
January 5, 2012

TO: Eligible Providers of Physician Services
   Chief Executive Officers, Managed Care Plans (MCPs)
   Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Limited Family Planning Benefit Policy and Clarification of Existing Family Planning Policy

Summary
The rules addressed in this transmittal letter are being filed to implement section 2303 of the Patient Affordability and Accountable Care Act which gives states the option to extend a limited family planning benefit to eligible individuals.

Rule Changes

Rule 5101:3-21-02, "Medicaid covered reproductive health services: pregnancy prevention/contraception services," describes covered services for reproductive health and family planning.

Changes: This rule is being rescinded and replaced by a new rule of the same number entitled "Reproductive health services: pregnancy prevention/contraceptive management services." The new rule reorganizes and clarifies language that existed in the rescinded rule. There are no policy or coverage changes.

Rule 5101:3-21-02.3, "Limited Family Planning Benefit," establishes coverage of family planning and family planning related services that are available to individuals who meet the eligibility criteria in rule 5101:1-41-40.

Changes: This newly-created rule defines family planning-related services and the appendix to the rule delineates services covered under this limited benefit package.

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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1. Select the 'Ohio Health Plans - Provider’ folder.
2. Select 'General Information for Medicaid Providers'.
(3) Select 'General Information for Medicaid Providers (Rules)'.

(4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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**Additional Information**

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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
TO: Eligible Providers of Physician Services
    Chief Executive Officers, Managed Care Plans (MCPs)
    Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Coverage and Reimbursement Updates

Summary
The rules addressed in this transmittal letter are being filed for three reasons: (1) to update reimbursement of physician administered drugs to an amount commensurate with acquisition costs, (2) to remain HIPAA compliant by providing coverage information on Healthcare Common Procedure Coding System (HCPCS) codes that have been added by the Centers for Medicare and Medicaid Services, and (3) to reduce administrative costs by removing the prior authorization requirement for certain Durable Medical Equipment (DME) codes.

Rule Changes
Rule 5101:3-1-60, "Medicaid Reimbursement," describes the reimbursement policies for all professional providers.

Changes: New HCPCS codes have been added, obsolete HCPCS codes have been deleted, reimbursement amounts have been updated and definitions have been revised. Maximum payment amounts for the new HCPCS codes have been created, reimbursement for existing physician administered drugs has been updated to reflect acquisition costs, and payment amounts for HCPCS codes that are now obsolete have been deleted.

Rule 5101:3-4-12, "Immunizations," describes and defines general provisions for coverage and reimbursement of immunizations.

Changes: The reimbursement of Current Procedural Terminology (CPT) code 90378 (Synagis) has been updated from $985.89 to $1180.19 to reflect increased acquisition costs.

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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(1) Select the 'Ohio Health Plans - Provider' folder.
(2) Select the appropriate service provider type or handbook.
(3) Select the desired document type.
(4) Select the desired item from the 'Table of Contents' pull-down menu.

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

(1) Select the 'Ohio Health Plans - Provider' folder.
(2) Select 'General Information for Medicaid Providers'.
Select 'General Information for Medicaid Providers (Rules)'.

Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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**Additional Information**

Questions pertaining to this letter should be addressed to:

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 3336-11-03 (MITS-Related Changes to Rules in OAC Chapters 5101:3-4 and 5101:3-9 for Clearance Waiver)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-11-03

July 29, 2011

TO: Eligible Physician Providers
    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 Chapters 5101:3-4 and 5101:3-9 for Clearance Waiver

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 5101:3-4-01, "Eligible providers of physician services," identifies the providers which may be able to bill for physician services.

Changes: This revision recognizes that physicians may incorporate into or join a professional medical group in accordance with the provisions set forth in rule 5101:3-1-17.

Rule 5101:3-4-02.1, "By-report services," establishes the conditions under which reimbursement for a service requires manual review, as well as the documentation that must be submitted with claims for services designated by Medicaid as by-report services.

Changes: This new rule replaces a rescinded rule of the same number and title. A clearer description is given of the documentation that is required for submission to Medicaid or its designee for coverage determination and reimbursement of by-report services. Limits have been placed on the use of "not otherwise listed" Healthcare Common Procedure Coding System (HCPCS) codes. Existing language has been clarified.

Rule 5101:3-4-02.2, "Site differential payments and place of service," lists codes for which there is a variance in Medicaid payment based on place of service.

Changes: Existing language regarding the location of the list of services subject to site differential payments has been clarified. Language has been added to clarify that Medicaid uses place-of-service codes maintained by the Centers for Medicare and Medicaid Services. Claim format language has been updated. References to outdated billing instructions have been removed.

Rule 5101:3-4-06, "Physician visits," establishes guidelines for reimbursement of physician services by place of service.

Changes: Existing language regarding the surgical follow-up period and outpatient hospital observations has been clarified. Reimbursement information for nursing facility services has been updated. References to outdated billing instructions have been removed.

Rule 5101:3-4-06.1, "Physician attendance during patient transport," establishes policies regarding the coverage of and reimbursement for physician attendance during patient transport.

Changes: A reference to rule 5101:3-1-19.3, which is being rescinded, has been removed. Existing language has been clarified.

Rule 5101:3-4-11, "Diagnostic and therapeutic procedures," establishes reimbursement policies for diagnostic and therapeutic procedures.

Changes: This new rule replaces a rescinded rule of the same number and title, and explains the policy for coverage of professional and technical modifiers. To give providers additional information about
place-of-service restrictions and applicability of the professional and technical modifiers, the body of the rule has been amended. Providers are directed to Appendix DD to rule 5101:3-1-60, where the codes with a professional and technical modifier and relevant place of service restrictions are identified.

**Rule 5101:3-4-13**, "Therapeutic injections (including trigger point injections) and prescribed drugs," establishes coverage and reimbursement policies for injections and prescribed drugs administered in a physician's office, a clinic, or a patient's home.

Changes: Language specifying how information about miscellaneous drugs should be entered on a claim has been revised. A clarification has been added to the prohibition against billing CPT codes 20552 and 20553 for the same patient on the same date of service. Language regarding prescribed drugs for take-home use has been removed.

**Rule 5101:3-4-16**, "Cardiovascular diagnostic and therapeutic services," establishes guidelines regarding the appropriate use of modifiers to be used by providers when billing for the provision of services for the diagnosis and treatment of cardiovascular system disorders. The rule also addresses place-of-service restrictions that determine when a code may be reimbursed as a physician or laboratory service.

Changes: This new rule replaces a rescinded rule of the same number and title. A reference to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60 has been included. Information that is duplicative of the "PCTC Indicator" column has been removed. Language specifying the values in the "lab and prof/tech indicator" column of Appendix DD as the determining factor in reimbursement methodology has been removed. Language has been updated to reflect policy changes in the determination of CPT codes with professional and technical components. References to the billing of evaluation and management services in conjunction with cardiovascular diagnostic and therapeutic procedures have been relocated to the beginning of the rule body.

**Rule 5101:3-4-18**, "Pulmonary services," establishes coverage and place-of-service provisions for pulmonary services.

Changes: Providers are directed to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60. Information that is duplicative of the "PCTC Indicator" column has been removed. Existing language has been clarified.

**Rule 5101:3-4-19**, "Allergy services," establishes coverage and place-of-service provisions for the performance and evaluation of allergy sensitivity tests.

Changes: Additional information regarding place-of-service restrictions has been included. Instruction has been provided on the appropriate use of modifier 25 when an office visit is billed with an allergen immunotherapy service. Directs providers to rule 5101:3-4-11 for the appropriate use of professional and technical modifiers and relevant place of service restrictions. Existing language has been clarified.

**Rule 5101:3-4-20**, "Chemotherapy treatment, " establishes coverage and reimbursement policies for the administration of chemotherapy and the provision of chemotherapeutic agents.

Changes: This new rule replaces a rescinded rule of the same number and title. Providers are directed to rule 5101:3-4-11 for place of service restrictions. Clarifying language has been added.

**Rule 5101:3-4-25**, "Laboratory and radiology services," lists services for which physicians and certain other providers may be reimbursed and addresses the use of professional and technical modifiers in association with CPT codes for these services.

Changes: Providers are directed to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60. Existing language regarding mammography services has been clarified.

**Rule 5101:3-4-35**, "Skin substitutes for wound treatment and healing," establishes coverage policies in an office setting for skin substitutes used in conjunction with standard wound care regimens for the treatment of burns or ulcers.

Changes: This newly created rule delineates the HCPCS codes that may be reimbursed in an office setting and the conditions under which and frequency with which skin substitutes may be used.
Rule 5101:3-9-01, "Eligible providers of pharmacy services," lists the types of providers eligible for reimbursement for pharmacy services.

Changes: Eligible providers of pharmacy services have been limited to pharmacies, hospitals, and clinics. Other prescribers dispensing medication to their patients to be used at home will not be reimbursed for the "take-home" prescriptions. Existing language has been clarified.

Access to Rules and Related Material

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Additional Information

Questions pertaining to this letter should be addressed to:

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 3336-11-02 (Coverage of ECMO Services)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-11-02

April 21, 2011

TO: Advanced Practice Nurse, Ambulatory Clinics, and Physicians
    Chief Executive Officers, Managed Care Plans
    Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: Coverage of Extra-Corporeal-Membrane-Oxygenator (ECMO) Services

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-4-31. This rule has been amended to comply with five-year rule review requirements.

Changes: Clarification of existing policy regarding coverage of extra-corporeal-membrane-oxygenator services.

Access to Rules and Related Material

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3. Select the desired document type.
4. Select the desired item from the 'Table of Contents' pull-down menu.

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

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2. Select 'General Information for Medicaid Providers'.
3. Select 'General Information for Medicaid Providers (Rules)'.
4. Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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Additional Information

Questions pertaining to this letter should be addressed to:

    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
January 21, 2011

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Providers, Home Health Agencies
Providers, Hospice Agencies
Providers, Otherwise-accredited Agencies
Providers, Independent Private Duty Nursing
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care and Hospice
Director, Ohio Home Care Organization
Director, Ohio Hospice and Palliative Care Organization
Vice-President, SEIU District 1199, WV/KY/OH
President, Ohio State Medical Association
President, Ohio Osteopathic Association
All Eligible General Practice Physicians
Providers, Family Practice Physician
Providers, Pediatrician
Providers, Internal Medicine Practitioner
Providers, Obstetrician
Providers, Physician Services
Comprehensive Clinics
Public Health Department Clinics
Outpatient Health Facilities
FROM:  Michael B. Colbert, Interim Director

SUBJECT:  Rule Changes Affecting Home Health Services and Hospice Services

The Ohio Department of Job and Family Services (ODJFS) has amended rules 5101:3-12-01, 5101:3-56-02, 5101:3-56-04, and 5101:3-56-06 of the Administrative Code (OAC). The amendments to these rules will 1) require a face-to-face encounter (between the consumer and the consumer's physician, advanced practice nurse in collaboration with the qualifying treating physician, or physician assistant under the supervision of the qualifying treating physician), prior to the supervising physician certifying medical necessity for home health services in order to align these rules with the implementation of Section 6407(d) of the federal Patient Protection and Affordable Care Act (PPACA) of 2010 and 2) specify that a child under age twenty-one who completes a hospice election form does not waive any rights to be provided with, or to have payment made for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made in order to align these rules with the implementation of Section 2302 of the federal Patient Protection and Affordable Care Act (PPACA) of 2010. A description of these rules follows below.

OAC rule 5101:3-12-01, Home health services: provision requirements, coverage and service specification, explains the services available through the home health benefit for Medicaid consumers and providers. The proposed amendment to this rule sets forth the following: 1) a requirement for a face-to-face encounter as described above must occur within ninety days prior to the start of home health services start of care date, or within thirty days following the start of care date inclusive of the start of care date, preceding certification of medical necessity of home health services in order to align this rule with the implementation of Section 6407(d) of the federal Patient Protection and Affordable Care Act (PPACA) of 2010, 2) a change from the Ohio Department of Mental Retardation and Developmental Disabilities to the Ohio Department of Developmental Disabilities and 3) correction of citations.

OAC rule 5101:3-56-02, Hospice services: eligibility and election requirements, explains hospice eligibility requirements for consumers. The proposed amendment to this rule sets forth that when a child voluntarily elects hospice, he or she does not waive the right to be provided with, or have payment made for, services that are related to the treatment of the child's condition for which a diagnosis of terminal illness has been made in order to align this rule with the implementation of Section 2302 of the federal Patient Protection and Affordable Care Act (PPACA) of 2010.

OAC rule 5101:3-56-04, Hospice services: provider requirements, explains responsibilities of hospice providers. The proposed amendment to this rule sets forth the following additional requirements: 1) facilitation of concurrent care for children under age twenty-one with other Medicaid providers, 2) documentation about how services are coordinated between the hospice provider and other Medicaid providers, 3) provision of a copy of the consumer's advance directive and hospice election form to other Medicaid providers, 4) notification to consumers of their responsibilities to report to the hospice provider the names of their other Medicaid providers and 5) correction of citations. These amendments are part of the implementation of Section 2302 of the federal Patient Protection and Affordable Care Act (PPACA) of 2010, and provide for the assurance of continuity of care and coordination to avoid duplication of equivalent services.

OAC rule 5101:3-56-06, Hospice services: reimbursement, explains the requirements for the reimbursement of hospice providers. The proposed amendment to this rule sets forth the following: 1) specification that the Ohio Department of Job and Family Services will reimburse only non-hospice providers for curative treatments delivered to consumers under age twenty-one for the consumer's terminal illness, and that Medicaid providers who provide curative treatments for these consumers must comply with all the requirements for Medicaid providers in Chapter 5101:3-1 of the Administrative Code and not bill hospice organizations and 2) correction of citations.

Instructions:
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Web Pages:

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This transmittal letter and attachments may be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (right column).
(2) Select "Physician Services" (right column).
(3) Select "Medicaid Handbook Transmittal Letters (in the "Physician Services Table of Contents" dropdown).

It may also be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (right column).
(2) Select "Hospice Services" (right column).
(3) Select "Medical Assistance Letters", "Hospice Rules" (in the "Hospice Services Table of Contents" dropdown).

Questions:

Questions about this MAL and MHTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long-Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
http://jfs.ohio.gov/ohp
(614) 466-6742
MHTL 3336-10-03 (MITS-Related Changes to Rules in OAC Chapters 5101:3-1 and 5101:3-4)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-03

December 8, 2010

TO: Eligible Physician Providers
    Medicaid Managed Care Plans
    Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: MIT-S-Related Changes to Rules in OAC Chapters 5101:3-1 and 5101:3-4

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 in the near future. The effective date of these rules is December 6, 2010.

Rule Changes

Rule 5101:3-1-60, "Medicaid reimbursement," establishes Medicaid reimbursement policies.

Changes: To give providers additional information about place-of-service restrictions and applicability of the professional and technical modifiers, a new "Professional Component and Technical Component (PCTC) indicator" column has been created in Appendix DD to the rule. The PCTC indicators will be defined in a new version of rule 5101:3-4-11 that will be made effective upon MITS implementation. Appendix DD has also been updated to reflect reimbursement and coverage changes. The reimbursement amounts for 12 Current Procedural Terminology (CPT) codes have been reduced to comply with the mandated Medicaid payment ceiling of not paying more than the Medicare fee schedule. The reimbursement amount for two CPT codes has been increased to reflect changes in cost to physicians. Twenty-nine codes have been changed to "Not Covered" (NC) to reflect the requirement that only valid, HIPAA-compliant codes as determined by the American Medical Association and the Centers for Medicare and Medicaid Services may be covered. Reimbursement amounts have been assigned to two codes previously listed as "By Report." Coverage and reimbursement will begin for two new codes, A4466 and E2377. The annual fiscal impact of these changes will be approximately $312,819.56.

Rule 5101:3-4-17, "Gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy and special dermatology services," addresses coverage of these services by setting and the appropriate use of associated professional and technical procedural modifiers.

Changes: This new rule replaces a rescinded rule of the same number and title, and directs providers to rule 5101:3-4-11 for the appropriate use of professional and technical modifiers and relevant place of service restrictions. A new version of rule 5101:3-4-11 will be made effective upon MITS implementation and will contain additional information about place-of-service restrictions and applicability of the professional and technical modifiers.

Rule 5101:3-4-22, "Surgical services," establishes conditions under which surgical procedures are reimbursed and addresses reimbursement levels, billing for multiple and bilateral surgeries, and the appropriate use of modifiers associated with CPT surgery codes.

Changes: Language regarding the bundling of surgical services incidental to the main procedure has been clarified. The use of modifier 50 for bilateral procedures has been clarified. Language has been added to explain the appropriate use of the newly accepted modifiers LT and RT with bilateral codes and the appropriate use of site modifiers when procedures are performed on fingers, toes, eyelids, or coronary arteries. Information previously contained in Appendix A and Appendix B to this rule has been combined into a new appendix. To reduce duplication of information and to clarify the appropriate use
of site modifiers for surgery services, additional detail has been added to the appendix to this rule. Site modifiers and LT/RT modifiers will affect claim submission and adjudication upon MITS implementation.

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Additional Information

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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 3336-10-02 (Immunizations Rule Updates)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-02

July 22, 2010

TO: All Eligible General Practice Physicians, Family Practice Physicians, Pediatricians, Internal Medicine Practitioners, Obstetricians, Nurse Midwives, Advanced Practice Nurses, Providers of Physician Services, Comprehensive Clinics, Public Health Department Clinics, Directors, County Departments of Job and Family Services, Outpatient Health Facilities, Rural Health Clinics, Federally Qualified Health Centers, Home Health-Private Duty Nursing Providers, Managed Care Plans

FROM: Douglas E. Lumpkin, Director

SUBJECT: Immunizations Rule Updates

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule 5101:3-4-12, Immunizations.

Rule 5101:3-4-12, entitled Immunizations, sets forth the specific immunizations that are covered for the Medicaid population. This rule is being amended because of five-year review and to update and clarify coverage and reimbursement information.

Changes include adding the Current Procedural Terminology (CPT) code 90670 (Prevnar 13; pneumococcal conjugate vaccine, 13 valent, for intramuscular use) to the list of designated free vaccines. Prevnar 13 succeeds the seven valent version of the vaccine (Prevnar 7, CPT 90669). Allowing providers to bill for Prevnar 13 will result in protecting against six additional strains of the Streptococcus pneumoniae bacteria, which causes pneumococcal diseases such as pneumonia and meningitis. The Department will reimburse providers $10 for the administration of each dose of this vaccine needed for children under five years of age.

The rule is also being amended to clarify coverage and reimbursement for the quadrivalent (CPT 90649) and bivalent (CPT 90650) Human Papilloma virus (HPV) vaccines. Coverage information for CPT code 90649 [HPV vaccine, types 6,11,16,18 (quadrivalent), 3 dose schedule, for intramuscular use] has been updated to reflect recommendations issued by the Advisory Committee on Immunization Practices (ACIP). Males age nine to eighteen may be immunized against HPV using the quadrivalent vaccine (CPT 90649). In addition, the reimbursement amount for CPT code 90650 (HPV vaccine, types 16, 18 bivalent, 3 dose schedule, for intramuscular use) is being changed in Appendix A from "By Report" to $10 to clarify its coverage through the Vaccines for Children (VFC) program.

Additionally, Appendix B is being amended to clarify that CPT codes 90634, 90707, 90710, 90733 and 90734 are covered services and to change the reimbursement amount for CPT code 90734 from "By Report" to $104.71 to clarify its coverage for adults.

These changes are not expected to increase or decrease expenditures.

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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:

1. Selecting the "Ohio Health Plans - Provider" folder;
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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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Questions:

Questions pertaining to this letter should be addressed to:

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

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-01

April 2, 2010

TO: All Eligible General Practice Physicians, Family Practice Physicians, Pediatricians, Internal Medicine Practitioners, Obstetricians, Nurse Midwives, Advanced Practice Nurses, Providers of Physician Services, Maternal/Child Health Clinics, Comprehensive Clinics, Public Health Department Clinics, Directors, County Departments of Job and Family Services, Outpatient Health Facilities, Rural Health Clinics, Federally Qualified Health Centers, Home Health-Private Duty Nursing Providers, Managed Care Plans

FROM: Douglas E. Lumpkin, Director

SUBJECT: Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule 5101:3-4-12 Immunizations.

Rule 5101:3-4-12 sets forth the immunizations that are covered for the Medicaid population. The rule is being proposed for amendment to include the Current Procedural Technology (CPT) code 90650 [Human Papilloma virus (HPV) vaccine, types 16, 18, bivalent, 3 dose schedule, for intramuscular use] to the list of designated free vaccines. This will allow providers to bill for the administration of this immunization for children ages nine to 18. The Department reimburses providers $10 for administering free vaccines.

The rule is also being modified to add appendices of covered immunization codes which are being relocated from Appendix DD of OAC rule 5101:3-1-60. This change is being made in response to stakeholder request and will accelerate the adoption of new vaccines into the Medicaid program.

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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:
(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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Telephone 800-686-1516
MHTL 3336-09-07 (Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule)

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-09-07

January 22, 2010

TO: All Eligible General Practice Physicians, Family Practice Physicians, Pediatricians, Internal Medicine Practitioners, Obstetricians, Nurse Midwives, Providers of Physician Services, Maternal/Child Health Clinics, Comprehensive Clinics, Public Health Department Clinics, Directors, County Departments of Job and Family Services, Managed Care Plans

FROM: Douglas E. Lumpkin, Director

SUBJECT: Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule 5101:3-4-12 Immunizations.

Rule 5101:3-4-12 specifies immunizations that are covered for the Medicaid population. The rule is being proposed for amendment to include the Current Procedural Technology (CPT) code 90663 (Influenza virus vaccine, pandemic formulation) to the list of designated free vaccines so that providers may bill for immunizations against the pandemic influenza virus, H1N1. The Department will reimburse $10 for the administration of each dose of this vaccine needed for both children and adults. The rule also specifies how Medicaid providers can obtain the pandemic influenza vaccine free of charge from the Ohio Department of Health. It is also being modified for five-year rule review, to update date references and to clarify existing policy.

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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:

1. Selecting the "Ohio Health Plans - Provider" folder;
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Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
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 ambulance 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 ambulance 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
The reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately $4,231,876.

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P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516
TO: All Eligible Providers of Physician 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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MHTL 3336-09-04
Medicaid Handbook Transmittal Letter (MHTL) No. 3336-09-04
July 10, 2009

TO: All Eligible Physician 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/contraceptive 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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Columbus, OH 43216-1461
Telephone 800-686-1516
To: All Eligible Providers of Physician Services  
Directors, County Departments of Job and Family Services  

From: Douglas E. Lumpkin, Director  

Subject: Physician Policy Update: Medicaid Reimbursement  

Ohio Administrative Code (OAC) rule 5101:3-1-60  

The purpose of this Medicaid Handbook Transmittal Letter is to announce a routine update to Appendix DD of the Medicaid reimbursement rule, OAC 5101:3-1-60. Appendix DD contains pricing and coverage information for medical services billed by providers using Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes.  

The changes in appendix involve the addition or deletion of some codes and revised pricing for others. These include:  

1) the addition of two durable medical equipment repair codes (K0739 and K0740). These codes are not covered by the program and are included in the appendix for informational purposes;  
2) revised pricing for five newborn care services codes (in the range 99460-99465). These codes revert back to the July 1, 2008 payment level, resulting in increased reimbursement for providers billing these codes;  
3) the addition of 15 pharmacy related codes for skin substitutes used for non-healing wounds (in the range Q4100-Q4114);  
4) the deletion of two pharmacy related family planning codes (J7303 and J7304). These services will no longer be covered at physician offices but will be available through pharmacies by prescription;  
5) revised pricing for 18 pharmacy related injection codes (in the range 90371-90733);  
6) revised pricing for five family planning codes (11975, 58565, H1010, 55400 and 76948);  
7) revised pricing for 399 pharmacy codes for drugs administered by non-oral method (in the range J0130-J9600);  
8) revised pricing for four pharmacy related radiology codes (in the range A9576-A9579);  
9) revised pricing for seven pharmacy related temporary codes (in the range Q0515-Q9966); and  
10) the deletion of one family planning code (H1011).  

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800-686-1516
MHTL 3336-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-09-02

April 6, 2009

To: All Eligible Providers of Physician Services
Directors, County Departments of Job and Family Services

From: Douglas E. Lumpkin, Director

Subject: Physician Policy Updates: New 2009 HCPCS Codes and Policy Updates

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce the adoption of the 2009 Healthcare Procedural Coding System (HCPCS) codes and 2009 Current Procedural Terminology (CPT) codes effective January 1, 2009, in order to maintain consistency with industry standards, which the Ohio Department of Job and Family Services is required to do under the Health Insurance Portability and Accountability Act (HIPPA), pursuant to 45 CFR 162.1000 and 45 CFR 162.1002. These rules replace the emergency rules which were effective on December 31, 2008.

Rule 5101:3-1-19.3, entitled "Claim submission [except for services provided to consumers who are members of a Medicaid managed care program]," sets forth criteria for submitting claims to Ohio Medicaid. Changes include updating the references to HCPCS texts published by the American Medical Association. References to "Health Care Common Procedure Coding System HCPCS 2007" (1/07 edition) and the "Health Care Common Procedure Coding System HCPCS 2008" (1/08 edition) are replaced with references to "Health Care Common Procedure Coding System HCPCS 2008" (1/08 edition) and "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition), respectively. The codes found in the replacement references are effective for dates of service January 1, 2008 through December 31, 2008, and for dates of services January 1, 2009 through December 31, 2009, respectively. The department estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-06, entitled "Physician visits," defines what constitutes a physician visit and sets forth criteria for submitting claims to Medicaid. Changes include updating the references to HCPCS codes to reflect those in the "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition) published by the American Medical Association. References to the "Health Care Common Procedure Coding System HCPCS 2008" (1/08 edition) are replaced with references to "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition). The codes found in the replacement references are effective for dates of services January 1, 2009 through December 31, 2009. The department estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-06.1, entitled "Physician attendance during patient transport," sets forth the services covered and claims submission criteria for physician attendance during transport. Changes are limited to updating the references to HCPCS codes to reflect those in the "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition) published by the American Medical Association. References to the "Health Care Common Procedure Coding System HCPCS 2008" (1/08 edition) are replaced with references to "Health Care Common Procedure Coding System HCPCS 2009" (1/09 edition). The codes found in the replacement references are effective for dates of services January 1, 2009 through December 31, 2009. The department estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-13, entitled "Therapeutic injections (including trigger point injections) and prescribed drugs," sets forth coverage provisions for these services provided by physician providers of Medicaid services. Changes include the addition of new HCPCS codes. The department estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-14, entitled "Dialysis," sets forth the conditions of Medicaid coverage of physician professional services associated with the medical management of end-stage renal disease patients. Changes include the addition of new HCPCS codes and the deletion of obsolete HCPCS codes. The department estimates that there is no fiscal impact resulting from these changes.
Rule 5101:3-4-17, entitled "Gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy and special dermatology services," addresses Medicaid's coverage of gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy and special dermatology services. The change is limited to the deletion of an obsolete HCPCS code and the correction of grammatical and spelling errors. The department estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-22, entitled "Surgical services," sets forth coverage provisions for these services provided by physician providers of Medicaid services. Changes include the addition of new HCPCS codes, deletion of obsolete HCPCS codes, revision of definitions, revision of appendix A of this rule, and rescission and enactment of appendix B of this rule. The department estimates that there is no fiscal impact resulting from these changes.

**Web Page:**

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

Providers may view documents online by:

1. Selecting "Ohio Health Plans - Provider" folder;
2. Selecting the appropriate topic from the document list; and
3. Selecting the desired item from the "Table of Contents" pull-down menu.

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:

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

The Legal/Policy Central - Calendar site (http://www.odjfs.state.oh.us/lpc/calendar/) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (http://www.odjfs.state.oh.us/lpc/mtl/). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

**Paper Distribution:**

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 the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans  
Bureau of Provider Services  
P.O. Box 1461  
Columbus, OH 43216-1461  
800-686-1516
This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-4-02, "Scope of coverage" and the rescission and adoption of new OAC rule 5101:3-4-03, "Physician assistants."

OAC rule 5101:3-4-02 is titled "Scope of coverage." This amended rule outlines the requirements regarding physician supervision of non-physicians when non-physicians provide Medicaid reimbursable services. This rule is amended to incorporate changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This amended rule updates the reference to the required level of physician supervision of physician assistants so that such reference is consistent with proposed rule 5101:3-4-03, "Physician assistants," of the Administrative Code.

Specifically, this rule removes paragraph (C)(2)(c), which indicated that physician assistants must be "under the general supervision of the physician" in order for Medicaid to reimburse eligible providers for provision of physician assistant services. This amended rule includes a new reference, paragraph (D), to rule 5101:3-4-03 and Chapter 4730-1 of the Administrative Code, "Physician assistants." This referenced rule addresses the required level of physician supervision of physician assistants in order for Medicaid to reimburse eligible providers for provision of physician assistant services.

OAC rule 5101:3-4-03 is titled "Physician Assistants." This new rule incorporates changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This new rule explains the conditions under which Ohio Medicaid will reimburse Medicaid providers for physician assistant services.

This new rule:

- Provides new and updated definitions as well as definitions by reference;
- Provides updated references to the Section 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code that govern the practice of Physician Assistants in Ohio;
- Removes requirements that a patient new to a physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant;
- Removes requirements that an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition;
- Removes requirements that medical records for patients new to a physician's practice and medical records for established patients with a new condition must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant;
- Clarifies that Medicaid providers will not be reimbursed for visits provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic; and
Clarifies that direct reimbursement is not available for services provided by a hospital employed physician assistant. The reimbursement for the services provided by the physician assistant is bundled into the facility payment made to the hospital.

This rule does not include information regarding Medicaid coverage of Pharmacy, Durable Medical Equipment, and Laboratory Services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for Ohio Medicaid requirements related to these topics.

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Providers may view documents online by:

1. Selecting the "Ohio Health Plans - Provider" folder;
2. Selecting the appropriate topic from the document list; and
3. Selecting the desired item from the "Table of Contents" pull-down menu.

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:

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

The Legal/Policy Central - Calendar site (http://www.odjfs.state.oh.us/lpc/calendar/) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (http://www.odjfs.state.oh.us/lpc/mtl/). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
800-686-1516
MHTL 3336-08-06

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-08-06

December 22, 2008


Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: New Vaccines Available Through the Vaccines for Children Program

This letter announces the availability of three new vaccines through the Vaccines for Children (VFC) program. Under this program, participating providers receive vaccines free of charge through the Ohio Department of Health. The new vaccines and their corresponding CPT codes are presented below. A listing of all the vaccines covered by the VFC program in Ohio as well as additional information on ordering, billing and reimbursement can be found in Ohio Administrative Code rule OAC 5101:3-4-12.

Code # Vaccine
90681 Rota (Rotavirus vaccine, live, oral);
90696 DTaPIPV (diphtheria and tetanus toxoids and acellular pertussis adsorbed and inactivated poliovirus vaccine); and
90698 DTaPIPHI (diphtheria and tetanus toxoids and acellular pertussis adsorbed, inactivated poliovirus and haemophilus b conjugate).

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1. Selecting the "Ohio Health Plans - Provider" folder;
2. Selecting the appropriate topic from the document list; and
3. Selecting the desired item from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (http://www.odjfs.state.oh.us/lpc/calendar/) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (http://www.odjfs.state.oh.us/lpc/mlt/). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Paper Distribution:

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 the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
TO:     All Eligible Providers of Physician Services  
        Directors, County Departments of Job and Family Services  
        Medical Assistant Coordinators  
FROM: Helen E. Jones-Kelley, Director  
SUBJECT: Eligible Providers of Physician Services  

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rule governing eligible providers of physician services.

**Eligible Providers of Physician Services: Rule 5101:3-4-01**

This rule is being amended to incorporate policy changes associated with the adoption of the National Provider Identifier requirements. Under the new definition, a physician group practice means a business enterprise that consists of two or more physicians, or a single physician who is incorporated, enrolled in the Medicaid program for the purpose of providing physician services.

Another amendment, found in paragraph (A) (2) (a), involves the removal of a foundation as a valid physician group practice arrangement.

**Web Page and Paper Distribution:**

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Providers may view documents online by:

1. Selecting "Ohio Health Plans - Provider" folder;  
2. Selecting "Physician Services" from the document list; and  
3. Selecting the desired item from the "Table of Contents" pull-down menu.

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:

1. Selecting the "Ohio Health Plans- Provider " folder;  
2. Selecting the "General Information for Medicaid Providers;  
3. Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu; and  
4. Selecting the link to Appendix DD located near the bottom of the web page.

The Legal/Policy Central- Calendar site (http://www.odjfs.state.oh.us/lpc/calendar) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (http://www.odjfs.state.oh.us/lpc/mtl). The listing is categorized by letter number and subject, and a link is provided to each 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 with all attachments (rule 5101:3-4-01) 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
TO: All Eligible Providers of Physician Services
    Directors, County Departments of Job and Family Services
    Medical Assistant Coordinators
FROM: Helen E. Jones-Kelley, Director
SUBJECT: Physician Attendance During Patient Transport

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to transmit the amended rule governing physician attendance during a patient transport.

Physician Attendance During Patient Transport: Rule 5101:3-4-06.1

This rule is being amended because of five year rule review. All amendments associated with this rule are grammatical or aid in the clarification of existing policy.

Web Page and Paper Distribution:

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Providers may view documents online by:
(1) Selecting "Ohio Health Plans - Provider" folder;
(2) Selecting "Physician Services" from the document list; and
(3) Selecting the desired item from the "Table of Contents" pull-down menu.

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:
    (1) Selecting the "Ohio Health Plans- Provider " folder;
    (2) Selecting the "General Information for Medicaid Providers;
    (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu; and
    (4) Selecting the link to Appendix DD located near the bottom of the web page.

The Legal/Policy Central Calendar site (http://www.odjfs.state.oh.us/lpc/calendar) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (http://www.odjfs.state.oh.us/lpc/mlt). The listing is categorized by letter number and subject, and a link is provided to each 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 with all attachments (rule 5101:3-4-06.1) 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
To: Eligible Providers of Physician 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:

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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 "Physical Therapy Services"; and,
Selecting this MHTL number from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (http://www.oddjs.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.oddjs.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 3336-08-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-08-02

July 17, 2008

To: Eligible Providers of Physician 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:

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Medicaid Maximum</th>
<th>New Medicaid Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New patient office visits</td>
<td></td>
</tr>
<tr>
<td>99202</td>
<td>$34.42</td>
<td>$36.05</td>
</tr>
<tr>
<td>99203</td>
<td>$48.01</td>
<td>$53.48</td>
</tr>
<tr>
<td>99204</td>
<td>$70.32</td>
<td>$81.55</td>
</tr>
<tr>
<td>99205</td>
<td>$87.97</td>
<td>$102.47</td>
</tr>
<tr>
<td></td>
<td>Established patient office visits</td>
<td></td>
</tr>
<tr>
<td>99212</td>
<td>$24.74</td>
<td>$24.75</td>
</tr>
<tr>
<td>99213</td>
<td>$34.35</td>
<td>$40.38</td>
</tr>
<tr>
<td>99214</td>
<td>$52.57</td>
<td>$61.24</td>
</tr>
<tr>
<td>99215</td>
<td>$81.04</td>
<td>$82.99</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Current Medicaid Maximum</th>
<th>New Medicaid Maximum</th>
</tr>
</thead>
</table>
New patient preventive medicine visit

<table>
<thead>
<tr>
<th>Code</th>
<th>New</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381</td>
<td>$50.70</td>
<td>$59.07</td>
</tr>
<tr>
<td>99382</td>
<td>$57.61</td>
<td>$63.75</td>
</tr>
<tr>
<td>99383</td>
<td>$57.51</td>
<td>$62.84</td>
</tr>
<tr>
<td>99384</td>
<td>$64.52</td>
<td>$68.22</td>
</tr>
<tr>
<td>99385</td>
<td>$61.21</td>
<td>$68.22</td>
</tr>
</tbody>
</table>

Established patient preventive medicine visit

<table>
<thead>
<tr>
<th>Code</th>
<th>New</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>99391</td>
<td>$44.18</td>
<td>$47.59</td>
</tr>
<tr>
<td>99392</td>
<td>$51.12</td>
<td>$52.97</td>
</tr>
<tr>
<td>99393</td>
<td>$51.12</td>
<td>$52.12</td>
</tr>
<tr>
<td>99395</td>
<td>$55.66</td>
<td>$56.62</td>
</tr>
</tbody>
</table>

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

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Providers may view documents online by:

1. Selecting "Ohio Health Plans - Provider";
2. Selecting "Physician"; 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/mlt). 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
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 "Physician 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
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.

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

Paragraph (C) (1) has been amended to specify that the code describing an electronic analysis of an implanted neurostimulator pulse generator system, gastric neurostimulator pulse generator/transmitter; initial
or subsequent is considered a professional service and is covered as a physician service regardless of setting.

**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 - 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"
Selecting "Physician Services"; and

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/mlt). 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 3336-07-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-07-02

November 8, 2007

To: All Eligible Providers of Physician Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Updates to Anesthesia Services and Physician Reimbursement for Medical Supplies and Durable Medical Equipment

Effective November 20, 2007

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce policy changes to the rules regarding anesthesia services as a result of five year rule review and to reinstate policies physicians must follow in order to receive reimbursement for medical supplies and durable medical equipment.

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.

Medical supplies and durable medical equipment - Rule 5101:3-4-27

This rule covers the policies and procedures related to reimbursement of medical supplies and durable medical equipment dispensed by physicians. The policies in the rule specify that a physician may not receive separate reimbursement for medical supplies and durable medical equipment utilized in a physician's office, clinic, or patient's home during a physician visit. A physician may receive reimbursement for medical supplies and durable medical equipment dispensed by the physician in a physician's office, clinic, or patient's home, for use in the patient's home if the physician has a "supplies and durable medical equipment" category of service (32). All physicians who have a valid "Medicaid provider agreement" are eligible to apply for and receive a "supplies and durable medical equipment" category of service. The scope and extent of coverage of medical supplies and durable medical equipment services are detailed in Chapter 5101:3-10 of the Administrative Code. All medical supplies and durable medical equipment require a written prescription by a physician, which must be kept on file in accordance with rule 5101:3-1-17.2 of the Administrative Code. All claims for medical supplies and durable medical equipment must be billed in accordance with rule 5101:3-10-05 of the Administrative Code.

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 "Physician Services"; and
3. Selecting the desired item from the "Table of Contents" pull-down menu.

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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
TO: All Eligible Providers of Physician Services
    Directors, County Departments of Job and Family Services
    Medical Assistance Coordinators
FROM: Helen E. Jones-Kelley, Director
SUBJECT: Updates to certain current procedure codes 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 Physician 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
TO: All Eligible Providers of Physician Services
  Directors, County Departments of Job and Family Services
  Medical Assistance Coordinators
FROM: Barbara E. Riley, Director
SUBJECT: Physician 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 physician 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.

Physician Services Handbook Updates: Policy Updates

Rules 5101:3-4-06, 5101:3-4-17, 5101:3-4-18, and 5101:3-4-22 are to be filed on an emergency basis on December 29, 2006, and are 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 Physician Services handbook. If you are maintaining a paper copy of the Physician 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

Consultation services: Rule 5101:3-4-06

Paragraph (E)(7) addressing consultations has been revised to incorporate changes made in the CPT book. The title of paragraph (E)(7) has been revised to eliminate the word "initial" since it has been deleted from the CPT book. Similarly, paragraph (E)(7)(b) has been revised to add language specified in CPT. The paragraph now reads, "Subsequent consultative visits requested by the patient's attending physician or subsequent visits required to complete the initial consultation to hospital inpatients or to residents in an LTCF must be billed using the code listed in the CPT for subsequent hospital care or subsequent nursing facility care including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem"

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

Paragraph (B) (4) of this rule has been amended to delete code 92573 discontinued by the American Medical Association (AMA).

Paragraph (C)(3) has been amended to specify that the new 2007 code 92640 is considered a technical service and is reimbursable to a physician only if the service is provided in a non-hospital setting.

Pulmonary services: Rule 5101:3-4-18

Paragraph (C) (1) of this rule has been amended to add the service "continuous inhalation treatment with aerosol medication" (codes 94644 and 94645) to the list of services considered technical services. These codes are reimbursable only if provided in a non-hospital setting as specified in the rule.
Paragraph (D) of this rule has been added to address other new 2007 pulmonary services. Codes 94002, 94003, and 94610 are considered physician professional (not technical) services. Codes 94002 and 94003 (for ventilation assist and management) may not be billed in conjunction with the codes for critical care services and are valid only in an inpatient hospital setting.

**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.

**Appendices Revised:**

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

- **Payable Surgical Procedure Codes (10000-69999)**
- **List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components**
- **Injection Codes**
- **Radiology Codes with Professional and Technical Splits**
- **Valid Modifiers:** This appendix has been updated to list the 51 modifier in accordance with the specifications in physician surgery rule 5101:3-4-22.

**Waived Laboratory Procedures** This appendix has been deleted from the Physician Services handbook. To determine whether a lab procedure is considered a waived test go to the CMS website listing all waived codes at [http://www.cms.hhs.gov/](http://www.cms.hhs.gov/).

**Rule Change 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.

**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 the 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 Physician 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 physician must perform the screening.

Rule Changes Effective March 29, 2007

Physician visits: Rule 5101:3-4-06

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

Paragraph (E)(6)(b) on office consultations and paragraph (E)(7)(c) regarding inpatient consultations are being amended to clarify that when a consultation code is billed, the physician must submit the required referring physician provider information specified in the Department’s billing instructions in accordance with rule 5101:3-1-19.3.

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 physician 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 inappropriately will not be paid. To receive reimbursement:

1) The provider must send to the Department, a completed JFS 0678 "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 rules 5101:3-4-06, 5101:3-4-12, 5101:3-4-17, 5101:3-4-18, 5101:3-4-22, 5101: 3-4-28, and 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
TO: All Eligible Providers of Physician Services
   Directors, County Department of Job and Family Services
   Medical Assistance Coordinators
FROM: Barbara E. Riley, Director
SUBJECT: Physician 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, 5101:3-4-16, Cardiovascular, diagnostic and therapeutic services, 5101:3-1-60, Medicaid reimbursement, 5101:3-4-12, Immunizations, and 5101:3-4-22, Surgical services.

Note: Rules 5101:3-4-21.1 and 5101:3-4-16 are in a proposed status and are 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 Physician 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.

Cardiovascular, diagnostic and therapeutic services: 5101:3-4-16
Rule 5101:3-4-16 of the Ohio Administrative Code (OAC), "Cardiovascular diagnostic and therapeutic services" has been amended to include additional professional services in paragraph (B) and additional services CPT considers technical in paragraph (D). Additional professional services include percutaneous transcatheter closure of congenital interatrial or ventricular septal defect and ambulatory blood pressure monitoring, including review and report.

Procedures considered technical that were added to paragraph (D) include telephonic transmission of post-symptom electrocardiogram rhythm strips, ambulatory blood pressure monitoring, recording only and ambulatory blood pressure monitoring, scanning analysis with report. All other amendments to this rule were for the purpose of clarifying existing language.

EFFECTIVE OCTOBER 15, 2006
Medicaid reimbursement: 5101:3-1-60,
Amendments to this rule relative to physician services were updates to Appendix DD of the rule to include quarterly pricing updates from the Centers for Medicare and Medicaid Services on physician-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 when the code is billed with the 50 modifier.

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.

REMONDER

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, 5101:3-4-16, 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 3336-06-04**

**Medicaid Handbook Transmittal Letter (MHTL) 3336-06-04**

June 30, 2006

TO: All Eligible Providers of Physician 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 of 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/](http://emanuals.odjfs.state.oh.us/emanuals/) in the Physician 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
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 "Physician 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
TO:  All Eligible Providers of Physician Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators  
FROM:  Barbara E. Riley, Director  
SUBJECT:  Physician Policy Updates: 5101:3-4-13, 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, 5101:3-4-12, Immunizations and 5101:3-4-13, Therapeutic injections (including trigger point injections) and prescribed drugs.  

Note: Rule 5101:3-4-13 is effective July 1, 2006 for dates of service on or after July 1, 2006. Rules 5101:3-1-60 and 5101:3-4-12 are in a proposed status and 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 Physician Services handbook.  

EFFECTIVE JULY 1, 2006  

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

This rule has been amended to delineate policy relating to trigger point injections. Paragraph (B) of this rule defines trigger point injections, details the criteria for reimbursement, defines documentation requirements, and sets limitations for these services. Other changes are for clarifications of existing policy.  

Definition:  
A trigger point injection is one of the many modalities utilized in the management of chronic pain. A trigger point is an area of hyperexcitability where the application of stimulus will provoke pain to a greater degree than in the surrounding area. Injection of a corticosteroid mixed with a local anesthetic or a local anesthetic by itself, directly into the affected body part may alleviate or treat inflammation and pain. The treatment goal should be to treat not just the symptom of pain but also the cause of the pain.  

Criteria for reimbursement  
All of the following coverage criteria must be met before this service can be reimbursed by the department:  

- The services must be considered medically necessary;  
- The conditions for reimbursement for therapeutic injections listed in paragraph (A)(3) of rule 5101:3-4-13 must be met;  
- The patient's diagnosis must support the need for the service; and,  
- There must be documentation in the patient's medical record to confirm that a trigger point injection was provided.  

Documentation:  
The following items must be documented in the patient's medical record:  

- A proper evaluation including a patient's history and physical examination leading to diagnosis of a condition requiring a trigger point;  
- Identification of the affected muscle(s);  
- Reasons for selecting therapeutic option;  
- The muscles injected and the amount of injections;
Frequency of injections required;
The name of the medication used in the injection;
For a follow up visit, the results of the initial visit; and,
Documentation that supports the medical necessity of the service.

Limitations:

In accordance with CPT guidelines, only one unit of service will be reimbursed for codes 20552 and 20553 per patient, per date of service, per provider regardless of the number of sites or regions injected. Units of service are not determined by the number of injections given.

Codes 20552 and 20553 are not to be billed collectively for the same patient on the same date of service. In accordance with CPT, only one of these codes will be reimbursed per date of service, per provider.

Trigger point injections should be repeated only if reasonable and medically necessary. For dates of service on or after the effective date of this rule, trigger point injections of local anesthetic and/or steroids will be limited to a maximum of eight dates of service per patient per year. Claims with injections exceeding this limit in a calendar year period will be denied.

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.

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 rules 5101:3-4-13 and 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 3336-06-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-06-02

July 14, 2006

To: All Eligible Providers of Physician 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. 3336-06-02 is to inform providers of physician services of the coverage and limitation of OAC rule 5101:3-4-33 Coverage of fluoride varnish by non-dental providers.

This new physician services rule, effective July 1, 2006, authorizes Medicaid program coverage and separate reimbursement for eligible providers of physician services 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 up to age three when medically appropriate. Coverage of fluoride treatments by physicians 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, physician providers should follow their standard billing procedures and must submit CDT code D1203 (topical application of fluoride (prophylaxis not included) - child).

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 JFS03400.

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
TO: All Eligible Providers of Physician Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators
FROM: Barbara E. Riley, Director
SUBJECT: PHYSICIAN 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
- Otorhinolaryngologic services
- Psychological and neuropsychological testing and neurobehavioral status exams
- Endocrinology
- Gastric restrictive procedures
- Reimbursement for supplies for radiologic procedures
- Vision co-payment
- Anatomical laboratory codes

EFFECTIVE FEBRUARY 12, 2006
- Teaching physicians

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 physician services.

2006 Codes
Rules 5101:3-4-06, 5101:3-4-07, 5101:3-4-12, 5101:3-4-17, 5101:3-4-25, 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.

Physician 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 physician 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.

**Otorhinolaryngologic Services: Rule 5101:3-4-17**
The code for aural rehabilitation following cochlear implant has been removed from the CPT. Several codes detailing procedures for aural rehabilitation have been added (92626-92633). These codes are considered technical services and are covered only when provided in a non-hospital setting.

**Psychological and neuropsychological testing and neurobehavioral status exams:** Rule 5101:3-4-17

Several codes were added to the CPT under "Central Nervous System Assessments/Tests." The codes used to bill assessments were expanded to include who could administer and interpret the results. The previous codes, 96100 and 96115 were deleted and split into three new codes each specifying the type of medical professional involved in the procedure. The Department will be covering testing and interpretation done by a physician or a psychologist (codes 96101, 96116, 96118). The additional codes with interpretation by a technician or a qualified health care professional will not be covered.

**Endocrinology:** Rule 5101:3-4-17

Under the endocrinology portion of the rule the description of code 95250 has been revised by CPT to be a technical service only for ambulatory glucose monitoring of interstitial tissue fluid via a subcutaneous sensor. Code 95251 has been added to this section of the CPT to provide for physician interpretation and report of this procedure. Code 95251 is reimbursable only when it is provided in a non-hospital setting.

**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.

**Reimbursement for Supplies for Radiologic Procedures:** Rule 5101:3-4-25

Paragraph (B)(9) of this rule was amended to remove code A9511 that was deleted by CMS and replaced with code A9536. The Medicaid maximum for codes for supplies for radiologic procedures are listed in the appendix to rule 5101:3-1-60 of the Ohio Administrative Code.

**Vision Co-Pay:** Rules 5101:3-1-09, 5101:3-1-60, and 5101:3-6-01

If you are a physician that provides vision examinations, specifically CPT codes 92002, 92004, 92012, or 92014, or dispenses glasses (codes 92340, 92341, 92342), please refer to Medicaid's copayment rules for vision services that are effective for dates of services on or after January 1, 2006. See Ohio Administrative Code rules 5101:3-1-09, 5101:3-1-60, and 5101:3-6-01.

**Anatomical Lab Codes:** Clinical Procedures and Anatomical Pathology Procedure Codes Appendix in rule 5101:3-11-03

The following new 2006 lab codes will be considered anatomical: 88333, 88334, 88384, 88385, and 88386.

**Appendices Revisions**

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

- [Payable Surgical Procedure Codes (10000-69999)]
- [List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components]
- [Injection Codes]
- [Radiology Codes with Professional and Technical Splits]
- [Clinical Lab Procedures with Pathology Consultations]
- [Waived Laboratory Procedures]

**RULE CHANGES EFFECTIVE FOR FEBRUARY 12, 2006**

Teaching Physician Services: Rule 5101:3-4-05

The teaching physician services rule has been amended to update the policy relating to maternity services. It has been proposed and will become effective February 12, 2006. Changes include adding language stating that supervising physicians in teaching settings must be present during deliveries. This has always been
Medicaid's requirement but the language was mistakenly removed from the September 1, 2005 version of the rule.

RULE CHANGES EFFECTIVE FOR APRIL 1, 2006

Family Planning Visits: Rule 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
TO: All Eligible Providers of Physician Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Physician Policy/Rule Updates

- Additional immunization coverage
- Radiopharmaceutical diagnostic imaging agents
- Observation care codes
- Place of service codes
- Teaching physician policies
- Allergy coverage criteria
- Billing bilateral claims
- Five-year rule review
- Price changes

EFFECTIVE SEPTEMBER 1, 2005

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing physician services and to provide reminders regarding existing policy. Note: The rules relating to these policy changes are in a proposed 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 physician book.

I. 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 older (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. However, this date is dependent work being completed by the Department's Management Information Systems (MIS). Should required MIS work be incomplete on September 1, the Department will notify providers via a remittance advice newsletter of the revised date.

II. Coverage of radiopharmaceutical diagnostic imaging agents - Rule 5101:3-4-25

The following codes will be covered effective for dates of service on and after September 1, 2005, to replace code 78990 that was deleted by the American Medical Association on December 31, 2004: A9500, A9502, A9503, A9505, A9507, A9508, A9510, A9511, and A9700. These A codes will only be valid in a non-hospital setting.

Codes A4643 - A4647 are being replaced by Q9945 - Q9954 for procedures performed in a non-hospital setting. The Q codes will only be valid in a non-hospital setting.

J1563 is being replaced with Q9941 or Q9943. Similarly, J1564 is being replaced with Q9942 or Q9944.

III. Observation care codes - 5101:3-4-06

The following is a clarification of existing policy. If observation care extends over to a second date of service, the code for observation care discharge day management may be billed (99217) when the patient is discharged as specified in the "initial observation care" section of the CPT book. However when initial observation care is less than eight hours, the Department will not reimburse for the code for discharge day management (99217) even if the care extends over to a second day of service.

In order to bill the observation care codes, the patient must be in observation care status for a minimum of eight hours. Otherwise, the physician must bill the admission codes (99218 - 99220).

Observation care provided to a patient who is discharged on the same date must be billed using the codes specific in the "observation or inpatient services" section of the CPT book (99234-36).

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

Additional valid place of service codes are being added to Medicaid's claims system. These additions are dependent on work that needs to be completed by our MIS department. 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 work by the Department's Management Information Systems staff has been completed.

V. Teaching physician policies - 5101:3-4-05

The Department has amended its teaching physician rule to be more closely aligned with Medicare's policy stated in section 15016 of the Medicare carrier's manual as of 9/1/05, particularly in the area of documentation. The teaching physician policy changes include, but are not limited to:

- Documentation means notes recorded in the patient's medical record by a teaching physician and resident.
- Documentation must be dictated and typed, handwritten, or computer-generated.
- The teaching physician must meet the documentation instructions for evaluation and management services stated in section 15016 of the Medicare carrier's manual (9/1/05) including but not limited to the following requirements:

To be eligible for reimbursement for evaluation and management services, the teaching physician must personally document the following, at a minimum:

1) the teaching physician must personally document that the teaching physician personally performed the service or

2) was physically present during the key or critical portion of the service when performed by the resident. Physically present means that the teaching physician is in the same room (or partitioned or curtained area, if the room is subdivided to
accommodate multiple patients) as the patient and/or performs a face-to-face service; and

3) the participation of the teaching physician in the management of the patient.

Note: documentation by the resident of the participation and presence of the teaching physician is not sufficient to establish the presence and participation of the teaching physician in the service.

The combined entries in the medical record by the teaching physician and the resident together must document the medical necessity of the service.

- Documentation must identify:
  1) the service provided;
  2) whether the teaching physician was present during the critical or key portions of the services provided by a resident;
  3) the participation of the teaching physician in providing the service;
  4) the date; and
  5) a legible signature or identity alone.

Unacceptable documentation includes the following even when followed by a legible countersignature or identity because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care:

Agree with above;
Rounded, Reviewed, Agree;
Discussed with resident; Agree; Seen and agree;
Patient seen and evaluated; or
A legible countersignature or identity alone.

- Any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or the physical presence of a resident in a service. The only documentation from a student that the teaching physician may refer to is limited to the review of systems and/or past family/social history.

- Critical or key portions means that part(s) of a service that is/are a critical or key part of a service. Critical or key portions is defined based on the type of service:

For anesthesia services, the teaching physician must be present during all critical or key portions of the anesthesia procedure (see rule 5101:3-4-21 for details). Presence during only the preoperative or post-operative visit is not sufficient.

For surgery, the teaching physician is not required to be present during the opening and closing of the surgical area but must be present during all key portions.

In order for a teaching physician to bill for 2 overlapping surgeries, the critical or key portions of both surgeries may not take place at the same time. Billing for 3 or more concurrent surgical procedures is never allowed. The teaching physician must personally document that he/she was physically present during the critical portion of both procedures.

For complex or high-risk procedures such as cardiac catheterization, cardiovascular stress tests, radiologic and cardiologic supervision and interpretation codes, the teaching physician must be physically present with the resident and must supervise the performance of the procedure or he/she must personally perform the procedure.
For procedure codes determined on the basis of time, the teaching physician must be present for the entire period of time for which the claim is made. For example, a code that specifically describes a service of 20-30 minutes in length should be billed only if the teaching physician is present for the entire 20-30 minutes. Time spent by the resident in the absence of the teaching physician should not be added to time spent by the teaching physician alone with the patient or to time spent by the resident and teaching physician with the patient.

Interpretation of diagnostic radiology and other diagnostic tests are reimbursable if the interpretation is performed by or reviewed by a teaching physician.

For psychiatry codes, the teaching physician must be present during the time for which the claim is made. A teaching physician may not add time spent by a resident in the absence of the teaching physician to the total amount of time billed for the service. For certain psychiatric service, the presence of a teaching physician may be met by use of a one-way mirror or video equipment. Audio-only equipment is not acceptable.

If none of the guidelines in these paragraphs apply, the teaching physician may determine what portion of the service is critical or key.

- For evaluation and management codes, the teaching physician must be physically present during the medical decision making process, at a minimum. The teaching physician must personally document his/her presence and participation in the service in the medical records.
- For E/M services based on time, the teaching physician must be physically present for the entire period of time billed. Time spent by the resident in the absence of the teaching physician is not billable. Examples of codes falling in this category include but are not limited to individual psychotherapy codes, critical care services, inpatient neonatal and pediatric critical care services, and E/M service in which counseling and/or coordination of care is more than 50% of the encounter and time is considered the controlling factor.
- For maternity services, the teaching physician must be present for the delivery. The teaching physician must be physically present for the initial prenatal visit, any visits in which there are patients complaints, abnormal findings, the need for non-routine testing, or for post date equal to or greater than 42 week gestation.

Prenatal visits billed with the TH modifier with codes 99201 - 99203 or 99211 - 99213 fall under the primary care exception. Payment may be made for the services of a teaching physician provided by residents without the presence of teaching physician provided that all of the requirements listed in 42 CFR 415.174 are met.

- When a resident is assigned to a physician's office away from the hospital or primary care center where he/she is assigned or is making home visits, the primary care center exception does not apply and the teaching physician services are not billable.
- An assistant at surgery in a teaching hospital will not be reimbursed when a resident qualified to perform the service is available to assist at surgery.

Please review the teaching physician rule 5101:3-4-05 in its entirety for a complete understanding of the new teaching physician policy. Teaching physicians must comply with all of the provisions stated in rule 5101:3-4-05 for a service to be reimbursed by the department.

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

The allergy rule was amended to include the following new policy provisions.

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.

VII. 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.

VIII. Rule review for other physician rules 5101:3-4-01 and 5101:3-4-21.2

The Department completed 5 year rule review as required under ORC 119.032 for the following physician rules: 5101:3-4-01 entitled Eligible providers of physician services, and rule 5101: 3-4-21.2 entitled Anesthesia conversion factors. There were no policy changes to these rules, only grammatical changes or corrections to references to other OAC rules.

IX. 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 many J codes, some immunization codes, and selected surgical and radiology codes.

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
TO: All Eligible Providers of Physician Services
    Directors, County Department of Job and Family Services
    Medical Assistance Coordinators
FROM: Thomas J. Hayes, Director
SUBJECT: PHYSICIAN HANDBOOK UPDATE: 2005 HCPCS Changes

2005 HCPCS CODE AND POLICY CHANGES
EFFECTIVE JANUARY 1, 2005

- Critical care visits
- Otorhinolaryngologic services therapy codes
- 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 physician 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.

Physician 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.ohio.gov:6336/dynaweb/medicaid in the physician book. If you are maintaining a paper copy of the new physician 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: Rule 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.

Otorhinolaryngologic services therapy codes: Rule 5101:3-4-17

The following new codes have been added to the list of otorhinolaryngologic services which are considered technical services and are reimbursable to a physician only if they are provided in a non-hospital setting:
1) 92620 Evaluation of central auditory function, with report; initial 60 minutes;
2) 92621 Evaluation of central auditory function, with report; each additional 15 minutes; and
3) 92625 Assessment of tinnitus (includes pitch, loudness, matching, and masking).

The following new codes have been added to the list of neurology services which are considered professional services and covered as physician services regardless of setting:

1) 95978 Electronic analysis of implanted neurostimulator pulse generator system, complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; first hour; and
2) 95979 Electronic analysis of implanted neurostimulator pulse generator system, complex deep brain neurostimulator pulse generator/transmitter, with initial or subsequent programming; each additional 30 minutes after first hour.

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)
List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components
Injection Codes
Radiology Codes with Professional and Technical Splits
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_lst.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://jfs.ohio.gov/ohp/bhpp/lpplpt/providerlead.stm or call Donna Bush at 614-466-6420.

Requesting Paper Updates:
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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
The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules which govern physician 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. Pulmonary services - Rule 5101:3-4-18

The pulmonary code 94664, "evaluate patient use of inhaler" has been added to the list of pulmonary services which are considered a technical service and can be billed only when technical services (not professional) are provided.

III. Injection code update - Rule 5101:3-4-13 and appendix DD of Rule 5101:3-1-60

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 miscellaneous codes, the national drug code (NDC) number, name of the drug/injectable, and the dosage must be provided in the remarks column (item 19 on the CMS 1500 form) of the billing invoice. All three items must be included in the remarks column 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.

IV. 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.

V. 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](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.
VI. 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.

VII. 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.

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

FROM: Thomas J. Hayes, Director

SUBJECT: PHYSICIAN HANDBOOK UPDATE: 2004 HCPCS Changes

2004 HCPCS CODE AND POLICY CHANGES
EFFECTIVE JANUARY 1, 2004

- Critical care visits
- Consultations- clarification
- Visits performed in conjunction with surgical procedures- follow-up day revisions
- Immunizations code deleted
- Neurology and photodynamic therapy codes
- Scope of coverage: supervision requirements
- New Epo injection codes for ESRD patients
- Elimination of adult psychology and chiropractic services
- Use of new family planning exam codes
- Bilateral modifier added to codes
- Revisions to professional/technical split for certain anatomical laboratory codes
- New code for PACT program supervision
- Professional dialysis services
- 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 physician 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.

Physician 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 physician book. If you are maintaining a paper copy of the new physician 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: Rule 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 confirm that these codes are to be used for inpatient critical care only.

Procedures performed as part of resuscitation such as endotracheal intubation (31500) should be billed separately from the resuscitation only if the procedures are performed as a necessary component of the resuscitation and not as convenience before admission to the neonatal intensive care unit.

Critical care services provided in the outpatient setting e.g. emergency department or office for neonates and pediatric patients up through twenty-four months of age should be billed with the critical care codes 99291-99292.

If the same physician provides critical care services for a neonatal or pediatric patient in both the outpatient and inpatient settings on the same day, bill only the appropriate neonatal or pediatric critical care code (99293-99296) for all critical care services provided that day.

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.

Neurology and photodynamic therapy codes: Rule 5101:3-4-17

New code 95991, "refilling and maintenance of an implanted pump or reservoir for drug delivery, spinal or brain, administered by a physician" has been added to the list of neurology services which are professional services and covered as physician services regardless of setting.

Code 95990 "electronic analysis of implanted neurostimulator pulse generator system..." and code 96567 "photodynamic therapy by external application of light..." have been added to the list of codes which are considered technical services and are reimbursable to a physician only if they are provided in a non-hospital setting.

Photodynamic therapy code 96570 "photodynamic therapy by endoscopic application of light.." and 96571 "photodynamic therapy by endoscopic application each additional 15 minutes.." are considered professional services and covered as physician services regardless of setting.

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 category/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.

General supervision must be practiced for the services for the diagnosis and treatment of mental and emotional disorders provided by clinical social workers and professional clinical counselors in accordance with rule 5101:3-4-29. Services provided by licensed social workers and professional counselors must meet the supervision requirements and the documentation requirements listed in rule 5101:3-4-29.

New Epo Injection codes: Rule 5101:3-4-13

CMS has discontinued the current codes for EPO (Q9920-Q9940) for the treatment of anemia associated with chronic renal failure. Therefore effective for dates of service on and after January 1, 2004, these codes will be discontinued by Ohio Medicaid. The Department will add the new codes for EPO for ESRD patients, Q4054 injection darbepoetin alfa, 1 mcg (for ESRD dialysis) and Q4055, Injection epoetin alfa, 1000 units (for ESRD dialysis).

Elimination of adult chiropractic and psychology services: Rules 5101:3-8-11 and 5101:3-8-05

Effective for dates of service on and after January 1, 2004, chiropractic services provided in any setting and psychology service billed by independent psychologists (billing Medicaid directly) for adults are no longer covered services.

Psychology services for adults will continue to be covered if provided by a psychologist employed by or under contract with a physician provided that the provisions described in the scope of coverage rule 5101:3-4-02 are met. Any psychology services billed by a physician must be modified by "AH" to signify that the service was personally provided by a psychologist.

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 is provided for the purpose of family planning. 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 50 has been added to hundreds of surgical codes. Please bill the 50 modifier when the code is considered bilateral as instructed in rule 5101:3-4-22, the surgery rule.

Revised: The above modifier "50" was corrected June 22, 2004. The hard copy erroneously identified the modifier as 51. Effected providers were notified via remittance advice.
Revisions to certain anatomical laboratory professional/technical splits: Rule 5101:3-1-60

The professional/technical splits have been revised for some anatomical laboratory procedures effective for dates of service January 1, 2004.

**PACT provider code change:**
The Primary Alternative Treatment Program (PACT) is a non-voluntary utilization control program in which recipients who have either exceeded the Department's utilization criteria for medical or pharmacy services and/or utilized medical services without medical necessity are enrolled with a designated pharmacy for at least 18 months.

To comply with HIPAA, the Department has changed the code that may be billed for the PACT case management fee effective for dates of service on and after January 1, 2004. X0690 has been discontinued and G9008 is the PACT coordinated care fee code for physician's coordinating services. If you would like to know more about the PACT program, please see rule 5101:3-20-03. If you would like to participate as a designated primary care provider for recipients enrolled in this program, please contact the Care Management Unit or the Surveillance and Utilization Review section of Plan Operations at 614-466-9689.

**Professional Dialysis Services**
The Department will not be adopting the new G codes established by Medicare for professional dialysis services. We will continue to use the existing CPT codes for professional dialysis services.

**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.

**New anatomical laboratory codes:**
There are new anatomical lab codes added by the AMA for 2004: They are 88112 and 88361. These codes will be added to the anatomical lab code table now found under the section called "billing and coding aids".

**Appendices Revisions**
The following appendices have been revised as a result of the 2004 HCPCS code update or as a result of HIPAA code/modifier changes:
- Payable Surgical Procedure Codes (10000-69999)
- List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components
- Injection Codes
- Office Surgery Incentive Program
- Valid Physician Modifiers
- Valid Alpha HCPCS Codes
- Radiology Codes with Professional and Technical Splits

**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
TO: Eligible Providers of Physician Services  
   Directors, County Department of Job and Family Services
FROM: Thomas J. Hayes, Director
SUBJECT: New Physician Services Policy Book

The Department wishes to announce that the program policies for physicians participating in the Medicaid program have a new look effective December 1, 2003. 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. PHY.1101 Physician 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 physician services" is linked to OAC 5101:3-4-01. We encourage providers to navigate the new physician book and become familiar with the organization and location of the physician 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 physician handbook previously but was in a different format. The new physician 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 physician book will be divided into the following sections:

- Medicaid Handbook Transmittal Letters (MHTL)
- Medical Assistance Letters (MAL)
- Chapter 1: General Information for Physicians
- Chapter 2: Physician Reimbursement
- Chapter 3: Utilization Review
- Chapter 4: Physician Coverage and Reimbursement Policies
- Additional Physician Information
  - Medicaid Forms for Physicians
  - Billing and Coding Aids for Physicians
- Appendices

There will also be an alphabetic index to the physician book showing 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 physicians can access them for historical information.

Chapter 1 titled "General Information for Physician Providers" contains rules that are related to general topics such as eligibility, hospital based physicians, teaching physician policies, etc.

Chapter 2 titled "Physician 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 Physician Services" contains preadmission certification provisions, prior authorization rules, and rules governing the Primary Alternative Care and Treatment Program (PACT).
Chapter 4 called "Physician Coverage and Reimbursement" contains all of the rules governing coverage of physician services. It lists each rule by rule title. For example, the rule governing abortion services is first. 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 physician program.

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

The section titled "Medicaid Forms" contains forms that physicians' offices may use such as the Abortion Certification Form.

The section called "Billing and Coding Aids for Physicians" is new. This section includes information that was previously contained in various sections of the current physician handbook that is not in OAC rules. For example, under "Cardiovascular", providers can access a listing of "codes needing to be billed unmodified" or a listing of "cardiovascular codes requiring modifiers". Both of these documents were previously in the section PHY.1110 called "Cardiovascular Diagnostic and Therapeutic Services" of the physician 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. A third example of information in this section can be found under "physical medicine" that contains a listing of the covered physical medicine codes and a history of the limitations the Department has had for physical medicine services.

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

It should be stressed that all of the information formerly contained in the physician 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.
Miscellaneous Medicaid Handbook Transmittal Letters
MHTL 3334-13-04

MHTL 3334-10-02

MHTL 3334-09-02

Medical Assistance Letters
MAL 588 (Modifications to Payment Amounts and Claim-Submission Requirements for Radiology Services)

Medical Assistance Letter (MAL) 588

December 16, 2013

TO: Eligible Medicaid Providers of Radiology Services
    Chief Executive Officers, Managed Care Plans
    Directors, County Departments of Job and Family Services

FROM: John B. McCarthy, Director of Medicaid

SUBJECT: Modifications to Payment Amounts and Claim-Submission Requirements for Radiology Services

Provider Notice

With the establishment of the Ohio Department of Medicaid as an independent entity, administrative rules affecting providers have been renumbered: Rule numbers formerly beginning with 5101:3 now begin with 5160. It is likely, however, that these rules will continue to be referred to for some time by their old 5101:3 numbers, especially in online sources.

Policy Update

A new payment-reduction provision has been incorporated into the Medicaid administrative rules governing radiology services. It will go into effect for dates of service beginning January 1, 2014, and it applies when more than one radiology procedure is performed by the same provider or provider group for an individual patient on the same date. Payment will be made, as it is under Medicare, at 100% for the primary procedure and at 50% for each additional procedure. (The procedure having the greatest Medicaid maximum payment amount is considered to be primary.)

How these services appear on claims will also be changing. To enable the claim-payment system to determine which procedure is primary, a quantity restriction of one unit will be imposed on radiology procedure codes subject to the multiple-procedure reduction. Providers will no longer be able to report more than one unit for a single claim detail. Instead, they will report multiple claim details of one unit each.

Access to Rules and Related Material

The main web page of the Ohio Department of Medicaid (ODM) includes links to valuable information about its services and programs; the address is http://medicaid.ohio.gov/.

ODJFS maintains an "electronic manuals" web page of ODJFS and Medicaid rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is http://emanuals.odjfs.state.oh.us/emanuals/.

From the "eManuals" page, providers may view documents online by following these steps:

1. Select the 'Medicaid - Provider' collection.
2. Select the appropriate service provider type or handbook.
3. Select the desired document type.
4. Select the desired item from the 'Table of Contents' pull-down menu.

Current Medicaid maximum payment amounts for many professional services are listed in rule 5160-1-60 or in Appendix DD to that rule. (This rule was formerly numbered 5101:3-1-60.) Providers may view this information by following these steps:

1. Select the 'Medicaid - Provider' collection.
2. Select 'General Information for Medicaid Providers'.
3. Select 'General Information for Medicaid Providers (Rules)'.

...
(4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then select the link to Appendix DD.

The Legal/Policy Central - Calendar site, [http://www.odjfs.state.oh.us/lpc/calendar/](http://www.odjfs.state.oh.us/lpc/calendar/), is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS and ODM transmittal letters, [http://www.odjfs.state.oh.us/lpc/mlt/](http://www.odjfs.state.oh.us/lpc/mlt/). The listing is categorized by transmittal letter number and subject, and it provides a link to a PDF copy of each document.

To receive automatic notification by e-mail when new Medicaid transmittal letters are published, interested parties may sign up at [http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx](http://medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx).

**Additional Information**

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516
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 578 (Limited Family Planning Benefit - Pharmacy Coverage)

Medical Assistance Letter No. 578 is maintained in the Pharmacy Services e-book.
Medical Assistance Letter No. 576 is maintained in the Pharmacy Services e-book.
MAL 569 (Changes to the Medicaid Preferred Drug List Effective October 1, 2010)

Medical Assistance Letter No. 569 is maintained in the Pharmacy Services e-book.
Medical Assistance Letter No. 561 is maintained in the Pharmacy Services e-book.
MAL 556 (Changes to Vision Care Services)

Medical Assistance Letter No. 556 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.
Medical Assistance Letter No. 546 is maintained in the Pharmacy Services e-book.
Medical Assistance Letter No. 542 is maintained in the Vision Services e-book.
MAL 539 (October 19, 2007 - Federal delay of requirement for use of tamper-resistant prescription pads)

Medical Assistance Letter No. 539 is maintained in the Pharmacy Services e-book.
Medical Assistance Letter No. 535 is maintained in the Pharmacy Services e-book.
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 518 (Information Providers Must Know about the NPI in Order to Get Paid)

Medical Assistance Letter (MAL) 518

March 7, 2007

To: Individual Physicians and Physician Sole Proprietary 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 physicians and sole proprietary physician practices who 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 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 May 23, 2007, physicians 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.*

Physicians MUST enumerate through NPPES and receive their NPI prior to the May 23, 2007 deadline. This MAL provides direction to providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Physician claims received by ODJFS before May 23, 2007 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 May 23, 2007 will be rejected or denied.*

Physician claims submitted to ODJFS on or after May 23, 2007 will be denied if the physician's NPI number is not in the required field(s) on the claim. Physician claims submitted on or after May 23, 2007, 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 physicians 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 physician (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 allopathic or osteopathic physicians 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 physician or a physician sole proprietary practice to ODJFS at least once during the last twelve months. When physicians are doing business with ODJFS as an individual physician or as a physician sole proprietary practice, ODJFS currently only issues an individual physician Medicaid legacy number and expects the billing provider, pay to provider, and rendering provider to be the same provider (the individual physician).

Services rendered by other practitioners employed by or under contract with the physician or physician's sole proprietary practice should be billed under the physician's NPI and/or the physician's Medicaid legacy number (when both numbers are required). This directive applies as soon as a physician receives their NPI number and remains in effect after May 23, 2007.

Physicians must submit only the individual (entity type1) NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as an individual physician. Only one NPI number can be associated with your individual Ohio Medicaid legacy number. An individual physician's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another physician.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for physicians who do business with ODJFS as individual physicians or as physician sole proprietary 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 517.

Instructions for submitting the NPI by either an individual physician or a physician group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: http://jfs.ohio.gov/OHP/providers/npi.stm (see the box titled "Trading Partner").

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.

Billing NPI on EDI 837 Professional Claims

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The physician'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 May 23, 2007, the physician'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. If it is your normal practice to send a Medicaid legacy number in the REF02 with a 1D qualifier in the REF01 of the 2310B loop (i.e., rendering provider information loop) whether or not the rendering provider is the same as the pay to provider, you must also send the appropriate, corresponding NPI in the NM109 of 2310B with the qualifier value of XX in the NM108 of the 2310B loop.

Billing on Paper Claims or by Tape

*Special Instructions for Paper and Tape formats
At this time, ODJFS only accepts the Center for Medicare and Medicaid Services (CMS)1500 (12-90) paper form, also referred to as CMS 1500 (12-90) or old CMS 1500. ODJFS will continue to only accept the old CMS 1500 until a date for the adoption of the new CMS 1500 (or CMS 1500 (08/05)) is established and announced by ODJFS. ODJFS is making every effort to be ready to adopt the new CMS 1500 form by May 23, 2007, but there is a possibility that the old CMS 1500 will continue to be required for a period of time after May 23, 2007. Providers who currently use tape formats must transition to EDI claim formats by May 23, 2007.

Providers using tape formats or paper on the old CMS 1500 (required until announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on these formats (i.e., the old CMS 1500 or tape) will cause the claim to reject or may cause the claim to pay inappropriately.

When the new paper CMS 1500 is adopted by ODJFS, NPI numbers will be required on the new claim form and the processing and submission rules that apply to EDI claims will also apply to the new paper CMS 1500 form.

IV. If my sole proprietary physician practice (practices owned by one physician) 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 physician that owns the practice and each physician employed by or under contract with the practice to also obtain an individual (entity 1) physician 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). Other physician 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 your practice is an incorporated sole proprietary 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 517.

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 physicians 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 physician 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 physician must disclose to ODJFS the NPI number that has been assigned to the physician. 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://jfs.ohio.gov/OHP/providers/npi.stm.

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

Yes, as stated in V, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the physician 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) will need your NPI to submit as the attending provider, the operating provider or other 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.

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 517 (Information Providers Must Know about the NPI in Order to Get Paid)

Medical Assistance Letter (MAL) 517

March 7, 2007

To: Group Physicians
Trading Partners
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 physician group practices in the Ohio Medicaid program that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI 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.

Physician group practices will also be required to use the unique (entity type 1) NPI numbers for each individual physician providing/rendering services for the group practice on claims* submitted to ODJFS. The group practice should work with the individual physicians in the group to determine if the group will obtain the individual physician numbers from NPPES for the practice’s physicians or the individual physicians will independently obtain their own individual physician 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 physician group NPI and the individual physician NPI numbers and until May 23, 2007, all physician 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 physician 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.* Until May 23, 2007, claims received by ODJFS from physician 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 May 23, 2007, 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.*

Physician claims submitted to ODJFS on or after May 23, 2007 will be rejected and/or denied if the group and/or individual NPI number is not in the required field(s) on the claim. Physician claims submitted on or after May 23, 2007 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.

Physicians and physician group practices must:

- enumerate through NPPES,
- receive their NPI, and
- disclose their NPI to ODJFS prior to the May 23, 2007 deadline.

Physicians and physician group practices must be ready to submit their NPI(s) on claims by May 23, 2007.*

*See special instructions for paper and tape claims (below in this MAL).
I. How do I get an NPI?

Physician group practices can receive an (entity type 2) NPI number for the physician group practice and an individual (entity type 1) physician provider number for each physician in the group practice by submitting an application to NPPES. To obtain a National Provider Identifier, 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 physician 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, social security number and/or IRS individual tax identification number (TIN). 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 physicians 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 physician 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 physician 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 physician the taxonomy code that best describes the physician's specialty. You may submit more than one physician taxonomy number.

A listing of taxonomy codes for allopathic or osteopathic physicians can be found at http://www.wpec-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 May 23, 2007, 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 physician who rendered the service. Group physician practices must submit the (entity type 1) NPI assigned to the individual physician 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 physician 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 physician or other valid individual practitioner that can provide Ohio Medicaid covered services under a physician group practice. Only one individual (entity type 1) NPI number can be associated with an (unique) individual Ohio Medicaid legacy number. An individual physician's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another physician or another individual, group or organizational entity.
Instructions for submitting NPI on claims for a physician group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: http://jfs.ohio.gov/OHP/providers/npi.htm (see the box titled "Trading Partner").

**Billing on Paper Claims or by Tape**

*Special Instructions for Paper and Tape formats*

At this time, ODJFS only accepts the Center for Medicare and Medicaid Services (CMS)1500 (12-90) paper form, also referred to as CMS 1500 (12-90) or old CMS 1500. ODJFS will continue to only accept the old CMS 1500 until a date for the adoption of the new CMS 1500 (or CMS 1500 (08/05)) is established and announced by ODJFS. ODJFS is making every effort to be ready to adopt the new CMS 1500 form by May 23, 2007, but there is a possibility that the old CMS 1500 will continue to be required for a period of time after May 23, 2007. Providers who currently use tape formats must transition to EDI claim formats by May 23, 2007.

Providers submitting tape formats or the old CMS 1500 (the required paper form until otherwise announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on these formats (i.e., the old CMS 1500 or tape) will cause the claim to reject or may cause the claim to pay inappropriately.

When the new paper CMS 1500 is adopted by ODJFS, NPI numbers will be required on the new claim form and the processing and submission rules that apply to EDI claims will also apply to the new paper CMS 1500 form.

**III. Is the physician 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 physicians and physician 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 physician 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 physician group practice required to share with ODJFS the NPI numbers assigned to the group and the individual physicians 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 physician that practices in the group to ODJFS, unless the individual physician 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://jfs.ohio.gov/OHP/providers/npi.htm.

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

Yes, physicians and physician group practices must disclose their NPI, when requested, to any entity that needs the NPI to identify that physician/physician 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 physician 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) will need your NPI to submit as the attending provider, the operating provider or other 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.

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:
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
Medical Assistance Letter No. 516 is maintained in the General Information e-book.
MAL 495 (December 23, 2005 - Changes to the Medicaid Pharmacy Program: New Consumer Co-Payments and Medicare Part D)

Medical Assistance Letter No. 495, is maintained in the Pharmacy Services e-book.
Medical Assistance Letter No. 491, is maintained in the Pharmacy Services e-book.
Mal 486 (Reminder for Billing with the Bilateral Modifier)

Medical Assistance Letter (MAL) No. 486

August 11, 2005

TO: Providers of Physician Services, Atten: Specialty Providers of Otolaryngology
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Reminder for billing with the bilateral modifier

This is an important reminder about bilateral surgical procedure billing, which is outlined in rule 5101:3-4-22 (issued via MHTL 3336-05-02, dated 7/14/05).

**Bilateral procedures must be billed on one line using the code modifier 50.** This code modifier indicates that the procedure was done bilaterally on the same date of service. For example, if you billed 6943650 with modifier 50, that would indicate a tympanostomy was performed on both ears. If the code were given without the modifier 50, that would indicate the procedure was performed on one ear only.

**A bilateral procedure should never be billed on two lines or on separate bills.** The department is in the process of implementing systems logic that will begin denying bilateral services that are billed twice.

This MAL is posted on the department’s web site at: [http://emanuals.odjfs.state.oh.us/emanuals/](http://emanuals.odjfs.state.oh.us/emanuals/)
in the Physician Services Handbook under the links "Ohio Health Plans - Provider" (left column), "Physician Services" (right column), "Medical Assistance Letters" (left column).

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216

In-state toll free telephone number 1-800-686-1516
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.
Medical Assistance Letter No. 456, is maintained in the Pharmacy Services e-book.
Medical Assistance Letter (MAL) 450-A

To: Providers billing for pre-natal services
From: Thomas J. Hayes, Director
Re: Prenatal care reimbursement - Important Billing Change

This is a follow-up notice relating to Medical Assistance Letter (MAL) # 450 dated June 26, 2003 regarding reimbursement for pre-natal services. Effective for dates of service on and after July 1, 2003, the local level code 59420 is no longer reimbursable since it is not HIPAA-compliant. Providers should bill the appropriate office visit code which best describes the type of obstetrical visit provided and modify the code with the TH modifier to document that pre-natal services were provided. Billing instructions for obstetrical services were provided in MHTL 3336-02-05 dated December 6, 2002.

If the office visit code is modified by the TH modifier, providers will receive the reimbursement amounts shown below for prenatal services billed with the TH modifier:

<table>
<thead>
<tr>
<th>Code</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-99203</td>
<td>$48.40</td>
</tr>
<tr>
<td>99204</td>
<td>$70.32</td>
</tr>
<tr>
<td>99205</td>
<td>$87.97</td>
</tr>
<tr>
<td>99211</td>
<td>$19.73</td>
</tr>
<tr>
<td>99212-99214</td>
<td>$48.40</td>
</tr>
<tr>
<td>99215</td>
<td>$81.04</td>
</tr>
</tbody>
</table>

Should you have any questions, please call Provider Network Management at 1-800-686-6108 in state or 614-728-3288 for out-of-state providers.
MAL 450 (Prenatal Care Reimbursement)

Medical Assistance Letter (MAL) No. 450

June 26, 2003

TO: Physicians, Clinics, Advanced practice nurses
    Directors, County Department of Job and Family Services

FROM: Thomas Hayes, Director

SUBJECT: Prenatal care reimbursement

BILLING CHANGES EFFECTIVE JULY 1, 2003

It has been brought to our attention that the billing instructions for prenatal care visits (formerly billed as code 59420) provided in MHTL 3336-02-05 dated December 6, 2002 for physicians and MHTL 3355-02-05 for advanced practice nurses could, in some instances, result in reduced reimbursement to providers billing for prenatal visits.

It is not the intent of the Department to pay providers less in the aggregate than what providers are currently receiving if the non-HIPAA compliant code 59420 is billed. The Department will be implementing system changes to implement the following rates for a prenatal obstetrical visit when the TH modifier is billed effective for dates of service on and after 7/1/03:

<table>
<thead>
<tr>
<th>Code</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-</td>
<td>$48.40</td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>99204</td>
<td>$70.32</td>
</tr>
<tr>
<td>99205</td>
<td>$87.97</td>
</tr>
<tr>
<td>99211</td>
<td>$19.73</td>
</tr>
<tr>
<td>99212-</td>
<td>$48.40</td>
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<tr>
<td>9</td>
<td></td>
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<tr>
<td>9</td>
<td></td>
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<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>99214</td>
<td>$52.57</td>
</tr>
<tr>
<td>99215</td>
<td>$81.04</td>
</tr>
</tbody>
</table>

The Department plans to implement system fixes by July 1, 2003.

It will be critical for providers to bill the TH modifier when the service is for a prenatal visit to receive the correct reimbursement for prenatal visits.

*Note: An RN visit will be paid less but complex physician visits (99214, 99215) will be reimbursed at a higher level.

Questions pertaining to this MAL should be addressed to:

The 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 614-728-3288
March 6, 2003

To: Prescribers of Pharmacy Services
From: Tom Hayes, Director
Subject: Preferred Drug List (PDL) Information

Effective April 7, 2003 Ohio Medicaid will move to the next phase of pharmacy management - a Preferred Drug List (PDL). The classes listed below were reviewed to determine those products that the Department considers "preferred" for Ohio Medicaid recipients. A "preferred" status in these classes indicates that the product does not require prior authorization (PA) in most situations. Those products in these classes that are "non-preferred" are subject to prior authorization.

What does this mean for you?
Click here to view the explanation chart.

All drugs in classes not listed below remain available as per current coverage. Those classes listed below will require PA for "non-preferred" products beginning with all new prescriptions or refills filled on or after the dates indicated below:

- **April 7** - PPIs, H-2 Receptor Antagonists
- **April 14** - Narcotics, NSAIDs
- **April 21** - Nasal Steroids, Inhaled Steroids, Inhaled Beta-Agonists, 2nd Generation Antihistamines
- **April 28** - ACE Inhibitors, Angiotensin Receptor Antagonists, Beta-Blockers, Calcium Channel Blockers
- **May 5** - COX-2IIs for patients under age 60 only

You can be proactive and request prior authorization prior to the effective rollout date for a given category.

The enclosed documents have been included for your benefit. We encourage you to keep them available for quick reference.

- The list printed on color paper gives a listing of "preferred" drugs in each category. It has been arranged so you can make it a tri-fold to keep in your pocket.
- A more comprehensive list includes both "preferred" and "non-preferred" products in each class. This can be duplicated and hung on a wall or placed in a binder for reference.

Effective immediately, a new fax number has been implemented for requesting PA. The new fax number is 1-800-396-4111. The phone numbers have remained the same:

**Technical Calls 1-877-518-1545 PA Requests 1-877-518-1546**

These PDL documents can also be found on our website:
http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm

If you have additional questions or would like to schedule an educational visit, please call our vendor, First Health Services, at 614-481-3519.

We appreciate your continued support of our efforts to maintain a quality, cost-effective pharmacy program.
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
The Department is pleased to announce that fees for certain physician services (including services provided by podiatrists, advanced practice nurses, optometrists, physical therapists and fee-for-service clinics) have been updated for procedures performed on and after January 1, 2000. Overall the updated fees result in an aggregate increase of approximately 14%. On a code-by-code basis the percentage change for some procedures will be higher and others will be lower than 14%.

The new fees were calculated using 1999 national resource-based relative value units (RVUs) and are based on varying percentages of the 1999 conversion factor. The services affected by the fee revision include: evaluation and management services, family planning, pregnancy-related, delivery and postpartum services, diagnostic and therapeutic services, surgeries and radiology.

**Anesthesia Services**

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.

**Physical Medicine Services**

Effective for dates of service on and after January 1, 2000, the Medicaid maximum fee for physical medicine and rehabilitation services will be the payment for one unit (or modality) of service as defined by the CPT. For example: if one modality of a CPT code is defined as a 15 minute increment, the Medicaid payment for one (1) unit of that code is payment for one modality (or a single 15 minute increment); Medicaid payment for 2 units would reflect reimbursement for 30 minutes or two 15 minute increments. Prior to January 1, 2000, payment for physical medicine services was not made on the basis of time; providers could bill for, and payment was limited to one unit regardless of the time spent. Although providers were limited to billing one unit, please note that the fees for time delimited physical medicine services (e.g., 15 minute increment) performed prior to January 1

**Speech and Hearing Services**

The Department has recently become aware that code “Z2594 - Hearing/hearing aid/language consultation service” was being inappropriately billed on a relatively frequent basis. Therefore, this code will no longer be valid for dates of service on and after January 1, 2000; payment for services reported by code Z2594 will be included in the reimbursement for other speech and hearing evaluation and treatment codes. The Medicaid
fees for speech and hearing services have been adjusted to include compensation for services formerly reported by code Z2594.

**HCPCS CODE CHANGES EFFECTIVE JANUARY 1, 2000**

On January 1, 2000, the Department will begin accepting the 2000 HCPCS codes effective for services rendered on and after that date. To give providers ample 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. A Medicaid Handbook Transmittal Letter (MHTL) will be issued to providers in January 2000 with more detailed information regarding Medicaid implementation of the additions, deletions and revisions applicable for HCPCS coding changes (including the CPT) for 2000.

**Updated Fee Schedule**

The updated fee schedule can be viewed on the Ohio Department of Human Services Public Hearing Notices and Rule Publications web page at: [http://www.state.oh.us/odhs/legal/index.htm](http://www.state.oh.us/odhs/legal/index.htm) The fees are listed in rule 5101:3-1-60 (entitled "Medicaid Reimbursement") which can be found in the "Rule Publications" section on the web site. Rule 5101:3-1-60 has a proposed effective date of 01/01/2000.

**Questions pertaining to this MAL should be addressed to:**

Bureau of Plan Operations  
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Relationship of Other Covered Medicaid Services to Nursing Facilities (NFS) and Intermediate Care Facilities for the Mentally Retarded (ICFs-MR) Services

*Formerly* 5101:3-19  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.
Physicians and Other Eligible Providers of Physician Services

*Formerly* 5101:3-4-01

Physicians and Other Eligible Providers of Physician Services

MHTL 3336-12-01 / MHTL 3337-12-01

Effective Date: March 2, 2012

Most Current Prior Effective Date: December 2, 2011 (Emergency)

(A) The following definitions and clarifications apply to division 5101:3 of the Administrative Code:

1. "Physician" is an individual currently licensed under the laws of Ohio or of another state to practice as a doctor of medicine and surgery or as a doctor of osteopathic medicine and surgery. An unlicensed individual who is authorized to practice under the laws of the state in which the services are performed is not a physician, even if the person holds a staff or faculty appointment.

2. "Provider-based physician" is a physician who has entered into an employment agreement, contract, or other legally binding arrangement with a site-based provider entity such as a hospital, clinic (either fee-for-service or cost-based), or long-term care facility and is consequently under the fiscal, administrative, and professional control of that provider entity. Interns, residents, and fellows are not physicians. Services provided by interns, residents, and fellows are treated as hospital services.

3. Physicians may form or enter into a professional medical group in accordance with the provisions set forth in rule 5101:3-1-17 of the Administrative Code. A professional medical group may submit claims for physician services performed by its member physicians.

(B) The following Ohio medicaid providers are eligible providers of physician services:

1. A physician;

2. A professional medical group;

3. An ambulatory health care clinic, which is defined in Chapter 5101:3-13 of the Administrative Code;

4. A federally qualified health center, which is defined in Chapter 5101:3-28 of the Administrative Code;

5. An outpatient health facility, which is defined in Chapter 5101:3-29 of the Administrative Code;

6. A rural health clinic, which is defined in Chapter 5101:3-16 of the Administrative Code; and,

7. For the sole purpose of demonstrating eligibility for incentive payments made in accordance with Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA, Pub. L. No. 111-5) and the regulations published at 42 C.F.R. Part 495 (July 28, 2010), an optometrist operating within the appropriate scope of practice defined in section 4725.01 of the Revised Code.

(C) Reimbursement for providers of physician services is subject to the following provisions:

1. A provider of physician services may be reimbursed for providing covered services only if two conditions are met:

   a. The provider of physician services is currently enrolled as a medicaid provider; and
   b. The services are rendered to medicaid-eligible Ohio recipients in a state in which the provider is licensed or authorized to practice.

2. Professional services rendered by a provider-based physician directly to or for the benefit of an individual patient are separately reimbursable only if the following requirements are met:

   a. The physician is separately enrolled as an Ohio medicaid provider;
   b. The physician personally rendered the services to the individual patient;
   c. The services contribute directly to the diagnosis or treatment of the individual patient;
The services ordinarily require performance by a physician;

In the case of anesthesiology, laboratory, or radiology services, the additional requirements set forth in rules 5101:3-4-21 and 5101:3-4-25 of the Administrative Code are met; and

The expenses associated with the provision of the professional services are excluded from the cost report of the site-based provider entity.

Facility-related services rendered by a provider-based physician that are of benefit to patients in general (e.g., teaching; research; administration; supervision of professional or technical personnel, residents, interns, or fellows; or service on provider committees) are reimbursable only to the employing or contracting provider.

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Date: 02/21/2012
Promulgated Under: 119.03
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Rule Amplifies: 5111.01, 5111.02, 5111.021
(A) Definitions.

(1) "Supervision," for the purposes of this rule, is defined in accordance with Chapter 4730-1 of the Administrative Code.

(2) "Physician assistant," in accordance with Chapter 4730 of the Revised Code, means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant under the supervision, control, and direction of one or more physicians who are responsible for the physician assistant's performance.

(3) "Supervising physician," for the purpose of this rule, means the physician(s) responsible for the physician assistant's performance, and with whom the physician assistant has a supervision agreement approved by the state medical board of Ohio, in accordance with Chapter 4730-1 of the Administrative Code.

(B) Coverage and limitations.

(1) Services/procedures provided by a physician assistant are covered by medicaid only if:

(a) The services are provided in accordance with Chapter 4730-1 of the Administrative Code;

(b) The services are:

(i) Specified in section 4730.09 of the Revised Code with the exception of the services listed in paragraph (C)(5) of this rule; or

(ii) The services are approved by the state medical board as special services for that physician assistant if the services provided by the physician assistant are beyond the scope of services authorized under division (A) of section 4730.09 of the Revised Code;

(c) The services are within the scope of practice of the physician assistant's supervising physician;

(d) The services are covered by the department in accordance with rule 5101:3-1-60 of the Administrative Code and not specifically excluded from coverage in accordance with paragraph (C) of this rule;

(e) The physician assistant is employed by or under contract with a physician, physician group practice, or clinic; and

(f) The physician assistant provides services in compliance with all applicable state laws (each physician assistant and his/her supervising physician(s) is responsible for compliance with applicable state laws).

(2) The department may reimburse a physician assistant, physician, physician group practice, or clinic for physician assistant evaluation and management services commensurate with his/her training, experience, the scope of practice of the physician assistant's supervising physician, and the physician supervisory plan.

(C) Provisions applicable to medicaid payment for physician assistant services:

(1) Medicaid payment may be made to the physician assistant directly, or to the physician, physician group practice, or clinic employing or contracting with the physician assistant who is providing services in accordance with this rule.
Physician assistant services are subject to the site differential payments in all places of service specified in rule 5101:3-4-02.2 of the Administrative Code.

A physician assistant, physician, physician group practice, or fee-for-service clinic must bill for services provided by a physician assistant using the appropriate procedure code with the UD modifier except as provided in paragraph (C)(4) of this rule.

A physician assistant, physician, physician group practice, or fee-for-service clinic must bill for services provided by a physician assistant using the appropriate procedure code without the UD modifier if:

(a) A physician also provided distinct and identifiable services during a visit or encounter; or
(b) The services are the type usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations).

The department will reimburse physician assistants, physicians, physician group practices, and fee-for-service clinic for services provided by a physician assistant:

(a) The lesser of the provider's billed charge or eighty-five per cent of the medicaid maximum for all services billed in accordance with paragraph (C)(3) of this rule; and
(b) The lesser of the provider's billed charge or one hundred per cent of the medicaid maximum for all services billed in accordance with paragraph (C)(4) of this rule.

A physician assistant, physician, physician group practice, or clinic will not be reimbursed for the following when provided by a physician assistant:

(a) Assistant-at-surgery services;
(b) Visits and/or procedures provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic and billed as separate procedure codes;
(c) Consultations and critical/intensive care services (although physician assistants may provide services that are valuable components of a consultation, ultimately a consultation is the responsibility of a physician); and
(d) Services prohibited in accordance with rule 4730-1-03 of the Administrative Code.

A physician assistant, physician, physician group practice, or clinic may be directly reimbursed for services provided in a nursing facility or intermediate care facility for the mentally retarded by a physician assistant, as described in rule 5101:3-3-19 of the Administrative Code.

Reimbursement for services provided by a hospital-employed physician assistant is available only to hospitals. Reimbursement for services provided by a hospital-employed physician assistant is bundled into the facility payment made to that hospital.

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Prior Effective Dates: 9/1/89, 4/1/92 (Emer), 7/1/92, 4/1/93, 11/1/01, 10/1/03, 2/16/09
(A) Definitions

(1) "Teaching physician" means a physician (other than a resident) who involves residents in the care of his/her patients.

(2) "Resident" means an individual who participates in an approved graduate medical education (GME) program. The term includes interns and fellows in approved GME programs. A medical student is never considered a resident.

(3) "Teaching setting" means any hospital-based provider setting that receives medicare or medicaid payment for the services of residents under the direct GME payment methodology.

(4) "Student" means an individual who is enrolled in an accredited medical school. A student is never considered to be an intern or a resident.

(5) "Documentation" means notes recorded in the patient's medical records by a resident or teaching physician.

(6) "Physically present" means that the teaching physician is in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

(7) "Critical or key portions" means that part(s) of a service that is/are a critical or key part of the service. For the purpose of this rule, these terms are used interchangeably. Critical or key portions means the following:

   (a) For anesthesia services, it is the part of the service described in paragraph (C)(2) of rule 5101:3-4-21 of the Administrative Code;

   (b) For procedures, it means the parts of the service described in paragraph (E)(1)(a) to (E)(1)(h) of this rule;

   (c) For evaluation and management services, it means the key portion of the service as defined in paragraph (E)(2)(b) of this rule. This definition does not apply to the evaluation and management codes listed in paragraph (E)(3)(b) of this rule; and

   (d) If none of the guidelines in this paragraph apply, the teaching physician determines the critical or key portions of the service.

(8) "CPT or codes" as used in this rule is defined in rule 5101:3-1-19.3 of the Administrative Code.

(B) General reimbursement requirements

Payment may be made directly to the teaching physician for services performed in teaching settings only under the following circumstances:

(1) The covered services are personally performed by a physician who is not a resident in a teaching setting; or

(2) The covered services are provided in a teaching setting jointly by a teaching physician and resident or by a resident in the presence of a teaching physician with certain exceptions listed in paragraph (E)(3) of this rule.

(C) A teaching physician may not be directly reimbursed for direct medical and surgical services if the teaching hospital elects to receive payment for direct medical and surgical services on a reasonable cost basis (expensed on the hospital's cost report).

(D) Documentation
For a teaching physician to be eligible for reimbursement for services, the patient’s medical record must document that the requirements for reimbursement as detailed in this rule were met. Documentation may be dictated and typed, hand written, or computer-generated.

The teaching physician must meet the documentation instructions for evaluation and management (E/M) services stated in section 15016 of the medicare carrier’s manual (09/01/200511/2002) including, but not limited to the following requirements:

(a) To be eligible for reimbursement for evaluation and management services, the teaching physician must personally document the following, at a minimum:

(i) A teaching physician performed the service or was physically present during the key or critical portion of the service when performed by the resident;

(ii) Documentation by the resident of the participation and presence of the teaching physician is not sufficient to establish the presence and participation of the teaching physician in the service;

(iii) The participation of the teaching physician in the management of the patient; and

(iv) The combined entries in the medical record by the teaching physician and resident together must document the medical necessity of the service.

(b) Documentation must identify:

(i) The service(s) provided;

(ii) Whether the teaching physician was present during the critical or key portions of the service provided by a resident;

(iii) The participation of the teaching physician in providing the service;

(iv) The combined entries in the medical record by the teaching physician and resident together must document the medical necessity of the service.

(v) The date; and

(vi) A legible signature or identity alone.

(c) Any contribution and participation of a student to the performance of a billable service (other than review of systems and/or past family/social history that are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service meeting the requirement set forth in paragraph (B) of this rule.

Students may document services in the medical record. However, the documentation of an E/M service by a student that may be referred to by the teaching physician is limited to documentation related to the review of systems and/or past family/social history. The teaching physician may not refer to a student's documentation of physical exam findings or medical decision making in his or her personal note. If the medical students documents E/M services, the teaching physician must verify and redocument the history of present illness and perform and redocument the physical exam and medical decision-making activities of the service.

(d) The following are examples of unacceptable documentation because the documentation does not make it possible to determine whether the teaching physician was present, evaluated the patient, and/or had any involvement with the plan of care:

(i) "Agree with above," followed by legible countersignature or identity;

(ii) "Rounded, Reviewed, Agree," followed by legible countersignature or identity;

(iii) "Discussed with resident. Agree," followed by legible countersignature or identity;

(iv) "Seen and agree," followed by legible countersignature or identity;

(v) "Patient seen and evaluated," followed by legible countersignature or identity; and
(vi) A legible countersignature or identity alone.

(E) Special situations

Payment will be made for the services of a teaching physician only if the teaching physician is personally present during all critical or key portion(s) of the service.

(1) Procedures

(a) Surgery

The teaching physician must be present during all critical or key portions of the procedure and must be immediately available to provide services during the entire procedure. The teaching physician is not required to be present during the opening and closing of the surgical area. During the periods of the surgery that are not key portions, the teaching physician must be immediately available to return to the procedure. He/she must not be involved in another procedure from which he/she cannot return.

Documentation of the teaching physician's presence during a surgery must be documented in the medical record by the physician, resident, or operating room nurse.

In order to bill for two overlapping surgeries, the teaching physician must be present during all critical and key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the critical or key portions of the initial procedure have been completed, the teaching physician may begin to become involved in a second procedure. The teaching physician must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. The teaching physician may not bill for three or more concurrent surgical procedures. These are classified as a supervisory service to an individual patient and are not payable under the physician fee schedule.

(b) Minor procedures

For procedures that take five minutes or less, the teaching physician must be present for the entire procedure to be considered reimbursable procedures by the department.

(c) Endoscopy procedures

To be considered a reimbursable endoscopy procedure, the teaching physician must be present during the entire viewing including the insertion and removal of the device.

(d) Complex or high-risk procedures

For complex or high-risk procedures such as cardiac catheterization, cardiovascular stress tests, radiologic and cardiologic supervision, and interpretation codes, the teaching physician must be physically present with the resident and must supervise the performance of the procedure or he/she must personally perform the procedure.

(e) Maternity services

In order to be considered a reimbursable service the teaching physician must be present for the delivery. The teaching physician must be physically present for the initial prenatal visit. The teaching physician must also be present during any and all prenatal visits during which there are patient complaints requiring more detailed evaluation, abnormal findings, the need for non-routine testing (e.g. non-routine ultrasonography, fetal monitoring, non stress testing, etc.), or for post date equal to or greater than forty-two week gestation.

(f) Time-based codes

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service from twenty to thirty minutes should only be billed if the teaching physician is present for twenty to thirty minutes. Time spent by the resident in
the absence of the teaching physician should not be added to time spent by the resident and teaching physician with the patient or time spent by the teaching physician alone with the patient.

(g) Interpretation of diagnostic radiology and other diagnostic tests
The department will reimburse for the interpretation of diagnostic radiology and other diagnostic tests if the interpretation is performed by or reviewed by a teaching physician.

(h) Psychiatry
Time-based psychiatry codes must meet the requirements in paragraph (E)(1)(f) of this rule. A teaching physician may not add time spent by a resident in the absence of the teaching physician to the total amount of time billed for the service.

For certain psychiatric services, the presence of the teaching physician may be met by concurrent observation of the service through the use of a one-way mirror or video equipment. Audio-only equipment does not satisfy the physical presence of the teaching physician.

(i) Anesthesia
The department will reimburse for anesthesia services as outlined in 5101:3-4-21 of the Administrative Code for a teaching anesthesiologist involved in an anesthesia procedure with a resident. The teaching physician must document in the medical records that he/she was present during all critical or key portions of the procedure. The teaching physician's physical presence during only the preoperative or post-operative visits with the patient is not sufficient to receive reimbursement.

(j) Assistants at surgery furnished at teaching hospitals
The department will not reimburse for an assistant at surgery in a teaching hospital when a resident qualified to perform the service is available to assist at surgery.

(2) Evaluation and management services
(a) The "documentation guidelines for evaluation and management services" published by the American medical association in the CPT book must be the basis for the selection of the most appropriate level of evaluation and management service.
(b) The teaching physician must be physically present during the medical decision making process.
(c) The teaching physician must personally document his/her presence and participation in the service in the medical records as described in paragraph (D) of this rule.
(d) For evaluation and management services and other services based on time, the teaching physician must be physically present for the entire period of time billed. Time spent by the resident in the absence of the teaching physician is not billable. Examples of codes falling in this category include, but are not limited to, individual psychotherapy codes, critical care services, inpatient neonatal and pediatric critical care services, and evaluation and management codes in which counseling and/or coordination of care is more than fifty percent of the encounter and time is considered the controlling factor to qualify for that specific code.

(3) Evaluation and management services furnished at primary care centers
(a) The following primary care residency programs qualify for an exception to the teaching physician policies described in paragraph (E)(2) of this rule if the programs attest in writing that they meet all of the conditions in medicare's teaching physician policy as described in 42 C.F.R. 415.174 (11/22/1996 10/1/2005). The primary care centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception. Prior approval by the department is not required. The provider must make available a copy of this attestation to the department upon request.
Family practice;
(ii) General internal medicine;
(iii) Pediatrics;
(iv) Obstetrics/gynecology; and
(v) Geriatric medicine.

(b) Payment may be made for the services of teaching physicians provided by residents without the presence of a teaching physician provided that all of the requirements listed in 42 C.F.R. 415.174 (08/05) are met. The following lower and mid-level evaluation and management codes may be billed under this exception when provided at a primary care center:

(i) New patient office or other outpatient codes including 99201 to 99203;
(ii) Established office or other outpatient visit codes including 99211 to 99213;
(iii) New patient preventive medicine visits codes including 99381 to 99384;
(iv) Established patient preventive medicine visits including 99391 to 99394; and
(v) Prenatal services billed with the TH modifier and codes 99201 to 99203 or 99211 to 99213 except for those listed in paragraph (E)(1)(e) of this rule.

(c) The services must be furnished in a primary care center located in a hospital outpatient department or another ambulatory care entity in which the time spent by residents in patient care duties is included in the GME payment made to a teaching hospital or hospital's fiscal agent.

(d) When a resident is assigned to a physician's office away from the hospital or primary care center where he/she is assigned or is making home visits, the primary care center exception does not apply and teaching physician services are not billable. In this situation, the physician's office where the resident is assigned should bill for services provided.

(F) Modifiers

To bill for services provided by a teaching physician that meet all the provisions of this rule, the following modifiers must be used to bill for services:

(1) To bill for services performed in part by a resident under the direction of a teaching physician, use modifier "GC."

(2) To bill for services performed by a resident without the presence of a teaching physician under the primary care exception rule described in paragraph (E)(3) of this rule, use modifier "GE."

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MHTL 3336-06-01
Chapter 2 - Physician Reimbursement
Click here to view OAC 5160-1-01, Medicaid: Medical Necessity

This rule is maintained in the General Information eManual, located in the Ohio Health Plans - Provider collection.
Click here to view OAC 5160-1-60, Medicaid Reimbursement

This rule is maintained in the General Information eManual, located in the Ohio Health Plans - Provider collection.
A) Direct and general physician supervision

(1) "Direct supervision" in the physician's office, group practice, or clinic setting means that the physician must be present in the office suite throughout the time the nonphysician is providing the service and immediately available to provide assistance and direction throughout the time the nonphysician is performing services. Direct supervision does not mean the physician must be in the same room while the nonphysician is providing services. The availability of the physician by telephone or the presence of the physician somewhere in the institution does not constitute direct supervision.

(2) "General supervision" means that the physician is available, but not necessarily present in the office suite or clinic, to provide those medical services which constitute the practice of medicine and surgery as defined under section 4731.34 of the Revised Code. However, if the physician is not physically present in the office suite he/she must be immediately available to the nonphysician for consultation purposes by telephone and within a thirty-mile radius of the office.

(3) "Non-physician" means, for the purposes of this rule, an individual who is not licensed to practice medicine but who is licensed, credentialed, trained, or otherwise qualified and legally allowed to perform designated physician services.

B) When services are provided by non-physicians, the services rendered must be within the non-physician's scope of licensure (if licensure is required) or a service for which the non-physician is legally authorized to provide under Ohio law and documented in the patient's medical records. Services provided by non-physicians may not be the type of services which constitute the practice of medicine and surgery as defined under section 4731.34 of the Revised Code.

B)(C) Services performed under direct supervision

(1) The department will reimburse an eligible provider of physician services for covered physician services personally provided by the physician or by a nonphysician (e.g., nurse, etc.) non-physician under the direct supervision of the physician unless otherwise stated in other rules in Chapter 5101:3-4 of the Administrative Code.

(2) Services provided under direct supervision are covered only if the following conditions are met:

(a) The nonphysician personnel involved in performing the service must meet the following requirements:

(i) The nonphysician 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 nonphysician must be an independent contractor engaged by the physician through a written agreement; and

(ii) If the nonphysician is a leased employee or independent contractor, the physician 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 physician would exercise if the leased employee or contractor was an employee of the physician or legal entity.

(b) The service must represent an expense to the physician or legal entity;

(c) The physician must provide direct, personal supervision of the service as defined in paragraph (A) of this rule;
(d) The service must be furnished in connection with a covered physician service which was billed to the department. Therefore, the patient must be one who has been seen by the physician; and

(e) There must have been a personal professional service furnished by the physician 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 physician of a frequency that reflects his/her continuing participation in the management of the course of treatment.

(D)(D) Services performed under general supervision

(1) Services provided under general supervision are covered only if the following conditions are met:

(a) The nonphysician personnel involved in performing the service must meet the following requirements:

(i) The nonphysician 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 nonphysician must be an independent contractor engaged by the physician through a written agreement; and

(ii) If the nonphysician is a leased employee or independent contractor, the physician 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 physician would exercise if the leased employee or contractor was an employee of the physician or legal entity.

(b) The service must represent an expense to the physician or legal entity.

(2) The department will reimburse an eligible provider of physician services for the following services provided under the general supervision of the physician by nonphysicians provided under the general supervision of the physician:

(a) Early and periodic screening, diagnosis, and treatment (EPSDT, also known as healthchek) program services provided by a registered nurse with significant training and/or experience in the field of pediatrics;

(b) Pregnancy related services as detailed in rule 5101:3-4-10 of the Administrative Code;

(c) Physician services provided by a rural health facility (RHf), federally qualified health center (FQHC) or outpatient health facility (O HF);

(d) Minimal office visits as defined in the "Physicians' Current Procedural Terminology" (CPT). "CPT" as used in this rule is defined in rule 5101:3-1-19.3 of the Administrative Code;

(e) Family planning/Pregnancy prevention/contraceptive management visits as defined in rule 5101:3-4-07 of the Administrative Code;

(f) Allergy injections administered by a properly instructed person in accordance with the physician’s prescribed plan of treatment;

(g) Services for the diagnosis and treatment of mental and emotional disorders provided by clinical social workers, and professional clinical counselors in accordance with rule 5101:3-4-29 of the Administrative Code. Services provided by licensed social workers and professional counselors must meet the supervision and documentation provisions specified in rule 5101:3-4-29 of the Administrative Code; and

(h) Physician services provided by public health department clinics, rehabilitation clinics, or family planning clinics.

(E)(E) Physician assistants must provide services in accordance with supervision requirements of rule 5101:3-4-03 and Chapter 4730-1 of the Administrative Code.
When services are provided by nonphysicians, the services rendered must be within the nonphysician’s scope of licensure (if licensure is required) or a service for which the nonphysician is legally authorized to provide under Ohio law and documented in the patient’s medical records. Services provided by nonphysicians may not be the type of services which constitute the practice of medicine and surgery as defined under section 4731.34 of the Revised Code.

Except as provided in paragraph (G) of this rule, the following provisions apply:

1. Services rendered by non-physicians falling under paragraph (C)(2)(D)(2) of this rule must be provided under general supervision;

2. Other services not falling under paragraph (C)(2)(D)(2) of this rule provided by non-physicians must be provided under direct supervision as described in paragraph (B) of this rule; and

3. When services are provided by non-physicians, patients’ records must be reviewed and countersigned by the supervising physician.

Services provided by non-physicians who have their own provider category/type (e.g. clinical psychologists, advanced practice nurses, occupational therapists, 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)(D)(1) of this rule must be met in order for the services of a non-physician such as a 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.

Eligible providers of physician services may not be reimbursed for physician services provided in a long-term care facility (LTCF), inpatient hospital, outpatient hospital, or emergency room by nonphysicians employed by the hospital or LTCF, even though the physician ordered the services.

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MHTL 3336-11-03

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Most Current Prior Effective Date: January 1, 2001 (No Change)

(A) A "by-report" service is any service requiring manual review by the Ohio Department of Job and Family Services (ODJFS) or its designee to determine one or all of the following: if the service rendered was medically necessary and is reimbursable; the reimbursement rate on an unpriced procedure; or if special conditions or requirements were met. By-report services are set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code.

(B) Claims for by-report services rendered must be submitted to ODJFS or its designee along with reports and documentation necessary to complete a coverage determination. Reports documenting the services or procedures performed, specific methodology or treatment programs, medical history and indications must be provided at a minimum. Coverage and reimbursement for by-report services rendered will be determined by ODJFS or its designee on a case-by-case basis.

(C) Unlisted (miscellaneous) Healthcare Common Procedure Coding System (HCPCS) codes are not covered. Unlisted HCPCS may be submitted by-report only when there is no other specific HCPCS code that adequately describes the procedure or service. If an unlisted code is submitted for review and ODJFS or its designee verifies the unlisted code is appropriate, the claim and reports will be reviewed. If it is determined that an unlisted code was submitted in error because the procedure or service is described by one or more specific HCPCS codes, ODJFS or its designee shall deny the claim. If denied, the provider may submit a new claim using the specific CPT code(s) or alphanumeric HCPCS code(s) for the procedure or service described in the reports. Codes that do not require by-report manual review shall be submitted directly to ODJFS by electronic data interchange (EDI) or though the ODJFS claims portal for adjudication and must not be submitted as a by-report claim for manual review.

Replaces: 5101:3-4-02.1
Effective: 08/02/2011
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Site Differential Payments and Place of Service

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

MHTL 3334-13-12

Effective Date: January 1, 2014

Most Current Prior Effective Date: August 2, 2011

(A) Site differentials.

(1) The site "Site differential" refers to the variance is a difference in medicaid payment based on the place (site) of service.

(2) The site differential percentages are listed in appendix A to this rule.

(3) When the services identified in appendix A to this rule are provided in a hospital setting (i.e., inpatient, outpatient or emergency department), the maximum reimbursement will be either the lesser of the provider's billed charge or the product of the site differential percentage and the medicaid maximum set forth in appendix DD to rule 5101:3-1-60 of the Administrative Code. If payment for a service is subject to a site differential, then the payment amount is the lesser of the provider's submitted charge or the appropriate fee specified in appendix DD to rule 5101:3-1-60 of the Administrative Code:

(a) The maximum facility fee applies when the service is rendered at one of the following sites:

(i) A hospital (inpatient hospital, outpatient hospital, emergency department, or inpatient psychiatric facility);

(ii) A skilled nursing facility;

(iii) An ambulatory surgery center (ASC); or

(iv) A community mental health center (CMHC).

(b) The maximum non-facility fee applies when the service is rendered at any other site.

(B) Place of service codes. The centers for medicare and medicaid services (CMS) maintains place of service codes used throughout the health care industry. The following place of service codes affect payment and must be entered on the billing invoice:

(1) The place of service code assigned to "office" must be entered when the service is provided in a physician or professional medical group office that is not a part of an outpatient hospital facility. A physician or group practice office is considered a part of an outpatient hospital facility if the hospital bills the department on submits claims in an institutional claim format for hospital services provided in conjunction with the physician's services.

(2) The place of service code assigned to "home" must be entered when the service is rendered in the patient's place of residence except when the patient's place of residence is a long-term care facility.

(3) The place of service code assigned to "hospital" must be entered when the service is provided to an inpatient hospital patient as defined in Chapter 5101:3-160-2 of the Administrative Code.

(4) The place of service code assigned to "outpatient hospital" must be entered when the service is provided by a physician or a clinic provider and the hospital bills the department using submits claims in an institutional claim format for hospital services provided in conjunction with the physician's services.

(5) The place of service code assigned to "emergency room" must be entered when the service is provided in a hospital emergency room department whether the physician is an emergency room staff physician or not.
One of the place of service codes assigned to "clinics" must be entered in accordance with the type of clinic when the service is rendered in a facility that meets the department's definition of a clinic, the facility possesses a provider number designated with the provider type "clinic" and the clinic is not a part of an outpatient hospital facility. A clinic is considered a part of an outpatient hospital facility if the hospital bills the department using an institutional claim format for hospital services provided in conjunction with clinic services.

The place of service code assigned to "ambulatory surgery centers" must be entered when the service is provided in an ambulatory surgery center that possesses a provider number designated with the provider type ambulatory surgery center.

One of the place of service codes assigned to long-term care facilities including nursing facilities, custodial care facilities, or intermediate care facilities for persons with mental retardation or individuals with intellectual disabilities must be entered when the service is provided in a long-term care facility.

The appropriate place of service code must be entered when the service is provided in a setting not meeting any of the service locations designated listed in paragraphs (B)(1)(a) to (B)(1)(h)(B)(8) of this rule and a specific code has been assigned for that location.

The place of service code assigned to "other, unlisted facility" must be entered if a specific place of service code has not been assigned for that location.

Except as specified in this rule and elsewhere in Chapter 5101:3-4 of the Administrative Code, the payment for most physician services is the same regardless of the place of service. When the physician payment rate is dependent on the place of service reported, errors in reporting the place of service may result in an overpayment to the provider.

If a postpayment review of a physician's records reveals that the physician reported the wrong place of service, the provider will be informed of this error and requested to correctly report the place of service on all claims submitted to the department in the future; and

If the error resulted in an overpayment, the department will recoup the overpayment.
Most Current Prior Effective Date: November 13, 2006

The following physician services are noncovered:

(A) All services exceeding the policies and limitations defined in Chapters 5101:3-1 and 5101:3-4 of the Administrative Code.

(B) Services determined by the department as not medically necessary as defined in rule 5101:3-1-01 of the Administrative Code.

(C) Services of a preventive nature, such as routine laboratory procedures and annual physical checkups except for the covered preventive medicine services listed in rule 5101:3-4-34 of the Administrative Code.

(D) Abortions, except other than those meeting the requirements in Chapter criteria for coverage set forth in rule 5101:3-17-01 of the Administrative Code.

(E) Hysterectomies performed for sterilization purposes or not meeting the requirements in Chapter 5101:3-21 of the Administrative Code.

(F) Voluntary sterilizations not meeting the requirements in Chapter 5101:3-21 of the Administrative Code.

(G) Artificial insemination and related services.

(H) Services for or related to the treatment of infertility. Infertility services, defined in accordance with rule 5101:3-21-03 of the Administrative Code, including but not limited to artificial insemination, in vitro fertilization, assisted reproductive technologies (ART), and procedures for reversal of voluntary sterilization.

(I) Services for the treatment of obesity, including but not limited to gastroplasty, gastric stapling, ileojejunal shunt, or other gastric restrictive procedures.

(J) Plastic or cosmetic surgery when surgery is performed for aesthetic purposes, including, but not limited to: rhinoplasty, ear piercing, mammary augmentation or reduction, tattoo removal, excision of keloids, fascioplasty, osteoplasty (prognathism and micrognathism), dermabrasion, skin grafts, lipectomy, and blepharoplasty.

(K) Services related to forensic studies.

(L) Paternity testing.

(M) Acupuncture.

(N) Biofeedback services.

(O) Services determined by another third-party payer or Medicare as not medically necessary.

(P) Services of a research nature or services that are experimental and not in accordance with customary standards of medical practice.

(Q) Autopsy services.

(R) Special services and reports listed under miscellaneous services in the CPT. "CPT" (current procedural terminology) as used in this rule is defined in rule 5101:3-1-19.3 of the Administrative Code.

(S) Assisted suicide which are other services for the purpose provided for the specific intent of causing, or assisting to cause, the death of an individual. This assisted suicide does not pertain to the include withholding or withdrawing of medical treatment, care, nutrition, or hydration, or to the provision of a service for the purpose of alleviating pain or discomfort palliative care, even if the use of service may
increase the risk of death, so long as the service is not furnished for the specific purpose of causing death.

(Q) Patient convenience items, including television service.

(R) Pregnancy related services pertaining to a pregnancy that is a result of a contract for surrogacy services. For the purposes of this rule, "surrogacy services" means a woman agrees to become pregnant for the purpose of gestating and giving birth to a child she will not raise, but hand over to a contracted party.

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R.C. 119.032 review dates: 04/14/2009 and 07/01/2014

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Preventive Medicine Services

Effective Date: December 22, 2011

Most Current Prior Effective Date: July 1, 2009

(A) Preventive medicine is that part of medicine engaged with preventing disease and the maintenance of good health practices. The purpose of preventive medicine is to take a proactive approach to avoiding disease, disability, and death.

(B) Medicaid-covered preventive medicine services may include, but are not necessarily limited to:

- All health check (EPSDT) services in accordance with Chapter 5101:3-14 of the Administrative Code; Routine infant checkups;
- All health check (EPSDT) services in accordance with Chapter 5101:3-14 of the Administrative Code;
- Immunizations in accordance with rule 5101:3-4-12 of the Administrative Code;
- Gynecologic examinations that include pelvic and breast examinations, and pap smears;
- Pregnancy prevention/contraceptive management visits and services in accordance with rule 5101:3-21-02 of the Administrative Code;
- Pregnancy-related services in accordance with rule 5101:3-4-10 5101:3-21-04 of the Administrative Code;
- Annual chest x-rays for long term care facility (LTCF) residents;
- The required physician visits for LTCF residents;
- Routine infant checkups;
- Mammography services in accordance with rule 5101:3-4-25 of the Administrative Code;
- Required physicals for employment or for participation in job training programs, when the employer does not provide a physical free of charge or when other available funds do not pay for an employment physical. Documentation to support that the physical was performed for employment must be in the patient’s medical records;
- The required physician visits and annual chest x-rays for long term care facility (LTCF) residents;
- Required annual physical examinations for individuals living in residential facilities licensed by the Ohio department of mental retardation and developmental disabilities. This annual examination is not required for those individuals who are receiving ongoing medical services from a licensed physician;
- Prostate cancer screening tests;
- Glaucoma screening in accordance with Chapter 5101:3-06 of the Administrative Code; and
For required physicals for employment or job training programs mentioned in paragraph (B)(10) of this rule, providers should bill the proper office visit code (not preventive visit code) if the recipient is over age twenty-one years of age.

(14) Screening and counseling for obesity provided during an evaluation and management or preventive medicine visit;

(15) Medical nutritional therapy

(a) When medical nutritional services are provided by a registered dietician, providers should do the following:

(i) Use the medical nutrition therapy codes 97802 to 97804;

(ii) Use the AE modifier; and

(iii) Bill under the national provider identifier (NPI) of the supervising physician, physician assistant, or advanced practice nurse.

(b) When medical nutritional services are provided by a physician or physician assistant, providers should use the appropriate evaluation and management or preventive medicine code.

(c) When medical nutritional services are provided by an advanced practice nurse, providers should use either the medical nutrition therapy code or the appropriate evaluation and management or preventive medicine code; and

(16) Tobacco cessation counseling (99406 and 99407) and classes (S9453) are covered for the following populations:

(a) Pregnant women; and

(b) Children under the age of twenty-one.

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Chapter 3 - Utilization Review of Physician Services
OAC rule 5160-20-01 is maintained in the ODJFS OAC.

OAC rule 5101:3-20-03 is maintained in the ODJFS OAC.
Pre-Certification Review

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

OAC rule 5160-2-40 is maintained in the Hospital Services e-book.
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.**
Chapter 4 - Physician Coverage and Reimbursement
Definitions pertaining to physician visits.

1. A "physician visit" or an "evaluation and management (E & M) service" is a face-to-face encounter by a physician with a patient for the purpose of medically evaluating or managing the patient except for code 99211, which does not require the presence of a physician.

2. "Outpatient visits" are visits provided to a patient in a physician's office, a physician's group practice office, a patient's home (excluding long-term care facilities), hospital emergency room, outpatient hospital, or clinic.

3. "Inpatient visits" are visits provided to a hospital inpatient as defined in rule 5101:3-2-02 of the Administrative Code or visits provided to a patient in a long-term care facility (LTCF).

4. "Current procedural terminology (CPT)" is a comprehensive listing of medical terms and codes published by the American medical association, www.ama-assn.org, for the uniform designation of diagnostic and therapeutic procedures in surgery, medicine, and the medical specialties. The following terms are defined in the current procedural terminology (CPT):

   a. New and established patient;
   b. Concurrent care;
   c. Counseling;
   d. Levels of E & M services;
   e. Presenting problem; and
   f. Intra service, face-to-face and unit/floor time.

Providers must select and bill the appropriate visit code. Visits in conjunction with diagnostic or therapeutic codes are billable in accordance with the provisions set forth in rule Chapter 5101:3-4 of the Administrative Code.

Office or other outpatient services.

1. For the reimbursement of physician services provided to a patient in a physician's office, a professional medical group office, a fee-for-service clinic, or an outpatient hospital, the provider must bill the appropriate code listed in the CPT as office or other outpatient services.

2. For reimbursement of visits provided to a patient in a rural health clinic, an outpatient health facility or a federally qualified health center, the provider must itemize the appropriate covered code listed under office or other outpatient services in conjunction with the appropriate encounter code for the service and provider type.

3. After hours care.

   a. The department will compensate providers of physician services for visits provided after regularly scheduled office hours when the services are provided in an office or clinic setting.

   b. Reimbursement for after hours care is in addition to the basic services provided to the patient. For reimbursement, providers should bill the appropriate covered code listed in appendix DD to rule 5101:3-1-60 of the Administrative Code in addition to the surgical and/or visit codes.

Hospital inpatient services.
For the reimbursement of visits provided to hospital inpatients, the provider must bill the appropriate code listed in the CPT under hospital inpatient services in accordance with the instructions and definitions in the CPT.

Hospital care to newborns should be billed in accordance with paragraph (N) of this rule.

Consultations.

A consultation is a type of service provided by a physician whose opinion or advice regarding the evaluation and/or management of a specific problem is requested by another physician or other appropriate source. 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 a physician assistant or an advanced practice nurse) requests a physician to evaluate a patient, these services are not reimbursable as a consultation. The physician consultant may also initiate diagnostic and/or therapeutic services.

The request for a consultation from the attending physician or other appropriate source as defined in paragraph (E)(1) of this rule and the need for consultation must be documented in the patient’s medical record. The consultant’s opinion and any services that were ordered or performed must also be documented in the patient’s medical record and communicated to the requesting physician or other appropriate source.

A consultation initiated by a patient and/or family, and not requested by a physician, may not be billed using the initial or consultation codes but may be billed using the codes for regular office visits, as appropriate.

If a consultant subsequently assumes responsibility for management of a portion or all of the patient’s condition(s), the appropriate evaluation and management services code for the site of service should be reported.

Consultations are subject to the coverage and limitations specified in paragraph (P) of this rule.

Office or other outpatient consultations.

For the reimbursement of consultations provided to patients in an outpatient setting, the provider must bill one of the codes listed in the CPT under office or other outpatient consultation.

When an outpatient consultation code is billed, the provider must submit the required referring physician provider information.

Follow-up visits initiated by and to the consulting physician must be billed using the regular visit codes.

If an additional request for an opinion or advice regarding the same or new problem is received from the attending physician and documented in the medical record, the office and other outpatient consultation codes may be billed.

Inpatient consultations.

Physician consultations provided to a hospital inpatient or a resident of to an individual residing in a long term care facility (LTCF) in the LTCF setting must be billed using the codes listed in the CPT under initial inpatient consultations. Only one initial consultation code should be billed by a consultant per admission.

Subsequent consultative visits requested by the patient’s attending physician or subsequent visits required to complete the initial consultation to hospital inpatients or to residents in a LTCF must be billed using the code listed in the CPT for subsequent hospital care or subsequent nursing facility care including services to complete the initial consultation, monitor progress, revise recommendations, or address a new problem.

When an initial inpatient consultation code is billed, the provider must submit the required referring physician provider information.
Emergency department services.

(1) An "emergency department" (sometimes referred to as a "hospital emergency room" or "ER") is defined as an organized, twenty-four-hour, hospital-based facility for the provision of unscheduled episodic services to patients who seek or are in need of immediate medical attention.

(2) Whether or not the provider normally practices in the emergency department setting, evaluation and management services provided in an emergency department must be billed using:
   (a) One of the codes listed in the CPT under emergency department services;
   (b) The codes for critical care in accordance with paragraph (G) of this rule; and/or
   (c) The appropriate surgical procedure codes in accordance with rule 5101:3-4-22 of the Administrative Code.

(3) When ER services are billed using the emergency department E & M codes:
   (a) No distinction is made between new and established patients in the emergency department.
   (b) ER visits are subject to the coverage and limitations specified in paragraph (P) of this rule.

(4) Surgical codes may be billed in lieu of an E & M service (e.g., code 12006).

Critical care services

(1) Critical care includes the care of critically ill patients as defined in the CPT.

(2) Management of a critically ill patient may be billed using the codes listed in the CPT under critical care services.

(3) Certain services are included in the critical care codes and are not separately reimbursable when the critical care codes are billed. These services are specified in the critical care services section of the CPT.

(4) Critical care begins at the time the physician arrives to begin evaluation and treatment and ends when the physician's presence is no longer required as defined in the CPT.
   (a) The critical care codes may be billed to report the total duration of time, to a maximum of two hours, spent by a physician providing constant attention to a critically ill patient even if the time spent by the physician is not continuous on that day.
   (b) Code 99291 must be billed to report the first thirty to seventy-four minutes of critical care provided on a given day and code 99292 must be billed to report each additional thirty minutes as defined by the CPT.
   (c) If the total duration of time spent with the patient is less than thirty minutes, the provider must bill the appropriate hospital, emergency department, or other visit code.
   (d) Inpatient critical care provided to infants twenty-nine days up through twenty-four months of age must be reported with the inpatient pediatric critical care codes 99471 and 99472. These codes must be billed only once per day per physician per patient. Inpatient critical care services provided to neonates twenty-eight days or less should be billed with the inpatient neonatal critical care codes 99468 and 99469 as long as the neonate qualifies for critical services during the hospital stay. Inpatient care for a critically ill or critically injured child older than two years when admitted to an intensive care unit must be billed with hourly critical care codes 99291 and 99292.
   (e) Inpatient critical care provided to neonates who are defined as infants twenty-eight days of age or less at the time of admission to a critical care unit, are reported with the neonate critical care codes listed in the CPT book.
(i) Once the neonate is no longer considered to be critically ill, the continuing intensive (non-critical) low birth weight service codes specified in CPT must be used to bill for services subsequent to the day of admission provided by a physician directing the intensive care of the low birth weight or very low birth weight infant who no longer meets the definition of critically ill for those with present body weight of less than five thousand grams, the appropriate E & M code must be billed. When the present body weight of the infant exceeds five thousand grams, bill the appropriate code under subsequent hospital care. All codes 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 in CPT under "inpatient neonatal and pediatric critical care services."

(ii) Inpatient neonatal and pediatric critical care codes are global twenty-four hour codes and must be billed on a per day basis. Services for a patient who is not critically ill, but happens to be in a critical care unit, must be reported using other appropriate evaluation and management codes.

(iii) Certain procedures are included in the global pediatric and neonatal codes and must not be billed separately. These procedures are specified in the neonatal and pediatric critical care section of the CPT.

(iv) The initial neonatal inpatient critical care code 99468 may be billed as appropriate in addition to 99464 or 99465 when the physician is present for the delivery (99464) and newborn resuscitation (99465) is required. Other procedures performed as part of the resuscitation such as endotracheal intubation (31500) should be billed separately if they are performed as a necessary component of the resuscitation and not as a convenience before admission to the neonatal intensive care unit.

(v) Critical care services provided in the outpatient setting, e.g. emergency department or office for neonates and pediatric patients up through twenty-four months of age, should be billed with the critical care codes 99291 to 99292.

(vi) If the same physician provides critical care services for a neonatal or pediatric patient in both the outpatient and inpatient settings on the same day, bill only the appropriate neonatal or pediatric critical care code (99471 to 99469) for all critical care services provided that day.

(H) Other evaluation and management service- initial intensive hospital care for the management of a neonate, twenty-eight days of age or less.

(1) Initial hospital care for the evaluation and management of neonates twenty-eight days or less requiring intensive observation, frequent interventions, and other intensive care services are reported under the other evaluation and management services code listed in the CPT book.

(2) Initial hospital care for the evaluation and management of neonates twenty-eight days or less requiring intensive observation, frequent interventions, and other intensive care services is a global twenty-four hour code and must be billed once per admission and on the first day of care.

(3) For the initiation of inpatient hospital care of a normal newborn, or a critically ill neonate, or for initial inpatient hospital care of a neonate not requiring intensive observation, frequent interventions, and other intensive care services, bill the codes specified in the CPT.

(4) CPT code 99477 will not be reimbursed when billed on the same date of service with CPT codes 99468 or 99221 through 99223.

(5) Subsequent inpatient hospital intensive care services provided to neonates are reported following CPT guidelines under the subsequent inpatient neonatal critical care code.

(I) Transitional care management services.
These services are for individuals whose medical and or psychosocial problems require moderate or high complexity medical decision making during a transition in care from an acute hospital or other acute care facility setting to the individual's community setting.

Transitional care management is comprised of one face-to-face visit within the specified time frames, in combination with non face-to-face services performed by a physician or other qualified healthcare professional.

Non face-to-face services include but are not limited to communication with the individual or family member regarding aspects of care, assessment and support of treatment regimen and/or medication management, identifying available community resources, facilitating access to care or services for the individual, and educating the individual, family member and/or caregiver.

The complexity of the medical decision making and the date of the first face-to-face visit are used to report the appropriate transitional care management code.

Nursing facility services.

A physician may not be directly reimbursed for a LTCF visit if the service provided is the periodic review of a resident's medical record, plan of care, and/or habilitation plan and a face-to-face encounter with the patient is not provided.

A physician may be reimbursed for one LTCF visit, per patient, per date of service, as detailed in rule 5101:3-3-19 of the Administrative Code and only if the physician personally performed a physical examination on a LTCF resident and documented the visit in the resident's medical record. The guidelines listed in the CPT for LTCF codes must be followed.

A physician may also be reimbursed for a LTCF visit provided by a physician assistant (PA) or nurse practitioner under the physician's employment in accordance with rule 5101:3-3-19 of the Administrative Code.

Domiciliary, rest home (e.g., boarding home) or custodial care services.

Visits provided to patients in a facility that does not meet the definition of a LTCF, such as a domiciliary, rest home, or custodial care service facility, (e.g., boarding home or assisted living facility), that provides room, board and other personal assistance services, must bill using the visit codes listed in the CPT under domiciliary, rest home, or custodial care services.

Domiciliary, rest home, or home care plan oversight services.

Codes listed in this section of the CPT are not separately reimbursable, but are bundled into other services performed.

Home services.

For visits provided to a patient confined to his or her private residence ("homebound patient"), the provider must bill the appropriate code listed in the CPT under home services.

Newborn care.

(1) Predelivery visit to a pediatrician or other primary care physician.

(a) To encourage families to obtain early and continuous well-child and primary sick care for their newborn, the department will cover a predelivery visit to a pediatrician or other primary care provider of physician services. The purpose of this service is to give the mother (or family) the opportunity to select, and establish a patient relationship with, a physician for the care of her (their) newborn.

(b) For reimbursement of this service, the provider must bill the appropriate evaluation and management code.

(2) The newborn care codes should be used for the following:

(a) The initial history and examination of a normal newborn delivered in a hospital or birthing room setting;
(b) Subsequent hospital care provided to a normal newborn on a per day basis;
(c) Initial history and examination of a normal newborn delivered in a setting other than a hospital or birthing room setting; and
(d) Initial history and examination of a high-risk newborn in accordance with paragraph (N)(3) of this rule.

(3) Pediatrician delivery services for high risk newborns and newborn resuscitation services.

A "high-risk newborn" shall be defined as an infant who is delivered by Cesarean or determined, prior to (or after) the immediate delivery, to be at-risk of prematurity or a poor prognosis.

(a) Services of a pediatrician, when requested by the delivering physician, in attendance at a delivery and for the initial stabilization of a high risk newborn or a Cesarean section may be billed using code 99464. This code cannot be used when the billing physician does any of the following while in attendance at the delivery:
   (i) Provide care or services to other patients;
   (ii) Perform a procedure subject to a surgical package; or
   (iii) Proctor another physician.

(b) The newborn resuscitation code may be billed only if resuscitation services are actually provided to the newborn. This service involves the provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output.

(c) The newborn resuscitation code and the physician attendance codes may be billed with the codes for newborn care, neonatal intensive care and hospitals visits.

(4) Subsequent care of a sick newborn in an inpatient hospital setting must be billed using the subsequent hospital visit codes or the newborn critical care codes in the CPT.

(5) Routine well baby care provided in an outpatient setting should be billed in accordance with Chapter 5101:3-14 of the Administrative Code.

(6) Subsequent care of a sick newborn in an outpatient setting should be billed using the codes for outpatient E & M services.

(O) Hospital observation services (including admission and discharge services).

(1) The department will recognize initial observation care for patients who are treated in a hospital and the patient's condition does not require an inpatient hospital admission but does require a period of medical observation for less than twenty-two hours. To bill for initial observation care, the provider must bill the appropriate code in the CPT under the initial observation care section.

(2) It is only appropriate to bill hospital observation E & M services provided to patients designated as "observation status" in a hospital. Billing hospital observation services for emergency department services is inappropriate.

(3) For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission should be reported with the appropriate initial hospital care code.

(4) If patient care during observation services results in a hospital admission and the physician who provided the initial observation care continues to be the patient's attending physician after the admission, the physician must bill the hospital inpatient E & M codes in lieu of the initial observation codes.

(5) If patient care during observation services results in a hospital admission on the same date that observation care was initiated and the physician who provided the observation care does not continue to be the patient's attending physician after the admission, (care is transferred to another physician), the physician who provided the observation care may bill for the initial observation services and the new attending physician may bill a hospital inpatient E&M code.
For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with the appropriate code listed under the "observation or inpatient care services (including admission and discharge services)" section of the CPT.

(6) Do not report an observation discharge in conjunction with a hospital admission.

(7) Observation codes may not be utilized for post-operative recovery if the service is considered a global surgical procedure code.

(P) Limitations on physician visits.

(1) Outpatient visits.

(a) Reimbursement will be made for all physician visits provided to a recipient in an outpatient or an LTCF setting during a calendar year up to a total of twenty-four visits.

(b) Physician visits in excess of twenty-four will be paid as the services are billed to the department but will be subject to post-payment review by the department.

(c) The total number of physician visits accrued by a recipient during a calendar year will be calculated by the department and shall be referred to as the year-to-date visit total.

(d) The following codes will be counted as a physician visit and added to the recipient’s year-to-date visit total, unless the codes are billed on an institutional claim form or institutional electronic transaction or the codes are billed with one of the diagnoses listed in paragraph (P)(1)(d)(vi) of this rule:

(i) Codes 99050 to 99051;

(ii) Codes 99304 to 99310, 99315 to 99324, 99328, and 99334 to 99337;

(iii) Codes 99241 to 99255 when the service is provided in a setting other than inpatient hospital;

(iv) Codes 99201 to 99215;

(v) Codes 99281 to 99285; and

(vi) Codes 99341 to 99350.

The year-to-date visit total will be an accumulative total of visits provided by all providers of physician services, including but not limited to all physicians, clinics, and podiatrists.

(e) The following physician visits shall be exempted from counting towards the recipient’s year-to-date visit total:

(i) All antepartum and postpartum visits as detailed in rule 5101:3-4-08 of the Administrative Code and all pregnancy related services as detailed in rule 5101:3-4-10 of the Administrative Code;

(ii) All well-child or EPSDT (healthchek) visits as detailed in rule 5101:3-14-04 of the Administrative Code;

(iii) All inpatient hospital and critical care visits as defined in this rule;

(iv) Allergen immunotherapy services not billed in conjunction with a code listed in paragraph (P)(1)(d) of this rule;

(v) All other visits or services billed under a code not listed in paragraph (P)(1)(d) of this rule;

(vi) All visits provided for the following diagnoses:

(a) End-stage renal disease;

(b) Chemotherapy or radiation therapy for malignancy;

(c) End-stage lung disease;
Unstable diabetes or diabetes with complications;
Uncontrolled hypertension or hypertension with complications;
Neoplasms and leukemia;
Organ transplants;
Hereditary anemias;
Hemophilia or other congenital disorders of clotting factors;
Acquired hemolytic anemias;
Aplastic anemias;
Deficiency of humoral immunity;
Deficiency of cell-mediated immunity;
Combined immunity deficiency;
Cystic fibrosis;
Malabsorption;
Failure to thrive;
Infant prematurity;
Respiratory distress syndrome and other respiratory conditions of the fetus and newborn; and
Terminal stage of any life-threatening illness.

For a visit not to count towards the year-to-date visit total, the provider must bill either a code indicating an exempted service was provided or the visit code with the primary or secondary diagnosis code indicating the patient has one of the exempted conditions.

When the department has paid for more than twenty-four unexempted physician visits for a recipient during a calendar year, information from paid claims history will be reviewed by the department to determine whether the recipient should be referred to a primary care alternative and treatment (PACT) program coordinated services program (which is defined in Chapter 5101:3-20 of the Administrative Code).

In addition, the department or its contractual designees may:

- Review the medical records of any recipient exceeding twenty-four visits during a calendar year to determine whether the services were medically necessary and appropriate for the recipient's illness, symptoms or injury; and/or
- Conduct an in-depth review of any provider and the provider's medical records if the provider shows an unusual pattern of providing greater than twenty-four visits to Medicaid recipients.

If the department determines that the physician visits were not medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, the payment for the visits may be recovered from the provider by the department.

Inpatient hospital visits.
- Inpatient hospital visits, excluding critical care visits, shall be limited to one visit per day per patient per provider.
- Critical care visits must be billed in accordance with paragraph (G) of this rule.
- Critical care codes may not be billed in conjunction with a hospital or emergency room visit.
(3) Visits performed in conjunction with surgical procedures.

(a) Minimum follow-up period.

(i) The minimum surgical follow-up period is defined for each surgical procedure under follow-up days in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(ii) The day of surgery is included in the minimum follow-up period, except when the procedure is identified by an asterisk in appendix DD to rule 5101:3-1-60 of the Administrative Code.

In the 2004 CPT, the starred procedure designation was removed from surgical codes. Therefore the department has removed the asterisk from most surgical procedures. The department will continue the asterisk designation in appendix DD to rule 5101:3-1-60 of the Administrative Code for a limited number of procedures such as venipuncture procedures.

(a) For those procedures where the asterisk was removed, for claims received on and after January 1, 2004 a follow-up visit will no longer be allowed;

(b) For the venipuncture procedures, which are asterisked in rule 5101:3-1-60 of the Administrative Code, a visit on the same day as surgery will be allowed if the provisions in paragraph (P)(3)(c) of this rule are met.

(iii) When more than one procedure is performed on the same day, the follow-up period will be equal to the follow-up period of the surgical procedure with the most follow-up days.

(iv) When another surgical procedure is performed during the follow-up period of a previously performed surgery, the follow-up period will be equal to the follow-up period of the most current surgical procedure or the remaining days left of the follow-up period for the original (or first) surgical procedure, whichever is longer.

(b) Preoperative visits.

(i) Preoperative examinations to evaluate the patient and to determine the necessity of surgery are separately reimbursed when the examination is not performed on the day of surgery.

(ii) All preoperative visits performed by the surgeon after the decision to have surgery is made are included in the global surgical package.

(c) Visits on the same day as surgery.

A provider may be reimbursed for a visit on the same day as surgery, only if the procedure is identified as reimbursable on the same day of surgery in appendix DD to rule 5101:3-1-60 of the Administrative Code and it is customary for the physician to charge a visit for all patients.

(d) Postoperative visits.

(i) Routine postoperative visits.

Reimbursement for all routine postoperative care is included in the physician’s reimbursement for surgical procedures.

(a) The physician may not be separately reimbursed for routine postoperative visits provided during the minimum follow-up period.

(b) The physician may not be separately reimbursed for routine postoperative visits, even if the visits occurred after the minimum follow-up period.

(ii) Nonroutine postoperative visits.
(a) A physician 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.

(b) Visits provided during the minimum surgical follow-up period must be billed as described in this paragraph.

(i) When the visits described in paragraph (P)(3)(d)(ii)(a) of this rule are provided by a physician who did not perform the surgical procedure, the physician may be reimbursed by billing the code for the visit.

(ii) When the visits described in paragraph (P)(3)(d)(ii)(a) of this rule are provided by the physician who also performed the surgical procedure, the physician may be reimbursed by billing the code for the visit modified by the modifier 24 (unrelated evaluation and management service by the same physician during a postoperative period).

(e) Visits performed in conjunction with surgical procedures are subject to all other visit limitations defined in this rule.

(3) Visits related to surgical procedures.

(a) A preoperative examination related to a particular surgical procedure is not separately reimbursable either when it is performed on the day of surgery or after the decision to have surgery has been made.

(b) For each surgical procedure, a postoperative period, expressed in days, is shown in appendix DD to rule 5101:3-1-60 of the Administrative Code. The day of surgery is included in the postoperative period. For reimbursement purposes, the length of a postoperative period may be adjusted if two surgical procedures are performed within a certain number of days of one another.

(i) If two surgical procedures are performed on the same day, then the longer postoperative period applies to both procedures.

(ii) If a second surgical procedure is performed within the postoperative period of another surgical procedure, then the number of days remaining in the postoperative period of each procedure is set equal to the greater of two figures:

(a) The number of days remaining in the unadjusted postoperative period of the first surgical procedure; or

(b) The number of days remaining in the unadjusted postoperative period of the second surgical procedure.

(c) A blood draw or transfusion procedure performed on the day of surgery is separately reimbursable only if the physician customarily charges all patients for the procedure.

(d) Reimbursement for all routine postoperative care is included in the payment for surgical procedures. A routine postoperative visit is not separately reimbursable even if it is made after the postoperative period has ended.

(e) A nonroutine postoperative visit made to a physician during the postoperative period is separately reimbursable if one of the following conditions is met:

(i) The physician also performed the surgical procedure, and the visit was made for the diagnosis or treatment of a symptom, illness, or condition unrelated to the surgical procedure.

(ii) The physician did not perform the surgical procedure.
Effective: 09/01/2013
R.C. 119.032 review dates: 06/17/2013 and 09/01/2018
Certification: CERTIFIED ELECTRONICALLY
Date: 08/22/2013
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.021
Physician Attendance During Patient Transport

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

MHTL 3336-11-03

Effective Date: August 2, 2011

Most Current Prior Effective Date: March 31, 2009

(A) The following paragraphs apply to patient transports for both pediatric patients twenty-four months of age or less and patients older than twenty-four months of age:

(1) Face-to-face time begins when the physician assumes responsibility of the patient at the referring facility/hospital and ends when the receiving facility/hospital accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport may be billed.

(2) Services provided by other members of the transport team must not be billed by the physician, but must be billed by the transportation company (e.g., ambulance provider).

(3) Routine monitoring evaluations (e.g., heart or respiratory rate, blood pressure, pulse oximetry, and the initiation of mechanical ventilation) are included in the face-to-face time reported in the patient transport codes and will not be paid separately.

(4) The direction of emergency care to transporting staff by a physician located in a hospital/facility by two-way communication is not considered direct face-to-face care and must not be reported using the patient transport codes.

(5) The patient transport services are covered by the department only if the service is personally provided by a physician.

(6) The codes for the initial care of the critically ill or critically injured patient may be billed only once on a given date.

(7) "CPT" as referenced in this rule is defined in rule 5101:3-1-19.3 of the Administrative Code.

(B) The following paragraphs apply to patient transports of pediatric patients:

(1) The procedure codes 99466 and 99467 for pediatric patient transport found in rule 5101:3-1-60 of the Administrative Code are used to report the physical attendance and direct face-to-face time spent by a physician during the inter-agency facility transport of a critically injured or critically ill pediatric patient twenty-four months of age or less.

(2) These procedure codes are time-based. Pediatric patient transport services involving less than thirty minutes of face-to-face physician care may not be reported using the patient transport codes.

(3) Certain procedures are included in the global critically ill or critically injured pediatric patient transport codes and may not be billed separately. These procedures are specified in the pediatric critical care patient transport section of the current procedural terminology (CPT).

(C) The following paragraphs apply to patient transports for individuals older than twenty-four months of age:

(1) Critical care codes 99291 and 99292 should be billed when a physician is in attendance during the transport of a critically ill or critically injured patient over twenty-four months of age to or from a facility/hospital.

(2) When billing the critical care codes specified in paragraph (C)(1) of this rule for a patient transport, the provider must use modifier "UB" to indicate that the code is being billed for a patient transport for a critically ill or injured patient over twenty-four months of age. When billing 99292 for a critically ill patient who has had a physician in attendance during the patient transport and then received critical care in the hospital, bill 99292 UB for the time the physician
spent in attendance during the transport. Bill code 99292 unmodified for the time spent providing

(3) The critical care code policies specified in paragraph (G) of rule 5101:3-4-06 of the
Administrative Code apply to patient transports billed with critical care codes, except that there
is no maximum time limit for the face-to-face physician time spent during the transport of a
critically ill or injured patient over twenty-four months of age.

Effective: 08/02/2011
R.C. 119.032 review dates: 09/20/2010 and 08/01/2016
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Date: 06/28/2011
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.021
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Effective Date: July 1, 2003

Most Current Prior Effective Date: March 21, 1996

(A) Providers of obstetrical services must bill each antepartum visit, the postpartum visit, and the delivery separately. The department does not recognize the CPT codes for "global obstetrical care" which bundle these services under a single procedure code. The department does recognize the code for delivery which may be billed using a single procedure code when the services are provided by the same provider.

(B) The following obstetrical services are covered as detailed below:

1. Prenatal risk assessment;
2. All antepartum care including pregnancy related services;
3. Delivery; and
4. Postpartum care.

(C) Prenatal risk assessment (PRA)

1. The "Prenatal Risk Assessment (PRA)" form, ODHS JFS 3535 03535, is a checklist of medical and social factors which is used as a guideline to determine when a patient is at risk of a preterm birth or poor pregnancy outcome.

2. The PRA form must be completed on each obstetrical patient during the initial antepartum visit in order to bill for the prenatal at-risk assessment code. Although providers are required to complete this form, effective December 1, 1991, payment for any obstetrical service billed on or after December 1, 1991 is not dependent on the submission of this form, to the department. A copy of the PRA form should be placed in the patient's record to serve as documentation that the service was provided.

3. A copy of the PRA form must be placed in the patient's medical records and submitted to the patient's residential county department of human services (CDHS). The PRA form maintained in the patient's medical record will serve as documentation that the service was provided. Providers must submit a copy of the PRA form to the patient's residential county department of job and family services since the county staff can assist patients obtaining needed services.

4. When significant risk factors that were not noted on the original PRA form are identified during the course of the pregnancy, providers are encouraged to complete another risk assessment form and to send a copy to the county department of human job and family services.

5. Providers may receive reimbursement for completing the PRA form by billing HCPCS the code X5400 for prenatal risk assessment specified in rule 5101:3-4-10 of the Administrative Code.

(D) Antepartum care

1. Antepartum visits
   
   (a) The antepartum visit is inclusive of:

   (i) Instruction, education and counseling on a variety of topics related to pregnancy, nutrition, baby-care and family;

   (ii) Routine urinalysis screening tests (dipstick) to detect the presence of sugar or protein;

   (iii) A physical examination which includes recording of weight, blood pressure, and fetal heart tones or similar routine services;

   (iv) Coordination of the patient's medical care including at a minimum a planned hospital delivery, arrangements for medical care and/or consultation (by
telephone) in case of an emergency, and referrals to appropriate medical services (i.e., ultrasounds, etc.).

(b) Medical care coordination, education and counseling services provided as part of the antepartum visit should be consistent with those services generally required for all obstetrical patients. When the care coordination and/or counseling and educational services provided to an individual are more extensive than the services routinely provided to obstetrical patients, a provider may be compensated for these services by billing the pregnancy related services detailed in rule 5101:3-4-10 of the Administrative Code.

(c) Antepartum visits must be billed to the department on a per-visit basis using the CPT evaluation and management (office visit) code for antepartum care, 59420 appropriate for the type of visit documented in the patient's record. When the antepartum visit is billed, specify a diagnosis to signify pregnancy such as V22 for supervision of normal pregnancy, V23 for supervision of a high-risk pregnancy, or V28 for antenatal screening. Bill the code modified by the "TH" modifier to signify "obstetrical services, prenatal or post-partum".

(d) Providers may receive additional payment for the first antepartum visit by modifying the antepartum CPT code. If the initial antepartum visit occurs during the first trimester (before fifteen weeks gestation), providers will be paid seventy dollars for the visit. If the initial visit occurs after the first trimester and before thirty-six weeks of gestation, providers will be paid fifty dollars for the visit. For the enhanced first-visit payment, providers must use the following modifiers with the antepartum visit CPT code:

IF For an initial visit provided before fifteen weeks gestation (e.g., 59420IF);
IV For an initial visit provided between fifteen and thirty-six weeks gestation (e.g., 59420IV).

(2) Additional services

(a) In addition to the antepartum visit, reimbursement is available for the following services provided during the antepartum and postpartum periods:

(i) Pregnancy related services which are described in rule 5101:3-4-10 of the Administrative Code and include:

(a) Individual counseling;
(b) Group counseling (e.g., Lamaze or other similar childbirth education classes);
(c) Care coordination;
(d) Predelivery visit to a pediatrician (or other primary care physician);
(e) Nutrition intervention; and
(f) High-risk patient monitoring.

(ii) All obstetrical-related radiology and laboratory procedures (with the exception of urinalysis screening tests) actually performed in the physician's office;

(iii) All obstetrical diagnostic procedures identified in the CPT standard code sets; and
(iv) All covered medical services provided in addition to the antepartum visit.

(b) The services listed in paragraph (D)(2)(a) of this rule may be provided independently on any date of service, or they may occur sequentially on the same date as the antepartum visit or any other covered service.

(E) Delivery and postpartum care.
"Delivery services" include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without forceps and/or episiotomy), or Cesarean section delivery.

"Postpartum care" includes hospital and office visits for routine, uncomplicated care following a vaginal or Cesarean section delivery.

Under paragraph (E) of this rule, "same provider" means the rendering provider or any member of the same group practice.

The following codes should be billed:

(a) For delivery and postpartum services provided to patients for which a vaginal or Cesarean delivery after a previous Cesarean delivery (VBAC) was not attempted.

   59409 For a vaginal delivery when outpatient postpartum care is provided by another provider or provider group.
   59410 For a vaginal delivery when outpatient postpartum care is provided by the same provider or provider group.
   59514 For a Cesarean section when outpatient postpartum care is provided by another provider or provider group.
   59515 For a Cesarean section when outpatient postpartum care is provided by the same provider or provider group.

(b) For delivery and postpartum services provided on or after January 1, 1996 to patients for which a VBAC was attempted.

   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 outpatient postpartum care is provided by another provider or provider group.
   59622 Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery when outpatient postpartum care is provided by the same provider or provider group.

(c) Postpartum care when performed as a separate procedure.

   59430 For postpartum care only.

For the reimbursement of CPT 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.

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.

(a) For the reimbursement of the delivery only codes the provider or provider group must render, at a minimum, the delivery service;

(b) 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.

Additional reimbursement will not be recognized for the complexity of the delivery, for multiple births, or for two physicians performing the same vaginal delivery.

Reimbursement is available for inpatient and outpatient evaluation and management services provided for post-delivery complications or services unrelated to the delivery in accordance with paragraph (M)(3) of rule 5101:3-4-06 of the Administrative Code.

Services of an assistant-at-surgery during a Cesarean delivery are covered in accordance with paragraph (G) of rule 5101:3-4-22 of the Administrative Code.

Services of a pediatrician in attendance at a delivery of a high risk newborn or a Cesarean section are covered in accordance with rule 5101:3-4-06 of the Administrative Code.

All pregnancy related services are covered services during the postpartum period with the exception of high-risk patient monitoring (X5432) and the predelivery visit.

Transportation services for pregnant women to medicaid covered services will be provided by the patient's residential county department of human job and family services, if it is requested by the provider, the recipient or other person acting on the recipient's behalf.

Effective: July 1, 2003
R.C. 119.032 review dates: 10/8/2002
Certification
Date
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.02
Paragraph (D)(1)(c) of rule 5101:3-4-08 of the Administrative Code specifies that providers billing for an antepartum/prenatal visit must bill the code for an evaluation and management office visit to receive reimbursement for a prenatal visit. Providers must choose the office visit code appropriate for the visit documented in the patient's record and modify the code by the "TH" modifier to signify that the visit was for prenatal services.

When the "TH" modifier is billed with an office visit code, the following reimbursement will be made effective for dates of service on and after July 1, 2003:

<table>
<thead>
<tr>
<th>Office Visit Type</th>
<th>Codes</th>
<th>Medicaid Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>new patient</td>
<td>99201 to and including 99203-99202</td>
<td>$48.40</td>
</tr>
<tr>
<td>new patient</td>
<td>99203</td>
<td>see rule 5101:3-1-60 of the Administrative Code</td>
</tr>
<tr>
<td>new patient</td>
<td>99204</td>
<td>see rule 5101:3-1-60 of the Administrative Code</td>
</tr>
<tr>
<td>new patient</td>
<td>99205</td>
<td>see rule 5101:3-1-60 of the Administrative Code</td>
</tr>
<tr>
<td>established patient</td>
<td>99211</td>
<td>$19.73</td>
</tr>
<tr>
<td>established patient</td>
<td>99212 to and including 99213</td>
<td>$48.40</td>
</tr>
<tr>
<td>established patient</td>
<td>99214</td>
<td>see rule 5101:3-1-60 of the Administrative Code</td>
</tr>
<tr>
<td>established patient</td>
<td>99215</td>
<td>see rule 5101:3-1-60 of the Administrative Code</td>
</tr>
</tbody>
</table>

Providers must follow the instructions for selecting the level of evaluation and management service specified in the "CPT" manual. "CPT" as used in this rule is defined in rule 5101:3-1-19.3 of the Administrative Code.
**Pregnancy Related Services**

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

**Effective Date:** July 1, 2003

Most Current Prior Effective Date: January 1, 2001

(A) "Pregnancy related services" identified in paragraphs (B) to (F) of this rule are optional preventive health services available to all medicaid-eligible women. These services are intended to promote positive birth outcomes by supplementing regular obstetrical care. Services identified in paragraph (G) and (H) of this rule are covered services for women who need therapeutic intervention to prevent poor birth outcome.

(1) Pregnancy related services may be delivered by physicians, hospitals, clinics, home health agencies, rural health clinics, outpatient health facilities, federally qualified health centers, and nurse midwives advanced practice nurses who are eligible medicaid providers. When provided, these services must be billed in accordance with the specific billing requirements and procedures for the provider type of the rendering provider as specified in Chapter 5101:3 of the Administrative Code.

(2) These services may also be delivered, but not billed directly, by health care professionals (e.g., dietitians, social workers) who are not eligible medicaid providers, if the services provided are within the professional's scope of practice and the professional is employed by or under contract with an eligible medicaid provider.

(3) Pregnancy related services may be provided in a patient's home in accordance with paragraph (F) of this rule or at the provider's practice site.

(4) When billing for pregnancy related services listed in this rule with the exception of the predelivery 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.

(B) Care coordination

(1) A provider may be reimbursed a monthly care coordination fee (once every four weeks) if the provider furnishes all the following services, as appropriate, to the patient:

(a) Performs a social/psycho social assessment identifying factors which may affect the patient's ability to follow prescribed care and necessary social services.

(b) Develops a written individual care plan which includes a timetable for the delivery of medical services as prescribed by the physician or nurse midwife and any recommended social services.

(c) Assists the physician and patient in the scheduling and coordination of services identified in the care plan;

(d) Reviews the care plan at least once every four weeks and updates the plan to reflect any revisions;

(e) Provides a copy of the care plan to the patient;

(f) Makes necessary referrals for nonmedical services, including but not limited to:

   (i) County department of human service job and family services for needed transportation, casework, or social services (e.g., food, clothing, shelter, etc.);

   (ii) Special supplemental food program for women, infants, and children (WIC); and
Other social service agencies as needed (e.g., child support, children services, mental health, drug and alcohol);

(g) Makes telephone contact or provides a written reminder for the patient prior to all appointments;

(h) Telephones the patient or sends a written notice of any missed appointments and makes arrangements with the patient to reschedule the appointment. Requests assistance from the at-risk pregnancy coordinator at the patient’s residential county department of human services job and family services when the patient is noncompliant in keeping appointments (e.g., misses back-to-back appointments).

(2) For reimbursement, the provider must bill HCPCS code X5431 H1002. This code may be billed on the initial date of service and once every twenty-eight days thereafter.

(C) Group education

Group pre-natal at-risk education

(1) Group education CLASSES classes on a variety of topics relating to pregnancy, birth, childcare, nutrition, family and support systems are covered on a per class basis. (E.g., Lamaze or other childbirth classes would be considered a covered group education service).

(2) Group education may be a single class covering a single topic or multiple topics or it may be a series of classes covering a single topic or multiple topics.

(3) Group education classes must consist of a face-to-face presentation by a medical professional in a group of no more than twelve patients (not including partners/coaches).

(4) For reimbursement, the provider must bill HCPCS code X5412 for each date the recipient attended class. For example, if class was held on November 1, 8, 15, 22, and the patient attended all four classes, the provider would bill HCPCS code X5412 for each of those dates (a total of four times) the appropriate code listed in this paragraph to indicate the type of group session attended by the recipient. The unit of service for each session (one or more classes) is limited to one per pregnancy. The following group education sessions for pregnancy session are covered by medicaid effective with services provided on and after the effective date of this rule:

(a) For childbirth preparation / Lamaze classes, non-physician provider, per session, bill S9436.

(b) For childbirth refresher classes, non-physician provider, per session, bill S9437;

(c) For nutrition classes provided to pregnant women by a non-physician provider, per session, bill S9452.

(d) For baby parenting classes provided to pregnant women by a non-physician provider, per session, bill S9444; and

(e) For infant safety classes provided to pregnant women by a non-physician provider, per session, bill S9447.

(D) Individual counseling and education

When the counseling and educational services exceed those normally provided during a prenatal visit, focus primarily on the specific needs of the individual, and involve an individual face-to-face encounter of approximately fifteen minutes or more, the provider may be paid for an individual counseling and education service in addition to the antepartum visit.

(2) For reimbursement, the provider must bill HCPCS code X5411 H1003.

(E) Predelivery visit to a pediatrician or other primary care provider

To encourage families to obtain early and continuous well-child and primary care for their newborn, the department covers pre-delivery visits to a pediatrician or other primary care physician. The purpose of this service is to give the mother (or family) the opportunity to select, and establish a patient-physician relationship with, a physician for the care of her (their) infant.
For reimbursement, the provider must bill \textbf{HCPCS code X9380} the most appropriate evaluation and management (visit) code.

\textbf{(F) Home visit travel}

\begin{enumerate}
\item When pregnancy related services are provided in a patient's home, the provider may receive additional reimbursement for travel by billing HCPCS procedure code X5500.
\item Reimbursement for travel is limited to once per patient per provider per date of service.
\item HCPCS procedure code X5500 must be billed in conjunction with at least one of the pregnancy related codes.
\end{enumerate}

\textbf{(G)(F) High-risk patient monitoring /antepartum management}

\begin{enumerate}
\item A provider may be reimbursed for high-risk patient monitoring now known as antepartum management provided on a weekly basis to a patient who has been determined by the provider to be at-risk of a preterm birth.
\item "High-risk patient monitoring" /antepartum management is a service which includes counseling and educational services associated with identifying and reducing the risks of a preterm labor, telephone or face-to-face contact with the patient a minimum of three times a week to identify signs of preterm labor and accessibility of the provider to the patient in the event the patient begins to show signs of preterm labor.
\item High-risk patient monitoring /antepartum management must be provided by a health care professional who is qualified to identify the signs of preterm labor and is employed by or under contract with an eligible provider of physician services.
\item For reimbursement, the provider must bill \textbf{HCPCS code X5432 H1001} for antepartum management.
\end{enumerate}

\textbf{(H)(G) Nutrition intervention}

\begin{enumerate}
\item Basic nutrition education and counseling services are considered a part of routine antepartum care.
\item "Nutrition intervention" is a service provided to a pregnant or postpartum woman who has a medical need for a therapeutic diet. Nutrition intervention includes the following:
  \begin{enumerate}
  \item Specialized nutrition counseling and education as it relates to the medically diagnosed problem or high-risk factor;
  \item Development of an individual diet plan, including a therapeutic diet calculation;
  \item Teaching of therapeutic diet or other nutritional modifications of diet, and the provision of sample meal plans and patterns;
  \item Monitoring the results of the nutrition intervention and making any necessary changes in the dietary plan.
  \end{enumerate}
\item Nutrition intervention may be delivered by a physician or a dietitian who is licensed by the state of Ohio or who has equivalent qualifications if practicing outside the state.
\item Dietitians delivering nutrition intervention may not bill for the service directly but must be under contract with or employed by an eligible medicaid provider.
\item For reimbursement, the provider must bill \textbf{HCPCS code, X5422 S9470} for medical nutrition therapy counseling for pregnant women provided by a dietician employed by or under contract with an eligible medicaid provider. For nutrition therapy provided by a physician, bill the appropriate evaluation and management code with diagnosis code V22, V23, or V28. In both cases, the "TH" modifier must be billed to reflect that the nutrition intervention is for prenatal at-risk educational purposes and the appropriate pregnancy diagnosis code must be billed.
\item For group nutrition classes which are described in paragraph (C) of this rule, bill the code S9452.
\end{enumerate}
Prenatal risk assessment

(1) Providers may receive reimbursement for a prenatal risk assessment if the provisions described in paragraph (C) of rule 5101:3-4-08 are met.

(2) To receive reimbursement for a prenatal risk assessment, providers must bill code H1000.

Reimbursement

(1) Payment for pregnancy related services provided by providers of physician services in an office or fee-for-service clinic setting will be the provider’s billed charge or the payment amount listed in appendix DD of rule 5101:3-1-60 of the Administrative Code.

(2) When pregnancy services are provided by the hospital to hospital outpatients, the hospital will be reimbursed the rates listed in appendix F of rule 5101:3-2-21 of the Administrative Code.

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R.C. 119.032 review dates: 10/08/2002
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Rule Amplifies: 5111.01 and 5111.02
Prior Effective Dates: 4/1/88, 5/15/89, 2/14/92, 1/1/01
This rule describes reimbursement and place of service restrictions for diagnostic and therapeutic (D&T) procedures by defining a PCTC indicator policy. PCTC indicators are a single numeric value, a lower case alpha value, or a numeric value accompanied by a lower case alpha value. The PCTC indicators for D&T procedures are listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.

General Guidelines:

1. A provider may be reimbursed for a global procedure when the provider performed both the professional and technical components of a D&T procedure. For reimbursement, the provider must bill the appropriate CPT code unmodified. Global procedures are not reimbursable when performed in an institutional place of service.

2. A provider may be reimbursed for the professional component of a D&T procedure with both a professional and technical component, regardless of the place of service, unless otherwise indicated by a PCTC indicator and alpha character. Professional component means the provider interprets the results of a test, but did not perform the test. For reimbursement, submit the appropriate CPT code with the modifier 26 indicating professional component only.

3. A provider may be reimbursed for the technical component of a D&T procedure with both a professional and technical component if the provider performed the test, but did not interpret the results. Technical only procedures are not reimbursable when performed in an institutional place of service. For reimbursement, the provider must bill the appropriate CPT code with the modifier TC indicating technical component only.

PCTC indicator policy:

1. D&T procedures that consist of both a technical (TC) and professional (26) component are identified by a PCTC indicator of 1.
   
   (a) Global procedures unmodified, or technical only procedures modified with a TC modifier are not reimbursable in an institutional setting.
   
   (b) There are no place of service restrictions for professional only procedures with a 26 modifier indicating professional only unless otherwise indicated by a PCTC indicator and alpha character.

2. D&T procedures that are professional only, meaning they do not consist of separate components and the TC and 26 modifiers do not apply because the procedures are considered professional only, technical only, or global by definition are identified by a PCTC indicator of 2 (professional only), 3 (technical only), or 4 (global procedure).
   
   (a) Global procedures, or technical only procedures are not reimbursable in an institutional setting.
   
   (b) There are no place of service restrictions for professional only procedures, unless otherwise indicated with a PCTC indicator and alpha character.

3. D&T procedures that do not consist of separate components, because they are considered professional only codes by definition, are identified by a PCTC indicator of 0. The TC and 26 modifiers do not apply.
D&T procedures that are considered incident to codes, technical only codes, or are considered a hospital facility service or a long term care facility service when performed in those settings are identified by a PCTC indicator 5 or 7, unless otherwise indicated by a PCTC indicator and alpha character. The TC and 26 modifiers do not apply.

The following lower case alpha values also define place of service restrictions, when they stand alone or when they accompany a numeric PCTC indicator. For example, a PCTC indicator of 0b means the professional service is not separately reimbursable when performed in an inpatient hospital, outpatient hospital, or emergency room.

(a) Lower case value (a) means is reimbursable in an inpatient hospital place of service.

(b) Lower case value (b) means the service is not separately reimbursable when performed in an inpatient hospital, outpatient hospital, or emergency room.

(c) Lower case value (c) means the service is not separately reimbursable when performed in an inpatient hospital, outpatient hospital, emergency room, or long-term care facility.

(d) Lower case value (d) means the service is reimbursable when performed in a office, clinic, or urgent care place of service.

(e) Lower case value (e) means the service is not separately reimbursable when performed in an inpatient hospital.

Limited practitioners, chiropractors, physical therapists, occupational therapists, and psychologists have additional place of service restrictions in accordance with Chapter 5101:3-4 of the Administrative Code.

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"Current procedural terminology (CPT)" is a comprehensive listing of medical terms and codes published by the American medical association, www.ama-assn.org, for the uniform designation of diagnostic and therapeutic procedures in surgery, medicine, and the medical specialties. "Healthcare common procedure coding system (HCPCS)" is a numeric and alphanumeric code set maintained and distributed by the Centers for Medicare & Medicaid Services (CMS), www.cms.gov, for the uniform designation of certain medical procedures and services.

- A "not otherwise specified," "unlisted," or "miscellaneous" procedure code should be reported on a claim only if no procedure code is available that identifies the particular service or item provided.
- An immunization, injection, infusion, vaccine, toxoid, or provider-administered pharmaceutical is not separately reimbursable as a physician service or a clinic service if it is provided in a hospital setting (inpatient hospital, outpatient hospital, or hospital emergency department).
- A provider-administered pharmaceutical reported on a claim submitted in accordance with Chapter 5101:3-9 of the Administrative Code is regarded as a pharmacy service rather than a physician service, and reimbursement of the claim is governed by the provisions of that chapter. For example, a vaccine, toxoid, or other provider-administered pharmaceutical prescribed for a resident of a long-term care facility (LTCF) and subsequently administered by a LTCF staff member is a pharmacy service.
- Reimbursement for an immunization, injection, or infusion includes payment for related supplies (e.g., alcohol wipes, needles, syringes, and tubing).

Coverage of immunizations.

- An immunization has two components: the administration of the vaccine or toxoid (represented by a CPT code in the range from 90460 to 90474) and the vaccine or toxoid itself (represented by a CPT code in the range from 90476 to 90749). In general, medicaid does not allow reimbursement for the administration of a vaccine or toxoid; instead, separate reimbursement may be made either for the least complex evaluation and management service (represented by CPT code 99211) or for another medical service that includes an evaluation and management element. An eligible provider specified in rule 5101:3-1-60.3, however, may receive separate reimbursement for covered immunization administration performed on a date specified in that rule.
- Providers participating in the federal vaccines for children (VFC) program, which is administered by the Ohio department of health (ODH), may obtain selected vaccines at no cost; reimbursement is therefore not allowed for the cost of VFC-designated vaccines obtained from a source other than ODH. In addition to reimbursement for an evaluation and management service, described in paragraph (B)(1) of this rule, participating VFC providers may receive a supplemental fee for each VFC-designated vaccine they administer.
- Limitations based on age or gender apply to certain vaccines.
  - Regardless of the formulation, hepatitis B vaccine (HBV) administered to individuals younger than nineteen years of age is reimbursable only under the VFC program. Different procedure codes must be reported on claims to distinguish HBV administered to
individuals younger than nineteen from HBV administered to individuals nineteen or older.

(b) The quadrivalent vaccine for the human papilloma virus (HPV) is covered for both males and females from nine through twenty-one years of age. For both males and females who are eligible for medicaid only through the family planning services benefit, coverage extends through twenty-six years of age.

(c) The bivalent vaccine for HPV is covered for females from nine through twenty-one years of age. For females who are eligible for medicaid only through the family planning services benefit, coverage extends through twenty-six years of age. This vaccine is not covered for males.

(C) Coverage of therapeutic, prophylactic, or diagnostic injections or infusions (excluding chemotherapy and other complex procedures).

(1) An injection or infusion has two components: the administration of a fluid medium (represented by a CPT code in the range from 96360 to 96379) and, except in the case of hydration, the pharmaceutical itself (represented by an appropriate procedure code, such as a CPT code in the range from 90281 to 90399 or a HCPCS code beginning with the letter J). No separate reimbursement is made for the administration service if an injection or infusion is given during the course of an office visit or in conjunction with another medical service that includes an evaluation and management element.

(2) Reimbursement may be made for an injection or infusion or a provider-administered pharmaceutical only if the following criteria are met:

(a) Its use for a particular indication has been approved by the U.S. food and drug administration; or

(b) According to accepted standards of medical practice, it is a specific or effective treatment for the particular condition for which it is given.

(3) No separate reimbursement is made for an injection or infusion or a provider-administered pharmaceutical that meets either of the following criteria:

(a) The frequency or duration of its administration exceeds accepted standards of medical practice for the particular condition; or

(b) It is provided for or in association with noncovered medicaid services, which are defined in rule 5101:3-4-28 of the Administrative Code.

(4) Immune globulin is covered when it is medically necessary to provide passive immunity to an individual who is immunosuppressed; has an acquired or congenital immunodeficiency; is at risk of Rho(D) isoimmunization; or is in immediate danger of contracting hepatitis B, tetanus, or rabies through direct contact with blood, saliva, or other body fluids through an open wound, bite, puncture, or mucous membrane. Immune globulins include nonspecific human serum globulin and specific hyperimmune globulins such as hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, and varicella-zoster. "Not otherwise specified" or "unlisted" immune globulin is not reimbursable.

(5) Epoetin alfa (EPO) for the treatment of anemia, either associated with or not related to chronic renal failure, is covered as a physician service when a provider of physician services incurs the cost of the drug and the service is provided in a clinic (e.g., a renal dialysis facility) or office setting.

(a) The appropriate procedure code must be reported on a claim.

(b) For each one thousand units of EPO administered (rounded to the nearest thousand), one unit of service must be reported on a claim.

(6) Certain procedure codes represent a specific number of dosage units. On a claim, the fewest number of procedure codes must be reported together to represent the administered dosage.
Coverage of trigger-point injections.

(1) A trigger point is a hyperexcitable area of the body, where the application of a stimulus will provoke pain to a greater degree than in the surrounding area. The purpose of a trigger-point injection is to treat not only the symptom but also the cause through the injection of a single substance (e.g., a local anesthetic) or a mixture of substances (e.g., a corticosteroid with a local anesthetic) directly into the affected body part in order to alleviate inflammation and pain. Reimbursement may be made for a trigger-point injection only if the following criteria are met:

(a) The patient must have a diagnosis for which the trigger-point injection is an appropriate treatment; and
(b) The following information must be documented in the patient's medical record:
   (i) A proper evaluation including a patient history and physical examination leading to diagnosis of the trigger point;
   (ii) The reason or reasons for selecting this therapeutic option;
   (iii) The affected muscle or muscles;
   (iv) The muscle or muscles injected and the number of injections;
   (v) The frequency of injections required;
   (vi) The name of the medication used in the injection;
   (vii) The results of any prior treatment; and
   (viii) Corroborating evidence that the injection is medically necessary.

(2) A trigger-point injection is normally considered to be a stand-alone service. No additional reimbursement will be made for an office visit on the same date of service unless there is an indication on the claim (e.g., in the form of a modifier appended to the evaluation and management procedure code) that a separate evaluation and management service was performed.

(3) Certain trigger-point injection procedure codes (e.g., CPT codes 20552 and 20553) specify the number of injection sites. For these codes, the unit of service is different from the number of injections given. Reimbursement may be made for one unit of service of the appropriate procedure code reported on a claim for service rendered to a particular patient on a particular date.

(4) Trigger-point injections should be repeated only if doing so is reasonable and medically necessary. For trigger-point injections of a local anesthetic or a steroid, reimbursement will be made for no more than eight dates of service per patient per calendar year.

Reimbursement.

(1) On the Fee Schedules and Rates page of the medicaid web site (http://jfs.ohio.gov/ohp/bhpp/FeSchdRates.stm) is a link to a list of vaccines, toxoids, and other provider-administered pharmaceuticals each of which is reimbursable by medicaid either as a physician service or as a VFC-designated vaccine. The reimbursement amount for a covered non-VFC vaccine, toxoid, or other provider-administered pharmaceutical is the lesser of the submitted charge or the maximum allowable fee. The maximum allowable fee is the first applicable item from the following ordered list:

   (a) An amount specified in or determined in accordance with the Administrative Code (e.g., the fee for a "by report" procedure);

   (b) The payment limit shown in the current average sales price (ASP) medicare part B drug pricing file or the current not otherwise classified (NOC) pricing file;

   (c) One hundred seven per cent of the wholesale acquisition cost (WAC); or

   (d) Eighty-five and six-tenths per cent of the average wholesale price (AWP).
(2) The reimbursement amount for a covered administration service or evaluation and management service is the lesser of the submitted charge or the maximum allowable fee listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(3) The supplemental fee for each immunization provided under the VFC program is ten dollars.

(4) For dates of service January 1, 2013, and after, the reimbursement amount for medroxyprogesterone acetate reported with HCPCS procedure code J1050 is the lesser of the submitted charge or twenty-eight cents per milliliter.

Replaces: 5101:3-4-12, 5101:3-4-13
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Date: 08/22/2013
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.021
Provisions for coverage and reimbursement of injections and pharmaceuticals administered as physician services are set forth in rule 5101:3-4-12 of the Administrative Code.

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Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021
Routine maintenance dialysis.

(1) All physician professional services associated with the medical management of end-stage renal disease (ESRD) patients receiving maintenance dialysis are paid on a monthly capitation payment (MCP) basis.

(2) The following services may be billed in addition to the MCP:
   (a) The declotting of shunts; and
   (b) Covered physician services which are unrelated to the patient’s dialysis or renal condition.

(3) To receive the MCP, the physician must bill the department on the last day of the month using the appropriate CPT code 90918, 90919, 90920 or 90921 (90951 to 90966).
   (a) Several physicians may form a team to provide the monthly continuity of services to a single patient or to a group of ESRD patients, or a physician in independent practice may make arrangements with an associate to provide the services to his/her ESRD patients when he/she is temporarily unavailable. Such arrangements are referred to as joint provision arrangements. Under a joint provision, each physician may cover for the other and the MCP may be billed by and reimbursed to the primary physician. The primary physician must make arrangements to compensate the other physicians involved in the dialysis care of the patient(s).

   (b) When the dialysis care of a patient is provided by more than one physician during a calendar month and there is not a joint provision arrangement between the physicians, the physicians who provided the split services during the month must bill the department separately using the appropriate CPT code 90922, 90923, 90924 or 90925 (90967 to 90970) for each day the physician was responsible for the patient’s care.

   (c) For a recipient during a calendar month, the following payments should never be made:
      (i) More than one monthly capitation payment (codes 90918 to 90921 90951 to 90966);
      (ii) More than thirty-one days of dialysis care (codes 90922 to 90925 90967 to 90970); or
      (iii) Payment for the MCP and daily dialysis care (any combination of codes 90918 to 90926 90951 to 90970).

(4) If a dialysis patient is admitted to a hospital for no reason other than to receive maintenance dialysis (e.g., there was no space available in the dialysis unit or the patient was scheduled for extended intermittent peritoneal dialysis), reimbursement for the professional services associated with the dialysis is still considered routine maintenance dialysis and is only reimbursable on a MCP basis.

Inpatient dialysis services.

(1) Except as provided for in paragraph (A)(4) of this rule, physicians may be paid on a fee-for-service (procedure code) basis for physician professional services provided to hospital inpatients. To be eligible for reimbursement on a fee-for-service basis, the physician must be present with the patient some time during the dialysis, the patient’s medical records must
document that the physician was present, and the dialysis must be performed for one of the following reasons:

(a) For acute renal failure or renal trauma;
(b) As an initial course of dialysis (the "initial course of dialysis" means the first dialysis treatment and all subsequent dialysis treatments performed prior to the patient’s stabilization on dialysis); or
(c) For an ESRD patient who was admitted to the hospital for a condition or illness that is unrelated to the patient’s renal condition and the physician has elected to bill the inpatient dialysis services on a fee-for-service basis. If the physician has elected to bill the inpatient dialysis services on a fee-for-service basis and the physician usually is paid the MCP, the physician may not bill for the MCP (CPT codes 90918 to 90921, 90951 to 90966) that month and must bill using the appropriate CPT code 90922, 90923, 90924 or 90925 (90967 to 90970) only for the days the patient was not a hospital inpatient.

(2) For reimbursement for inpatient dialysis services on a fee-for-service basis, the provider must bill the appropriate dialysis code from the range of 90935 to and including 90947.

(3) All evaluation and management services related to the patient's end stage renal disease that are rendered on a day when dialysis is performed and all other patient care services that are rendered during the dialysis procedure are included in the payment for codes 90935 to 90947.

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Cardiovascular diagnostic and therapeutic (D and T) services are procedures listed in the 90000 code range of the current procedural terminology (CPT), and are for the diagnosis and treatment of cardiovascular system disorders.

Refer to rule 5101:3-4-11 of the Administrative Code and appendix DD to rule 5101:3-1-60 of the Administrative Code for appropriate usage of the professional and/or technical modifiers and relevant place of service restrictions.

All cardiovascular diagnostic and therapeutic procedures, including electrocardiogram interpretations, may be billed with evaluation and management services when appropriate in accordance with rule 5101:3-4-06 of the Administrative Code.

Replaces: 5101:3-4-16

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The appropriate use of professional and technical modifiers and relevant place of service restrictions for gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy, and special dermatology procedures are set forth in rule 5101:3-4-11 of the Administrative Code.

Otorhinolaryngologic services.

(1) The following speech and hearing services are professional services and may not be reimbursed in addition to an evaluation and management service:
   (a) Otorhinolaryngologic examination under general anesthesia;
   (b) Binocular microscopy performed as a separate procedure;
   (c) Evaluation of speech, language, voice, communication, auditory processing, and/or aural rehabilitation status;
   (d) Individual treatment of speech, language, voice, communication, and/or auditory processing disorder, including aural rehabilitation;
   (e) Group treatment of speech, language, voice, communication, and/or auditory processing disorder, including aural rehabilitation;
   (f) Nasopharyngoscopy performed as a separate procedure;
   (g) Nasal function studies;
   (h) Facial nerve function studies;
   (i) Laryngeal function studies;
   (j) Tympanometry and reflex threshold measurements; and
   (k) Treatment of swallowing dysfunction and/or oral function for feeding.

(2) Procedure codes 92613, 92615 and 92617 are bundled into the related surgical procedure and are not separately reimbursable.

(3) When audiologic procedures are provided in a hospital setting, the services are considered hospital services and reimbursement will be made only to the hospital.

(4) Professional services associated with audiologic function tests are included either in the evaluation and management codes or the procedures listed in paragraph (B)(1) of this rule.

(5) Hearing aid examination and selection services are covered as part of the dispensation of the hearing aid in accordance with Chapter 5101:3-10 of the Administrative Code and will not be reimbursed as a separate procedure.

Special dermatological procedures. Physician services associated with 96900, 96910, 96911, and 96912 are considered a part of the evaluation and management service.
Effective Date: August 2, 2011

Most Current Prior Effective Date: March 29, 2007

(A) Pulmonary services are categorized as:
   (1) Ventilation/pulmonary management services;
   (2) Technical services;
   (3) Bundled services (services that are considered a part of another provided service); or
   (4) Procedures composed of professional and technical components.

(B) Ventilation/pulmonary management
   (1) Ventilation/pulmonary management services are physician professional services that are
       included in the physician's evaluation and management service (visit) and may not be billed in
       conjunction with the codes for critical care, evaluation and management, or consultation
       services.
   (2) A physician may be reimbursed for professional services associated with the pulmonary
       management of a hospital inpatient over a twenty-four-hour period if the physician's primary
       responsibility is to manage the patient's pulmonary care, the physician is not the patient's
       primary or attending physician, and the physician is not billing a visit for the same date of
       service. For reimbursement, the provider must bill the appropriate code for pulmonary
       management services.
   (3) Ventilation management includes:
       (a) The initiation and maintenance of mechanical ventilation and controlled oxygen
           administration;
       (b) The establishment of mechanisms necessary for the monitoring of the patient;
       (c) The evaluation of all laboratory procedures used to determine ventilation treatment
           and/or diagnosis;
       (d) The adjustment of treatment plan(s); and
       (e) Maintenance of medical records.

(C) Technical-pulmonary services
   (1) Technical-pulmonary services include:
       (a) Nonpressured inhalation treatments;
       (b) Aerosol or vapor inhalations, diagnostic;
       (c) Manipulation of chest wall;
       (d) Continuous airway pressure ventilation;
       (e) Evaluate patient use of inhaler and;
       (f) Continuous inhalation treatment with aerosol medication.
   (2) Physicians may be reimbursed for the services listed in paragraph (C)(1) of this rule, only if the
       services are provided in a nonhospital setting.

(C) Professional services
Surfactant administration may not be billed in conjunction with critical care services codes.
(1) Codes 94002, 94003, and 94610 are considered physician professional services.

(2) Codes 94002, 94003, and 94610 may not be billed in conjunction with the codes for critical care services.

(3) Codes 94002, 94003, and 94610 are valid only in an inpatient hospital setting.

(D) Bundled services

The interpretation of blood gases and noninvasive oximetry services are considered incidental services and are bundled into the services for which they are incidental (e.g., visits, ventilation management, surgery anesthesia services, pulmonary consultations or oxygen supplier services). Blood gas and invasive oximetry procedures performed by certified laboratories are reimbursable in accordance with Chapter 5101:3-11 of the Administrative Code.

(E) Pulmonary services composed of professional and technical services

(1) The department will recognize a professional and technical component for all pulmonary procedures not listed in paragraphs (B) to (D) of this rule.

(2) These procedures shall be billed and reimbursed in accordance with rule 5101:3-4-11 of the Administrative Code. Professional and technical modifiers and associated place of service restrictions are set forth in the definition of "PCTC indicator" values contained within rule 5101:3-4-11 of the Administrative Code.

(3) Procedures that have a professional and technical component and the corresponding percentage splits for payment are set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code.

(F) Pulmonary consultation services must be billed in accordance with paragraph (E) of rule 5101:3-4-06 of the Administrative Code.

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(A) Allergy testing.

(1) Providers of physician services may be reimbursed for the performance and evaluation of allergy sensitivity tests as set forth in appendix DD to rule 5101:3-1-60 of the Administrative Code.

(a) A complete medical and immunologic history and physical examination must be done prior to performing diagnostic testing and be made available to the department upon request; and

(b) 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 and be documented in the patient's medical record; and

(c) Based on the information in the medical record, the testing must be limited to the minimal number of necessary tests to reach a diagnosis.

(2) The appropriate use of professional and technical modifiers and relevant place of service restrictions are set forth in rule 5101:3-4-11 of Administrative Code.

(3) Physician professional services associated with allergy testing are bundled into the code for evaluation and management services (visit).

(4) Percutaneous tests, intracutaneous/intradermal tests, photo patch tests, and patch tests, photo tests, or application tests are reimbursed on a per test basis. When billing, the provider must specify the number of tests performed.

(5) Quantitative or semi-quantitative in vitro allergen specific IgE tests (formerly referred to as RAST tests) are covered if skin testing is not possible or not reliable and they are performed by providers certified under the "Clinical Laboratory Improvement Amendment of 1988" (CLIA '88) to perform the tests and billed in accordance with Chapter 5101:3-11 of the Administrative Code.

(6) The qualitative multiallergen screen for allergen specific IgE, CPT code 86005, is not covered since it is not considered medically necessary.

(7) Provocative testing, CPT code 95078, is not covered since it is not considered medically necessary.

(8) Ophthalmic mucous membrane tests and direct nasal mucous membrane tests are allowed only when skin testing cannot test allergens.

(9) Ingestion challenge tests, CPT code 95075, are allowed once per patient encounter regardless of the number of items tested. Ingestion challenge tests include the evaluation of the patient's response to the test items.

(B) Allergen immunotherapy.

(1) "Allergen immunotherapy" is the provision of and parenteral administration of allergenic extracts as antigens at periodic intervals, usually on an increasing dosage scale to a dosage that is maintained as maintenance therapy.
(2) Providers may be reimbursed for the professional services necessary for allergen immunotherapy. Coverage and reimbursement of allergen immunotherapy is set forth in rule 5101:3-4-11 of the Administrative Code.

(3) 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.

(4) An office visit may be billed in addition to the allergen immunotherapy codes (95115, 95117, 95144-95180) only if other identifiable services are provided at that time. If an office visit code is billed with an allergen immunotherapy service, the modifier 25 must be used.

(5) 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.

(6) The department recognizes two components of allergen immunotherapy, one being the administration (injection) of the antigen, which includes all professional services associated with the administration of the antigen, and the other being the antigen itself. These two components must be billed separately, regardless of whether or not the provider who prescribes and provides the antigen is the same as the provider who administers the antigen.

(a) Injections.

For reimbursement for the administration (injection) of allergenic extract or stinging insect venom, the provider must bill CPT code 95115 or 95117. The allergenic extract may be administered by the physician or by a properly instructed employee under the general supervision of the physician in an office setting. These codes may not be billed with CPT code 95144.

(b) Antigens (excluding stinging insect venoms).

(i) When the provider prescribes and provides single or multiple antigens for allergen immunotherapy in multiple-dose vials (i.e., vials containing two or more doses of antigens), the provider must bill CPT code 95165 in the procedure/service code block and the number of doses contained in the vial in the unit(s) block on the invoice. If the provider dispenses two or more multiple-dose vials of antigen, for each vial dispensed CPT code 95165 must be billed on a separate line along with the corresponding number of doses.

For example, if a patient cannot be treated with immunotherapy by placing all antigens in one vial and two multidose vials containing ten doses each must be dispensed, the CPT code 95165 must be billed on two separate lines and a "10" (for ten doses) must be entered for the corresponding units.

(ii) CPT code 95144, the single dose vial antigen preparation code, must not be billed as one of the components of a complete service performed by a provider. The code must be billed only if the provider providing the antigen is providing it to be injected by some other entity. The number of vials prepared must be indicated.

(iii) The department does not recognize CPT codes 95120 through 95134 because they represent complete services, i.e., services that include both the injection service as well as the antigen and its preparation. Only component billing will be allowed. Providers providing both components of the service must do component billing. The provider must, as appropriate, bill one of the injection CPT codes (95115 or 95117) and one of the antigen/antigen preparation CPT codes (95145 through 95149, 95165, or 95170). The number of doses must be specified.

(c) Insect venoms in single dose vials or preparations.
(i) If the provider administers the venom(s), CPT code 95115 or 95117 must be billed for the injection(s) of the antigen(s).

(ii) When a provider prescribes and/or provides stinging insect venom antigens in single dose vials or preparations, CPT codes 95145 to 95149 must be billed.

(a) For each single dose vial or preparation provided, a unit of service of "1" must be reported.

(b) If the provider also administers the venom, CPT code 95115 or 95117 must be billed for the injection(s).

(iii) For any single dose vial or preparation of stinging insect venoms, the provider must use CPT codes 95145 to 95149 with a unit of service of "1" for each single dose vial/preparation provided.

(d) Insect venoms in multiple dose vials or preparations.

(i) When a provider prescribes and provides single or multiple stinging insect venom(s) in multiple dose vials, CPT codes 95145 to 95149 must be billed. The number reported as the unit of service must represent the total number of doses contained in the vial.

(ii) Regardless of the number of doses, the date of service reported should be:

(a) The date the vial is dispensed to the patient, if the patient takes the vial home to be administered elsewhere or at another time; or

(b) The date that the first dose is administered to the patient, if the vial is kept in the physician's office.

(iii) If the provider also administers the venom, CPT code 95115 or 95117 must be billed for the single or multiple injection(s). The correct quantity billed is one for either code.

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**Chemotherapy Treatment**

*Formerly* 5101:3-4-20  Chemotherapy Treatment

**MHTL 3336-11-03**

**Effective Date: August 2, 2011**

**Most Current Prior Effective Date: March 30, 1995 (No Change)**

(A) **Provision of the chemotherapeutic agent.**

When the chemotherapeutic agent is provided through the physician's office, physician's group practice, or clinic and is administered in a nonhospital setting, the physician may be reimbursed for the cost of the chemotherapeutic agent by billing the appropriate healthcare common procedure coding system (HCPCS) injection code.

(B) **Reimbursement for chemotherapy administration is restricted to certain place of service settings as set forth in rule 5101:3-4-11 of the Administrative Code.**

1. **The administration of chemotherapy includes the preparation of the chemotherapeutic agent and all therapeutic services and medical supplies provided during treatment.**

2. **When chemotherapy is administered in the physician's office, group practice, or clinic, the physician may be reimbursed for chemotherapy treatments personally administered by the billing physician or by a qualified employee supervised by the billing physician. For reimbursement, the provider must bill the appropriate current procedural terminology (CPT) code for chemotherapy.**

3. **The administration of chemotherapy is independent of the physician's professional service and the office visit. When a physician examines the patient, a visit may be billed in conjunction with the chemotherapy injection and administration codes (nonhospital setting only). The professional services involved in the supervision and monitoring of the chemotherapy treatments are considered a part of the evaluation and management (visit) service.**

Replaces: 5101:3-4-20

Effective: 08/02/2011

R.C. 119.032 review dates: 08/01/2016

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Date: 06/28/2011

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Anesthesia Services

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

MHTL 3336-07-02

Effective Date: November 20, 2007

Most Current Prior Effective Date: September 1, 2002

(A) The department will reimburse a physician for general, regional, or supplementation of local anesthesia services (or monitored anesthesia care services as described in paragraph (I) of this rule) provided during a surgical or diagnostic procedure. Anesthesia services include the usual 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 basic monitoring procedures. ECG, temperature, blood pressure, oximetry, capnography and mass spectometry are considered usual monitoring procedures. Unusual monitoring procedures such as intra-arterial, central venous and Swan Ganz are not included in the payment for anesthesia services and may be separately billed and reimbursed.

(B) Reimbursement for anesthesia services is the lesser of the provider's billed charge or the medicaid maximum payment as specified in paragraph (J)(5) of rule 5101:3-1-60 of the Administrative Code for services provided before May 1, 2001. For services provided on or after May 1, 2001, reimbursement for anesthesia services will be the amount obtained using the following formula:

Except for the exceptions set forth in paragraph (B) (7) of this rule, the formula for calculating the reimbursement of anesthesia services will be the base unit value and the time unit value multiplied by the appropriate conversion factor or percentage of a conversion factor as set forth in rule 5101:3-4-21.2 of the Administrative Code.

(1) "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 monitoring services.

(2) "Base unit value" means the value for a base unit for each anesthesia code. These values are taken from the 2000/01/01/2007 American society of anesthesiologists' relative value guide. For purposes of medicaid reimbursement, base unit values from the American society of anesthesiologists will be used for anesthesia codes. For any anesthesia code covered by the department, after the effective date of this rule, the department will use the base unit value assigned by the American society of anesthesiologists for the year that the code was added.

(3) "Time unit" means the continuous actual presence of the physician (or of the medically directed resident or medically-directed CRNA/AA) and starts when he/she begins to prepare the patient for anesthesia and ends when the anesthesiologist (or medically directed CRNA/AA) is no longer in personal attendance with the exception of anesthesia for neuraxial analgesia for obstetrical services defined in paragraph (C) of rule 5101:3-4-21.1 of the Administrative Code.

(4) "Anesthesia time" is the actual number of anesthesia minutes as reported on the claim. Anesthesia time is defined in paragraph (D) (3) of this rule.

(5) "Time unit value" means one unit for each fifteen minutes of reported anesthesia time. Since only the actual time of a fractional time unit is recognized, the resulting time unit value will be rounded to one decimal place.

(6) Anesthesia conversion factors are specified in rule 5101:3-4-21.2 of the Administrative Code.

(7) The following formula exceptions apply:

(a) 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 anesthesia codes; and
(b) Services billed with the "AD" modifier will be paid at three times the conversion factor set forth in rule 5101:3-4-21.2 of the Administrative Code.

(C) The department will reimburse a physician for anesthesia services only if all of the following conditions are met.

(1) Except as provided for in paragraph (C)(5) of this rule, the physician is acting exclusively as an anesthetist and is not also acting as the surgeon or assistant surgeon.

(2) For each patient, the physician:
   (a) Performs a pre-anesthetic examination and evaluation;
   (b) Prescribes the anesthesia plan;
   (c) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
   (d) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
   (e) Monitors the course of anesthesia administration at frequent intervals;
   (f) Remains physically present and available for immediate diagnosis and treatment of emergencies; and
   (g) Provides indicated post-anesthesia care.

(3) The physician either personally performs the services itemized in paragraph (C)(2) of this rule, without the assistance of a CRNA/AA, resident, intern, fellow, or other qualified anesthetist; or the physician uses assistance of a CRNA/AA, resident, intern, fellow or other qualified anesthetist in the performance of the services in paragraph (C)(2) of this rule, and does not perform any other services while providing medical direction.
   (a) "Medical direction" is when a physician meets the requirement set forth in paragraph (C)(1) of this rule and the physician utilizes the assistance of a CRNA/AA, resident, intern, or fellow in the performance of the services listed in paragraph (C)(2) of this rule and is involved in no more than four concurrent anesthesia cases.
   (b) "Medical supervision" is when the physician meets the requirement set forth in paragraphs (C)(1), (C)(2)(a) and (C)(2)(b) of this rule and the physician anesthesiologist is involved in furnishing services for more than four concurrent procedures or is performing other services while directing the concurrent procedures.

(4) In situations where the physician is involved in medically supervising more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the physician must be involved in the pre-surgical anesthesia services.

(5) When a surgeon or a group practice of surgeons employs CRNA to provide anesthesia services, the physician or group practice may bill and receive reimbursement for the services of the CRNA in addition to the reimbursement for the surgical procedures performed by the physician.

(D) For reimbursement for services provided on and after the effective date of this rule, the physician must bill the appropriate anesthesia code for the service provided modified by the appropriate anesthesia modifier, and report the anesthesia time in minutes.

(1) The following anesthesia modifiers must be used for billing anesthesia services:
   AA Anesthesia services personally performed by the anesthesiologist.
   AD Medical supervision by a physician: more than four concurrent anesthesia procedures.
   QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
   QX CRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist.
QY Medical direction of one CRNA by an anesthesiologist; and
QZ CRNA without medical direction by physician.

Note: Anesthesiologist assistants may use the modifier "QX" to bill for services provided under the medical direction of an anesthesiologist if they are employed by a physician or in an independent practice. An anesthesiologist may bill the "QY" modifier if he/she provides medical direction to an anesthesiologist assistant.

(2) Except as provided for in paragraph (H) of this rule, reimbursement for the services of a CRNA/AA may not be made to a provider of physician services, including hospitals.
   (a) Services of a hospital employed CRNA/AA are included in the facility payment made to the hospital.
   (b) Services of a self-employed CRNA/AA or a CRNA/AA who is a member of an independent CRNA/AA group practice is reimbursable directly to the CRNA/AA or CRNA/AA group practice.

(3) Anesthesia time begins when the anesthetist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthetist is no longer in personal attendance, that is, when the patient may be safely placed under post anesthesia post-anesthetic supervision.

(4) The modifier "AA" may be used if a teaching anesthesiologist is continuously involved in one procedure with one resident or with one student certified registered nurse anesthetist. The teaching anesthesiologist must document in the medical records that he or she was present during all critical portions of the procedure including induction and emergence.

(5) A physician who provides medical direction of a CRNA/AA may submit claim(s) for medical direction of a CRNA/AA as described in paragraph (H)(3) of this rule.

(E) No additional reimbursement will be paid for the physical status of the patient, the age of the patient, body hypothermia, body hyperthermia, emergency conditions, or time of day.

(F) When it is medically necessary to provide general anesthesia services for extensive restorative dental procedures or for a medicaid covered oral surgery procedure for which there is not a surgical code, the anesthesia services must be billed using code 00170 modified by the appropriate anesthesia modifier.

(G) For the reimbursement of anesthesia services the physician must bill the anesthesia code which best describes the anesthesia procedure performed modified by the appropriate anesthesia modifier as listed in paragraph (D) of this rule, and report the total anesthesia time in minutes.

(1) Except as provided for in paragraph (G)(2) of this rule, when anesthesia services are provided for more than one surgical procedure performed on the same date of service for the same patient, the department will reimburse for only one anesthesia service. Reimbursement will be based on the appropriate anesthesia code and the total anesthesia time reported should be inclusive of the anesthesia time encompassing all of the surgical procedures.

(2) The department will pay for two anesthesia services provided on the same patient on the same date of service on a case-by-case basis only if one or more of the following conditions apply:
   (a) The patient was either discharged from the hospital or was released from the recovery/surgical area to the floor or surgical intensive care unit;
   (b) The patient had to return to the operating room on an emergency basis; or
   (c) It was medically necessary for the two procedures to be performed separately and two separate anesthetics were required; or
   (d) The patient had 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 performed separately on the same day.
Reimbursement will be made to a provider of physician services for CRNA/AA services under the following conditions:

(1) When the CRNA/AA is employed by a physician, hospital, or other valid provider of physician services and the claim is for the medicare coinsurance and deductible amounts due for medicare covered CRNA/AA services provided to a patient who is dually eligible for medicare and medicaid, even if separate 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/AA services).

(a) The coinsurance and deductible payments should normally be made through the automatic crossover mechanism.

(b) If the claims for the anesthesia services provided by the CRNA/AA did not get paid through the automatic crossover system, the provider must submit a medicaid crossover "F-type 6780" claim, in accordance with the crossover billing instructions specified in BIN.1101 except that the CRNA/AA's provider medicaid legacy number must be submitted as the rendering provider number and the employing provider's medicaid legacy number must be submitted as the "pay to" provider.

(c) If the claims for the anesthesia services provided by the CRNA/AA were paid but the claims for the anesthesia services provided by the physician were denied through the automatic crossover system, the provider must submit a medicaid crossover "F-type 6780" claim, with the physician's provider medicaid legacy number listed as the rendering provider. If it is a physician group practice the provider medicaid legacy number for the group practice must be submitted as the "pay to" provider.

(2) When the CRNA is employed by the surgeon. In such cases, the services of the CRNA must be billed on a separate physician claim form from the surgeon and the provider medicaid legacy number and national provider identifier number (NPI) of the CRNA must be listed as the rendering provider and the provider medicaid legacy number and the NPI number of the employing physician or the physician group practice must be listed as the "pay to" provider.

(3) When a CRNA/AA is employed by a physician acting exclusively as an anesthetist as specified in paragraph (C) (1) of this rule or an anesthesiology group practice.

(a) One claim must be submitted when no medical direction or supervision was provided by the physician/anesthesiologist.

(b) Two claims must be submitted when the physician/anesthesiologist meeting the requirement in paragraph (C) (1) of this rule provides medical direction or medical supervision to CRNAs/AAAs.

(i) On one claim the physician/anesthesiologist who provided the medical direction would be listed as the rendering provider and the anesthesia code for the anesthesia procedure modified by the appropriate modifier indicating medical direction listed in paragraph (D) (1) of this rule should be billed.

(ii) On the second claim for services provided by the CRNA/AA, the CRNA/AA who provided the service under the medical direction of a physician would be listed as the "pay to" provider. The appropriate anesthesia code must be modified by "QX" to denote a CRNA/AA under the medical direction of a physician.

(I) Monitored anesthesia care (MAC) is a combination of local anesthesia and certain anxiolytic and analgesic medications. When this type of anesthesia is used, the patient maintains protective reflexes and consciousness except for a brief period of time. Monitored anesthesia care requires the same expertise and work as required in the delivery of general anesthesia. Billing and reimbursement for monitored anesthesia care is the same as for general anesthesia when all of the conditions for
reimbursement listed in paragraph (C) of this rule are met. There is no additional reimbursement for monitored anesthesia.

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Rule Amplifies: 5111.01, 5111.02, 5111.021
Anesthesia for Neuraxial Analgesia for Obstetrical Services

Effective Date: October 1, 2006

Most Current Prior Effective Date: January 1, 2002

(A) This rule applies to the following obstetrical care anesthesia procedures:

(1) subarachnoid needle placement and drug injection and/or necessary placement replacement of an epidural anesthesia catheter during labor; and

(2) Anesthesia for cesarean delivery following Neuraxial-neuraxial analgesia/anesthesia for labor ending in a cesarean delivery (this includes any repeat subarachnoid needle placement and drug injection and/or necessary placement of an epidural anesthesia during labor).

(B) All of the provisions of rule 5101:3-4-21 of the Administrative Code apply to anesthesia services for the obstetric anesthesia listed in paragraph (A) of this rule, except for:

(1) Paragraph (B)(3) of rule 5101:3-4-21 of the Administrative Code, which defines "time unit";

(2) Paragraph (C)(2) of rule 5101:3-4-21 of the Administrative Code;

(3) Paragraph (C)(4) of rule 5101:3-4-21 of the Administrative Code; and

(4) Paragraph (D)(3) of rule 5101:3-4-21 of the Administrative Code.

(C) In the case of anesthesia for obstetrical services listed in paragraph (A) of this rule, "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.

(D) The department will reimburse for neuraxial analgesia for obstetrical services if the following conditions are met:

(1) For each patient, the physician, must:
   (a) Perform or approve a pre-anesthesia examination and evaluation for labor analgesia performed by a qualified anesthesia provider;
   (b) Prescribe or approve an anesthesia plan;
   (c) Personally participate in all critical portions of the procedure, including placement of the epidural or other regional technique;
   (d) Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual anesthesia provider;
   (e) Periodically monitor the course of anesthesia/analgesia administration or ensure that a qualified anesthesia provider performs the monitoring;
   (f) Remain readily available for immediate diagnosis and treatment of emergencies as required by Ohio statute; and
   (g) Provide indicated post anesthesia care.

(2) 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.
   (a) Medical supervision applies to labor analgesia services when:
      (i) 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;
(ii) The anesthesiologist is supervising more than four epidural placements at the same time; or

(iii) The anesthesiologist is not in the obstetrical suite while supervising the critical portion of the neuraxial technique.

(b) Paragraph (D)(1)(c) of this rule does not apply to medically-supervised labor analgesia services.

(E) In the event that anesthesia for surgery is required during the course of a labor analgesic technique, i.e., cesarean section, the provisions outlined in paragraph (C) of rule 5101:3-4-21 of the Administrative Code apply.

Effective Date: October 1, 2006
R.C.119.032reviewdates:06/15/2006
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Prior Effective Dates: 1/01/02
Effective Date: January 1, 2010

**Most Current Prior Effective Date:** September 1, 2005

(A) For modifiers "AA", "AD", or "QZ", the conversion factor is fifteen dollars and twenty-eight cents for dates of service on and after between May 1, 2001 and December 31, 2009. For dates of service on or after January 1, 2010, the conversion factor is fourteen dollars and eighty-two cents.

(B) For modifiers "QK", "QX", or "QY", the conversion factors are as follows:
factor is sixteen dollars and twenty-six cents for dates of service between September 1, 2002 and December 31, 2009. For dates of service on or after January 1, 2010, the conversion factor is fifteen dollars and seventy-seven cents.

1. Sixteen dollars and ninety-eight cents for dates of service between May 1, 2001, until September 1, 2002; and

(C) Services billed with the "QK", "QX", or "QY" modifiers described in paragraph (D)(1) of rule 5101:3-4-21 of the Administrative Code will be reimbursed at fifty per cent of the conversion factor stated in paragraph (B) of this rule.

Effective: 01/01/2010

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Prior Effective Dates: 9/1/02, 9/1/05
**Effective Date: December 31, 2014 (Emergency)**

**Most Current Prior Effective Date:** March 27, 2014

### 5160-4-22 Appendix

(A) The department will reimburse physicians for most surgical procedures. The surgical procedure includes the operation per se, local infiltration, metacarpal/digital block or topical anesthesia when used, and the normal uncomplicated preoperative and postoperative care. Payment for conscious sedation is bundled into the payment for the related surgical or radiological procedure and is not reimbursed separately by the department.

(B) Physicians will be reimbursed for physician visits in addition to the surgery only as detailed in rule 5160-4-06 of the Administrative Code.

(C) For the reimbursement of surgical services, the physician must bill the appropriate code for the surgical procedure(s). Each surgical procedure must be billed using the most comprehensive surgical procedure code(s). This means procedures that are incidental to, or performed as an integral part of the comprehensive surgical service(s), must not be billed in component parts or "unbundled."

(D) Multiple surgeries.

1. Surgical codes subject to multiple surgery pricing are indicated in the appendix to this rule. Multiple surgery pricing will apply to the procedures indicated with an "x" in the corresponding column for multiple surgery in the appendix to this rule.

2. Reimbursement for multiple surgical procedures performed on the same patient by the same provider shall be the lesser of billed charges or:
   - One hundred per cent of the medicaid maximum allowed for the primary procedure.
     The primary procedure is considered to be the surgical procedure that has the highest medicaid maximum listed in appendix DD to rule 5160-1-60 of the Administrative Code.
   - Fifty per cent of the medicaid maximum allowed for the secondary procedure.
   - Twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

3. Surgical codes subject to multiple surgery pricing may not be billed with multiple units. Billing a multiple surgery code with more than one unit will result in a denial of that line. Each surgery subject to multiple surgery pricing must be billed on a separate line using the most comprehensive surgical procedure code.

4. Surgical procedure codes that are not considered multiple surgery and are not bundled into the reimbursement of another surgical procedure billed 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 indicated with an "x" in the multiple surgery column of the appendix to this rule.

5. The Ohio department of medicaid (ODM) allows the 51 modifier signifying a "multiple procedure."

(E) Bilateral procedures.

1. Surgical codes subject to bilateral surgery pricing are contained in the appendices to this rule. Bilateral surgery pricing will apply to procedures indicated with an "x" in the corresponding column for bilateral surgery in the appendix to this rule.

2. Bilateral procedures, when performed bilaterally, should be billed with the bilateral surgery code on a single line with the modifier 50.
The medicaid maximum for bilateral procedures is one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally when the code is billed on a single line with the 50 modifier.

Surgical codes that are considered bilateral codes but are performed unilaterally on only one side of the body should be billed on one line unmodified or on one line with either the LT or the RT modifier indicating the side of the body on which the procedure was performed.

Surgical codes that are considered bilateral codes but are performed more than once on one or each side of the body and/or body part indicated by the code definition must be billed using only the LT and RT modifiers on each line to demonstrate the procedure was performed more than once on one or each side.

Surgical procedures that may be billed with site modifiers.

Surgical procedures performed on fingers, toes, eyelids, or coronary arteries may be billed with site modifiers. Procedures that may be billed with site modifiers are indicated with an "x" in the corresponding column in the appendix to this rule.

Surgical procedures performed on hands, feet, fingers, and/or toes may be billed modified or unmodified depending on the definition of the code and the site at which the procedure was performed. For example, if the code definition indicates the right thumb, the code defines the site of the procedure.

Surgical procedures performed on one body part, for example one finger or one hand, one toe or one foot, may be billed unmodified.

Surgical procedures performed on more than one body part, according to the definition of the code, must be billed with the appropriate digit modifier for each finger or toe, and/or with the LT modifier for each left hand or left foot procedure, and/or with the RT modifier for each right hand or right foot procedure.

Surgical procedures performed on eyelids may be billed using eyelid modifiers. An eyelid modifier is required if the surgery involves more than one eyelid. If the surgery was performed on only one eyelid (right or left side), the code must be billed using the appropriate eyelid modifier. If the surgical procedure was performed on both eyelids of one eye on a side, the code must be billed using the LT or the RT modifier demonstrating that the surgery was performed on both eyelids of one eye on a side.

Surgical procedures performed on the coronary arteries may be billed using the appropriate coronary artery modifier to demonstrate which artery and side.

Incidental procedures.

When incidental procedures are performed through the same incision, during the same operative session, the allowable fee shall be that of the major, more comprehensive, procedure only.

Assistant at surgery.

Surgical codes subject to assistant at surgery pricing are contained in the appendix to this rule. Assistant at surgery pricing will apply to procedures indicated with an "x" in the corresponding column for assistant at surgery in the appendix to this rule.

The billing by a surgical assistant shall be no greater than his/her customary charge for the professional work rendered.

The department’s payment for an assistant at surgery will be limited to the billed charge, or twenty-five per cent of the medicaid maximum allowed for the primary surgical procedure, whichever is lower.

No assistant fees will be reimbursed for assistant-at-surgery services provided by a non-physician (e.g., registered nurses, advanced practice nurses, or physician assistants).
Reimbursement will not be made for more than one assistant at surgery, regardless of the extent of surgery.

Conditions for payment for assistants at surgery in a teaching hospital.

(a) Reimbursement will not be made for assistants at surgery in teaching hospitals with a training program relating to the medical specialty required for the surgical procedure and where a resident in a training program is available to serve as an assistant at surgery.

(b) Reimbursement for an assistant at surgery in a teaching hospital may be made only if the services:

(i) Are required due to exceptional medical circumstances;

(ii) Are performed by team physicians needed to perform complex medical procedures;

(iii) Constitute concurrent medical care relating to a medical condition that requires the presence of and active care by a physician of another specialty during surgery; or

(iv) Are medically required and are furnished by a physician who is primarily engaged in the field of surgery and the primary surgeon does not utilize residents and interns in the surgical procedure he or she performs (including preoperative and postoperative care).

Billing assistant at surgery services.

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

Application of casts, splints, straps or other traction devices.

(1) Services listed in the musculoskeletal surgery section of the current procedural terminology (codes 20000 through 28899 and 29800 through 29999) include the application and removal of the first cast, splint, strap or other traction device.

(2) The casting, splinting and strapping procedures listed at the end of the musculoskeletal surgery section of the current procedural terminology (CPT) (codes 29000 through 29799) may be billed only when the casting, splinting or strapping is performed as a replacement procedure during or after the period of follow-up care. A visit may not be billed with any of the casting, splinting or strapping codes.

(a) The casting codes include all professional services and supplies provided during the service.

(b) The splinting and strapping codes do not include the splints or straps (elastic bandages). Splints or straps may be billed as a durable medical equipment (DME) service, if it was medically necessary to replace the splint or strap.

(3) If a cast application, strapping or splinting is provided as an initial procedure in which no surgery code is applicable (e.g., the casting or strapping of a sprained ankle or knee), the provider must bill using the appropriate visit code. When this service is provided in a non-hospital setting, the provider may also be reimbursed for the cost of the cast, splint, or strap.

(a) For the strapping or splinting materials, the provider must bill the appropriate DME code in accordance with Chapter 5160-10 of the Administrative Code.

(b) For casting materials, the provider must bill the appropriate code for casting materials in appendix DD to rule 5160-1-60 of the Administrative Code. The provider must maintain, at a minimum, documentation that supports that the service was an initial cast application for a non-surgical service and the quantity and description of the casting supplies.

(4) When a cast has been damaged and it is medically appropriate to repair rather than to remove and replace the cast, the provider may bill and be reimbursed for an evaluation and management service. If the casting repair is performed in a non-hospital setting, the provider
may also be compensated for the casting materials by billing one of the appropriate codes for casting materials.

Effective: 12/31/2014
Certification: CERTIFIED ELECTRONICALLY
Date: 12/31/2014
Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5162.03, 5164.02, 5164.70
A physician may be reimbursed for all covered surgical procedures performed in an ambulatory surgery center (ASC) regardless of whether the surgery is a covered ASC surgical procedure.

An ASC will be reimbursed a facility fee for only covered ASC surgical procedures. "Covered ASC surgical procedures" are procedures that meet the standards described in 42 CFR 416.65(a) and (b) and are designated as ASC procedures in appendix DD of rule 5101:3-1-60 of the Administrative Code.

A physician may be reimbursed for the professional component of a covered laboratory, radiology, diagnostic, or therapeutic service only if the physician personally performed the service and the service was not performed by an employee of the ASC in the ASC.
A. Laboratory.

The department will reimburse physicians for laboratory procedures that are necessary in the treatment of a patient's condition in accordance with Chapter 5160-11 of the Administrative Code.

B. Radiology.

The department will reimburse physicians and certain other providers for covered radiology services in accordance with paragraphs (B)(1) to (B)(9) of this rule.

1. The department recognizes a professional component and a technical component for each radiological procedure. When both components are performed by one provider, they are recognized as the total (radiological) procedure.

2. X-rays and documentation of all results of radiological procedures must be maintained on file for a period of six years. In addition, x-rays must be of sufficient quality to ensure ease of diagnosis and must be marked with the patient's name and dated for ready identification.


When billing for radiology services, providers must bill using the appropriate modifiers. Appendix DD to rule 5160-1-60 of the Administrative Code identifies which current procedural terminology (CPT) modifier applies to a particular procedure code.

"26 Professional component only"

"TC Technical component only"

"Unmodified Total procedure (both technical and professional components)"

4. Professional component.

(a) The department will directly reimburse a radiologist the professional component when the radiologist performs the initial interpretation of a radiological examination.

(b) The department will directly reimburse a radiologist or cardiologist for the professional component when the radiologist or cardiologist interprets a radiological procedure that has already been interpreted by another physician. In this case, the radiologist's or cardiologist's interpretation is a specialist's evaluation (of the interpretation of the treating physician) whose findings could affect the course of treatment initiated or cause a new course of treatment to begin.

(c) Reimbursement is not allowed for an interpretation of a radiological procedure performed by the attending, treating, or emergency room physician after a radiologist's or cardiologist's interpretation. Such a service would be considered a part of the physician's overall workup or treatment of the patient and reimbursed as part of the visit.

(d) A physician providing radiological services in an inpatient hospital, an outpatient hospital, or an emergency room setting may bill only for the professional component.

(e) To bill for the professional component only use the appropriate procedure code modified by 26 (e.g., 7001026).

5. Technical component.

(a) The department will reimburse a physician/provider for only the technical component if:
The physician personally performed the service or the service was performed by an employee of the physician/provider;

(ii) The professional component was performed by another physician/provider; and

(iii) The service was performed in a setting other than an inpatient hospital, an outpatient hospital or an emergency room.

(b) To bill for the technical component only, use the appropriate procedure code modified by TC (e.g., 70010TC).

6 Total procedure.

(a) The department will reimburse a physician for the total procedure when the radiologist or treating physician performs the professional and technical components of a radiological procedure in a setting other than an inpatient hospital, an outpatient hospital, or an emergency room.

(b) The department will reimburse any other non hospital provider for the total procedure when:

(i) The physician who performed the professional component has an employment or contractual arrangement for the provider to bill for the professional services; and

(ii) The technical component was performed in a setting other than an inpatient hospital, an outpatient hospital, or an emergency room.

(c) To bill for the total procedure, use the appropriate procedure code unmodified (e.g., 70000).

7 Radiation treatment services.

(a) For reimbursement for the professional services associated with radiation treatments, the provider must bill the appropriate procedure code for clinical treatment management modified by the modifier 26.

(i) One of the weekly clinical management codes must be billed for each five fractions provided regardless of the time interval used in delivering the five fractions.

(ii) The radiation therapy management code must be billed "by report" when the complete course of treatment consists of one or two fractions.

(b) The radiation treatment delivery codes are considered technical only procedures and may be reimbursed to a non-hospital provider only if the service was provided in a non-hospital setting and the code was billed without a modifier.

8 Reimbursement of radiology procedures.

(a) Radiology procedures have a key listed identifying the professional and technical split in appendix DD to rule 5160-1-60 of the Administrative Code. This key specifies the split between the professional and technical component. For example, the indicator K indicates that fifty per cent of the fee amount is for professional services and fifty per cent is paid for technical services.

(b) Reimbursement for radiology procedures provided by non-hospital providers is the lesser of the provider’s submitted charge or:

(i) For the total procedure, the maximum fee listed in appendix DD to rule 5160-1-60 of the Administrative Code;

(ii) For the professional component, the maximum fee listed in appendix DD to rule 5160-1-60 of the Administrative Code multiplied by the percentage indicated by the code for the professional component; or
For the technical component, the maximum fee listed in appendix DD to rule 5160-1-60 of the Administrative Code multiplied by the percentage indicated by the code for the technical component.

(c) If more than one advanced imaging radiology procedure (CT, MRI, or ultrasound) is performed by the same provider or provider group for an individual patient on in the same date session, then the procedure with the highest fee specified in appendix DD to rule 5160-1-60 of the Administrative Code is considered to be the primary procedure. The maximum fee for a radiology procedure is the lesser of the provider’s submitted charge or a percentage of the amount specified in appendix DD to rule 5160-1-60 of the Administrative Code, determined in the following manner:

(i) For a primary procedure, it is one hundred per cent.
(ii) For each additional global or technical component of a procedure, it is fifty per cent.
(iii) For each additional professional component of a procedure, it is seventy-five per cent.

(d) Payment for conscious sedation is bundled into the payment for the related surgical or radiological procedure and is not reimbursed separately by the department.

(9) Reimbursement for supplies for radiological procedures.

(a) Effective for dates of service on or after January 1, 2006, the department will reimburse a physician or other eligible (non-hospital) provider in accordance with rule 5160-1-60 of the Administrative Code for supplies for radiological procedures performed in a non-hospital setting.

(b) Codes for supplies for radiological procedures are invalid for all hospital places of service.

(10) Mammography services.

(a) Payment may be made for screening mammography services if the services are provided by a facility having a certificate issued by the food and drug administration (FDA) and the services are provided in accordance with:

(i) All federal, state, and local laws pertaining to the provision and quality assurance standards of radiological and mammography services; and
(ii) The frequencies and conditions set forth in paragraph (B)(10)(b) of this rule.

(b) Frequency and conditions of coverage.

(i) No payment may be made for a screening mammography provided to a medicaid recipient under thirty-five years, unless a woman is at high risk of developing breast cancer. The patient’s medical records must clearly document the patient’s immediate risk of developing breast cancer at an age less than thirty-five.

(ii) One screening mammography may be paid for a medicaid recipient over the age of thirty-four and under the age of forty.

(iii) One screening mammography every twelve months may be paid for a medicaid recipient who is over the age of thirty-nine.

(c) Mammographies provided for the diagnosis and treatment of women who show clinical symptoms indicative of breast cancer are covered regardless of the recipient’s age.

(d) Under the medicaid program, mammography services may be provided by the following Ohio medicaid providers as long as the provider complies with all applicable federal, state, and local laws governing mammography services:

(i) Physicians and physician group practices;
(ii) Clinics;
(iii) Rural health clinics (RHCs);
(iv) Outpatient health facilities (OHFs);
(v) Federally qualified health centers (FQHCs);
(vi) Hospitals; and
(vii) Independent diagnostic testing facilities (IDTFs).

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Date: 07/21/2014
Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5162.03, 5164.02, 5164.70
(A) Payment may be made for covered physical medicine and rehabilitation services performed by a physician or by a licensed individual under the direct supervision of a physician in accordance with rule 5160-4-02 of the Administrative Code.

(B) Physical therapy, occupational therapy, speech-language pathology, and audiology are addressed in Chapter 5160-8 of the Administrative Code.

Replaces: Part of 5160-4-26

Effective: 01/01/2014

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Certification: CERTIFIED ELECTRONICALLY

Date: 12/20/2013

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.06, 5164.70

Physician Reimbursement of Medical Supplies and Durable Medical Equipment

*Formerly* 5101:3-4-27

**Effective Date:** November 20, 2007

**Most Current Prior Effective Date:** January 1, 2001

(A) Medical supplies and durable medical equipment are items and equipment as defined in rule 5101:3-10-02 of the Administrative Code.

(B) A physician may not be separately reimbursed for medical supplies or durable medical equipment utilized in a physician's office, clinic, or patient's home during a physician's visit.

(C) A physician may be reimbursed for medical supplies or durable medical equipment dispensed in the physician's office, clinic, or patient's home, for use in the patient's home, if the physician has a "supplies and medical equipment" category of service.

(D) All physicians who have a valid "medicaid provider agreement" are eligible to apply for and receive a "supplies and medical equipment" category of service.

(E) **Scope and extent of coverage.**

(1) The scope and extent of coverage of medical supplies or durable medical equipment services are detailed in Chapter 5101:3-10 of the Administrative Code.

(2) All medical supplies or durable medical equipment require a written prescription by a physician, which must be kept on file for six years in the physician's office in accordance with rule 5101:3-1-17.2 of the Administrative Code.

(F) **Reimbursement.**

All claims for medical supplies or durable medical equipment must be billed in accordance with rule 5101:3-10-05 of the Administrative Code.

Replaces: Former 5101:3-4-27

Effective: 11/20/2007

R.C. 119.032 review dates: 11/01/2012

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Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/8/79, 2/1/80, 5/19/86, 7/1/87, 4/1/88, 9/1/89
The text of OAC rule *Formerly* 5101:3-4-28 Noncovered Services, is located in Chapter 2 of this book.
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

MHTL 3334-13-04

Effective Date: March 28, 2013

Most Current Prior Effective Date: December 31, 2012 (Emergency)

(A) Definitions.

(1) For the purpose of this rule, "direct supervision and general supervision" by a physician are defined in rule 5101:3-4-02 of the Administrative Code.

(2) "Clinical social worker (CSW)" is defined in rule 5101:3-16-01 of the Administrative Code.

(3) "Licensed social worker" is defined in section 4757.28 of the Revised Code;

(4) "Professional counselor" is as defined in rule 4757-3-01 of the Administrative Code; and

(5) "Professional clinical counselor" is as defined in rule 4757-3-01 of the Administrative Code.

(6) "Non-physician" as used in this rule means either a clinical social worker, licensed social worker, professional counselor, professional clinical counselor, or clinical psychologist.

(B) Covered clinical psychiatric diagnostic services, evaluative procedures and therapeutic procedures personally provided by a physician are directly reimbursable to the physician, regardless of the place of service.

(C) Services for the diagnosis and treatment of mental and emotional disorders are covered as physician services when the services are performed by a licensed social worker, professional counselor, or professional clinical counselor who is employed by or under contract with the physician or clinic as long as the services provided are within the licensed social worker's professional counselor's, or professional clinical counselor's scope of practice as defined in Chapter 4757. of the Revised Code and:

(1) The services performed by a clinical social worker are provided under the general supervision of a physician;

(2) The services performed by a licensed social worker who does not meet the requirements of a clinical social worker are provided;
   (a) Under the direct supervision of a physician; or
   (b) Under the general supervision of a physician and the direct supervision of a clinical social worker.

(3) The services performed by a professional counselor are provided under the direct supervision of a physician as described in rule 5101:3-4-02 of the Administrative Code;

(4) The services performed by a professional clinical counselor are provided under the general supervision of a physician as described in rule 5101:3-4-02 of the Administrative Code.

(D) A licensed social worker, a clinical social worker, professional counselor or professional clinical counselor may not be directly reimbursed for services provided under the medicaid program. Services of a licensed social worker, clinical social worker, professional counselor or professional clinical counselor may only be billed by and reimbursed to the employing or contracting physician or clinic only when the following provisions are met:

(1) The supervision requirements listed in paragraph (C) of this rule have been met; and

(2) The physician provides supervision which, at a minimum, includes the following:
   (a) Discussion about the progress of the patient toward specified goals;
   (b) Updating treatment plans as needed; and
(c) Periodic participation in therapy sessions.
    Countersigning the therapist's signature is insufficient evidence of active supervision.

(E) Physicians or clinics may not be reimbursed for services provided by a licensed social worker, professional counselor or professional clinical counselor if the services are provided to patients in the inpatient hospital setting, in the outpatient hospital setting, or to residents of a LTCF.

(1) Services provided by a licensed social worker CSW, professional counselor or professional clinical counselor to patients in the inpatient or outpatient hospital setting are covered as hospital services in accordance with Chapter 5101:3-2 of the Administrative Code and may not be reimbursed separately.

(2) Services provided by a licensed social worker CSW, professional counselor or professional clinical counselor to residents of a long-term care facility are covered only as long-term care facility services in accordance with rule 5101:3-3-20.1, Chapter 5101:3-3 of the Administrative Code.

(F) The following services are noncovered under the Medicaid program:

(1) Services provided in facilities regulated by the state board of education;
(2) Sensitivity training, encounter groups or workshops;
(3) Sexual competency training;
(4) Marathons and retreats for mental disorders; and
(5) Educational activities, testing and diagnosis;
(6) Monitoring activities of daily living;
(7) Recreational therapy (art, play, dance, or music);
(8) Teaching grooming skills;
(9) Services primarily for social interaction, diversion, or sensory stimulation;
(10) Psychotherapy services are not covered if the patient’s cognitive deficit is too severe to establish a relationship with the psychotherapist; and
(11) Family therapy psychotherapy involving training of family members or caregivers if the purpose is the management of the patient.

(G) For reimbursement for services provided by non-physicians meeting the criteria in paragraph (C) of this rule, the services must be billed using the following codes and modifiers:

(1) Billable codes and services:
   (a) For individual therapy, bill the standard individual therapy codes specified in paragraphs (D)(2)(1)(a)(i) to (D)(2)(1)(a)(ii) and (D)(2)(1)(a)(iv) to (D)(2)(a)(v) of rule 5101:3-8-05 of the Administrative Code;
   (b) For group therapy, bill the standard codes specified in paragraphs (D)(2)(1)(b)(i) to (D)(2)(1)(b)(iv) of rule 5101:3-8-05 of the Administrative Code.

(2) Modifiers to signify the level of educational training of a non-physician providing therapy services:
   (a) If the non-physician providing the service is a clinical social worker, bill the appropriate code modified by "AJ" to signify that a clinical social worker provided the service.
   (b) If the non-physician providing the service is a clinical psychologist, bill the appropriate code modified by "AH" to signify that a clinical psychologist provided the service.
   (c) If the non-physician providing the service holds a doctoral degree and is not a clinical psychologist, bill the appropriate code modified by "HP" to signify a doctoral level trained professional.
If the non-physician providing the service holds a master's degree and is not a clinical social worker, bill the appropriate code modified by "HO" to indicate a masters degree level trained professional.

If the non-physician providing the service holds a bachelor's degree only, bill the appropriate code, modified by "HN" to signify that a bachelor's level clinical staff person provided the service.

Reimbursement for therapy provided by a non-physician will be reimbursed at the following levels:

(a) For services provided by a clinical psychologist, services will be reimbursed as stated in paragraph (D)(2)(1) of rule 5101:3-8-05 of the Administrative Code.

(b) For individual therapy provided by non-physicians except as described in paragraph (G)(3)(a) of this rule, services will be reimbursed at the lesser of the provider's billed charge or fifty per cent of the medicaid maximum for the individual therapy code.

(c) For group therapy services provided by non-physicians except as described in paragraph (G)(3)(a) of this rule, services will be reimbursed at the lesser or the provider's billed charge or fifty per cent of the medicaid maximum for the group therapy code.

The patient's medical record must substantiate the nature of the services billed including:

(1) The medical necessity of the services billed;

(2) A treatment plan which is signed and dated by the physician prior to initiating therapy. The treatment plan shall include but is not limited to:
   (a) Relevant medical and psychiatric diagnoses;
   (b) Treatment goals;
   (c) Type, duration, frequency of therapy services;
   (d) Response to treatment on an on-going basis;
   (e) Prognosis; and
   (f) Evidence of sufficient cognitive ability to benefit from therapy.

(3) Any medications prescribed;

(4) Information regarding the patient's symptoms, functional impairment, type, duration, and frequency of treatment including dates of treatment sessions;

(5) The face-to-face time period spent with the patient;

(6) Test results, if applicable.

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Rule Amplifies: 5111.01, 5111.02
Prior Effective Dates: 2/17/91, 11/1/01, 12/31/12(Emer)
A physician may be reimbursed for the professional services associated with ECMO treatments for patients that meet the criteria for ECMO as set forth by the hospital where the service is performed. The hospital's criteria for ECMO must be consistent with acceptable medical practices for this treatment.

The department will not cover ECMO treatments performed for conditions for which the efficacy of ECMO has not been established and the treatments have not been accepted as standard medical practice for the patient's condition. ECMO under these circumstances will be considered an experimental procedure. In general, ECMO is indicated for any cardiac and/or pulmonary condition (whether congenital or acquired) that is unresponsive to conventional therapy with a high likelihood of morbidity and/or mortality without ECMO.

The physician who performed the procedure for inserting the cannula for the ECMO procedure and initiates the ECMO treatment may be reimbursed for these services by billing current procedural terminology (CPT) code 36822. This procedure will be paid in addition to CPT code 33960 as noted in paragraph (I) of this rule.

Reimbursement is available for professional services associated with the maintenance and management of ECMO treatments provided over a twenty-four-hour period.

Except as provided for in paragraph (F) of this rule, reimbursement for evaluation and management services, including newborn critical care services, are bundled into the reimbursement for ECMO.

Reimbursement is available for evaluation and management services, including newborn critical care services, provided prior to the decision to initiate ECMO treatments.

Reimbursement is available for surgical, diagnostic, and therapeutic services that are not integral to ECMO treatment but are personally provided to the patient by the physician during the ECMO treatment if those services are not an integral part of the ECMO treatment.

For the supervising physician to be entitled to reimbursement when residents, interns, or fellows are involved in the management of a patient during an ECMO treatment, the medical records must demonstrate that the supervising physician was personally present in the unit with sufficient regularity during the twenty-four-hour period that it could be concluded that the supervising physician was personally responsible for the patient's care during the ECMO treatment.

Providers should bill CPT code 33960 for the first twenty-four hours and 33961 for each additional twenty-four hours.

Regardless of the number of providers, no more than twenty-four hours of ECMO services shall be reimbursed during a twenty-four hour period.

Under no circumstances shall more than twenty-four hours of ECMO services be reimbursed in total to more than one provider.
Rule Amplifies: 5111.01, 5111.02, 5111.021
Prior Effective Dates: 5/25/91, 4/1/92 (Emer), 7/1/92, 3/31/94, 1/1/01
Physicians may be reimbursed for the professional services associated with the application of fluoride varnish for children from first tooth eruption to age three. This service is billable in addition to a well or sick child visit but should not be the sole reason for the visit.

1. In order to be reimbursed for the professional services associated with the application of fluoride varnish, physicians must submit current dental terminology (CDT) code D1203 D1208 as contained in the HCPCS level II codes set as defined in rule 5101:3-1-19.3 5101:3-1-19 of the Administrative Code on a physician claim form.

2. Coverage of fluoride varnish application by physicians is limited to one application every one hundred eighty days.

The application of fluoride varnish has three components each of which must be performed: oral assessment, varnish application and referral.

1. The oral assessment is for the identification of obvious oral health problems and risk factors. When combined with an EPSDT visit, the oral assessment does not need to be repeated prior to fluoride varnish application.

2. At the time of the fluoride varnish application, parents/guardians must be provided with information about the fluoride varnish procedure and proper oral health care for their child.

3. If the child has obvious oral health problems and does not have a dental provider, the physician must provide referral to a dentist or the county department of job and family services.

Effective: 03/28/2013
R.C. 119.032 review dates: 07/01/2011
Certification: CERTIFIED ELECTRONICALLY
Date: 03/18/2013
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02
Prior Effective Dates: 7/01/06, 12/31/12(Emer)
The following skin substitutes are covered in an office setting in conjunction with standard wound care regimens for the treatment of burns or ulcers:

1. Q4101, skin substitute, apligraf, per square centimeter; and
2. Q4102, skin substitute, oasis wound matrix, per square centimeter; and
3. Q4103, skin substitute, oasis burn matrix, per square centimeter; and
4. Q4106, skin substitute dermagraft, per square centimeter; and
5. Q4110, skin substitute, primatrix, per square centimeter.

Skin substitutes may be used on burns when skin grafting is not the appropriate option. These covered bioengineered skin substitutes are expected to function as a permanent replacement for lost or damaged skin. They may be used for temporary wound coverage or wound closure as appropriate and medically necessary.

Skin substitutes are not separately reimbursable in any institutional setting, including long-term care facility, hospital inpatient, outpatient, or emergency room place of service.

If skin substitute applications and re-applications show no significant improvement after three separate treatments, additional re-applications are inappropriate and other treatment modalities should be considered. Skin substitute treatments should not last more than twelve weeks. Improvement of fifty per cent or greater must be documented in the medical records for the reimbursement of additional re-applications after twelve weeks of treatment. If after twelve weeks the medical records do not support the significant improvement of the wound using the skin substitute treatments, the Ohio department of job and family services may recoup any inappropriate reimbursement.

Wound preparation is considered part of the procedure. All products, including dressings, are included in the evaluation and management service and are not separately reimbursable.

Effective: 08/02/2011
R.C. 119.032 review dates: 08/01/2016
Certification: CERTIFIED ELECTRONICALLY
Date: 06/28/2011
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.02
(A) A physician may be reimbursed for all covered procedures performed in a freestanding birth center (FBC), as defined in rule 5101:3-18-01 of the Administrative Code.

(B) A physician may be reimbursed for the professional component of a covered laboratory, radiology, diagnostic, or therapeutic service only if the physician personally performed the service in the FBC and the service was not performed by an employee of the FBC.

Effective: 01/01/2012
R.C. 119.032 review dates: 01/01/2017
Certification: CERTIFIED ELECTRONICALLY
Date: 12/22/2011
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.02, 5111.021
Covered Physical Therapy and Rehabilitation Services and Limitations

*Formerly* 5101:3-8-02 Covered Physical Therapy and Rehabilitation Services and Limitations

OAC rule 5160-8-02 is maintained in the ODJFS OAC.
OAC rule 5160-8-27 is maintained in the ODJFS OAC.
Click here to view OAC 5160-11-03, Laboratory Services: Coverage and Limitations. This rule is maintained in the Laboratory Services Manual, located in the Ohio Health Plans - Provider collection.
Definitions. The following definitions apply to Chapter 5101:3-14 of the Administrative Code:

(A) "Current procedural terminology" (CPT) has the same meaning as in Chapter 5101:3-1 of the Administrative Code.

(B) "Healthchek" is Ohio’s early and periodic screening, diagnostic and treatment (EPSDT) benefit for all Medicaid recipients under twenty-one years of age.

(C) "Healthchek services," also known as "EPSDT services," has the same meaning as in rule 5101:1-38-05 of the Administrative Code.

(D) "Medically necessary services" has the same meaning as in rule 5101:3-1-01 of the Administrative Code.

(E) "Prior authorization" for a member of a Medicaid managed care plan is the process established by the Medicaid managed care plan as required by rule 5101:3-26-05.1 of the Administrative Code. For all other Medicaid recipients, prior authorization is the process outlined in rule 5101:3-1-31 of the Administrative Code.

(F) "Screening" means the identification of individuals at risk of health problems. Results of a screening do not represent a diagnosis, but rather may indicate the 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.

Subject to the limitations of 42 U.S.C. 1396d(r) (1/1/2011), healthchek requires the coverage of the following screening services, described in Chapter 5101:3-14 of the Administrative Code:

(A) A comprehensive health and developmental history (including assessment of both physical and mental health development);

(B) A comprehensive unclothed physical examination;

(C) Appropriate immunizations;

(D) Appropriate vision testing;

(E) Appropriate laboratory tests; and

(F) Appropriate dental screenings.

Healthchek requires coverage of all mandatory and optional medically necessary services (including treatment) and items listed in 42 U.S.C. 1396d(a) (1/1/2011) to correct or ameliorate defects and physical and mental illness and conditions discovered by a screening service described in paragraph (B) of this rule. Such services and items, if approved through prior authorization, include those services and items listed at 42 U.S.C. 1396d(a) (1/1/2011) that are in excess of state Medicaid plan limits applicable to adults. Nothing in Chapter 5101:3-14 requires healthchek to cover services or items that are not listed in 42 U.S.C. 1396d(a) (1/1/2011).
Screening: Healthchek (EPSDT) screening services, composed of the components described in rule 5101:3-14-03 of the Administrative Code, may be provided by the following eligible providers of physician services as defined in Chapter 5101:3-4 of the Administrative Code:

1. Eligible providers of physician services, in accordance with Chapter 5101:3-4 of the Administrative Code may provide physician services; and

2. Advanced practice nurses (APNs) may also provide healthchek (EPSDT) screening services, in accordance with Chapter 5101:3-8 of the Administrative Code.

Healthchek (EPSDT) diagnosis and treatment services, composed of the components described in rule 5101:3-14-05 of the Administrative Code, may be provided by the following eligible providers:

1. Eligible providers of vision services as defined in Chapter 5101:3-6 of the Administrative Code may provide vision services;

2. Eligible providers of dental services as defined in Chapter 5101:3-5 of the Administrative Code may provide dental services;

3. Eligible providers of physician or clinic services as defined in Chapters 5101:3-4 and 5101:3-13 of the Administrative Code may provide hearing services; and

4. Other medically necessary health care, diagnostic, or treatment services that are covered under the medicaid program may be provided by eligible medicaid providers.

Vision services may be provided by eligible providers of vision services as defined in Chapter 5101:3-6 of the Administrative Code.

Dental services may be provided by eligible providers of dental services as defined in Chapter 5101:3-5 of the Administrative Code.

Hearing services may be provided by eligible providers of physician or clinic services as defined in Chapters 5101:3-4 and 5101:3-13 of the Administrative Code.

Other health care, diagnostic services or treatments may be provided by eligible medicaid providers as long as the services are within the coverage and limitations set forth for the provider in Chapters 5101:3-1 to 5101:3-22 of the Administrative Code.

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The following this rule describes the screening components must be completed and documented that the healthchek (EPSDT) provider shall complete and document as part of every initial and periodic "HealthChek" healthchek (EPSDT) screening service visits, unless the patient individual or the individual's parent or guardian, refuses the components. The provider shall document such a refusal.

(A) Definitions.

(1) 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.

(2) For the purposes of Chapter 5101:3-14 of the Administrative Code, "CPT" (current procedural terminology) is defined in rule 5101:3-1-19.3 of the Administrative Code.

(B) Screening frequencies and indication of need for further evaluation.

(1) Screening components of the healthchek (EPSDT) visit shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care (March, 2000), www.aap.org.

(2) Healthchek (EPSDT) screening providers shall coordinate with public and private resources to eliminate duplicative screening and ensure comprehensive screening, evaluation, diagnosis, and treatment.

(3) When a healthchek (EPSDT) screening visit indicates the need for further evaluation of an individual's health, the provider shall, without delay, make a referral for evaluation, diagnosis, and/or treatment. For individuals enrolled in the medicaid managed care program (MCP), the healthchek (EPSDT) provider shall utilize referral requirements specified in rule 5101:3-26-05.1 of the Administrative Code in satisfying the referral requirements for healthchek (EPSDT) services as defined in Chapter 5101:3-14 of the Administrative Code.

(C) Comprehensive health and developmental history.

(1) A "comprehensive health and developmental history" is a profile of the individual's medical history and includes an assessment, a review of both physical and mental health development. The provider shall obtain the individual's medical history should be taken from the patient individual (if age appropriate), at the individual's parent, or a responsible adult who is familiar with the individual's history.

(2) The provider shall obtain or update the comprehensive health, mental health, and developmental history shall be taken or updated at every each initial and periodic "HealthChek" healthchek (EPSDT) screening service visit. The comprehensive health and developmental history shall include at a minimum:

(a) Current complaints/concerns;

(b) The patient's individual's and family's history of illnesses, diseases, and allergies;

(c) Information on current medications or and adverse effects to medications;

(d) Written notations pertaining to the patient's individual's social or physical environment which that may affect the patient's individual's overall health; and
(e) For adolescents, written notations on the individual’s sexual activity and contraceptive methods.

(B)(D) The provider shall perform a comprehensive unclothed physical examination shall be performed during each initial and periodic screening service visit, and the examination shall include at a minimum:

1. Measurements of height and weight, including comparisons of age-appropriate percentiles;
2. Blood pressure for patients age three through twenty years, as age-appropriate;
3. Head circumference for patients age birth through twenty-four months, including percentiles, as age-appropriate;
4. Examination of head, ears, eyes, nose, and throat; respiratory, cardiovascular, gastrointestinal, reproductive, musculoskeletal and neurological systems;
5. For age-appropriate females, a breast inspection and palpation, including and instructions in breast self-examination;
6. For age-appropriate males, testicular examination, including and instructions in self-examination of the testes; and
7. A pelvic examination may be provided for age-appropriate females as part of the "HealthChek" (EPSDT) screening service visit, when medically indicated. Pelvic examinations are considered part of the comprehensive unclothed physical examinations and are not reimbursed separately.

(C)(E) Developmental assessment screening (including physical and mental health development).

1. The provider shall perform or update the developmental assessment screening shall be performed or updated at each initial and periodic screening service visit. The developmental assessment screening shall include an age-appropriate developmental history and an assessment of the individual’s motor, speech, mental, and social development.
2. Formal developmental tests that are performed during the screening service visit will be reimbursed in addition to the "HealthChek" (EPSDT) screening service visit as described in rule 5101:3-14-04 of the Administrative Code.
3. When the assessment screening of the individual’s mental health indicates the need for diagnostic and/or therapeutic mental health services, the services are covered and will be reimbursed separately in accordance with Chapters 5101:3-4 (physician services), 5101:3-8 (limited practitioner services), and 5101:3-27 (community mental health agency services) of the Administrative Code. Drug and alcohol rehabilitation shall be covered and reimbursed separately in accordance with Chapter 5101:3-30 (alcohol and drug addiction services) of the Administrative Code.

(D)(F) Nutritional assessment screening.

An assessment The provider shall perform a screening of the individual’s nutritional status shall be performed as part of the basic examination component of each initial and periodic "HealthChek" (EPSDT) screening service visit through questions about dietary practices, measurements of height and weight (in accordance with paragraph (D) of this rule), laboratory testing (if medically indicated, in accordance with paragraphs (J) and (K) of this rule), and a complete physical examination in accordance with paragraph (D) of this rule, as required paragraph (B) of this rule, including and dental assessment screening (in accordance with paragraph (L) of this rule).

(E)(G) Vision assessment screening.

1. The provider shall perform a vision assessment screening shall be performed as a part of each initial and periodic "HealthChek" (EPSDT) screening service visit using the following criteria:
(a) Individuals ages birth to three years shall be evaluated by reviewing the individual's medical history for high-risk factors and by performing an external (gross) observation and (internal) ophthalmoscopy.

(b) Individuals ages three and older are required to be screened by:

(i) External (gross) observation and (internal) ophthalmoscopy;

(ii) Visual acuity test (e.g., Titmus, Snellen, Lea, or Tumbling E); and

(iii) Ocular muscle balance test, administered at distance and near; and,

(iv) Stereopsis test (e.g., random dot E).

(2) A vision screening is considered part of the comprehensive healthchek (EPSDT) visit and is not reimbursed separately.

(2)(3) When the vision assessment indicates a potential visual problem or when a parent, teacher, professional, or responsible adult suspects that an individual has a visual problem, the provider shall, without delay, make a referral for the individual to an ophthalmologist or an optometrist for evaluation, diagnosis, and/or treatment.

(F)(H) Hearing assessment.

(1) The provider shall perform a hearing assessment during each initial and periodic "HealthChek" screening visit using the following criteria:

(a) Individuals ages one to three years shall be evaluated by:

(i) Reviewing the patient's history for high-risk factors or symptoms indicative of hearing problems; and

(ii) Observing the child for, and questioning the parents about, physical behaviors or speech development that may suggest a hearing impairment.

(b) Individuals ages three and older shall be evaluated by:

(i) Using manually administered, individual pure-tone, air conduction equipment, if the provider has the equipment available; or

(ii) Using the screening method described in paragraph (F)(1)(a) of this rule, if pure-tone equipment is not available. When pure-tone equipment is not available, providers are encouraged to refer children to another provider for a pure-tone test.

(2) When pure-tone equipment is not available, the provider may use his/her discretion in referring the child to another provider for a pure-tone test.

(3)(2) If pure-tone equipment is used or other covered hearing services are provided, the service shall be separately reimbursed to the provider who performs the procedure as described in rule 5101:3-14-04 of the Administrative Code.

(4)(3) When the hearing assessment indicates a hearing impairment or a parent, teacher, professional, or other responsible adult suspects the child has a hearing problem, the provider shall, without delay, make a referral for the child to a health care provider who specializes in the evaluation, diagnosis, and treatment of hearing problems.

(G)(1) Immunization assessment.

(1) The provider shall perform an immunization assessment during as part of the basic examination component of each initial and periodic screening visit and must include a history of past immunizations.

(2) If, it is determined at the time of screening, an immunization is needed, the provider shall provide the immunization, or refer the patient for the appropriate
immunization unless the immunization is medically contraindicated. If medically contraindi- cated, the immunization shall be rescheduled as appropriate.

(3) The provider **must** use the standard immunization schedule as determined by a recognized medical authority such as the "American Academy of Pediatrics" in accordance with rule 5101:3-4-12 of the Administrative Code.

(4) When immunizations are administered they shall be reimbursed separately as described in rule 5101:3-14-04 of the Administrative Code.

**(H)(J)** Lead toxicity screening.

(1) All children are at risk for lead poisoning and must be screened.

(2)(1) Health care financing administration/center for disease control (HCFA/CDC). The centers for medicare and medicaid services (CMS) and centers for disease control and prevention (CDC) require the following lead screening:

(a) All children must receive a blood lead screening test at twelve months and twenty-four months of age;

(b) Children between the ages of thirty-six months and seventy-two months of age must receive a screening lead blood lead screening test if they have not been previously screened for lead poisoning.

(c) A lead blood lead screening test must be used when screening.

(i) Blood lead screening tests are covered whenever medically indicated.

(ii)(ii) The test methodology used for the required blood lead screening test must have the sensitivity to detect blood lead levels of ten micrograms per deciliter or lower.

(ii)(iii) Since the erythrocyte protoporphyrin test does not meet this standard, it is not acceptable as a blood lead screening test. As long as the provider confirms all negative results with a more sensitive lead test, the erythrocyte protoporphyrin may be used as a diagnostic procedure when the physician suspects lead toxicity or high lead levels. This is the best test immediately available, and the test results detect lead levels that are within the sensitivity range of this procedure. The erythrocyte protoporphyrin test may be still be used to diagnose other conditions such as iron deficiency.

(d) Children of any age may be screened.

**(I)(K)** Laboratory tests.

(1) Based on the individual's medical and nutritional history, age, physical condition, ethnic background, and home environment, the physician may determine and order the appropriate laboratory procedures.

(2) Reimbursement is available to a physician or clinic if the laboratory procedures are actually performed in the physician's office or clinic and the physician's office or clinic meets the requirements set forth in Chapter 5101:3-11 of the Administrative Code. Specimens that are sent to an outside laboratory for analysis must be billed by the laboratory which actually performs the procedure.

(3) These laboratory procedures shall include, but are not limited to, the following:

(a) Blood lead testing screening test, in accordance with paragraph (J) of this rule and rule 3701:82-02 of the Administrative Code.

(i) Blood lead testing is covered whenever it is medically indicated.

(ii) Blood lead screening is required in accordance with paragraph (H) of this rule.

(b) Hemoglobin and/or hematocrit.
Anemia is a common abnormality condition reported during the "HealthChek" healthcheck (EPSDT) screening service visit. At a minimum, a hematocrit and/or hemoglobin is recommended on all premature and low birth weight infants during the first six months of life, on all children around one year of age, and at least once during their adolescence. If medical indications are noted in the physical examination, a test for anemia may be performed at any age. Such medical indications include a nutritional history of inadequate iron in the diet, a history of blood loss, family history of anemia, or pallor.

(c) Sickle cell test.

It is recommended that a test for sickle cell and/or other hemoglobinopathies be performed at least once on all black children or other children of appropriate ancestry of African-American, Greek, Italian, Arabian, Egyptian, Turkish, or Asiatic Indian descent. If it cannot be determined that a child has been tested previously, a test for the sickle cell or other hemoglobinopathies should be performed.

(d) Pap smears and tests for sexually transmitted diseases.

Pap smears are recommended for all adolescent females (age sixteen-eighteen or older). If the adolescent is sexually active, the adolescent should be tested regardless of age. Tests for sexually transmitted diseases are covered if medically indicated. Patients shall be informed about all tests performed, given results of each test and educated about provided health education regarding sexually transmitted diseases, in accordance with paragraph (M) of this rule.

(e) Tuberculin test.

(i) A tuberculin test shall be performed on all individuals who are suspected of having a mycobacterial infection; have a known history or exposure to active tuberculosis (TB); are immigrants from high prevalence areas of TB; are from areas of high endemic rates of TB or are members of families or social groups with an increased incidence of the disease:

(a) Are suspected of having a mycobacterial infection;
(b) Have a known history or exposure to active tuberculosis (TB);
(c) Are immigrants from high prevalence areas of TB;
(d) Are from areas of high endemic rates of TB; or
(e) Are members of families or social groups with an increased incidence of the disease.

(ii) If an individual does not meet at least one of the conditions listed in paragraph (i)(3)(e)(i)(K)(3)(e)(ii) of this rule, TB testing is optional.

(iii) When a tuberculin test is administered, the test shall be reimbursed as described in accordance with rule 5101:3-14-04 of the Administrative Code.

(f) Other laboratory screens as medically necessary.

(L) Dental assessment screening.

A dental assessment shall be performed during each initial or periodic screening service and shall include at a minimum:

(1) For children from birth through the age of two years, the provider shall perform a dental screening as part of the basic examination component of each initial and periodic screening visit, and shall include, at a minimum:

(a) An assessment of the growth and development of the dentition and adjacent dento-facial structure, anticipatory guidance about baby bottle tooth decay prevention, and an oral inspection for dental caries shall be performed. Individuals shall be provided
health education regarding early childhood caries prevention in accordance with paragraph (M) of this rule. Children with suspected problems must be referred to a dentist or the county department of job and family services for a referral to a dentist.

(b) When a dental screening and oral inspection indicates the need for further evaluation, the provider shall, without delay, make a referral to a dentist or, in accordance with rule 5101:1-38-05 of the Administrative Code, to the county department of job and family services (CDJFS) for a referral to a dentist, for evaluation, diagnosis, and/or treatment.

(b)(c) Dental examinations for diagnostic and preventive dental services examinations are not required, but are covered for children of any ages shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care. Providers are encouraged to refer children, beginning at age two years to a dentist or the county department of job and family services for a referral to a dentist.

(2) For children ages three years through twenty, the provider shall perform a dental screening during each initial and periodic screening visit, and shall include, at a minimum:

(a) Providers of the "HealthChek" screening services are required to provide patients ages three years and older with referrals to a dentist or to the county department of job and family services if the individual has not been seen by a dentist or dental hygienist under the direct supervision of an individual during the last six months.

(b) Physicians are encouraged to emphasize the importance of preventive dental health care and the services that can be obtained under the medicaid program. Providers should explain that cleanings, examinations, and fluoride treatments are covered every six months. Additionally, dental sealants are covered for permanent first molars for children under age nine and for permanent second molars for individuals under age eighteen.

(K)(M) Health education, and counseling, anticipatory guidance, and risk factor reduction interventions.

(1) Health education and counseling, including anticipatory guidance to parents and individuals as well as risk factor reduction interventions, including counseling, anticipatory guidance, and risk factor reduction intervention, is a required component of the "HealthChek" each healthcheck (ESPDT) screening service visit. Health education and counseling should be designed to assist parents and individuals in understanding what to expect in terms of the individual's development and to provide information about the benefits of healthy lifestyles and practices, as well as disease prevention.

(2) Providers should encourage parents and individuals, if age appropriate, participating in the program to take advantage of screening services, dental services, vision services, and hearing services covered under medicaid.

(3) When the health education and counseling component of the "HealthChek" (EPSDT) screening service lasts approximately thirty minutes or more, additional reimbursement is available.

(a) Providers should bill the appropriate preventive medicine, individual counseling code from the "Physicians' Current Procedural Terminology."

(b) The preventive medicine, individual counseling codes will not be reimbursed unless a "HealthChek" (EPSDT) screening service code also appears on the claim.

(3) Health education and counseling is part of each initial and periodic healthcheck (EPSDT) visit. Additional health education codes and counseling will not be reimbursed on the same date of service as a healthcheck (EPSDT) visit.

(4) The preventive counseling code/anticipatory guidance shall be billed only when counseling/anticipatory guidance is provided at an encounter separate from the healthcheck (EPSDT) screening visit.
When a healthchek (EPSDT) screening visit indicates the need for further evaluation of an individual’s health, 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.

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(A) "HealthChek" HealthChek (EPSDT) screening service codes.

(1) "HealthChek" HealthChek (EPSDT) screening services must be billed using the appropriate preventive medicine procedure code(s), reflecting a comprehensive preventive medicine evaluation and management, focusing on age and gender appropriate history, examination, anticipatory guidance, and risk factor reduction interventions. For new patients, codes are 99381 to 99385; for established patients, codes are 99391 through 99395.

(2) **To comply with federal reporting requirements, provide**

Providers of healthChek (EPSDT) screening visits shall include the following information when billing the department based on the date of service and type of claim submission.

(a) For dates of service prior to October 16, 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 placing either:

   (i) An "E" in item 24h on the paper claim form or in the same block on an electronic claim. "E" means, indicating that HealthChek EPSDT services were visit was provided and no follow-up services were required; or

   (ii) An "R" in item 24h on the paper claim form or in the same block on an electronic claim. An "R" means, indicating that HealthChek EPSDT services were visit was provided, and follow-up is required, and a referral was made.

(b) For dates of service October 16, 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:

   (i) 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 by placing 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.

   (ii) If billing on paper, when using a paper claim form, follow the instructions provided in paragraphs (A)(2)(a)(i) and (A)(2)(a)(ii) of this rule, which require that item 24h on the paper claim form be completed.

(B) HealthChek screening services frequencies

(1) 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.

(G)(B) Other reimbursable Reimbursement for diagnostic and treatment services.

(1) In addition to the HealthChek EPSDT screening services, the department will reimburse providers for the following services provided during, or as part of, the HealthChek EPSDT screening service visit.

(a) Specimen collection and laboratory services in accordance with Chapter 5101:3-11 of the Administrative Code, although specimens sent to an outside laboratory for analysis must be billed by the laboratory that actually performs the procedure;
Immunizations in accordance with rule 5101:3-4-12 of the Administrative Code;
Formal developmental tests;
Pure-tone audiometry and other formal hearing tests using calibrated electronic equipment;
Tuberculin tests; and
Other covered physician services in accordance with Chapter 5101:3-4 of the Administrative Code.

Interperiodic examinations, vision, hearing, and dental services that are medically necessary to determine the existence of suspected physical or mental illnesses or conditions are covered under medicaid and may be billed in accordance with Chapters 5101:3-4, 5101:3-5, and 5101:3-6 of the Administrative Code.

The services listed in paragraph (C)(1)(B)(1) of this rule are services that may be performed on the same day as an "HealthChek" the healthchek (EPSDT) screening visit or they may be performed at another time as medically indicated or as necessary from a scheduling standpoint (e.g., a patient requires that an immunization service be administered in three months from the date of the screening service).

These services may be provided by the provider who performed the "HealthChek" healthchek (EPSDT) screening service or by another eligible provider under medicaid.

Only the provider who performed the service may bill for the service.

To receive separate reimbursement for these services, the provider must bill the department by itemizing the appropriate code in accordance with rule 5101:3-1-60 of the Administrative Code.

Prior authorization and claim submission requirements for healthchek (EPSDT) services provided through the medicaid managed care program (MCP) are specified in rule 5101:3-26-05.1 of the Administrative Code.

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When a screening examination 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. 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 5101:3-1-60 of the Administrative Code lists coverage of other codes that may be billed when services are provided as part of further evaluation, diagnosis, or treatment following a healthchek (EPSDT) screening visit.

(A) Vision services.

(1) The department covers vision services for the diagnosis and treatment of vision problems. The scope of vision services covered under the medicaid program are described in Chapter 5101:3-6 of the Administrative Code.

(2) The minimum periodicity schedule for vision assessments (screens) coincides with the minimum schedule for "HealthChek" (EPSDT) screening services which is at the ages of one, three, five, seven, eleven, and sixteen years screenings for individuals under twenty-one years of age is defined in accordance with rule 5101:3-14-03 of the Administrative Code.

(3) In addition to the vision assessments (screens) screenings performed during the "HealthChek" healthchek (EPSDT) screening service visit, the department covers vision examinations of all levels (minimal through comprehensive) performed by eligible providers of vision services in accordance with Chapter 5101:3-6 of the Administrative Code.

(B) Hearing services.

(1) The department covers hearing services for the diagnosis and treatment of hearing problems (e.g., hearing. The scope of hearing services covered under the medicaid program includes hearing aids, which are covered as a medical supplier service in accordance with Chapter 5101:3-10 of the Administrative Code).

(2) The minimum periodicity schedule for hearing assessments (screens) coincides with the minimum schedule for "HealthChek" (EPSDT) screening services which is at the ages of one, three, five, seven, eleven, and sixteen years screenings for individuals under twenty-one years of age is defined in accordance with rule 5101:3-14-03 of the Administrative Code.

(3) In addition to the hearing assessments (screens) screenings performed during the "HealthChek" healthchek (EPSDT) screening examination visit, the department covers hearing screenings and other hearing services (including hearing aids) performed by eligible providers of hearing services.

(C) Dental services.

(1) The department covers a wide range of dental services for the diagnosis and treatment of dental problems for individuals under age twenty-one. The scope of dental services covered under the medicaid program are described in Chapter 5101:3-5 of the Administrative Code.

(2) The department will cover a covers one diagnostic and preventive dental examination for the provision of diagnostic and preventive dental services every six months. The minimum periodicity schedule for dental services for individuals under twenty-one years of age is one
dental examination per year defined in accordance with rule 5101:3-14-04 of the Administrative Code.

(3) **Dental** Diagnostic and preventive dental examinations **for diagnostic and preventive dental services are not required for children under the age of three years** shall be provided to individuals at ages and at frequencies in accordance with American academy of pediatrics recommendations for preventative pediatric health care (March 2003), www.aap.org. Providers are encouraged to refer children, beginning at the age of two years to a dentist or to the county department of job and family services (CDJFS) for a referral to a dentist.

(4) **Dental** diagnostic and treatment services are covered for individuals under the age of twenty-one, at as early an age as necessary, needed for relief of pain and infections, restoration of teeth, and maintenance of dental health as described in Chapter 5101:3-14-05 of the Administrative Code.

(4)(5) Methods will be employed by the department to encourage dental examinations:

(a) By requiring providers of "HealthChek" healthchek (EPSDT) screening services to shall provide patients individuals ages three years and older with referrals to a dentist or to the county department of job and family services (CDJFS) if the individual has not been seen during the last six months by a dentist or a dental hygienist under the supervision of a dentist; and

(b) By requiring county departments of job and family services to The CDJS shall notify EPSDT recipients medicaid eligible individuals under the age of twenty-one at least once a year to remind them that it is time for a dental examination in accordance with the minimal periodicity schedule established for dental services.

(D) Interperiodic examinations, vision, hearing, and dental services that are medically necessary to determine the existence of suspected physical or mental illnesses or conditions are covered under medicaid and may be billed in accordance with Chapters 5101:3-4, 5101:3-5, and 5101:3-6 of the Administrative Code.

(E) **Diagnostic and treatment services for individuals under age twenty-one are covered under the medicaid program when the services are medically necessary, as defined in rule 5101:3-1-01 of the Administrative Code, to treat or ameliorate a defect, physical or mental illness, or condition. Covered diagnostic and treatment services for individuals under age twenty-one include:**

(1) Diagnostic and treatment services within the coverage and limitations set forth in Chapters 5101:3-1 to 5101:3-22, 5101:3-24 to 5101:3-30, and 5101:3-56 of the Administrative Code; and

(2) Diagnostic and treatment services beyond the coverage and limitations set forth in Chapters 5101:3-1 to 5101:3-22, 5101:3-24 to 5101:3-30, and 5101:3-56 of the Administrative Code that are:

(a) Prior authorized by the department in accordance with rule 5101:3-1-31 of the Administrative Code, and when provided through the medicaid managed care program (MCP), in accordance with rule 5101:3-26-05.1 of the Administrative Code; and

(b) Available in accordance with federal EPSDT requirements found at 42 U.S.C. 1396d(a) as amended.

(F) 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.

(G) 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 service is a service covered by the waiver and if the service is medically necessary for the waiver enrollee.

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Reimbursement for abortion services, other than those identified in paragraph (D) of this rule, is restricted to the following circumstances when the appropriate certification in paragraph (B) of this rule is made:

1. Instances in which the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

2. Instances in which the pregnancy was the result of an act of rape and the patient, the patient’s legal guardian, or the person who made the report to the law enforcement agency, certifies in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion; or

3. Instances in which the pregnancy was the result of an act of incest and the patient, the patient’s legal guardian, or the person who made the report certifies in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code, unless the patient was physically unable to comply with the reporting requirement and that fact is certified by the physician performing the abortion.

Certification.

Before reimbursement for an abortion can be made, the physician performing the abortion must certify that one of the three circumstances in paragraph (A) of this rule has occurred. The certification must be made on the Ohio department of job and family services "Abortion Certification Form" JFS 03197, contained in appendix A of this rule. The physician's signature must be in the physician's own handwriting. All certifications must contain the name and address of the patient. The certification form must be attached to the billing invoice.

I certify that, on the basis of my professional judgment, this service was necessary because:

(a) The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; or

(b) The pregnancy was the result of an act of rape and the patient, the patient’s legal guardian, or the person who made the report to the law enforcement agency certified in writing that a report was filed, prior to the performance of the abortion, with a law enforcement agency having the requisite jurisdiction; or

(c) The pregnancy was the result of an act of incest and the patient’s legal guardian, or the person who made the report certified in writing that a report was filed, prior to the performance of the abortion, with either a law enforcement agency having the requisite jurisdiction, or, in the case of a minor, with a county children services agency established under Chapter 5153. of the Revised Code; or

(d) The pregnancy was the result of an act of rape and in my professional opinion the recipient was physically unable to comply with the reporting requirement; or
(e) The pregnancy was a result of an act of incest and in my professional opinion the recipient was physically unable to comply with the reporting requirement.

(3) Reimbursement will not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion service itself cannot be reimbursed. All abortion services for the purposes of paragraph (A) of this rule must be submitted to the department on a hard copy billing invoice.

(C) Documentation that supports the certification made by the physician must be maintained by the physician in the recipient's medical record. When the physician certifies that paragraph (B)(2)(b) or (B)(2)(c) of this rule is true, a copy of a signed statement by the patient, the patient's legal guardian, or the person who made the report must be maintained in the patient's medical record.

(D) Nothing in this rule shall be construed to deny reimbursement for drugs or devices to prevent implantation of the fertilized ovum, or for medical procedures for the termination of an ectopic pregnancy. The requirements stated in this rule do not apply to those abortions which are treatments for incomplete, missed, or septic abortions.

Effective Date: 3/1/2005
R.C. 119.032 review dates: 11/12/2004
Certification:
Date:
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02
Prior Effective Dates: 7-22-77; 9-24-77; 12-30-77; 7-30-78; 8-21-78; 9-17-79; 11-12-80; 8-17-81; 5-12-94 (Emer.); 7-21-94; 8-10-98 (Emer.); 11-1-98; 8-1-01
"Preconception care" means Medicaid-covered preventive medicine services provided prior to a pregnancy for the purpose of achieving optimal outcome of future pregnancies.

Medicaid covered preconception care services may include, but are not limited to:

1. Laboratory tests and procedures including but not limited to:
   a. Screening, diagnostic, and counseling services for detection of genetic anomalies and/or hereditary metabolic disorders, including but not limited to:
      i. Chromosomal anomalies (in non-pregnant patients) that have neonatal implications;
      ii. Sickle cell and other abnormal hemoglobin syndromes;
      iii. Metabolic disorders such as phenylketonuria (PKU), galactosemia, or homocystinuria; and
      iv. Cystic fibrosis (carrier status);
   b. Screening for, diagnosis of, and treatment of sexually transmitted diseases and infections;

2. Individual preventive medicine counseling and or risk factor reduction(s) (health education), in accordance with appendix DD to rule 5101:3-1-60 of the Administrative Code.

For reimbursement of preconception care services Medicaid providers must use:

1. Valid Medicaid-covered CPT and/or HCPCS procedure codes as defined in paragraph (D) of rule 5101:3-1-19.3 of the Administrative Code; and


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R.C. 119.032 review dates: 07/01/2014
CERTIFIED ELECTRONICALLY
Certification
06/19/2009
Date
Promulgated Under: 119.03
Statutory Authority: 5111.02
Rule Amplifies: 5111.01, 5111.02, 5111.021
Effective Date: January 1, 2012

Most Current Prior Effective Date: July 1, 2009

(A) The following definitions apply for the purposes of Medicaid:

(1) "Family planning" is the prevention or delay of pregnancy.

(2) "Pregnancy prevention/contraceptive management services" or "family planning services" are services and supplies provided for the primary purpose of preventing or delaying pregnancy. They include services provided for the temporary prevention of pregnancy in accordance with rule 5101:3-21-02.1 of the Administrative Code, services provided for the permanent prevention of pregnancy in accordance with rule 5101:3-21-02.2 of the Administrative Code, and related supplies.

(3) "Family planning visit" is a visit to a health professional for the primary purpose of obtaining pregnancy prevention/contraceptive management services.

(B) Medicaid providers of pregnancy prevention/contraceptive management services must offer three assurances:

(1) Medicaid-eligible individuals have access to pregnancy prevention/contraceptive management services without regard to religion, race, color, national origin, disability, age, sex, number of pregnancies, or marital status;

(2) Medicaid-eligible individuals are able to obtain pregnancy prevention/contraceptive management services voluntarily, free from coercion or pressure and free to choose the method of pregnancy prevention/contraceptive management to be used; and

(3) Provision of pregnancy prevention/contraceptive management services is not a prerequisite to eligibility for or receipt of any other services or assistance from or participation in any other programs of the Medicaid provider.

(C) Medicaid-covered pregnancy prevention/contraceptive services include services provided for the temporary prevention of pregnancy, in accordance with rule 5101:3-21-02.1 of the Administrative Code and for the permanent prevention of pregnancy, in accordance with rule 5101:3-21-02.2 of the Administrative Code.

(D) Providers must include the following information on claims for pregnancy prevention/contraceptive management services:

(1) A valid current procedural terminology (CPT) or healthcare common procedure coding system (HCPCS) procedure code for each service provided; and

(2) An appropriate diagnosis code in the range from V25.0 through V25.9 to indicate an encounter for contraceptive management, as specified in the "International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)."

Replaces: 5101:3-21-02

Effective: 01/01/2012

R.C. 119.032 review dates: 01/01/2017

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Date: 12/22/2011

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Medicaid Reproductive Health Services: Temporary Pregnancy Prevention/Contraceptive Management Services

*Formerly* 5101:3-21-02.1  Medicaid Reproductive Health Services: Temporary Pregnancy Prevention/Contraceptive Management Services

MHTL 3336-09-04

Effective Date: July 1, 2009

(A) Medicaid covered temporary pregnancy prevention/contraceptive management services include:

(1) Evaluation and management (office) visits and consultations for the purpose of:
   (a) Temporary pregnancy prevention/contraceptive management; and/or
   (b) Pregnancy examination and testing, with either a negative or inconclusive result, that includes provision of information about pregnancy prevention;

(2) Individual preventive medicine counseling and or risk factor reduction(s) (health education) for the purpose of:
   (a) Temporary pregnancy prevention/contraceptive management, including but not limited to fertility awareness and natural family planning ("Natural family planning" is the use of fertility awareness-based methods to track ovulation in order to prevent pregnancy. Such methods may include but are not limited to observing changes in cervical mucus and recording the dates of menstrual cycles.); and/or
   (b) Pregnancy determination services when pregnancy testing yields a negative or inconclusive result and provision of information about pregnancy prevention is provided;

(3) Medical/surgical services/procedures provided for the purpose of temporary pregnancy prevention/contraceptive management (i.e., injection, fitting, insertion, removal of contraceptive devices);

(4) Laboratory tests and procedures provided for the purpose of temporary pregnancy prevention/contraceptive management, in accordance with Chapter 5101:3-11 of the Administrative Code;

(5) Drugs prescribed for the purpose of temporary pregnancy prevention/contraceptive management, in accordance with Chapter 5101:3-9 of the Administrative Code; and

(6) Supplies provided for the purpose of temporary pregnancy prevention/contraceptive management, in accordance with appendix A to rule 5101:3-10-03 of the Administrative Code.

Replaces: Part of 5101:3-4-07

Effective: 07/01/2009

R.C. 119.032 review dates: 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

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Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy

*Formerly* 5101:3-21-02.2 Medicaid Covered Reproductive Health Services: Permanent Contraception/Sterilization Services and Hysterectomy

MHTL 3334-11-10

Effective Date: January 1, 2012

Most Current Prior Effective Date: July 1, 2009

(A) Definitions.

(1) For the purposes of this rule, "hysterectomy" means, in accordance with 42 C.F.R. 441.251 (October 1, 2010 edition), a medical procedure or operation for the purpose of removing the uterus.

(2) For the purposes of this rule, "institutionalized individual" means, in accordance with 42 C.F.R. 441.251 (October 1, 2010 edition), an individual who is:

   (a) Involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or

   (b) Confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness.

(3) For the purposes of this rule, "mentally incompetent individual" means, in accordance with 42 C.F.R. 441.251 (October 1, 2010 edition), an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) For the purposes of this rule, "sterilization" means, in accordance with 42 C.F.R. 441.251 (October 1, 2010 edition), any medical procedure, treatment, or operation for the purpose of rendering an individual permanently incapable of reproducing.

(5) For the purposes of this chapter, "permanent pregnancy prevention" has the same meaning as "sterilization."

(B) Sterilization.

(1) Medicaid covered sterilization services include:

   (a) Management and evaluation (office) visits and consultations for the purpose of providing sterilization services;

   (b) Health education and counseling visits for the purpose of providing sterilization services;

   (c) Medical/surgical services/procedures covered in accordance with appendix DD to rule 5101:3-1-60 of the Administrative Code and provided in association with the provision of sterilization services;

   (d) Laboratory tests and procedures provided in accordance with Chapter 5101:3-11 of the Administrative Code and in association with the provision of sterilization services;

   (e) Drugs administered in accordance with Chapter 5101:3-4 of the Administrative Code and in association with the provision of sterilization services; and

   (f) Supplies provided in accordance with appendix A to rule 5101:3-10-03 of the Administrative Code and associated with the provision of sterilization services.

(2) The department will reimburse medicaid providers for sterilization services only if all the requirements of this rule and 42 C.F.R. part 441 subpart F (October 1, 2010 edition), are met:

   (a) The individual is at least twenty-one years old at the time consent is obtained;
(b) The individual is not a mentally incompetent individual;
(c) The individual is not institutionalized;
(d) The individual has voluntarily given informed consent in accordance with paragraph (B)(3) of this rule;
(e) At least thirty days, but not more than one hundred eighty days, have passed between the date of the informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least seventy-two hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery; and
(f) The medicaid provider requesting payment for the sterilization submits to the department a copy of the consent form, completed in accordance with paragraph (B)(3) of this rule.

(3) Informed consent for sterilization.

(a) For the purposes of this rule, an individual has given informed consent only if:
   (i) The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have had concerning the procedure, provided a copy of either "Consent for Sterilization," HHS-687 (11/2006) or "Consent for Sterilization Form," JFS 03198 (rev. 7/2009) and provided orally all the following information or advice to the individual to be sterilized has:

   (a) Offered to answer any questions the individual to be sterilized may have had concerning the procedure;

   (b) Provided a copy of one of the following to the individual to be sterilized:


      (iii) "Consent for Sterilization Form," JFS 03198 (rev. 7/2009), available at www.odjfs.state.oh.us/forms/inter.asp, which may be used for consent forms signed during the period from July 1, 2009 through June 30, 2012 by the individual to be sterilized; or

      (iv) "Consent for Sterilization Form," JFS 03198 (rev. 2/2003), which may be used for consent forms signed before July 1, 2010 by the individual to be sterilized, if the person obtaining consent has copies of this form available.

   (c) Provided orally all the following information or advice to the individual to be sterilized:

      (i) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;

      (ii) A description of available alternative methods of family planning and birth control;

      (iii) Advice that the sterilization procedure is considered to be irreversible;
(iv) A thorough explanation of the specific sterilization procedure to be performed;
(v) A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
(vi) A full description of the benefits or advantages that may be expected as a result of the sterilization; and
(vii) Advice that the sterilization will not be performed for at least thirty days, except under the circumstances specified in paragraph (B)(2)(e) of this rule;
(a) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;
(b) A description of available alternative methods of family planning and birth control;
(c) Advice that the sterilization procedure is considered to be irreversible;
(d) A thorough explanation of the specific sterilization procedure to be performed;
(e) A full description of the discomforts and risks that may accompany or follow the performance of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
(f) A full description of the benefits or advantages that may be expected as a result of the sterilization; and
(g) Advice that the sterilization will not be performed for at least thirty days, except under the circumstances specified in paragraph (B)(2)(e) of this rule.

(ii) Suitable arrangements were made to insure that the information specified in paragraph (B)(3)(a)(i) of this rule was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;
(iii) An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;
(iv) The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;
(v) The consent form requirements of this rule and of 42 C.F.R. 441.258 (October 1, 2010 edition) were met; and
(vi) Any additional requirement of state or local law for obtaining consent, except a requirement for spousal consent, was followed.

(b) For the purposes of this rule, informed consent may not be obtained while the individual to be sterilized is:
(i) In labor or childbirth; or
(ii) Seeking to obtain or obtaining an abortion; or
(iii) Under the influence of alcohol or other substances that affect the individual's state of awareness.
(c) Informed consent must be documented using either the "Consent for Sterilization," HHS-687 (11/2006) or "Consent for Sterilization Form," JFS 03198 (rev. 7/2009) on one of the forms specified in paragraph (B)(3)(a)(i)(b) of this rule.

(i) The consent form must be signed and dated by:
   (a) The individual to be sterilized;
   (b) The interpreter, if one was provided;
   (c) The person who obtained the consent; and
   (d) The physician who performed the sterilization procedure.

(ii) The person securing the consent must certify, by signing the consent form, that:
   (a) Before the individual to be sterilized signed the consent form, he or she advised the individual to be sterilized that no federal benefits may be withdrawn because of the decision not to be sterilized;
   (b) He or she explained orally to the individual to be sterilized the requirements for informed consent as set forth in this rule and on the consent form; and
   (c) To the best of his or her knowledge and belief, the individual to be sterilized appeared to the person securing the consent to be mentally competent and knowingly and voluntarily consented to be sterilized.

(iii) The physician performing the sterilization must certify, by signing the consent form, that:
   (a) Shortly before the performance of sterilization, he or she advised the individual to be sterilized that no federal benefits may be withdrawn because of the decision not to be sterilized;
   (b) He or she explained orally to the individual to be sterilized the requirements for informed consent as set forth in this rule and on the consent form; and
   (c) To the best of his or her knowledge and belief, the individual to be sterilized appeared to the physician to be mentally competent and knowingly and voluntarily consented to be sterilized.
   (d) In the case of premature delivery or emergency abdominal surgery (except for induced abortion in the first trimester of pregnancy) performed within thirty days of consent, the physician must certify that the sterilization was performed less than thirty days, but not less than seventy-two hours after informed consent was obtained because of premature delivery or emergency abdominal surgery and:
      (i) In the case of premature delivery, must state the expected date of delivery; or
      (ii) In the case of abdominal surgery, must describe the emergency.

(iv) If an interpreter is provided, the interpreter must certify that he or she translated the information and advice presented orally and read the consent form and explained its contents to the individual to be sterilized and that, to the best of the interpreter's knowledge and belief, the individual understood what the interpreter told him or her.

(C) Hysterectomy.

(1) The department will not reimburse medicaid providers for hysterectomy if:
   (a) The hysterectomy was performed solely for the purpose of rendering an individual permanently incapable of reproducing;
(b) There was more than one purpose to the hysterectomy, and it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing; or

(c) The requirements of this rule and 42 C.F.R. part 441 subpart F (October 1, 2010 edition) are not met.

(2) The department will reimburse medicaid providers for hysterectomy only if:

(a) All the requirements of this rule and 42 C.F.R. part 441 subpart F (October 1, 2010 edition) are met; and

(b) The medicaid provider requesting payment for the hysterectomy submits a copy of the JFS 01399, completed in accordance with paragraph (C)(3) of this rule, with the claim to the department.

(c) For a hysterectomy performed during a period of an individual's retroactive medicaid eligibility, the physician who performed the hysterectomy certifies in writing that:

(i) The individual was informed before the operation that the hysterectomy would make her permanently incapable of reproducing; or

(ii) The conditions of paragraph (C)(3)(a)(ii) of this rule were met.

(3) Informed consent for hysterectomy.

For the purposes of this rule, an individual has given informed consent only if:

(a) For the purposes of this rule, an individual has given informed consent only if:

(i)(a) The person who secures authorization to perform the hysterectomy has:

(α) Informed the individual and her representative, if any, orally and in writing that the hysterectomy will make the individual permanently incapable of reproducing;

(β) Offered to answer any questions the individual to have the hysterectomy may have concerning the procedure;

(γ) Offers the individual to have the hysterectomy a copy of "Acknowledgement of Hysterectomy Information," JFS 03199 (rev. 7/2009), and one of the following:

(a) "Acknowledgement of Hysterectomy Information," JFS 03199 (rev. 04/2011), available at www.odjfs.state.oh.us/forms/inter.asp, which may be used for consent forms signed by the individual on or after January 1, 2012;

(b) "Acknowledgement of Hysterectomy Information," JFS 03199 (rev. 7/2009), which may be used for consent forms signed by the individual on and after July 1, 2009 but before June 30, 2012 if the person obtaining consent has copies of this form available; or

(c) "Acknowledgement of Hysterectomy Information," JFS 03199 (rev. 7/2003), which may be used for consent forms signed by the individual before July 1, 2010 if the person obtaining consent has copies of this form available; and

(ii)(b) The individual to have the hysterectomy or her representative, if any, has signed the JFS 01399 as a written acknowledgment of receipt of the information specified in paragraph (C)(3)(a)(i) of this rule unless the individual:

(α) Was already sterile before the hysterectomy; or

(β) Requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgement is not possible.

(D) Claims.

(1) Claims for sterilization and hysterectomy procedures must be submitted to ODJFS the department with either an original or a copy of the appropriate consent form.
For dual eligibles, the JFS 03199 must not be attached to the medicare claim, but must be forwarded separately to the department. If the claim is rejected by medicare, the provider should submit a separate invoice to the department with the medicare rejection attached. The date that the JFS 03199 form was sent to the department should be entered in the provider remarks section of the medicaid claim.

(2) The department will not reimburse medicaid providers for services, procedures, and supplies associated with the provision of sterilization or hysterectomy services that do not meet the requirements of this rule.

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R.C. 119.032 review dates: 08/17/2011 and 10/01/2015
Certification: CERTIFIED ELECTRONICALLY
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Prior Effective Dates: 1/8/79, 2/6/79, 12/3/82, 7/1/83, 5/19/86, 9/1/89, 5/25/91, 4/1/92 (Emer), 7/1/92, 12/31/92 (Emer), 4/1/93, 5/2/94 (Emer), 7/1/94, 3/20/95, 1/1/01, 8/17/01, 10/1/03, 3/1/05, 12/30/05 (Emer), 3/27/06, 7/1/09
The following definitions apply for the purposes of this limited medicaid benefit:

(1) “Pregnancy prevention/contraceptive management services” or “family planning services” are defined in rule 5160-21-02 of the Administrative Code.

(2) “Family planning-related services” are medically necessary services identified during a routine or periodic family planning visit that satisfy two criteria:

(a) They belong to one of four specific types:

(i) Diagnosis of sexually-transmitted diseases or infections (STIs);
(ii) Treatment of STIs other than human immunodeficiency virus (HIV) and hepatitis;
(iii) Mammography when indicated by a breast examination; or
(iv) Vaccinations against human papillomavirus (HPV) or hepatitis B provided in accordance with rule 5160-4-12 of the Administrative Code; and

(b) They are provided as part of a family planning visit or within sixty days of the family planning visit where their need was determined.

(B) Individuals who meet the eligibility criteria in rule 5160-1:5-40 of the Administrative Code have a limited medicaid benefit that only includes the following:

(1) Family planning and family planning-related services listed in the appendix to this rule;

(2) Hospital services covered in Chapter 5160-2 of the Administrative Code when provided as a family planning-related service as defined in this rule; and

(3) Medicaid-covered, FDA-approved drugs covered in Chapter 5160-9 of the Administrative Code when provided as a family planning-related service as defined in this rule.

(C) When submitting claims for services available under the limited family planning benefit, providers must include the information specified in rule 5160-21-02 of the Administrative Code. All claims, including pharmacy claims, for family planning and family planning-related services must be submitted with a family planning diagnosis code in the V25 series.
Effective Date: July 1, 2009

(A) Definitions.

(1) For the purposes of this rule, "infertility" means any one of the following:
   (a) A woman of childbearing age is unable to get pregnant, after at least one year of trying; or
   (b) A man is unable to impregnate a woman, after at least one year of trying.

(2) For the purposes of this rule, "infertility services" means services:
   (a) Performed solely for the purpose of enabling an infertile individual capable of reproducing; and
   (b) With more than one desired outcome that would not have been performed if not for the fact that the services would of enable an infertile individual capable of reproducing.

(B) Medicaid recipients are not denied medically necessary services based on their fertility status.

(C) Medicaid does not cover infertility services. Under no circumstances are the following procedures covered:

(1) Drugs prescribed in accordance with Chapter 5101:3-9 of the Administrative Code and/or drugs administered in accordance with Chapter 5101:3-4 of the Administrative Code;

(2) Assisted reproductive technologies (ART);

(3) In vitro fertilization;

(4) Intrauterine insemination/artificial insemination; and

(5) Surgery, including procedures for the reversal of voluntary sterilization.

Effective: 07/01/2009

R.C. 119.032 review dates: 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021
Physician Medicaid Forms
Abortion Certification (JFS 03197)

Click here to view the JFS 03197, Abortion Certification
Consent to Hysterectomy (JFS 03199)

Click here to view the JFS 03199, Consent to Hysterectomy
Prenatal Risk Assessment (JFS 03535)
Click here to view the JFS 03535, Prenatal Risk Assessment
Abortions

Treatment for incomplete, missed, or septic abortions is considered medically necessary services covered under Medicaid. Reimbursement for abortion services other than service associated with incomplete, missed, or septic abortions are restricted to the provisions found in rule 5101:3-17-01.

With the exception of claims for incomplete, missed, or septic abortions, claims for all abortion services must be submitted to the Department on a hard copy billing invoice along with the completed "Abortions Certification Form", ODJFS 3197.
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.
Cardiovascular

Cardiovascular and Therapeutic Services- Codes requiring modifiers
The Medicaid maximum is split between payment for the professional component and the technical component. The professional/technical split is shown in the appendix titled List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical.

Cardiovascular and Therapeutic Services- Codes billed unmodified
Click here to view a description of the cardiovascular procedures and the associated codes for those procedures that should be billed using the CPT code unmodified:
92950 Cardiopulmonary resuscitation
92953 Temporary transcutaneous pacing
92960 Cardioversion
92970-92971 Internal or external cardio-assist-method of circulatory assist
92973 Percutaneous transluminal coronary thrombectomy
92974 Transcatheter placement of radiation delivery device for coronary brachytherapy
92975 Thrombolysis, by coronary infusion
92980-92981 Placement of intracoronary stents.
92982-92990 Percutaneous balloon procedures
92992-92993 Atrial Septectomy/Septostomy
92995-92996 Coronary atherectomy
92997-92998 Balloon angioplasty; pulmonary artery
93014 Physician review and interpretation of telephonic or telemetric transmission of electrocardiogram rhythm strip with report
93313, 93316 Placement of transesophageal probe
93025 Microwave T-wave assessment
93503 Insertion and placement of flow directed catheter
93530-93533 Right and/or left heart catheterization, congenital
93536-93545 Cardiac catheterization injection procedures when billed in conjunction with certain cardiovascular services
93651-93652 Intracardiac catheter ablation
93797-93798 Outpatient cardiac rehabilitation services
Diagnostic and Therapeutic Services

The appendix named List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components shows diagnostic and therapeutic codes requiring modifiers. The Medicaid maximum is split between payment for the professional component and the technical component. The professional/technical split is shown on this appendix.
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 item 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.
Hysterectomy

ODJFS payment can be made for a hysterectomy without obtaining the acknowledgement under the following circumstances:

- The individual was already sterile before the hysterectomy; or
- The individual requires a hysterectomy because of a life-threatening emergency situation in which the physician determines that prior acknowledgment is not possible.

Note: Two examples of the first circumstance where the acknowledgment statement would not be required is one in which the recipient is postmenopausal or has previously undergone a sterilization procedure. An example of the second circumstance is one in which the patient is admitted to the hospital through the emergency room and is in need of immediate medical attention but is unable to respond to information pertaining to the acknowledgment agreement because of the emergency nature of her admission. Please note that the federal government has specifically excluded from "life-threatening emergency" the situation where the individual is about to undergo abdominal exploratory surgery or a biopsy and the removal of the uterus would be a potential consequence of this surgery. In this case, the patient should be informed of the possible consequences and acknowledgment obtained.

Billing for a hysterectomy

All invoices submitted to the department for hysterectomies (whether performed as a primary or secondary procedure) or for medical procedures directly related to such hysterectomies, must include a copy of the Consent to Hysterectomy ODJFS 3199. Reimbursement will not be made for associated services when the hysterectomy procedure itself is not eligible for reimbursement, regardless of whether or not the hysterectomy procedure is itself billed to the department.

A consent form must be completed when a recipient is eligible for both the Medicare and Medicaid programs and requires a hysterectomy. The completed consent form must not be attached to the Medicare claim form, but must be forwarded separately to this department. If the claim is rejected by Medicare, submit a Medicaid claim with the Medicare rejection attached to the address below. Enter in the provider remarks section of the invoice the following statement:

"Consent form submitted (date)"

All invoices for hysterectomies along with an attached ODJFS 3199 Consent to Hysterectomy must be sent to the following address:

Ohio Department of Job and Family Services
P.O. Box 182411
Columbus, Ohio 43218-2411
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:

<table>
<thead>
<tr>
<th>Clinical</th>
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<tbody>
<tr>
<td>G0026</td>
<td>85130</td>
<td>86063</td>
</tr>
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<td>Q0111-Q0115</td>
<td>86140</td>
<td>87999</td>
</tr>
<tr>
<td>80048-80090</td>
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Anatomical Lab Codes

Anatomical pathology laboratory services

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<td>88300-88365</td>
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<td>88371-88399</td>
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<tr>
<td>89100-89105</td>
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<tr>
<td>89130-89141</td>
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</tbody>
</table>

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.
Otorhinolaryngology Services Speech and Hearing Professional Services

Otorhinolaryngology

Speech and hearing professional services are listed below:

92502* Otorhinolaryngologic examination under general anesthesia
92504 Binocular microscopy (separate procedure)
92506* Evaluation of speech, language, voice, communication, auditory processing and/or aural rehabilitation status
92507* Individual treatment of speech, language, voice, communication, and/or auditory processing disorder, including aural rehabilitation
92508* Group treatment of speech, language, voice, communication, and/or auditory processing disorder, including aural rehabilitation
92510 Aural rehabilitation following cochlear implant with or without speech processor programming
92511* Nasopharyngoscope with endoscope (separate procedure)
92512 Nasal function studies, (e.g., rhinomanometry)
92516 Facial nerve function studies
92520 Laryngeal function studies
92526 Treatment of swallowing dysfunction and/or oral function for feeding

* The procedure codes listed above with an asterisk may not be reimbursed in addition to an evaluation and management service (a visit code).
Neurology Services

Neurology, neuromuscular procedures, and central nervous system assessment procedures and associated codes that are covered as physician professional services are listed below. These procedure may never be billed with a modifier:

95830 Insertion by physician of sphenoidal electrodes for EEG recording
95831-95834 Manual muscle testing procedures performed as a separate procedure
95851-95852 Range of motion measurements performed as separate procedure
95857 Tensilon tests for myasthenia gravis without electromylographic recording
96004 Physician review/interpretation of comprehensive computer based motion analysis, dynamic plantar pressure measures, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report
Physical Medicine Services

Covered codes

Providers should use the procedure coding for covered physical medicine and rehabilitation within the following ranges to bill for physical medicine services covered by the Medicaid program.

97001 - 97002
97012
97016 - 97018
97022 - 97024
97032
97034 - 97036
97110 - 97116
97124
97140 - 97150
97504 - 97520
97532 - 97533
97601, 97703, 97750

Providers must follow the descriptions and provisions for each physical therapy procedure code as described in the CPT book and may bill only one code for each procedure performed during a visit. Timed codes must be billed in units appropriate to the time spent with the patient performing the procedure defined by the code.

Limitation History

Physical Medicine: history of the limits on physical therapy

For dates-of-service on or after July 1, 2002, the following limitations apply:

Physical medicine services are limited to thirty dates-of-service per recipient per twelve-month period regardless of the number of modalities or procedures the patient may receive during a visit. The number of units, e.g., modalities or procedures, will no longer be the limiting factor.

This 30-visit limitation is across all providers and provider types that a recipient receives physical medicine from during the rolling twelve-month period.

For purposes of this rule, a twelve-month period is described as a rolling twelve months that begins on the date the first physical medicine service is provided. For example, if the patient receives their first physical medicine service on September 1, 2002, the twelve-month period will end on August 31, 2002 and the patient may receive treatment for 29 more dates-of-service within that time period.

Note: For dates of service prior to July 1, 2002, the following limitations applied.

Physical therapy services are limited to 48 physical medicine procedures, modalities or visits per patient per provider per year.

Effective for dates of service on and after January 1, 2000 until July 1, 2002, the Medicaid maximum fee for physical medicine and rehabilitation services was the payment for one unit (or modality) of service as defined by the CPT. For example, if one modality of a CPT code is defined as a 15 minute increment, the Medicaid payment for one (1) unit of that code is payment for one modality (or a single 15 minute increment); Medicaid payment for 2 units would reflect reimbursement for 30 minutes or two 15 minute increments. Prior to January 1, 2000, payment for physical medicine services was not made on the basis of time; providers could bill for, and payment was limited to one unit regardless of the time spent. Although providers were limited to billing one unit, please note that the fees for time delimited physical medicine services (e.g., 15 minute increment) performed prior to January 1, 2000 were based on a RVU for a 30-minute service.
Pulmonary Services

Listing of Codes that are Technical Only

- Nonpressured inhalation treatments; (94640)
- Intermittent positive pressure breathing (IPPB 94650-94652);
- Aerosol or vapor inhalations, diagnostic (94642,94664-94665); and
- Manipulation of chest wall (94667-94668) and
- Continuous airway pressure ventilation (94660, 94662)
- Physicians may be reimbursed for the services identified above as pulmonary technical services, only if the services are provided in a non-hospital setting.

Pulmonary Services: professional and technical splits

Pulmonary codes with a professional and technical split are listed in the appendix titled List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical. The Medicaid maximum is split between payment for the professional component and the technical component. The professional/technical split is shown on this appendix.
Radiology

The appendix titled Radiology Codes with Professional and Technical Splits shows diagnostic and therapeutic codes requiring modifiers. The Medicaid maximum is split between payment for the professional component and the technical component. The professional/technical split is shown on this appendix.
Teaching Setting Services: Conditions That Must Be Met for an Exception to the Teaching Policy

42CFR 415.174

For the exception to apply, all of the following conditions must be met:

1. The services must be furnished in a center that is located in an outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under section 413.86.

2. Any resident furnishing the service without the presence of a teaching physician must have completed more than 6 months of an approved residency program.

3. The teaching physician must not direct the care of more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The teaching physician must:
   - Have no other responsibilities at the time;
   - Assume management responsibility for those beneficiaries (recipients) seen by the residents;
   - Ensure that the services furnished are appropriate;
   - Review with each resident during or immediately after each visit, the beneficiary's/ (recipient's) medical history, physical examination, diagnosis, and record of tests and therapies; and
   - Document the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary (recipient).

4. The range of services furnished by residents in the center include all of the following:
   - Acute care for undifferentiated problems or chronic care for ongoing conditions.
   - Coordination of care furnished by other physicians and providers.
   - Comprehensive care not limited by organ system, or diagnosis.

5. The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care and in which services are furnished by residents under the medical direction of teaching physicians."
Therapeutic Drugs and Injections

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

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

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)
Vision Care Services

Physicians may be reimbursed for the provision of certain vision care services as detailed in the Vision Care Services chapter in 5101:3-6.

The Vision Care rules:

- Define vision care coverage and prescription limitations;
- Define covered vision care examinations, diagnostic services and treatment services;
- Define Medicaid covered vision materials and eyewear under the Volume Purchase Contract;
- Define Medicaid covered vision materials and eyewear not under the Volume Purchase Contract;
- Provides instructions for billing vision care services and for prior authorization.
Archived MHTLs
TO: All Providers of Physician Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators  

FROM: Thomas Hayes, Director  

SUBJECT: PHYSICIAN 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  
- Clarification about coverage of conscious sedation  
- Code changes for casting materials and supply codes  
- Update for special genetic services  
- Update for psychological services  
- HIPAA wrap-up and review  

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.A.A.)  
To learn more about H.I.P.A.A. changes in ODJFS, please check the following web site address: http://www.state.oh.us/odjfs/ohp/hipaa.htm. 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.A.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.htm. 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. Conscious Sedation Coverage
Payment for conscious sedation is bundled into the payment for the related surgical or radiological procedure and is not separately reimbursable.

III. 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.

IV. Update for Special Genetic Services

Effective October 2003, local level genetic procedure codes X1470 to X1476 and X1478 are not HIPAA compliant codes. These codes will no longer be reimbursed as of October 1, 2003. Providers of genetic services will bill the appropriate evaluation and management code(s) for the coverage of genetic services. Ohio Administrative Code rule 5101:3-4-32 entitled "Special genetic services" will be rescinded on October 1, 2003.

V. Update for Psychological Services

Effective with services provided on and after October 1, 2003, a physician employing a licensed psychologist must bill the appropriate procedure code for the service and modify the code with the modifier "AH" to signify that the service was personally provided by a licensed psychologist.

Code 90801 for the diagnostic interview examination will be a covered service for licensed psychologist employed by a physician for dates of service on and after October 1, 2003.

- This code is not time-based and can be billed only as one unit of service.

Effective with services provided on and after January 1, 2004, psychology services will continue to be covered services to adult Medicaid recipients if provided by psychologists employed or under contract with a physician.

Documentation

- For a physician employing a licensed psychologist, all documentation provisions for therapeutic services outlined in paragraph (H) of rule 5101:3-4-29 or the Administrative code shall apply to therapeutic services provided by a psychologist with the exception that a licensed psychologist does not need to have the treatment plan signed and dated by a physician prior to initiating therapy.

VI. 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 3336-02-02 (dated June 14, 2002)

- Discontinuation of speech therapy local level Z-codes as of January 1, 2003.

MHTL 3336-02-04 (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.
- Discontinuation of laboratory modifier ZP as of July 1, 2003.

MHTL 3336-02-05 (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 3336-03-01 (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.
- Discontinuation of physician assistant modifier AU as of October 1, 2003 and use of new physician assistant modifier UD as of October 1, 2003.
- Changes in reimbursable codes, modifiers and reimbursement amounts for services provided by non-physicians, employed by a physician, for the treatment of a mental or emotional disorders as of October 1, 2003.

MHTL 3336-03-02 (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.
- Use of modifier UB with critical care codes when billing for emergency patient transport.
- Updates to Appendix L of the physician handbook for the List of Valid Physician Modifiers.
- Updates to Appendix M of the physician handbook for List of Valid Alpha HCPCS codes.

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 Physician Services.

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

to print the order form for MHTL 3336-03-03
TO:    All Providers of Clinic and Physician Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators  
FROM:  Thomas Hayes, Director  
SUBJECT: HANDBOOK UPDATE FOR 2003 HCPCS CHANGES

2003 HCPCS HANDBOOK UPDATE

- Clarification of use of acronym CPT and HCPCS  
- Update on critical care services  
- Update on physician attendance during patient transport  
- Update on newborn care services  
- Update on non-routine postoperative visits  
- Update on otorhinolaryngologic procedure codes  
- Update on radiology services  
- 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 physician 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 physician handbook will be posted to the department's web site at http://www.state.oh.us/odjfs/lpc/ml/.

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.

Physician 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 3336 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 - PHY.1101.1


Critical Care Services - PHY.1101.7
Critical care provided to infants 31 days old up to 24 months old must be reported with the pediatric critical care codes 99293 and 99294. These codes must be billed only once per day per physician per patient. Critical care services provided to neonates 30 days old or less must be billed with the neonatal critical care codes 99295 and 99296. Care for a critically ill or critically injured child older than two years when admitted to an intensive care unit must be billed with hourly critical care codes 99291 and 99292.

Critical care provided to neonates which are defined as infants 30 days of age or less at the time of admission to a critical care unit are reported with the neonate critical care codes listed in the CPT book. Once the neonate is no longer considered to be critically ill, the intensive (non-critical) low birth weight service codes must be used to bill for services subsequent to the day of admission provided by a physician directing the intensive care of the low birth weight or very low birth weight infant who no longer meets the definition of critically ill for those with present body weight of less than 2,500 grams (99298 and 99299) must be billed.

- The code 99298 must be billed for the subsequent care, per day, of the recovering very low birth weight infant (present body weight less than 1,500 grams).
- The code 99299 must be billed for subsequent intensive care of the recovering birth weight infant (present body weight of 1,500 grams to 2,500 grams).
- When the present body weight of the infant exceeds 2,500 grams, the codes for subsequent hospital care (99231 to 99233) must be billed.

The initial neonatal critical care code 99295 may be billed in addition to 99360, 99436 or 99440 when the physician is present for the delivery and newborn resuscitation is required.

**Physician Attendance During Patient Transport - PHY.1101.13**

The following policies apply to patient transports for both pediatric patients 24 months or less in age and patients older than 24 months in age:

- Face-to-face time begins when the physician assumes responsibility of the patient at the referring facility/hospital and ends when the receiving facility/hospital accepts responsibility for the patient’s care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be billed.
- Services provided by other members of the transport team should not be billed by the physician but should be billed by the transportation company, e.g. ambulance provider.
- Routine monitoring evaluations, e.g. heart or respiratory rate, blood pressure, pulse oximetry, and the initiation of mechanical ventilation are included in the face-to-face time reported in the patient transport codes and will not be paid separately.
- The direction of emergency care to transporting staff by a physician located in a hospital/facility by two-way communication is not considered direct face-to-face care and should not be reported using the patient transport codes.
- Patient transport services are covered by the department only if the services are personally provided by a physician.
- The codes for the initial care of the critically ill or critically injured patient should be billed only once on a given date.

In 2002, two new codes (99289 and 99290) were introduced specific to coverage of patient transport. The 2003 CPT manual has revised the description for these two codes. These codes are now specific to pediatric critical care patient transport only and are not applicable to transports for anyone older than two years old.

- The procedure codes 99289 and 99290 for pediatric patient transport are used to report the physical attendance and direct face-to-face time spent by a physician during the inter-agency transport of a critically injured or critically ill pediatric patient twenty-four months of age or less.
These procedure codes are time-based. Pediatric patient transport services involving less than thirty minutes of face-to-face physician care should not be reported using the patient transport codes.

Certain procedures are included in the global critically ill or critically injured pediatric patient transport codes and should not be billed separately. These procedures are specified in the pediatric critical care patient transport section of the 2003 edition of the CPT book.

The following paragraphs apply to patient transports for individuals older than 24 months of age:

- Critical care codes 99291 and 99292 should be billed when a physician is in attendance during the transport of a critically ill or critically injured patient over twenty-four months of age to and from a facility/hospital.

- When billing the critical care codes listed above for a patient transport, the provider must modify the code by "UB" to indicate that the code is being billed for a patient transport for a critically ill or injured patient over twenty-four months of age. When billing 99292 for a critically ill patient who has had a physician in attendance during the patient transport and then received critical care in the hospital, bill 99292 UB for the time the physician spent in attendance during the transport. Then bill 99292 unmodified for the time spent providing critical care in the hospital. When it is appropriate to bill 99292 UB and 99292 unmodified on the same date of service, these codes must be billed on the same claim to indicate that both critical care and patient transport were both provided to the same patient on the same date of service.

- The policies specified in section PHY.1101.7 for critical care services apply to patient transports billed with critical care codes, except for the maximum of two hours reimbursable for these codes.

Newborn Care - PHY.1101.11

Local level code X9380 for the pre-delivery visit to a pediatrician/primary care provider for the establishment of a patient relationship with the physician 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 provider must bill the appropriate evaluation and management code.

Non-routine Post Operative Visits - PHY.1101.14

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.

A physician 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 physician during a postoperative period.

Update on otorhinolaryngologic procedure codes - PHY.1111.2

Procedure codes 92613, 92615 and 92617 are considered bundled into the related surgical procedure and are not covered Medicaid services.

New procedure codes 92601 to 92604, 92607 to 92612, 92614 and 92616 are covered services, but considered technical services and covered as a physician service only when the service is provided in a non-hospital setting.

Update on radiology services - PHY.1122

For the following changes, please reference paragraph PHY.1122 paragraph (E) of the physician's manual. The title of paragraph (E) will change to "Reimbursement for supplies for radiologic procedures".

Effective with dates of service on and after July 1, 2003, codes A9000-A9999 in the 2003 edition of the HCPCS book will not be covered Medicaid services.
The department will reimburse for only codes A4641 and A4643 to A4647 to a physician or other eligible (non-hospital) provider for supplies for radiologic procedures when performed in a non-hospital setting.

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:

PHY.1150 Payable Surgical Procedure Codes (10000-69999)
PHY.1151 List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components
PHY.1154 Injection Codes (J0000 to J9999)
PHY.1161 List of Valid Physician Modifiers
PHY.1162 List of Valid Alpha HCPCS codes
PHY.1164 Radiology Codes with Professional and Technical Splits

**Appendix L (PHY.1161.) List of Valid Physician 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 L 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 M (PHY.1162.) List of Valid Alpha HCPCS Codes**

Again, due to H.I.P.A.A., many local level codes will not be compliant. Appendix M 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 PHY.1101.11 for Newborn Care, you need to indicate in the Information Request box PHY.1101.11 and MHTL 3336-03-02. 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

  to print the order form for MHTL 3336-03-02.
MHTL 3336-03-01

Medicaid Handbook Transmittal Letter (MHTL) 3336-03-01

March 5, 2003

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

FROM: Thomas Hayes, Director

SUBJECT: PHYSICIAN 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
- Physician assistant modifier update
- Services provided by non-physicians for the diagnosis and treatment of mental and emotional disorders- code and modifier 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.A.A.)

To learn more about H.I.P.A.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.A.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:

Family planning billing after October 1, 2003 - PHY.1102.8 H.I.P.A.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 physician 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 - PHY.1102.1 H.I.P.P.A Code changes**

• For reimbursement of family planning visits, providers may bill one of the H.I.P.P.A. compliant codes listed below in the crosswalk from the current local level code to the new code:

<table>
<thead>
<tr>
<th>Local level code (use for services prior to 10/1/03)</th>
<th>Description of current code</th>
<th>New code for services on and after 10/1/03</th>
<th>Description of new code</th>
</tr>
</thead>
<tbody>
<tr>
<td>X1450</td>
<td>Minimal family planning visit</td>
<td>99211</td>
<td>Office visit not requiring MD presence</td>
</tr>
<tr>
<td>X1451</td>
<td>Family planning counseling by non-physician</td>
<td>H1011</td>
<td>Non-medical family planning education visit</td>
</tr>
<tr>
<td>X1452</td>
<td>Examination not performed by a physician</td>
<td>S0610 or S0612</td>
<td>New patient gyn. exam- Must bill with SA or SB modifier</td>
</tr>
<tr>
<td>X1453</td>
<td>Examination performed by physician</td>
<td>S0610 or S0612</td>
<td>New patient gyn. exam.</td>
</tr>
</tbody>
</table>

**Other family planning codes - PHY.1102.5 H.I.P.P.A Code changes**

• To bill for implants the provider must bill A4260 for service provided on or after 10/1/03.

• For a crosswalk of other X codes for family planning to the new H.I.P.P.A. compliant code, consult the document "Crosswalk from local level code to H.I.P.P.A. compliant code" which can be found at http://www.state.oh.us/odjfs/ohp/hipaa.stm.

**Physician assistant modifier - PHY.1125 H.I.P.P.A Code changes**

• Current policy states that to be reimbursed for physician assistant services, the physician or clinic must bill the department using the 5-digit code followed by the AU modifier. This practice should continue for services provided prior to October 1, 2003.

• For services provided on an after October 1, 2003, bill the 5-digit code followed by the "UD" modifier to signify that the service was provided by a physician assistant. Should another modifier be created at the national level in the future to signify that a physician assistant provided the service, the department will adopt that national modifier.

**Services provided by a non-physician for the treatment of a mental or emotional disorder - PHY.1126 H.I.P.P.A Code changes**
For reimbursement for services provided by non-physicians meeting the criteria in paragraph (B) of PHY.1126 the services must be billed using the following codes and modifiers:

- **Billable codes and services:**
  - For services provided prior to October 1, 2003, bill the appropriate code such as H5010, H5020, or H5025.
  - For services provided on and after October 1, 2003, bill the code which best describes the service provided:
    - For individual therapy, bill the appropriate individual therapy code reimbursable for non-physicians:
      - 90804 Individual therapy, insight-oriented, 20-30 minutes face-to-face contact with patient
      - 90806 Individual therapy, insight-oriented 40-50 minutes face-to-face contact with patient
      - 90810 Individual therapy, interactive, 20-30 minutes face-to-face contact with patient
      - 90812 Individual therapy, interactive, 40-50 minutes face-to-face contact with patient
    - For group therapy, bill the appropriate group therapy code reimbursable for non-physicians from the following list:
      - 90846 Family psychotherapy (without patient)
      - 90847 Family psychotherapy (with patient)
      - 90849 Multiple-family group psychotherapy
      - 90853 Group psychotherapy other than multiple-family
  - **Modifiers to signify the level of educational training of a non-physician providing therapy services:**
    - If the non-physician providing the service is a clinical social worker, bill the appropriate code modified by "AJ" to signify that a clinical social worker provided the service.
    - If the non-physician providing the service is a clinical psychologist, bill the appropriate code modified by "AH" to signify that a clinical psychologist provided the service.
    - If the non-physician providing the service holds a doctoral degree and is not a clinical psychologist, bill the appropriate code modified by "HP" to signify a doctoral level trained professional.
    - If the non-physician providing the service holds a Master's degree and is not a clinical social worker, bill the appropriate code modified by "HO" to indicate a Masters degree level trained professional.
    - If the non-physician providing the service holds a Bachelor's degree only, bill the appropriate code, modified by "HN" to signify that a Bachelor's level clinical staff person provided the service.
  - **Reimbursement for therapy provided by a non-physician will be reimbursed at the following levels:**
    - For services provided by a clinical psychologist, services will be reimbursed at the lesser of the provider's billed charge or eighty-five per cent of the Medicaid maximum.
    - For individual and group therapy provided by non-physicians except for clinical psychologists, services will be reimbursed at the lesser of the provider's billed charge or fifty per cent of the Medicaid maximum for the individual therapy code.

New Vaccine for Children (VFC) Immunization Code- PHY.1104.1 H.I.P.A.A

- **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 diptheria, tetanus toxoids, acellular pertussis, hepatitis B, and polio virus.

- Please note a correction to an earlier statement in MHTL 3336-02-04. 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.
VII. HealthChek (EPDST) billing - PHY.1105.2 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 the physician 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

to print the order form for MHTL 3336-03-01.

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
TO: All Providers of Physician Services
     Directors, County Department of Job and Family Services
     Medical Assistance Coordinators
FROM: Thomas Hayes, Director
SUBJECT: PHYSICIAN 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 physician 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 - PHY.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 visit 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 IV modifier on or after July 1, 2003.

II. **Delivery and post partum care - PHY.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)*

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59409</td>
<td>For a vaginal delivery when outpatient postpartum care is provided by another provider or provider group.</td>
</tr>
<tr>
<td>59410</td>
<td>For a vaginal delivery when outpatient postpartum care is provided by the same provider or provider group.</td>
</tr>
<tr>
<td>59514</td>
<td>For a Cesarean section when outpatient postpartum care is provided by another provider or provider group.</td>
</tr>
<tr>
<td>59515</td>
<td>For a Cesarean section when outpatient postpartum care is provided by the same provider or provider group.</td>
</tr>
</tbody>
</table>

For delivery and postpartum services to patients for which a VBAC was attempted.

*(The table below contains delivery and post partum CPT codes)*

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59612</td>
<td>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.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59614</td>
<td>Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery when outpatient postpartum care is provided by another provider or provider group.</td>
</tr>
<tr>
<td>59620</td>
<td>Cesarean delivery only, following attempted vaginal delivery after previous Cesarean delivery when outpatient postpartum care is provided by the same provider or provider group.</td>
</tr>
</tbody>
</table>

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 - PHY.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 obtained 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 - PHY. 1103 - 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:

<table>
<thead>
<tr>
<th>Code prior to 7/1/03:</th>
<th>New Code 7/1/03 and after:</th>
<th>New description:</th>
</tr>
</thead>
<tbody>
<tr>
<td>X5431</td>
<td>H1002</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>X5412</td>
<td>(see S codes below)</td>
<td>Group prenatal at-risk education</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>S9436</td>
<td>Childbirth preparation/Lamaze classes, non-physician provider</td>
<td></td>
</tr>
<tr>
<td>S9437</td>
<td>Childbirth refresher classes, non-physician provider</td>
<td></td>
</tr>
<tr>
<td>S9452</td>
<td>Nutrition classes for pregnant women, non-physician provider</td>
<td></td>
</tr>
<tr>
<td>S9444</td>
<td>Baby parenting classes provided to pregnancy women, non-physician provider</td>
<td></td>
</tr>
<tr>
<td>S9447</td>
<td>Infant safety classes provider to pregnancy women, non-physician provider</td>
<td></td>
</tr>
<tr>
<td>X5411</td>
<td>Individual prenatal at-risk education</td>
<td></td>
</tr>
<tr>
<td>X5432</td>
<td>Antepartum management (formerly called high-risk patient monitoring)</td>
<td></td>
</tr>
<tr>
<td>X5422</td>
<td>Medical nutrition therapy counseling provided by a dieticist</td>
<td></td>
</tr>
<tr>
<td>X5422</td>
<td>Use appropriate E/M visit code</td>
<td></td>
</tr>
<tr>
<td>X5400</td>
<td>Pre-natal risk assessment</td>
<td></td>
</tr>
</tbody>
</table>

- 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 physician, 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 physician handbook.
• Medical necessity - PHY.1003

• 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 - PHY.1003.4

The paragraph addressing physician delegation of tasks has been revised.

• Prior Authorization - PHY 1004.1

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**

<table>
<thead>
<tr>
<th>Notice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paper Distribution Changes</strong></td>
</tr>
<tr>
<td>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, <a href="http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid">http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid</a>.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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 "physician services" book and click on PHY.1103 to view and/or print this new policy.

• A new consolidated physician handbook containing all physician policies as of this date is also available at the above-listed web site address. The consolidated physician handbook contains sections PHY.1000 describing general policies applicable to physicians and PHY.1100 containing all covered services and associated limitations. Related appendices to the physician handbook can be viewed and printed individually from the web site by clicking on each individual appendix.

VIII. **Requesting updates to the physician 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 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
to print the order form for MHTL 3336-02-05.

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
TO: All Providers of Physician Services  
Directors, County Department of Job and Family Services  
Medical Assistance Coordinators  
FROM: Thomas Hayes, Director  
SUBJECT: PHYSICIAN HANDBOOK UPDATE- Policy/Code Changes

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 - PHY.1104
- Immunization codes- PHY.1104
- HealthChek (EPSDT) screening frequencies- PHY. 1105
- Billing for HealthChek Services- PHY.1105
- Therapeutic injection language revisions- PHY.1106
- ZP modifier and other lab revisions - PHY.1121

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules which govern physician 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. 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 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.

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 - PHY.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 intra-muscular use and 90385 for the Rho(D) immune globulin, human, mini-dose for intra-muscular 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 - PHY.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**:

<table>
<thead>
<tr>
<th>Old code:</th>
<th>Description</th>
<th>New Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>W0703</td>
<td>Tetanus, adult, nineteen years or older</td>
<td>90703</td>
</tr>
<tr>
<td>W0706</td>
<td>Rubella virus, adult, nineteen years or older</td>
<td>90706</td>
</tr>
<tr>
<td>W0718</td>
<td>Tetanus and diphtheria toxoids, adult</td>
<td>90718</td>
</tr>
<tr>
<td>W0658</td>
<td>Influenza, split vaccine, adult, 19 years or older</td>
<td>90658</td>
</tr>
</tbody>
</table>

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 - PHY1105.2**

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 - PHY.1105.2. H.I.P.A.A. modifier changes**

Modifier changes for H.I.P.A.A

Effective for dates of service **October 16, 2003 (or H.I.P.A.A. implementation date)**, the modifiers NF, FR, FA, and FC will be 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 - PHY.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 - PHY.1121

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.

Codes 88130, 88140, and 88141 have been added to the table as clinical laboratory procedures and removed from the anatomical lab list.

For services rendered on or after July 1, 2003, the Department will no longer recognize the ZP modifier since it is not H.I.P.A.A.-compliant. Reimbursement for the total anatomical pathology procedure will be the lesser of the provider's total charged amount or the medicaid maximum for the appropriate code.

For services rendered prior to July 1, 2003, reimbursement of the total procedure will be made when provider's bill the most appropriate code for the anatomical pathology procedure modified by the modifier ZP (e.g., 88300ZP).

To bill for the technical component for anatomical pathology codes, for services rendered on or after July 1, 2003, the Department will no longer recognize the modifier ZP. Providers performing only the technical component must bill the appropriate code modified by the modifier TC (e.g., 88300TC).

For services rendered prior to July 1, 2003, when an eligible provider of laboratory services performs only the technical component of an anatomical procedure, the provider may bill for the technical component by billing the appropriate code unmodified.

The Department revised the anatomical pathology code list to delete obsoleted anatomical pathology codes. The obsoleted codes are 85102, 88170. The Department also removed the codes 88130, 88140, and 88141 from the anatomical list and added them to the clinical pathology list.

V. Requesting updates to the physician 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 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
to print the order form for MHTL 3336-02-04.

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

FROM: Thomas Hayes, Director

SUBJECT: PHYSICIAN 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 physician handbook will be available on the Department's website 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 PHY.1115 paragraph (B)(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 definitions 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/AA, resident, intern, or fellow in the performance of the services listed in PHY.1115 paragraph (C)(2) 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 PHY.1115 paragraph (C)(2) 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 PHY.1115 paragraph (H)(3)(a) and (H)(3)(b) which addresses billing of claims for a CRNA/AA 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.

Two claims must be submitted when the physician/anesthesiologist meets the requirements in section PHY.1115 paragraph (C)(1) provide medical direction or medical supervision to CRNAs/AA's.

III. Correction to Billing Instructions

**Please Note:** MHTL 3336-02-02 had an update to the address on page 25 of the Billing Instructions (BIN.1000. - BIN.1300.) issued 01-01-2002. On that same page, Item 22, Other Source Amount, states in parenthesis that when an amount is entered in this Item, Item 16 must also be completed. Item 16 is incorrect and should state Item 15.

This correction is in reference to the Medicaid/Medicare Crossover Billing Instructions. Please note this change in your handbook. A corrected handbook page will be issued with the full handbook issuance in January 2003.

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 3336-02-02

Medicaid Handbook Transmittal Letter (MHTL) 3336-02-02

June 14, 2002

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

FROM: Thomas Hayes, Director

SUBJECT: PHYSICIAN HANDBOOK UPDATE

EFFECTIVE JULY 1, 2002

- New Physical Medicine Rules
- Rate Adjustments
- Speech Therapy Local Level Codes
- Revisions to BIN 1100, Medicare/Medicaid Crossover Mailing Address For 6780 Claim Form Only
- Revisions to BIN 1202, Remittance Advice Form

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing physical medicine 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 July 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 physician handbook will be available on the Department's web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid/ by July of 2002.

Policy Changes:

I. Eligible Physical Medicine Providers

The rules for physical medicine services have been completely changed. Please read the attached copy of the physician handbook section PHY.1123. carefully. Important changes to the rules can be found in the following physician handbook sections:

Covered Services, handbook section PHY.1123.1
Reimbursement Requirements, handbook section PHY.1123.2
Modality Guidelines, handbook section PHY.1123.3
Maintenance Therapy, handbook section PHY.1123.4
Services Provided By Physical Therapy Students, handbook section PHY.1123.5
Documentation Requirements, handbook section PHY.1123.6
Limitations, particularly on the number of services per patient per twelve month period, handbook section PHY.1123.7

Physical medicine services are limited to thirty dates-of-service per recipient per twelve-month period regardless of the number of modalities or procedures the patient may receive during a visit. The number of units, e.g., modalities or procedures, will no longer be the limiting factor.
This 30 visit limitation is across all providers and provider types that a recipient receives physical medicine from during the rolling twelve month period.

Non-Covered Services, handbook section PHY.1123.8

II. Rate adjustments

The Department will be adjusting the Medicaid maximum for some CPT codes and for some J codes for injections effective for services provided on and after July 1, 2002. There is a state law that prohibits Ohio Medicaid from paying more than Medicare. A recent analysis revealed that the Department was paying more than Medicare for certain HCPCS codes. Therefore, the Medicaid maximum for these codes will be adjusted downward. However, the overall impact on physician services will be budget neutral since the price reductions for some codes will be offset by price increases for other codes.

III. Speech Therapy Local Level Codes

Due to H.I.P.A.A. requirements that providers and payers use the same codes for all payers, the Department will be discontinuing the local level Z codes currently used by many clinics that provide speech therapy services. Effective for services provided on and after January 1, 2003, the Z codes Z2585, Z2586, Z2591, Z2593, and Z2595 are no longer payable by the Department. All providers who currently use these Z codes should advise their billers that they will not be payable after December 31, 2002. Providers who offer speech therapy services may begin using the existing CPT codes for speech therapy (92506, 92507, and 92508) at any time.

IV. Medicare/Medicaid Crossover Change Of Address For 6780 Claim Form

The BIN 1100 Medicare/Medicaid Crossover 6780 Claim Form address where you send the original (pink) invoice (P.O. Box 182243, Columbus, Ohio 43216-2243) is incorrect. The correct address is:

Ohio Department of Job and Family Services
P.O. Box 2338
Columbus, Ohio 43216-2338

*DO NO FOLD INVOICE*

V. Billing Instructions Update

BIN 1202 Remittance Advice sample form has been updated to better help explain what should be placed in the different sections of the form. The new form is attached and will replace Ohio Medicaid Provider Handbook, Billing Instructions pages 30 and 31. Please remove the old handbook pages and replace them with the new pages attached.

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

Attachment

Remittance Advice sample form.
TO: All Providers of Physician 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  

- Most commonly asked questions - Update  
- H.I.P.A.A.  
- Physician attendance during patient transport  
- Prenatal care billing  
- Cardiovascular diagnostic and therapeutic services  
- Neurology and endocrinology services  
- Anesthesia for neuraxial analgesia for obstetrical procedures  
- Clarification of policy regarding physician assistant visits to nursing home patients  
- Exceptions to non-covered 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 3336 of the Ohio Medicaid Provider Handbook to eligible providers of physician 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 2002 HCPCS codes, the Department will continue to accept the 2001 codes for services rendered through March 31, 2002. Providers may choose to bill either the 2001 codes or the 2002 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.  

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 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)  

Physician Services Handbook Update
Policy Changes and Clarifications:

**Physician Attendance During Patient Transport - PHY.1101. (PHY.1101.13)**

- There are two new CPT codes for 2002 which describe physician services relating to the physician's attendance during the transporting of a critically ill or injured patient from one facility to another. These codes are:
  
  99289 Physician constant attention of the critically ill or injured patient during an interagency transport; first 30-74 minutes
  
  99290 Physician constant attention of the critically ill or injured patient during an interagency transport; each additional 30 minutes

- These codes are used to report the physical attendance and direct face-to-face time spent by a physician during the inter-agency transport of a critical care patient. Face-to-face time begins when the physician assumes primary responsibility for the patient at the referring facility/hospital and ends when the receiving facility/hospital accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport is billable.

- Patient transport services involving less than 30 minutes of face-to-face patient care should not be reported using the patient transport codes.

- The patient transport codes are covered only if the service is personally provided by the physician. Services provided by other members of the transport team should not be billed using these codes.

- Routine monitoring evaluations, e.g. heart or respiratory rate, blood pressure, pulse oximetry, and the initiation of mechanical ventilation are included in the face-to-face time report using the patient transport codes and will not be paid separately.

- The direction of emergency care to transporting staff by a physician located in a hospital by 2-day communication is not considered direct face-to-face care and should not be reported using the patient transport codes.

**Obstetrical Services - PHY 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.

**Cardiovascular Diagnostic and Therapeutic Services - PHY.1110.**

- There were a number of new CPT codes for 2002 relating to cardiovascular diagnostic and therapeutic services. Therefore, section PHY.1110 (PHY.1110(B)) has been revised to add the following CPT codes relating to cardiovascular services to the list of cardiovascular services which must be billed using the appropriate CPT unmodified:

  92973 Percutaneous coronary thrombectomy
  
  92974 Transcatheter placement of radiation delivery devices for coronary brachytherapy
  
  93025 Microvolt T-wave assessment.

**Neurology and Endocrinology Services - PHY.1111.**
There were a number of new CPT codes for 2002 relating to neurology and endocrinology services. Therefore, section PHY.1111(PHY.1111.3) has been updated to state policy relating to these new services.

Code 96004 entitled "Physician review and analysis of comprehensive computer-based motion analysis, plantar measurements, dynamic surface electromyography during walking or other functional activities, and dynamic fine wire electromyography, with written report" has been added to the list of neurology services which are covered as physician services regardless of setting.

CPT codes 96000 through 96003 which are new codes for motion analysis are considered technical services that are reimbursable to a physician only if they are provided in a non-hospital setting.

CPT code 95250 for glucose monitoring, a new endocrinology code, is considered a technical service and also is reimbursable to a physician only if the service is provided in a non-hospital setting.

**Policy Update: Anesthesia Services- PHY.1115. (PHY.1115(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 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 services 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.

Policy Clarification Regarding Physician Assistant Visits to Patients in a Long-term Care Facility - PHY.1125

Section PHY.1125 describing coverage for physician assistant services was revised effective November 1, 2001. In paragraph (C) (7) of this section, it states that a physician, physician group practice, or clinic may be reimbursed for physician assistant services provided in a long-term care facility. The Department wishes to clarify that the paragraphs in the Ohio Administrative Code which are referenced describe visits to a patient in a long-term care facility. A physician may delegate tasks to a PA or nurse practitioner who is acting within their scope of practice as defined by state law and is under the supervision of the billing physician. In regard to visits, the physician must make the initial visit and then he/she may choose to alternate visits between the physician and visits by a physician assistant or nurse practitioner.

Non-covered Service- PHY.1129. (PHY.1129(C13))

- 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( the vision care program); 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:

PHY.1150 Payable Surgical Procedure Codes (10000-69999)
PHY.1151 List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components
PHY.1154 Injection Codes (Alpha and Numeric )
PHY.1158 Waived Laboratory Procedure Categories
PHY.1160 Lead Poisoning Table
PHY.1161 Valid Physician Modifiers
PHY.1162 Valid Alpha HCPCS Codes
PHY.1164 Radiology Codes with Professional and Technical Splits

Appendix E (PHY.1154) 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 I (PHY.1158) Waived Laboratory Procedures
This appendix has been updated to include lab procedures which CLIA has indicated may be billed using the
QW modifier which indicates that the lab procedure is a waived procedure under CLIA. The procedures which
are new waived procedures are underlined and have an asterisk beside them in this appendix. Procedures
which were discontinued as waived are noted at the bottom of the waived procedure section of this appendix.
A current list of waived lab tests or PPMP tests can be found on the CLIA web site at
http://www.hcfa.gov/medicaid/clia/cliahome.htm under the section entitled "Categorization of tests under
CLIA. The Medicare intermediary also publishes updates to the list of waived tests in their monthly
newsletters.

Appendix K (PHY.1160) Lead Poisoning Table
This appendix has been updated to include a revised CDC chart adapted from "Screening Young Children for
Lead Poisoning" and is in accordance with Ohio Department of Health lead screening guidelines. It you have
questions about lead poisoning screening guidelines, please call the Ohio Department of Health’s lead
screening unit.

Appendix L (PHY.1161) Valid Physician Modifiers
This appendix has been updated to include the physician modifiers for anesthesia services which were
effective May 1, 2001. These new modifiers include:

- AD Medical supervision by a physician: more than 4 concurrent procedures
- QK (*the hardcopy erroneously cites this modifier as "OK") Medical direction of 2,3,or 4 concurrent
  procedures involving qualified individuals
- QY Medical direction of one CRNA by an anesthesiologist

Note: The AA and QX, and QZ modifiers are still in effect but anesthesia modifiers AB, AC, and AE were
discontinued effective for dates of service May 1, 2001. Modifiers QX and QZ are to be billed by CRNAs not
by physicians. Modifier QX may be used by an anesthesiology assistant under the medical direction of an
anesthesiologist.

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
TO: All Providers of Physician Services
   Directors, County Department of Job and Family Services
   Medical Assistance Coordinators
FROM: Tom Hayes, Director
SUBJECT: PHYSICIAN HANDBOOK UPDATE

PHYSICIAN ASSISTANT SERVICES AND SERVICES FOR EMOTIONAL AND MENTAL DISORDERS
HANDBOOK UPDATE
EFFECTIVE NOVEMBER 1, 2001

- Physician Assistant Definition
- Physician Assistant Coverage and limitations
- Reimbursement for Physician Assistant Services
- Licensed Counselors
- Supervision of Social Workers and Counselors
- Non-covered Mental Health Services
- Documentation of Mental Health Services

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing physician assistant services and services for emotional and mental disorders. Updated handbook pages are attached. New information is noted by a vertical line to the left of the new language. While these rules are still in a proposed status, they are scheduled to be effective on November 1, 2001.

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.

Attachment

Physician Assistant Services:

- Definition:
  "Physician assistant" means a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant in accordance with Chapter 4730 of the Revised Code under the supervision and direction of one or more physicians who are responsible for the physician assistant's performance.

- Coverage and Limitations
  The services/procedures provided by a physician assistant under the supervision and direction of his/her supervising physician(s) are covered if:
  The services are listed as standard functions for a physician assistant approved by the state medical board as described in 4731-4-01 of the Administrative Code; or
  The services have been approved by the state medical board as supplemental functions for that physician assistant as described in 4731-4-02 of the Administrative Code;
  The physician assistant is employed or under contract with an eligible provider of physician services as described in section PHY.1002 of the physician handbook; and
  The services must be covered by the Medicaid program.
It is the responsibility of each physician assistant to assure that he/she is in compliance with all state laws.

Physician assistants are allowed to perform evaluation and management services that are commensurate with his/her training and experience. However, "consultation and critical/intensive care services" are considered to involve the practice of medicine and are not covered services for physician assistants.

A physician or other employing provider may not be reimbursed for initial office visits provided by a physician assistant. A patient new to the physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated.

An established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition.

A physician assistant may not admit or release patients from a hospital independent of the supervising physician. The supervising physician must personally see and evaluate the patient prior to admission or discharge.

For an initial visit, established visit, and hospital admission or release, the medical record must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant.

- Reimbursement:

Payment for services of a physician assistant may be made only to the physician, physician group practice, or clinic employing or contracting with the physician assistant who is providing services under a physician's supervision. The following provisions apply:

With the exception of services considered "physician services" described in the next paragraph, reimbursement for physician assistant services will be the provider's billed charge or eight-five per cent of the Medicaid maximum, whichever is less.

For reimbursement of physician assistant services, the physician or clinic must bill the department using the five-digit CPT code followed by the AU modifier.

The following services will be considered physician services and will be paid at one hundred percent of the Medicaid maximum:

- Ancillary services such as collection of specimens provided by a physician assistant which are usually performed by nonphysicians;
- Procedures/services performed by a physician assistant and the employing physician/group also provides direct and identifiable services, including a face-to-face encounter with the patient; and
- These services should be billed with the appropriate CPT/HCPCS code unmodified.

A physician, physician group practice, or clinic may not be reimbursed for initial office visits provided by a physician assistant.

A physician, physician group practice, or clinic may not be reimbursed for physician assistant services in an inpatient hospital, outpatient hospital, emergency room or long-term care facility except when the physician assistant is employed by or under contract with a physician, physician group practice, or clinic.

A physician, physician group practice, or clinic may be directly reimbursed for services provided in a long-term care facility as described in paragraphs (F) (1) (c) (iii) or (F) (1) (c) (iv) of rule 5101: 3-3-19 of the Administrative Code by a physician assistant employee.

Reimbursement will not be made for a visit or service billed by both a physician and a physician assistant on the same date of service

Interpretative services such as electrocardiographic or radiological interpretation are considered to be physician services and are not covered if performed by a physician assistant.

Assistant-at-surgery services are not covered when provided by a physician assistant.
When the procedures/services are performed by a physician assistant and the employing physician/group also provides direct and identifiable services, including a face-to-face encounter with the patient, the services may be billed and reimbursed as physician services up to a maximum of one hundred per cent of the Medicaid maximum.

A physician, physician group practice, or clinic may not be reimbursed for services performed by a physician assistant which are prohibited under rule 4731-4-05 of the Administrative Code.

- Services performed by physician assistants are subject to the site differential payments in all places of service specified in rule 5101: 3-4-022 if the services are performed under the supervision of a physician as described in rule 5101: 3-4-02 of the Administrative Code.

**Mental and Emotional Disorder Services:**

- Services of a professional counselor and a professional clinical counselor as defined in rule 4757:3-01 of the Administrative Code are covered as physician services if provided under the supervision of a physician as described in section PHY1003.2 of the physician handbook. Services of a professional counselor must be provided under the direct supervision of a physician as described in paragraph B of PHY.1003.2 of the physician handbook while services of a professional clinical counselor are covered if provided under the general supervision of a physician as described in paragraph C of section PHY.1003.2 of the physician handbook. All counselors must be employed or under contract with the billing physician as described in section PHY.1003.2 of the physician handbook.

- For reimbursement of services provided by a professional counselor or a professional clinical counselor, use the same codes currently billed by social workers employed by or under contract with a physician. These codes are:
  
  H5010 Therapy, individual, by non-physician up to one hour.
  
  H5020 Psychotherapy, group (maximum 8 per group) by nonphysician, 45-55 minutes, per person, per session
  
  H5025 Psychotherapy, group maximum 8 per group) by nonphysician, ninety minutes, per person, per session

- For services of a clinical social worker, licensed social worker, professional counselor, or professional clinical counselor employed by or under contract with a physician to be billed and reimbursed to the employing or contracting physician or clinic only when the following provisions are met:

  The supervision requirements listed in this MHTL have been met; and

  The physician provides supervision to the non-physicians which, at a minimum: includes the following:
  
  - Discussion about the progress of the patient toward specified goals;
  - Updating treatment plans as needed; and
  - Periodic participation in therapy sessions.

  Countersigning the therapist's signature is insufficient evidence of active supervision.

- The following services are noncovered under the Medicaid program:
  
  Services provided in facilities regulated by the state board of education;
  
  Sensitivity training, encounter groups or workshops;
  
  Sexual competency training;
  
  Marathons and retreats for mental disorders; and
  
  Educational activities, testing and diagnosis;
  
  Monitoring activities of daily living;
  
  Recreational therapy (art, play, dance, or music);
  
  Teaching grooming skills;
  
  Services primarily for social interaction, diversion, or sensory stimulation;
Psychotherapy services are not covered if the patient's cognitive deficit is too severe to establish a relationship with the psychotherapist; and

Family therapy psychotherapy involving training of family members or care givers if the purpose is the management of the patient.

- The patient's medical record must substantiate the nature of the services billed including:
  - The medical necessity of the services billed;
  - A treatment plan which is signed and dated by the physician prior to initiating therapy. The treatment plan shall include but is not limited to:
    - Patient's relevant medical and psychiatric diagnoses.
    - Therapy goals;
    - Type, duration, frequency of therapy services;
    - Information regarding the patient's symptoms, functional impairment, type, duration, and frequency of treatment including dates of treatment sessions;
    - Patient's prognosis; and
    - Evidence of sufficient cognitive ability to benefit from therapy.
  - Any medications prescribed;
  - Information regarding the patient's symptoms, functional impairment, type, duration, and frequency of treatment including dates of treatment sessions;
  - The face-to-face time period spent with the patient;
  - Test results, if applicable; and
  - The patient's response to treatment on an on-going basis.

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
TO: All Providers of Physician Services
   Directors, County Department of Job and Family Services
   Medical Assistance Coordinators
FROM: Greg L. Moody, Director
SUBJECT: PHYSICIAN HANDBOOK UPDATE

LABORATORY, HEALTHCHEK (EPSDT), AND STERILIZATION SERVICES
HANDBOOK UPDATE
EFFECTIVE AUGUST 1, 2001

- HEALTHCHEK (EPSDT) Services
- Sterilization procedure
- Ordering of Laboratory Services
- Specimen collection
- Laboratory Specimens Sent to the Ohio Department of Health
- Billing Teaching Physician Modifiers

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 - PHY.1105:
A clarification has been made in the area of pap smears for adolescent females. Pap smears are recommended 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, 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.

Sterilization Services - PHY.1118:
As you know, informed consent must be obtained for sterilization. Normally the primary care physician who is scheduled to perform the procedure is responsible for securing the recipient's informed consent. However, the Department has revised the policy to recognize that occasionally, a recipient changes physicians between the time the original physician secures the recipient's consent and the date of the sterilization (another doctor performs the procedure). Should this occur, it is not necessary for the physician performing the sterilization procedure to complete a second consent form if the initial consent form is available to them to confirm that consent was obtained. However, all invoices submitted to the Department for payment of a sterilization, must include a copy of the signed consent form.

Laboratory Services - PHY.1121:
Policies addressing coverage for laboratory services have been amended to address the ordering of laboratory services. Laboratory services are covered only if they are performed at the written or electronic request of an authorized person.

- The laboratory procedure may be performed on the verbal order of the treating physician or treating non-physician provider, e.g. advanced practice nurse, in accordance with state law. The laboratory must obtain a written order that is dated and signed by the treating practitioner before the Department is billed. The laboratory must maintain the written authorization in their records for a period of six years or until any initiated audit has been completed as specified Ohio Revised Code 5101: 3-1-172. If the patient's medical record is used as a test requisition, it must be maintained for six years and must be available to the laboratory at the time of the testing and available to the Department upon request.
- The laboratory must assure that the requisition or test authorization includes:
  - The patient's name;
  - The name and address of the authorized person requesting the test, and, if appropriate, the individual responsible for utilizing the test results or the name and address of the laboratory submitting the specimen;
  - The test to be performed;
  - The date of the specimen collection;
  - For pap smears, the patient's last menstrual period, age, or date of birth, and indication of whether the patient had a previous abnormal report, treatment, or biopsy; and
  - Any additional information necessary to a specific test to assure accurate and timely testing and reporting.
- The laboratory which performed the test must meet all laboratory standards outlined in 42 CFR 493.

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.

Providers who send laboratory specimens to ODH may not bill the Department. Providers who use the state laboratory must complete the top portion of the HCFA 1500 claim form and include any attachments required by ODH and the ODH state laboratory will complete the claim form and submit the claim for payment. This is a clarification of an existing policy.

**Teaching Physician Modifiers- PHY.1003.3:**

It has come to our attention that in certain cases, a provider may need to bill both the GC or GE modifier and another modifier to delineate the service provided. If this is the case, please bill the CPT code for the service rendered and the other modifier, e.g. IF, IV or NF on the first line of the claim. Then, as indicated in the CPT book under multiple modifiers, bill modifier code 09999 with the modifier GC or GE to indicate that services were performed by a resident.

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
TO: All Providers of Physician Services
Directors, County Departments of Job and Family Services
Directors, District Offices
FROM: Jacqueline Romer-Sensky, Director
SUBJECT: REVISIONS TO THE ANESTHESIA POLICY

PHYSICIAN SERVICES
ANESTHESIA POLICY UPDATE

EFFECTIVE MAY 1, 2001

- CPT anesthesia coding
- New modifiers
- Billing for a physician-employed, medically-directed CRNA/AA
- Need for CRNAs/AAs to have Medicaid provider numbers
- Monitored anesthesia care
- Reimbursement using RVU-based pricing

The purpose of this transmittal letter is to give 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 PHY1115 entitled "Anesthesia Services" is attached. Please replace the old PHY1115 section with the new PHY1115 section. Please note that this revised section has not been numbered since the new PHY1115 is longer than the earlier PHY1115.

Policy Changes:
The major policy changes in the Department's anesthesia policy are discussed below.

- 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 April 30, 2001.
- To bill for professional anesthesia services, the physician 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 must be used:

  AA   Anesthesia services personally performed by the anesthesiologist.
  AD   Medical supervision by a physician: more than four concurrent anesthesia procedures
  QK   Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
  *QX  CRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist.
  QY   Medical direction of one CRNA by an anesthesiologist
  QZ   CRNA without medical direction by physician.

* Please note: Anesthesiologist Assistants may use the modifier "QX" to bill for services provided under the medical direction of an anesthesiologist if the AA is employed by a physician or physician group practice or is independent practicing (self-employed).
An individual recognized under section 4769 of the Ohio Revised Code as an anesthesiologist assistant may obtain a Medicaid provider number and bill the "QX" modifier for services provided if all provisions of Ohio law are met. Only AA's employed by a physician or independently practicing may bill for professional services.

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/AA employed by a physician will continue to be paid to the employing physician. Services of a self-employed CRNA/AA or a CRNA/AA who is a member of an independent CRNA/AA group practice will continue to be reimbursed directly to the CRNA/AA or CRNA/AA group practice.

When a physician practice employs a CRNA/AA and there is medical direction provided by the physician but the CRNA/AA 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/AA indicating that medical direction was given. The modifier "QX" must be used and the CRNA/AA must be listed as the rendering provider on the claim and the physician must be listed as the "pay to" provider on the claim.

Similarly, if a physician provides medical supervision and bills the "AD" modifier, a second claim must be submitted for the service provided by the CRNA/AA indicating that medical direction was given. The CRNA/AA may bill "QX" modifier and the CRNA/AA must be listed as the rendering provider on the claim.

Services of a hospital-employed CRNA or anesthesia assistant (AA) are included in the facility payment made to the hospital.

Services of a self-employed CRNA/AA or CRNA/AA who is a member of an independent CRNA/AA group who is a member of an independent group practice is reimbursable directly to the CRNA/AA or the CRNA/AA group practice.

Any CRNAs or AA's 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 above. To obtain an application for all of the CRNAs or AA's employed by your group, please call the provider enrollment unit in provider network management section for an application at the phone number listed on the last page of this MAL.

Any AA's working in an independent practice (self-employed) must obtain a Medicaid provider number before billing the Department for services rendered.

If a CRNA/AA works for multiple physician groups, the CRNA/AA should verify that each of the physician groups is listed on her/his provider record and linked to his Medicaid number as a "pay to" provider. Please call Provider Enrollment for further instructions.

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 before reimbursement is available.

Reimbursement for anesthesia services for dates of service on or after the final implementation date 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 as 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 monitoring services.

"Base unit value" means the value for a base unit for each CPT anesthesia code. These values were taken from the 2000 American Society of Anesthesiologists' Relative Value Guide;

"Time unit" means the continuous actual presence of the physician (or of the medically directed resident or medically-directed CRNA/AA) and start when he/she begins to prepare the patient for anesthesia and ends when the anesthesiologist (or medically directed CRNA/AA) is no longer in personal attendance. "Time unit" is the actual anesthesia time as reported on the claim.

"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 modifiers "AA" or "QZ" the conversion factor is $15.28;
- For modifiers "QK", "QX", or "QY" 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 "QK", "QX", and "QY" will be reimbursed at fifty percent (50%) of the conversion factor specified for "QK", "QX", and "QY" ($8.49).

Services billed with the "AD" modifier which indicates medical supervision of more than four concurrent anesthesia procedures will be reimbursed at a flat rate of three times the conversion factor for "AA" or "QZ" ($15.28) or $45.84. If the physician is medically supervising the procedure, the physician must be involved in the pre-surgical anesthesia services.

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.

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
February 6, 2001

TO: All Providers of Physician 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

- Clarification of New Teaching Physician Policy
- Preadmission Certification
- Immunization Code Revisions
- Clarification of a "physician visit"
- Clarification of Critical Care
- Admission and Discharge Services for Observation
- 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 3336 of the Ohio Medicaid Provider Handbook to providers of physician 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.

Physician 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 3336 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, 2001.

Policy Changes and Clarifications:

- Teaching Physician Policy - PHY.1003.3
  
  In paragraph (D) (3), the policy states that primary care residency programs must file a written attestation with the Medicare program that they meet all of the conditions described in Medicare's teaching physician policy as described in the federal code of regulations section 415.174. The Department will consider that a residency program meets this requirement if they have filed a request with Medicare prior to the January 1, 2001 effective date of this policy (regardless of whether Medicare has approved the request). For providers who file their attestation after January 1, 2001, the Department will assume that the provider meets this requirement for services provided on or after the
date of your filing the request with Medicare unless an attestation is filed with the Department that shows that the provider met the requirements as early as January 1, 2001.

In paragraph (D) (3) (5) (b) the handbook specifies the lower and mid-level evaluation and management codes which may be billed under the primary care exception rule. This same policy applies to two local level codes (59420- antepartum visit and X1453- gynecologist exam performed by a physician) used by the Department for certain types of physician visits. If an antepartum visit (59420) is billed and the medical records documents that the antepartum visit equates to a lower level evaluation and management visit code, then the primary care exception rule applies and modifier "GE" may be billed to indicate that services were performed by a resident without the presence of a teaching physician. However, if the antepartum visit billed equates to a more extensive evaluation and management code, the primary care exception does not apply and a teaching physician cannot bill for this code using the "GE" modifier to indicate that a resident performed the service without the presence of a teaching physician. This same policy applies to local level code X1453, a gynecological examination performed by a physician.

- **Preadmission Certification** - PHY.1004.3

Please review this section of the handbook and note the information previously presented in MHTL 3336-00-04 regarding the list of procedures requiring preadmission certification. Preadmission certification now is required for a targeted list of procedures. The place of service (inpatient versus outpatient) is no longer the deciding factor regarding whether a service requires preadmission certification.

Also, there is a new fax number for National Health Service for preadmission certification information. It is 1-800-591-1819. For preadmission certifications of psychiatric admissions, please call 1-800-598-6462. However, as stated in MHTL 3336-00-04, the hospital is ultimately responsible for preadmission certification and receives no payment if certification is not obtained.

- **Clarification of the definition of a physician visit** - PHY.1101.1

The Department wishes to remind providers that an evaluation and management code (physician visit) is reimbursable only when there is a face-to-face encounter by a physician 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 a physician for this code to be billed. This is not a change in policy.

- **Clarification of Critical Care Coverage** - PHY.1101.7

Effective January 1, 2001, the Department has incorporated revisions to the critical care section of the 2001 CPT book into the physician handbook. Please refer to the 2001 CPT book and review the language changes made by the AMA. It is important to remember that any services specified on page 18 of the 2001 edition of the CPT book are services which should be included in reporting critical care and should not be billed separately. The Department will implement an edit that will reject any claims for these services which should not be reported separately from critical care.

- **Initial Observation Care and Observation or Inpatient Care services (Including Admission and Discharge Services)** - PHY.1101.12

The Department will be following directions provided by the AMA for observation. Note that only when patients are admitted to observation or inpatient care and discharged on a different date may a physician bill for hospital discharge management (codes 99238-39).

When the inpatient stay is less than 8 hours, however, the Department will not reimburse for hospital discharge management even if the care extended over to a different date.

For discharge management to be covered by the Department, the billing physician must document that he/she was present and performed discharge management. Both admission and discharge notes must be written by the billing physician.

- **Immunization Code Changes and Coverage** - PHY.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 physician 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 have 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)

Two new vaccine codes, 90723 and 90743, will not be reimbursable by the Department. We were informed by the Vaccine for Children's program staff 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:**

- **Waived Laboratory Procedure Codes** - PHY.1158 Appendix I
  
  This appendix has been updated to include new laboratory procedure codes which may be billed using the QW modifier to indicate the procedure is considered a waived procedure under CLIA. The new waived codes are underlined in this appendix.

- **Valid Physician Modifiers** - PHY.1161 Appendix L
  
  Two new modifiers have been added and should be used when services are performed by a resident. These modifiers are to be used with the new teaching physician policy effective January 1, 2001 and described in MHTL 3336-00-04. The new modifiers are:

  GC Services performed in part by a resident under the direction of a teaching physician.
  
  GE Services performed by a resident without the presences of a teaching physician under the primary care exception rule (see PHY.1003.3)

- **Valid Alpha HCPCS Codes** - PHY.1162 - Appendix M
  
  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:

  PHY.1150 Payable Surgical Procedure Codes (10000-69999)
  
  PHY.1151 List of Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components
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
TO: All Providers of Physician Services
   Directors, County Departments of Human Services
   Directors, District Offices
FROM: Jacqueline Romer-Sensky, Director
SUBJECT: PHYSICIAN SERVICES HANDBOOK UPDATE

PHYSICIAN SERVICES HANDBOOK UPDATE
EFFECTIVE JANUARY 1, 2001

- Definitions:
  Physician-group practice
  Provider-based physician
  Teaching physician
- Eligible providers of physician services
- Direct and general supervision
- By-report services
- Services provided in a teaching setting
- Site differentials
- Preadmission certification

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to update the handbook with changes 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 have changed the page numbers of this 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 contain all of this new material.

Section 1000 Introduction - PHY.1000
Definition of a "physician group practice" - PHY.1001.1

The Department's definition of a "physician group practice" has been revised to reflect recent changes in the Ohio Revised Code. Please be aware that the Department’s definition of a group practice is:

"a group comprised solely of two or more physicians (as defined in the handbook) who are enrolled in the Medicaid program for the purpose of providing physician services."

The Department acknowledges that the Ohio Revised Code now allows physicians to organize in many different arrangements such as a corporation, a limited liability corporation, a professional association, etc. The physician handbook has been revised to acknowledge these different legal arrangements.

However, for the purposes of the Medicaid program, the Department's definition specifically does not include "a combination of professional services as set forth in ORC 1785.01 sections (A) or (B) which includes combinations of physicians with optometrists, chiropractors, psychologists, registered nurses, pharmacists, physical therapists, mechanotherapists, "or other professionals"."
Therefore, should a physician(s) legally organize with other professionals, the physician should bill Medicaid under his individual physician Medicaid number as the provider rendering the service and the other professional such as a psychologist should bill Medicaid under their individual provider number as a psychologist if he/she rendered the service. Using this example, the psychologist's claim will be paid based on the services covered for psychology services. The psychologist may, however, list the professional group as the "pay to" provider if he/she wants the check to go to the corporate address.

Provider-based physicians - PHY.1001.2

The definition of a "provider-based physician" has been revised to clarify that this definition applies not only to hospital-based physicians but also to any physician who is:

"under the fiscal, administrative, and professional control of a hospital, fee-for-service clinic, a cost-based clinic (FQHC, RHC, or OHF) a long-term care facility or other Medicaid participating provider through an employment, a contractual, or other legally-binding arrangement to provide hospital or (other provider) services in addition to the professional services he or she provides directly to, and for the benefit of, individual hospital (or other provider) patients."

Also, the Department wishes to reinforce that the services provided by a provider-based physician are reimbursable only to the employing or contracting Medicaid provider.

Physician in a teaching setting - PHY.1001.3

The Department has defined "teaching physicians", "resident" and "teaching setting" to more closely align our definitions with Medicare's definitions in this area. The terms are defined as follows:

"Teaching physician" means a physician (other than a resident) who involves residents in the care of his/her patients.

"Resident" means an individual who participates in an approved graduate medical education (GME) program. The term includes interns and fellows in approved GME programs. A medical student is never considered a resident nor is he/she a physician.

"Teaching setting" means any hospital-based provider setting that receives Medicare or Medicaid payment for the services of residents under the direct GME payment methodology.

Eligible Providers of Physician Services - PHY.1002

Federally-qualified health centers (FQHCs) were added to the list of "eligible physician providers".

General Coverage of Physician Services- Direct and General Supervision - PHY.1003.2

Please review carefully the attached handbook pages which detail the changes made in this section. Note that these changes are similar to but not identical to Medicare's policies on supervision.

The definitions of "direct supervision" and "general supervision" in paragraph (A) have been revised. Clarifying language was added to the definition of "direct supervision" to indicate that the physician must be "present in the office suite" throughout the time the nonphysician is providing the service. Also the "direct supervision" definition was expanded to clarify that "availability of the physician by telephone or the presence of the physician somewhere in the institution does not constitute direct supervision".

The "general supervision" definition was also revised. The revision specifies that "if a physician is not physically present in the office suite he/she must be immediately available to the non-physician for consultation purposes by telephone and within a 30-mile radius of the office."

Paragraph (B) has been expanded to indicate that "the department will reimburse an eligible provider of physician services for covered physician services personally provided by the physician or by a nonphysician (e.g. nurse, etc.) under the direct supervision of the physician unless otherwise stated in other sections of the physician handbook. For example, section PHY.1126 describing mental health services specifies supervision requirements which are required when certain mental health services are provided by nonphysicians.

Paragraph (B) (2) 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 physician, physician group practice, or of the legal entity that employs the physician or the nonphysician must be an independent contractor engaged by the physician through a written agreement; and

If the nonphysician is a leased employee or independent contractor, the physician 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 physician would exercise if the leased employee or contractor was an employee of the physician or legal entity.

- The service must represent an expense to the physician or legal entity;
- The physician 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 physician service which was billed to the department. Therefore, the patient must be one who has been seen by the physician; and
- There must have been a personal professional service furnished by the physician 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 physician of a frequency that reflects his/her continuing participation in the management of the course of treatment.

Paragraph (C) is now entitled "Services Performed under General Supervision". Under this section, the conditions which must be met for services to be covered when nonphysicians provide services under general supervision are listed.

Paragraph (C) (2) lists the services which are reimbursable when provided under general supervision by nonphysicians. It is amended to add that "The Department will reimburse for services provided under general supervision by nonphysician personnel when provided by a public health department clinic, family planning clinic, or by a rehabilitation clinic."

Paragraph (D) was expanded to clarify that any other services not listed under paragraph (C) (2) provided by nonphysicians must be provided under direct supervision.

**Services provided in a Teaching Setting - PHY.1003.3**

The Department has revised its policy regarding services provided in a teaching setting and has adopted Medicare’s policy in this area. 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 physician only if the teaching physician is personally present during the key portion(s) of the service for the following situations:
  - Procedures including surgery, minor procedures, endoscopies, deliveries, and time-based codes;
  - Evaluation and management (E/M) services described in section (D) (2) of this handbook. Section (D) (2) describes, in detail, how a teaching physician must personally document his/her presence and participation in the E/M visit in the medical record.

- Like Medicare, the Department is making an exception for primary care residency programs (as defined in the handbook) for certain specific E/M services if they have filed a written attestation with the Medicare program that they meet five conditions. The conditions are detailed in section (D) (3) (a) (1) to (5) of this handbook and are also located in section 415.174 of the Code of Federal Regulations.

- Under this primary care exception, payment may be made for certain services of a teaching physician provided by residents without the presence of a teaching physician provided that all of the conditions in section (D) (3) of the handbook are met. The following lower and mid-level evaluation and management codes may be billed under this exception when they are provided at a primary care center by a resident:
  - CPT codes 99201 - 99203 New patient office visits
CPT codes 99211 - 99213 Established patient office visits
CPT codes 99381 - 99384 New patient preventive medicine visits;
CPT codes 99391 - 99394 Established patient preventive medicine visits.

- **Modifiers**

  Effective January 1, 2001, to bill for services for a teaching physician which meet all the provisions of the teaching physician section of the physician handbook, use the following modifiers when services are performed by residents:

  Use "GC", to bill for services performed in part by a resident under the direction of a teaching physician; and

  Use "GE", to bill for E/M services performed by a resident without the presence of a teaching physician under the primary care exception rule.

- **Documentation**

  Please review section (F) of this section of the handbook which addresses documentation. For a teaching physician to be eligible for reimbursement, the patient’s medical record must document that the requirements for reimbursement as detailed in the teaching physician section of the physician 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 physician 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 physician personally perform the service or be present when a resident 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 physician; or

  The notes written by residents or nursing staff state that the teaching physician either personally provided the service or was present during the performing of the service.

**By Report Services** - PHY 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.

**Site Differentials** - PHY 1003.6

This section is amended to add the following services to the list of services where the Medicare maximum payment will vary:

  Office or Other Outpatient Consultations billed under CPT codes 99241-99242

  Confirmatory Consultations billed under CPT codes 99271-73.

**Preadmission Certification** - PHY 1004.3

The process for hospital precertification remains the same as described in this section of the handbook. The hospital is ultimately responsible for preadmission certification and receives no payment if precertification is not obtained. A new and revised precertification manual was sent to all hospitals including utilization/quality contacts prior to the implementation of this new precertification list. However since information is required by both the hospital and the patient's physician, all physician's offices should be aware of the following changes:

  As of June 30, 2000 precertification was no longer required for colonoscopy, lumbar MRI, chemonucleolysis, percutaneous lumbar diskectomy, and 24-hour EEG work-up procedures; and
Effective July 1, 2000 precertification is required for knee arthroscopy, carpal tunnel, cholecystectomy, coronary artery bypass graft, laparoscopy, hysterectomy, other orthopedic procedures (see pages 54-56 of the new precertification manual attached) and inpatient tonsillectomy and adenoidectomy procedures.

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
TO: All Providers of Physician Services
    Directors, County Departments of Human Services
    Directors, District Offices
FROM: Jacqueline Romer-Sensky, Director
SUBJECT: PHYSICIAN SERVICES HANDBOOK UPDATE

PHYSICIAN SERVICES HANDBOOK UPDATE
EFFECTIVE JANUARY 1, 2001

Immunizations (effective 10/1/00)
Therapeutic injections and prescribed drugs
Diagnostic and therapeutic procedure codes
Cardiovascular, diagnostic, and therapeutic services
Pulmonary services
Allergy services
ASC covered services
Radiology services
Mammography services
ECMO 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 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 - PHY.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 - PHY.1106
   PHY.1106.1 section is re-named to clarify that this section pertains to therapeutic injections or other pharmaceuticals administered during an office visit. Paragraph (A) (2) of this section is revised to indicate for which conditions interferon is covered.
   Section PHY.1106.2 is re-named to clarify that it pertains to prescribed drugs for take-home use. Section (A) of PHY 1106.2 entitled "Prescribed drugs for take-home use" is revised to refer dispensing physicians to the instructions for suppliers of pharmacy services for the prior authorization process administered by Medicaid's contractor for pharmacy services, First Health.

   Diagnostic and Therapeutic Procedure Codes with Professional and Technical Components - PHY 1109
This section is amended to clarify Appendix B, PHY.1151 which lists the professional and technical component for certain procedure codes. Appendix B contains the diagnostic and therapeutic procedure codes, the price for the procedure, and the code (H, J, K, etc.) signifying the professional/technical split for that code for the past three years. At the end of appendix B, PHY.1151, there is a key which explains the codes (H, J, K, etc) indicating the split between the professional and technical component. For example, the indicator K indicates that 50% of the total allowable amount for that procedure code is for the professional component and 50% is for the technical component.

Cardiovascular, Diagnostic, and Therapeutic Services - PHY.1110
Paragraph (B) is revised to add the following procedure to the list of cardiovascular services which must be billed using the appropriate CPT code unmodified:
Placement of transesophageal probe 93313, 93316
Paragraph (E) (1) which lists the cardiovascular services which are divided into professional and/or technical components is amended to delete certain CPT codes including 93201 through 93210 and 93220. CPT code 93224 is added.

Pulmonary Services - PHY.1112
The CPT codes for continuous airway pressure ventilation (codes 94660, 94662) are being added as a technical pulmonary service in section PHY.1113.2.

Allergy Services - PHY.1113
Section PHY.1113.2 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.

ASC Covered Surgeries - PHY.1120
A paragraph has been added to clarify that a physician may bill the professional component of a covered laboratory, radiology, or diagnostic service in an Ambulatory Surgery Center (ASC) only if he/she personally performed the service and the service was not performed by an employee of the ASC in the ASC.

Radiology Services - PHY.1122
Paragraph (B) entitled "Professional component" has been modified to replace the billing example (previously 7000026, a deleted CPT code) with an example of a current CPT code 7001026.

Paragraph (D) entitled "Reimbursement for nonionic and paramagnetic contrast material" is amended to delete two HCPCS codes, A4642 and A4643.

Mammography Services - PHY.1122
Effective January 1, 2001, the Department is expanding its mammography coverage to allow for annual screenings for women ages 40 and over.

Coverage of Extra Corporeal Membrane Oxygenator (ECMO) Services - PHY.1127
HCPCS code X3960, created in case more than one physician provided ECMO during a 24-hour period, has been deleted since it has not been used. The provision for the reimbursement of substitute physicians has been deleted.

Clarifying language has been added to state that no more than 24 hours of ECMO services shall be reimbursed to more than one provider group.

II. Appendices:
Office Surgery Incentive Program - Appendix H- PHY.1157
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:

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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
TO: All Providers of Physician Services
    Directors, County Department of Human Services
    Medical Assistance Coordinators
FROM: Jacqueline Romer-Sensky, Director
SUBJECT: Modifications to Section PHY.1150 (Appendix A) of the Physician Handbook

It has come to our attention that CPT codes are listed in Appendix A (PHY.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:

<table>
<thead>
<tr>
<th>Procedure Codes to be DELETED</th>
<th>Description of DELETED Codes</th>
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<tbody>
<tr>
<td>11719</td>
<td>Trimming of nondystrophic nails, any number</td>
</tr>
<tr>
<td>11920</td>
<td>Correct skin color defects</td>
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<td>11921</td>
<td>Correct skin color defects</td>
</tr>
<tr>
<td>11922</td>
<td>Correct skin color defects</td>
</tr>
<tr>
<td>11970</td>
<td>Replace tissue expander</td>
</tr>
<tr>
<td>15775</td>
<td>Hair transplant punch grafts</td>
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<tr>
<td>15776</td>
<td>Hair transplant punch grafts</td>
</tr>
<tr>
<td>15780</td>
<td>Abrasion treatment of skin</td>
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<tr>
<td>15781</td>
<td>Abrasion treatment of skin</td>
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<td>15782</td>
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<td>15783</td>
<td>Abrasion treatment of skin</td>
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<td>15788</td>
<td>Chemical peel, face, epiderm</td>
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<td>Chemical peel, face, dermal</td>
</tr>
<tr>
<td>15792</td>
<td>Chemical peel, nonfacial</td>
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<td>Chemical peel, nonfacial</td>
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<td>15810</td>
<td>Salabrasion</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>Revision of lower eyelid</td>
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<tr>
<td>15823</td>
<td>Revision of upper eyelid</td>
</tr>
<tr>
<td>15824</td>
<td>Removal of forehead wrinkles</td>
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<td>15825</td>
<td>Removal of neck wrinkles</td>
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<td>15826</td>
<td>Removal of brow wrinkles</td>
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<td>15828</td>
<td>Removal of face wrinkles</td>
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<td>15829</td>
<td>Removal of skin wrinkles</td>
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<td>15831</td>
<td>Excise excessive skin tissue</td>
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<td>15850</td>
<td>Removal sutures under anesthesia</td>
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<td>Hair removal by electrolysis</td>
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<td>19316</td>
<td>Suspension of breast</td>
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<td>19324</td>
<td>Enlarge breast</td>
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<tr>
<td>19325</td>
<td>Enlarge breast with implant</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
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<td>--------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>19355</td>
<td>Correct inverted nipple(s)</td>
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<tr>
<td>19380</td>
<td>Revise breast reconstruction</td>
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<td>19396</td>
<td>Design custom breast implant</td>
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<td>Interdental fixation</td>
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<td>Interdental wiring</td>
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<td>Removal of lung</td>
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<td>Donor pneumonectomy</td>
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<td>Removal of donor heart/lung</td>
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<td>33940</td>
<td>Removal of donor heart</td>
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<tr>
<td>36468</td>
<td>Injection(s); spider veins</td>
</tr>
<tr>
<td>36469</td>
<td>Injection(s); spider veins</td>
</tr>
<tr>
<td>41820</td>
<td>Excision, gum, each quadrant</td>
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<td>41828</td>
<td>Excision of gum lesion</td>
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<td>Repair gum</td>
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<td>Repair tooth socket</td>
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<td>Gastroplasty for obesity</td>
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<td>Gastric bypass for obesity</td>
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<tr>
<td>43848</td>
<td>Revision of gastric bypass for obesity</td>
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<td>47133</td>
<td>Removal of donor liver</td>
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<td>48550</td>
<td>Donor pancreatectomy</td>
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<td>Removal of donor kidney</td>
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<td>Electroejaculation</td>
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<td>Sex transformation, m to f</td>
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<td>Sex transformation, f to m</td>
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<tr>
<td>58321</td>
<td>Artificial insemination</td>
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<td>Description</td>
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<td>58322</td>
<td>Artificial insemination</td>
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<td>58323</td>
<td>Sperm washing</td>
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<td>58340</td>
<td>Inject for uterus/tube x-ray</td>
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<td>58345</td>
<td>Reopen fallopian tube</td>
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<td>58750</td>
<td>Repair oviduct(s)</td>
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<td>58752</td>
<td>Revise ovarian tube(s)</td>
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<td>58760</td>
<td>Remove tubal obstruction</td>
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<td>58770</td>
<td>Create new tubal opening</td>
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<td>58970</td>
<td>Retrieval of oocyte</td>
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<tr>
<td>59510</td>
<td>Cesarean delivery</td>
</tr>
<tr>
<td>65760</td>
<td>Revision of cornea</td>
</tr>
<tr>
<td>65765</td>
<td>Revision of cornea</td>
</tr>
<tr>
<td>65767</td>
<td>Corneal tissue transplant</td>
</tr>
<tr>
<td>65771</td>
<td>Radial keratotomy</td>
</tr>
<tr>
<td>69090</td>
<td>Pierce earlobes</td>
</tr>
</tbody>
</table>

Note: The amended 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
TO: All Providers of Physician 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
- Clarification of Critical Care and Neonate ICU Coverage
- Prostate Screening Coverage
- Non-covered Services
- Anesthesia Services Rates
- Physical Medicine Rates
- 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.

Physician 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 3336 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** PH.Y.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** - PH.Y.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** - PHY.1129
  
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** - PHY.1129
  
The Department will not reimburse for services related to assisted suicide.

- **Clarification of Critical Care Coverage** - PHY.1101.7
  
Effective January 1, 2000. the Department has incorporated CPT revisions into the critical care section of the physician visit rule. Please refer to this section for specific details. Major additions include:

  The physician must devote his/her full attention to the patient to bill these codes and cannot provide services to any other patient during the same period of time;

  Time spent in activities that occur outside of the unit, e.g. telephone calls may not be reported as critical care;

  The description for code 99291 has been revised to include critical care provided during the first 30-74 minutes. Critical care of less than 30 minutes duration should be reported with the appropriate E/M code.

- **Neonate Intensive Care Coverage** - PHY.1101.11
  
Effective January 1, 2000, the Department has incorporated CPT revisions into the Newborn Care section of the physician visit rule. Please refer to this section for specific details. Major additions include:

  Codes 99295-99298, the neonatal intensive care codes should be used to report care for neonates 30 days of age or less at the time of admission to an intensive care unit;

  Once the neonate is no longer considered to be critically ill and attains a body weight which exceeds 1,500 grams, the codes for subsequent hospital care should be used.
Certain procedures are included in the bundled global neonate codes and should not be billed separately. These are listed in the neonatal intensive care section of the CPT book. The Department will implement an edit which will preclude billing for these codes when the global neonate codes are billed. The Department will notify providers when this edit is finalized.

- **Anesthesia services- PHY.1115**

  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.

- **Physical Medicine Services- PHY.1123**

  Effective for dates of service on and after January 1, 2000, the Medicaid maximum fee for physical medicine and rehabilitation services will be the payment for one unit (or modality) of service as defined by the CPT. For example: if one modality of a CPT code is defined as a 15 minute increment, the Medicaid payment for one (1) unit of that code is payment for one modality (or a single 15 minute increment); Medicaid payment for 2 units would reflect reimbursement for 30 minutes or two 15 minute increments. Prior to January 1, 2000, payment for physical medicine services was not made on the basis of time; providers could bill for, and payment was limited to one unit regardless of the time spent. Although providers were limited to billing one unit, please note that the fees for time delimited physical medicine services (e.g., 15 minute increment) performed prior to January 1st were based on a RVU for a 30 minute service.

**Appendices:**

- **Waived Laboratory Procedure Codes - PHY.1158 Appendix I**

  This appendix has been updated to include new laboratory procedure codes which may be billed using the QW modifier to indicate the procedure is considered a waived procedure under CLIA.

  Procedure code 82120 was recently added to the waived laboratory procedure code list.

- **CDC Risk Assessment Questionnaire- formerly PHY.1161 Appendix L**

  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:

- **PHY.1150** Payable Surgical Procedure Codes (10000-69999)
- **PHY.1151** List of Diagnostic and Therapeutic Procedure Codes with Professional And Technical Components
- **PHY.1154** Injection Codes
- **PHY.1158** Waived Laboratory Procedure Categories
- **CDC Risk Assessment Questionnaire - has been deleted**
- **PHY.1162** Valid Alpha HCPCS Codes
- **PHY.1164** Radiology Codes with Professional and Technical Splits

- **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
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.

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