



Office of Policy

Hospital Billing

Guidelines

Applies to dates of discharge and dates of service on or after July 1, 2018

Revised 7/1/2018

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NEW CHANGES FOR 7/1/2018

Underlined text indicates new language.

- Form Locator 42 was updated to clarify the instances in which private room rates are covered and Form Locator 76 was updated to reflect requirements for Attending Provider Name and Identifiers. (Refer to [Section 1.2](#))
- A reference to a Medicaid Assistance Letter (MAL) was added to provide additional guidance for billing for abortion, sterilization, and hysterectomy services. (Refer to [Section 2.6](#))
- Additional language was added to clarify claims billed when a nursing facility (NF) resident is admitted to a hospital, discharged and readmitted to the NF, and subsequently readmitted to the same hospital within 24 hours. (Refer to [Section 2.9.2](#))
- Language was added to provide guidance on how to bill a hospital claim when a NF resident receives outpatient services within three calendar days of an inpatient admission. (Refer to [Section 2.13](#))
- With the transition from APR-DRG Version 34 to Version 35, DRG 003 (Bone Marrow Transplant) was separated into two DRGs: 007 (Allogeneic Bone Marrow Transplant) and 008 (Autologous Bone Marrow Transplant). DRG 003 was updated to DRG 007 to clarify that charges submitted with revenue 810 will be reimbursed using the cost application method. (Refer to [Section 2.17](#))
- Effective for dates of service on or after 7/1/2018, any pharmaceutical CPT/HCPCS code can be submitted with revenue code 25X or 636. (Refer to [Section 3.3.1](#))
- The vaccines section has been deleted as vaccine administration codes can be submitted on outpatient claims, effective for dates of service on or after 7/1/2018 (Former Section 3.3.2)
- A reference to revenue code 27X was added for independently billed services. (Refer to [Section 3.4](#))
- Outpatient claims that are not billed in accordance with National Drug Code (NDC) guidelines will deny, effective for dates of service on or after 10/1/2018. (Refer to [Section 3.6](#))
- Revenue codes 681, 682, and 683 will be covered, effective for dates of service on or after 7/1/2018. Revenue code 374 will be covered, effective for dates of service on or after 9/1/2018. Additional revenue code descriptions were added and revised. (Refer to [Appendix I](#))
- Clarification regarding transportation services in FAQ #5 of Appendix J (Incarcerated Inpatient Hospital Benefits Frequently Asked Questions) was added. (Refer to [Appendix J](#))

1. HOSPITAL BILLING OVERVIEW

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

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

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

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

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

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

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

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

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

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

<http://www.nubc.org/>

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

<http://www.medicaid.ohio.gov>

1.1 PROVIDER ENROLLMENT

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

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

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

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

1.2 UB-04 INSTRUCTIONS FOR HOSPITAL PROVIDERS

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

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

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

Form Locator #	Field	Required
47	Total Charges The total amount of charges related to the revenue code and/or CPT/HCPCS code, include both covered and non-covered charges. (See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board.) The difference between Total Charges and Non-Covered Charges would be the Total Medicaid Covered Charges. The Total Medicaid Covered Charges are used for outlier calculations.	IP, OP
48	Non-Covered Charges (See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board. Any charges that should be reported as non-covered should be listed here.) The difference between Total Charges and Non-Covered Charges would be the Total Medicaid Covered Charges. The Total Medicaid Covered Charges are used for outlier calculations.	
49	Reserved for assignment by the NUBC	
50	Payer Name	IP, OP
51	Health Plan Identification Number	IP, OP
52	Release of Information Certification Indicator	IP, OP
53	Assignment of Benefits Certification Indicator	IP, OP
54	Prior Payments – Payer	
55	Estimated Amount Due	
56	National Provider Identifier – Billing Provider (See Appendix H for additional notes regarding NPI use for Ohio Medicaid.)	
57	Other (Billing) Provider Identifier (Can be used to report the Ohio Medicaid legacy number.)	
58	Insured's Name	IP, OP
59	Patient's Relationship to Insured	IP, OP
60	Insured's Unique Identifier (Enter the patient's twelve (12) digit billing number exactly as it appears on the Medical Assistance I.D. card.)	IP, OP
61	Insured's Group Name	
62	Insured's Group Number	
63	Authorization Code/Referral Number	
64	Document Control Number (DCN)	
65	Employer Name (of the Insured)	
66	Diagnosis and Procedure Code Qualifier (ICD Revision Indicator) (Qualifier Code "9" or "0" is required on all claims.)	IP, OP
67	Principal Diagnosis Code and Present on Admission Indicator	IP, OP
67 A-Q	Other Diagnosis Codes	
68	Reserved for Assignment by the NUBC	
69	Admitting Diagnosis Code (Required on 011X and 012X)	IP

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

2. SPECIAL CASES BILLING INSTRUCTIONS

2.1 TRANSFER BILLING

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

2.1.1 TRANSFER BETWEEN ACUTE CARE AND MEDICARE DISTINCT PART PSYCHIATRIC UNITS

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

- 1) The stay in the two units will be considered one admission for payment purposes if either of the following is true:
 - The DRGs for both episodes of care fall within the range of APR-DRGs 750 – 760 (psychiatric DRGs); or
 - The DRGs for both episodes of care fall outside the range of APR-DRGs 750 – 760 (non-psychiatric DRGs)

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

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

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

For the acute care stay:

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

For the psychiatric stay:

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

2.1.2 MULTIPLE TRANSFERS BETWEEN ACUTE CARE AND MEDICARE DISTINCT PART PSYCHIATRIC UNITS

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

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

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

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

For the psychiatric stay:

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

2.1.3 TRANSFERS BETWEEN ACUTE AND DISTINCT PART REHABILITATION UNITS

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

2.2 INTERIM BILLING INSTRUCTIONS

According to OAC rule 5160-2-65, claims qualify for advance interim payment on the 30th day of a consecutive inpatient stay and at 30-day intervals thereafter.

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

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

- Use Type of Bill 112 or 113 (as defined by the NUBC)
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type
 - For 113 bill types, the admission date is not required to fall within the "Statement Covers Period" date span

- Covered days must be equal to or greater than 30 days
- Use Patient Status Code 30 (still patient)

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

For hospitals that are exempt from DRG-based reimbursement:

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

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

2.3 ADJUSTMENTS TO PAID CLAIMS

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

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

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

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

2.4 DENIED/PROBLEM CLAIMS

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

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

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

2.5 PRE-CERTIFICATION, PRIOR AUTHORIZATION REQUIREMENTS, AND UTILIZATION REVIEW

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

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

The use of the condition code “AN” is no longer recognized. If it is added to a claim to by-pass precertification and prior authorization requirements, the result will be a denied claim.

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

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

2.5.1 PRE-CERTIFICATION – PSYCHIATRIC ADMISSIONS

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

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

The pre-certification must be obtained prior to the admission or within two business days of the admission. Pre-certification is required for all payers, unless Medicare is the primary payer. If Medicaid eligibility was pending at the time of psychiatric admission, or if Medicaid eligibility was granted retrospectively, the hospital will need to submit a pre-certification request through the ODM MITS Web Portal to request a retrospective pre-certification number. The hospital should provide proof or reasonable assurance that eligibility was checked at the time of admission, so that their request may be processed in accordance with OAC guidelines.

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

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

2.5.2 PRIOR AUTHORIZATION – MEDICAL AND BEHAVIORAL HEALTH

Pursuant to Ohio Revised Code (ORC) 5160.34, a list of inpatient and outpatient services that require prior authorization is available on the ODM website (<http://medicaid.ohio.gov/PROVIDERS/PriorAuthorizationRequirements.aspx>). In addition, OAC rule 5160-2-03 describes the types of inpatient and outpatient services that would require prior authorization. Examples of services that would require prior authorization include investigational/experimental procedures, plastic surgery, and organ transplants (except kidney). Prior authorization will be granted if a service that is typically not covered is proven to be medically necessary for a consumer. Per OAC rule 5160-1-11, Ohio Medicaid will cover medically necessary services rendered by out-of-state providers if those services are not available within Ohio; the services must be prior authorized to be performed by the out-of-state provider. More information regarding Medicaid's prior authorization policy can be found in OAC rule 5160-1-31.

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

As of July 1, 2017, KEPRO is the contracted vendor responsible for reviewing medical prior authorization requests. KEPRO's toll-free phone number is 844-854-7281 and toll-free fax number

is 844-262-8990. More information regarding prior authorization requests is available on KEPRO's website: <http://ohmedicaid.kepro.com/providers/letter-to-ohio-medicaid-providers/>.

Refer to [Section 3.5.1](#) for guidance regarding prior authorization for outpatient hospital behavioral health services.

2.5.3 PRIOR AUTHORIZATION – TRANSPLANTS

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

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

Ohio Hematopoietic Stem Cell Transplant Consortium
9500 Euclid Avenue, Desk R32
Cleveland, Ohio 44195
Telephone: 440-585-0759
FAX: 440-943-6877

Once the applicable transplant consortium has approved the PA request, ODM enters the information into MITS and an approval letter is generated to the hospital and the consumer. Hospitals may also log into MITS to check for transplant approvals and authorization numbers. The assigned prior authorization number must be included on the claim. Transplant claims can be submitted via EDI or through the ODM MITS Web Portal.

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

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

2.5.4 UTILIZATION REVIEW AND ASSOCIATED CLAIM RESUBMISSION

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

Upon retrospective review, the medical review agency may determine billing errors, the wrong procedure code was used, or that the location of service was not medically necessary, but the services rendered were medically necessary. In the instance where the inpatient setting was not medically necessary, the hospital may bill Medicaid on an outpatient basis for those medically necessary services rendered on the date of admission in accordance with OAC rule 5160-2-75. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be submitted on the outpatient claim.

- 1) Payments for inpatient acute stays that have been recouped due to utilization review will include adjustment reason codes (ARC), which will indicate the reason for the recoupment.
 - a. ARC 8008 permits the provider to resubmit the claim for the same Type of Bill within 180 days of the voided claim. If a voided claim is assigned ARC 8008, the provider must submit the new claim, along with the letter from the utilization review entity, and include Condition Code C3 and/or the ICN of the voided claim. The new claim must be submitted within 180 days of the voided date of the original claim (the date the payment was taken back by ODM) to allow for the timely filing edits to be bypassed. If the provider fails to resubmit the claim in accordance with the criteria set forth in ARC 8008, audit 5045 (UR-DENY CLAIM WHEN 180 DAY FILING LIMIT EXCEEDED) will post to deny the claim. Do not use the 6653 form process when resubmitting the claim. When resubmitting the claim through the MITS web portal, click on the dropdown box and select "support data for claim", then upload your attachment and click on the submit button.
 - b. ARC 8010 is assigned when the payment is recouped and the provider is never allowed to resubmit the claim for this consumer for these dates of service. If a provider attempts to resubmit a claim after the original paid claim is voided, audit 5042 (UR-DENY NEW DAY CLAIM IF HIST PAID CLAIM ADJ TO \$0) or audit 5043 (UR-DENY ADJ CLAIM IF HIST PAID CLAIM ADJ TO \$0) will post to deny the claim.
 - c. ARC 8012 permits the provider to resubmit the claim as an outpatient claim within 60 days of the voided claim. If a voided claim is assigned ARC 8012, the provider must submit the new outpatient claim, along with the letter from the utilization review entity, and include Condition Code C3 and/or the ICN of the voided claim. The new outpatient claim must be submitted within 60 days from the voided date of the original claim (the date the payment was taken back by ODM) to allow for the timely filing edits to be bypassed. If the voided claim contains multiple dates of service, the provider can bill for all services rendered on the date of admission, but the provider can only bill for laboratory and radiology services rendered on dates of service subsequent to the date of admission. If the provider fails to resubmit the claim in accordance with the criteria set forth in ARC 8012, audit 5044 (UR-DENY INPATIENT CLM IF RESUBMIT AS OUTPATIENT), audit 5046 (UR-DENY CLAIM WHEN 60 DAY FILING LIMIT EXCEEDED), or audit 5048 (UR-INVALID INPATIENT PROCEDURE/DOS COMB BILLED) will post to deny the claim. Do not use the 6653 form or process when resubmitting the claim. When resubmitting the claim through the MITS web portal, click on the dropdown box and select "support data for claim", then upload your

attachment and click on the submit button.

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

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

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

2.5.5 UTILIZATION REVIEW – THIRD PARTY LIABILITY POST PAYMENT REVIEW

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

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

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

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

This information should be sent, by fax, to the HMS Recoupment Team at (877) 256-1226 with the subject line "Refund" or "Payment as Secondary," whichever applies. Please note that the list of

valid requests is sent to ODM for action on the last Friday of each month. The list of ICNs is then removed by ODM from the table and will be given a new ICN number that starts with the region code 56. This new ICN number will be on a remittance advice and is to be put on the claim in the Portal when reprocessing.

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

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

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

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

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

2.6 BILLING FOR SERVICES REQUIRING SPECIAL DOCUMENTATION

[Medicaid Advisory Letter \(MAL\) No. 62, 'Guidelines for Completing Ohio Department of Medicaid Form ODM 03199, "Acknowledgment of Hysterectomy Information," Ohio Department of Medicaid Form ODM 03197, "Abortion Certification Form," and U.S. Department of Health and Human Services Form HHS-687, "Consent for Sterilization"' provides additional guidance regarding what](#)

documentation must be submitted before Medicaid providers can receive payment for abortion, sterilization, or hysterectomy services.

2.6.1 ABORTIONS

Please refer to OAC rule 5160-17-01 for ODM requirements regarding reimbursement of abortion procedures. The requirements of OAC rule 5160-17-01 apply only to those abortions, which are induced, and not to those of a spontaneous nature which are normally otherwise defined as miscarriages.

Reimbursement for abortion services is restricted to the following circumstances:

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

Invoices for abortion services subject to the above requirements must be submitted through the ODM MITS Web Portal or through EDI with the ODM 03197 Abortion Certification Form attached. Reimbursement will not be made for hospital services, associated services, or laboratory tests if the abortion service is not eligible for reimbursement, regardless of whether or not the abortion itself is billed to the Department.

2.6.2 STERILIZATION

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

2.6.3 HYSTERECTOMY SERVICES

Please refer to OAC rule 5160-21-02.2, which describes the requirements regarding reimbursement for hysterectomy services. All invoices submitted to the Department for hysterectomies (whether performed as a primary or secondary procedure) or for medical procedures directly related to such hysterectomies, must include a copy of the ODM 03199

Acknowledgement of Hysterectomy Information Form. A consent form must be completed when a recipient is eligible for both the Medicare and Medicaid programs and requires a hysterectomy. However, a hysterectomy consent form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. The completed consent form does not have to be submitted with the Medicare crossover claim, but must be forwarded separately to Medicaid as an attachment. If the claim is rejected by Medicare, submit a Medicaid claim with the Medicare rejection attached. In the "Provider Remarks" section of the invoice, enter the following: Consent form submitted (date submitted).

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

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

2.7 COORDINATION OF BENEFITS / THIRD PARTY LIABILITY

2.7.1 THIRD PARTY LIABILITY

In order for Medicaid to pay secondary or tertiary, the primary payer's conditions of participation must be followed. For example, if the primary payer denies a claim because the patient went out of network or the services did not meet the primary payer's medical necessity requirements, Medicaid will not be responsible for those charges. Please refer to OAC rules 5160-1-05 and 5160-1-08 for further information regarding Medicaid coordination of benefits policies.

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

2.7.2 PARTIAL ELIGIBILITY / COVERED VS NON-COVERED DAYS

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

Example for partial eligibility stay:

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

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

2.7.3 NON-COOPERATIVE PATIENTS

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

OAC rule 5160-1-13.1, Medicaid Consumer Liability, describes circumstances under which a provider may “bill” Ohio Medicaid consumers. In accordance with OAC rule 5160-1-13.1(C), “Providers are not required to bill the Ohio department of medicaid (ODM) for medicaid-covered services rendered to eligible consumers. However, providers may not bill consumers in lieu of ODM unless:

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

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

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

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

2.7.4 MEDICARE PRIMARY

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

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

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

2.7.5 MEDICARE PART A EXHAUSTED DURING STAY OR MEDICARE BECOMES EFFECTIVE DURING ADMISSION

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

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

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

2.7.6 MEDICAID PRIMARY WITH MEDICARE PART B ONLY

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

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

- 1) Medicare Part B Cost sharing, Bill Type 121 (normal crossover claim):
 - a. Medicare Part B is billed first, and then the claim is submitted to Medicaid for cost sharing.
- 2) Medicaid as primary for all other charges, Bill Type 111:
 - a. If Medicare Part A exhausted before the inpatient stay, please include Occurrence Code A3 with the exhaust date.
 - b. Report all charges submitted to Medicare Part B as total charges and non-covered charges, OR remove the charges submitted to Medicare Part B from the Medicaid claim entirely (these charges were submitted to Medicare Part B on Bill Type 121).
 - c. Submit the claim to Medicaid as usual, according to the billing guidelines.
 - d. Since Medicaid is primary, do not include any other payer information or any other payments. If there is another payer besides Medicare Part B, then Medicaid is not primary. Do not include any payments received from Medicare Part B on this claim.

2.7.7 QMB EXHAUSTS MEDICARE PART A

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

2.8 MEDICAID AND MEDICAID MANAGED CARE PLAN SPLIT CLAIMS

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

Admit Plan	Enrollment Change	Responsible Plan*
FFS	FFS -> MCP	FFS
MCP	MCP -> FFS	MCP
MCP ₁	MCP ₁ -> MCP ₂	MCP ₁

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

In the situation where there are outpatient services within three days of the admission date and the patient also changes Medicaid coverage on the same day as the admission, the outpatient services would not be bundled into the inpatient claim. Refer to [Section 2.13](#) for additional details.

2.9 HOSPITAL AND NURSING FACILITY SPLIT CLAIMS

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

2.9.1 HOSPITAL LEAVE DAYS

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

Claim Denials – Possible Duplicates:

When billed correctly, the Hospital and NF Leave Days billed in common will bypass the duplicate claim edit, except for HCBS Waiver consumers in a short-term NF stay.* Refer to Scenarios 3 and 4 below.

NF Billing Scenarios:

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

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

1A) Resident in NF less than eight hours on date of transfer to hospital

Line 1) 01/01 – 01/04 Revenue Center Code (RCC) 101

Line 2) 01/05 – 01/17 RCC 185 (hospital leave days)

Line 3) 01/18 – 01/31 RCC 101

1B) Resident in NF for eight hours or more on date of transfer to hospital

Line 1) 01/01 – 01/05 RCC 101

Line 2) 01/06 – 01/17 RCC 185 (hospital leave days)

Line 3) 01/18 – 01/31 RCC 101

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

Scenario 2: NF resident to Hospital for overnight stay

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

2A) Resident in NF less than eight hours on date of transfer to hospital

Line 1) 03/01 – 03/12 RCC 101

Line 2) 03/13 – 03/13 RCC 185 (hospital leave day)

Line 3) 03/14 – 03/31 RCC 101

2B) Resident in NF eight hours or more on date of transfer to hospital

Line 1) 03/01 – 03/13 RCC 101

Line 2) 03/14 – 03/31 RCC 101

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

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

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

Line 1) 01/01 – 01/04 RCC 160

*Line 2) 01/05 – 01/17 RCC 185**

Line 3) 01/18 – 01/31 RCC 160

3B) Waiver Consumer in NF eight hours or more on date of transfer to hospital

Line 1) 01/01 – 01/05 RCC 160

*Line 2) 01/06 – 01/17 RCC 185**

Line 3) 01/18 – 01/31 RCC 160

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

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

4A) Resident in NF less than eight hours on date of transfer to hospital

Line 1) 03/01 – 03/12 RCC 160

*Line 2) 03/13 – 03/13 RCC 185**

Line 3) 03/14 – 03/31 RCC 160

4B) Resident is in NF eight hours or more on date of transfer to hospital

Line 1) 03/01 – 03/13 RCC 160

Line 2) 03/14 – 03/31 RCC 160

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

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

2.9.2 READMISSIONS TO A HOSPITAL

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

For example, if the consumer is hospitalized 1/1 and is discharged to a NF on 1/5, then re-admitted to the hospital on 1/6, the hospital must report one non-covered day for the first date of discharge (1/5) at the header, and one non-covered day at the detail level, RCC 180.

Depending on which claim (hospital or NF) is paid first, the second claim will deny as a duplicate due to a systems configuration limitation that will not process two claims with overlapping dates of service (i.e., the day the patient is readmitted to the NF for 8 hours or more). As a workaround, if your claim is denied as a duplicate, please resubmit your claim via the 6653 process for manual review.

2.10 INPATIENT HOSPITAL ADMISSION ORDERS

Per ORC 3727.06, a doctor, dentist, podiatrist, clinical nurse specialists (CNS), certified nurse-midwives (CNM), certified nurse practitioners (CNP), and physician assistants (PA) may admit a patient to a hospital. Due to this revision in the ORC, the term “physician” in OAC rule 5160-2-02 includes these other practitioners of physician services (i.e., CNS, CNM, CNP, and PA) and therefore are permitted to order an inpatient hospital admission per their scope of practice and their hospital credentials.

2.11 INPATIENT HOSPITAL SERVICES PROGRAM BENEFIT PLAN

If an individual is Medicaid eligible, incarcerated, and receives inpatient hospital services while admitted to a hospital for 24 hours or more, then Medicaid would pay for the claim using the Inpatient Hospital Services Program (IHSP) benefit plan. The IHSP benefit plan was established on August 1, 2016. Per OAC rule 5160:1-1-03, an exception to the prohibition against Medicaid payment for services is permitted during the part of the month in which an individual is not an inmate of a public institution. An individual is not an inmate of a public institution during such time as he/she is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or ICF-IID. In addition, there is no time limit on Medicaid payment for services as long as the individual continues to be eligible for Medicaid and is receiving services as an inpatient in the medical facility. Please refer to [Appendix J](#) of the Hospital Billing Guidelines for responses to frequently asked questions.

2.12 INPATIENT HOSPITAL STAY WITH OUTPATIENT SERVICES

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

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

2.13 THREE CALENDAR DAY ROLL-IN

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

Claim Example (Medicaid primary for entire stay):

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

Dates of inpatient stay: 1/10 – 1/15

1. The Statement Covers Period/'Admit through Discharge' is for the entire stay. This should include the first date of outpatient services and the 'Through Date' should be the date of discharge.
 - a. FDOS: 1/8
 - b. TDOS: 1/15
2. The admission date is the date the patient was admitted as an inpatient.
 - a. Admit Date: 1/10
3. Covered days are the inpatient days.
 - a. Covered Days: 5 (the date of discharge is not included, so only count 1/10 – 1/14 as covered days. Outpatient visit days are not included.)

- b. Non-covered Days: 0
- 4. When reporting room accommodations at the detail, the units should equal the total days (covered + non-covered days) reported at the header. (Note: any days listed as non-covered must have a separate line with matching units indicating total charges and listed again as non-covered charges.)

There are three exceptions to the three calendar day roll-in policy when the outpatient charges are not included with the inpatient claim:

1. When a patient's Medicaid coverage changes from Medicaid Fee-for-Service to a Medicaid Managed Care Plan, or vice versa, on the date of an inpatient admission. All outpatient services provided within three calendar days prior to the inpatient admission should be submitted to either Medicaid fee-for-service or the Managed Care Plan depending on the eligibility of the patient for those days. The inpatient claim should be submitted to either Medicaid fee-for-service or the Managed Care Plan depending on the eligibility of the patient on the date of admission.
2. When a patient is admitted under the IHSP benefit plan, the outpatient charges are not included in the inpatient stay. If any outpatient services are provided prior to the date of admission, the hospital would need to submit their claim to the Department of Rehab & Corrections (DRC) or the correctional facility where the inmate is being housed. However, any outpatient services provided on the date of admission, should be included on the inpatient hospital claim if provided at the same facility as the admission.
3. Per OAC rule 5160-2-75(G)(2)(d) and effective for dates of service on or after August 1, 2017, outpatient hospital behavioral health (OPHBH) services provided in the outpatient hospital setting within three calendar days prior to the inpatient admission are exempt from the three calendar roll-in policy. OPHBH services rendered within three calendar days of an inpatient admission should be submitted on an outpatient claim form that includes only BH services. All other outpatient services rendered within three calendar days of an inpatient admission should be included on the inpatient claim form.

For instances where the NF resident receives outpatient services within three calendar days of an inpatient admission, the hospital claim's FDOS – TDOS should reflect the entire inpatient stay, along with the dates in which outpatient services were rendered within three days of the inpatient admission. The NF claim should reflect the appropriate room and board days as well as hospital leave days. Depending on which claim (hospital or NF) is paid first, the second claim will deny as a duplicate due to a systems configuration that compares the FDOS on the hospital claim and NF claim. As a workaround, if your claim is denied as a duplicate, please resubmit your claim via the 6653 process for manual review.

2.14 PRESENT ON ADMISSION INDICATOR

In accordance with federal regulations (42 CFR § 447.26), payment for provider-preventable conditions are prohibited. Therefore, the NUBC instructions require the collection of Present on

Admission (POA) indicators on all claims for inpatient hospital services. Although Medicare exempts certain types of hospitals from POA reporting, OAC rule 5160-1-02 explicitly prohibits payment for hospital acquired conditions. As a result, ODM does not exempt any hospital from reporting POA indicators as the POA indicator is a crucial part of identifying hospital acquired conditions.

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

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

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

2.15 PREGNANCY / CHILD BIRTH DELIVERY

2.15.1 EARLY ELECTIVE DELIVERIES

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

2.15.2 GESTATIONAL AGE DIAGNOSIS CODES

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

The following table displays the ICD-10 diagnosis codes that must be present with a delivery procedure code beginning 10/1/2015. To allow providers six months to adjust to this ICD-10 billing requirement, the system logic to enforce this billing guidance will be set to post and pay starting 10/1/2015, and then set to deny for dates of service (outpatient and professional) or dates of discharge (institutional) on or after 2/1/2017.

ICD-10 Diagnosis Codes	
Z3A.00	Gestation not specified
Z3A.01	Less than 8 weeks Gestation of Pregnancy
Z3A.08	8 weeks gestation of pregnancy
Z3A.09	9 weeks gestation of pregnancy
Z3A.10	10 weeks gestation of pregnancy
Z3A.11	11 weeks gestation of pregnancy
Z3A.12	12 weeks gestation of pregnancy
Z3A.13	13 weeks gestation of pregnancy
Z3A.14	14 weeks gestation of pregnancy
Z3A.15	15 weeks gestation of pregnancy
Z3A.16	16 weeks gestation of pregnancy
Z3A.17	17 weeks gestation of pregnancy
Z3A.18	18 weeks gestation of pregnancy
Z3A.19	19 weeks gestation of pregnancy
Z3A.20	20 weeks gestation of pregnancy
Z3A.21	21 weeks gestation of pregnancy
Z3A.22	22 Weeks gestation of pregnancy
Z3A.23	23 Weeks gestation of pregnancy
Z3A.24	24 Weeks gestation of pregnancy
Z3A.25	25 Weeks gestation of pregnancy
Z3A.26	26 Weeks gestation of pregnancy
Z3A.27	27 Weeks gestation of pregnancy
Z3A.28	28 Weeks gestation of pregnancy
Z3A.29	29 Weeks gestation of pregnancy
Z3A.30	30 Weeks gestation of pregnancy
Z3A.31	31 Weeks gestation of pregnancy
Z3A.32	32 Weeks gestation of pregnancy
Z3A.33	33 Weeks gestation of pregnancy
Z3A.34	34 Weeks gestation of pregnancy
Z3A.35	35 Weeks gestation of pregnancy
Z3A.36	36 Weeks gestation of pregnancy
Z3A.37	37 Weeks gestation of pregnancy
Z3A.38	38 Weeks gestation of pregnancy
Z3A.39	39 Weeks gestation of pregnancy

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

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

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

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

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

2.16 LONG-ACTING REVERSIBLE CONTRACEPTIVES

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

2.16.1 INPATIENT HOSPITAL SETTING

Effective for dates of discharge on or after July 6, 2017 and per OAC rule 5160-2-79, when a LARC device or subdermal implant that is covered by Medicaid is provided to a Medicaid recipient in an inpatient hospital setting postpartum and prior to the patient's discharge, the hospital may submit an outpatient claim for the LARC. The claim for the LARC is separate from any claim submitted for other inpatient care the hospital provides to the Medicaid recipient in conjunction with the obstetrical delivery.

In order to receive separate reimbursement for a LARC device or subdermal implant when provided postpartum in an inpatient hospital setting, hospitals must adhere to the following guidelines:

- A paid inpatient obstetrical delivery claim must exist for the recipient.
- The paid inpatient claim must include a secondary ICD-10 CM diagnosis code from the Z37 – Outcome of Delivery range of codes.
- The LARC device or implant must be billed using Type of Bill 131.
- The outpatient claim for the LARC must include one detail line for the LARC device or implant only. No other procedure codes should be listed on the claim. *Note:* Only LARC devices and implants listed on the Department's Provider-Administered Pharmaceuticals Fee Schedule located under the Providers tab on the Ohio Department of Medicaid's website (<http://www.medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx>) as of the date of service will be eligible for reimbursement.
- The LARC device or implant must be reported using Revenue Center Code 278 – Medical/Surgical Supplies and Devices.
- The date of service on the outpatient claim for the LARC device or implant must fall within the date span on the corresponding paid inpatient claim for the obstetrical delivery excluding the date of discharge.

Reimbursement for the LARC device or implant will be made in accordance with the Medicaid Maximum Payment listed on the Provider-Administered Pharmaceuticals Fee Schedule as of the date of service.

For LARC services furnished prior to July 6, 2017 and provided in an inpatient hospital setting following a delivery, the hospital should use an ICD-10 delivery diagnosis code [or, for deliveries with inpatient discharge dates before October 1, 2015, an ICD-9 delivery diagnosis code] on the inpatient claim as well as the appropriate ICD-10/ICD-9 surgical procedure code to indicate an insertion of a contraceptive device. See the table below for the appropriate diagnostic and procedure codes needed to document that LARC services were provided. Per OAC rule 5160-2-65(E), for DRG hospitals, inpatient claims will process and pay in accordance with the All Patient Refined Diagnosis Related Group (APR-DRG) methodology. The cost of the device or drug implant

is captured in the hospital's charges on the inpatient claim. No additional or separate payment will be made to the hospital for LARC inpatient services.

Long Acting Reversible Contraceptive (LARC)				
Insertion/Removal of:	Inpatient Hospital Setting			
	ICD-9		ICD-10	
	Diagnostic	Procedural	Diagnostic	Procedural
IUD	V25.02, V25.11, V25.12, V25.13, V72.31, V25.42	69.7, 97.71	Z30.013, Z30.014, Z30.018, Z30.019, Z30.430, Z30.432, Z30.433, Z01.411, Z01.419, Z30.431	0UH97HZ, 0UH98HZ, 0UHC7HZ, 0UHC8HZ, 0UPD7HZ, 0UPD8HZ
Birth Control Implant	V25.5, V25.02, V72.31, V25.43	99.23, 99.24, 86.09*	Z30.49, Z30.013, Z30.017, Z30.018, Z30.019, Z01.411, Z01.419	OJHD0HZ, OJHD3HZ, OJHF0HZ, OJHF3HZ, OJHG0HZ, OJHG3HZ, OJHH0HZ, OJHH3HZ, OJHLOHZ, OJHL3HZ, OJHM0HZ, OJHM3HZ, OJHNOHZ, OJHN3HZ

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

2.16.2 PHYSICIAN BILLING FOR LARC SERVICES ON A PROFESSIONAL CLAIM

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

Long Acting Reversible Contraceptive (LARC)	
Insertion/Removal of:	Professional Billing
	CPT/HCPCS
IUD	58300, 58301, J7297, J7298, J7300, J7301, J7302 (no longer available as of 4/1/17), Q9984 (Effective 7/1/17 and end-dated 12/31/17), J7296 (Effective 1/1/18)
Birth Control Implant	11981, 11982, 11983, J7307

Notes:

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

2.16.3 OUTPATIENT HOSPITAL SETTING

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

Long Acting Reversible Contraceptive (LARC)			
Insertion/Removal of:	Outpatient Hospital Setting		
	ICD-9	ICD-10	CPT/HCPCS
	Diagnostic	Diagnostic	Procedural
IUD	V25.02, V25.11, V25.12, V25.13, V72.31, V25.42	Z30.013, Z30.014, Z30.018, Z30.019, Z30.430, Z30.432, Z30.433, Z01.411, Z01.419, Z30.431	58300, 58301, J7297, J7298, J7300, J7301, J7302 (no longer available as of 4/1/17), Q9984 (Effective 7/1/17 and end-dated 12/31/17), J7296 (Effective 1/1/18)
Birth Control Implant	V25.5, V25.02, V72.31, V25.43	Z30.49, Z30.013, Z30.014, Z30.017, Z30.018, Z30.019, Z01.411, Z01.419	11981-11983, J7307

Hospitals may elect to independently bill the pharmaceutical or medical supply costs of the LARC in lieu of billing for the surgical procedure. In such cases, the provider would only bill for the LARC using RCC 636 with one of the valid J-codes listed above, and would not include any other procedures/services on the claim provided on the same date. Effective for dates of service on or after August 1, 2017, outpatient LARC services will be paid in accordance with the EAPG reimbursement methodology as described in OAC rule 5160-2-75. Please refer to [Sections 3.3](#) and [3.4](#) for further information regarding EAPG guidance.

2.17 CALCULATING OUTLIER PAYMENTS

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

- 1) Calculate Claim Costs
 - Claim Cost = (Allowed Charges – RCC 810) * Hospital-Specific CCR
 - Allowed Charges = (Billed Charges – Non-Covered Charges)
 - CCR = Cost-to-Charge Ratio
- 2) Select Fixed Outlier Threshold
 - A claim qualifies for only one threshold as determined in the order below:

	Dates of Discharge on or before 7/5/2017	Dates of Discharge on or after 7/6/2017
Trach DRGs (004 & 005), Neonate DRGs (580 - 639)	\$42,900.00	\$25,000.00
Hospitals in either the Major Teaching or Children's peer groups	\$54,400.00	\$60,000.00
All other DRGs/peer groups	\$68,000.00	\$75,000.00

- 3) Conduct Outlier Qualification Test
 - Is Claim Cost > [(Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + Fixed (Outlier) Threshold]
 - If YES, claim qualifies for an outlier add-on payment
 - See #4 for outlier add-on payment calculation
 - See #5 for total claim payment calculation
 - If NO, calculate standard APR-DRG reimbursement
 - Standard APR-DRG reimbursement = #5 minus Outlier Add-On
 - SOI = Severity of Illness
- 4) Computation of Outlier Payment
 - Outlier Add-On Payment = [Cost of Case – ((Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + Fixed (Outlier) Threshold)] * 90%
 - Cost of Case = [(Covered Charges – RCC 810) * Hospital-Specific CCR]
- 5) Total Claim Payment = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + (Medical Education Add-On * DRG/SOI Rel. Wgt.) + Capital Add-On + Outlier Add-On (if applicable) + Non-Outlier Add-On (Organ Acquisition Costs or Charges, if applicable)

Please note:

- 1) Transfer/Partial Eligibility Pricing Calculation
 - Please refer to OAC rule 5160-2-65(M)(3) for ODM requirements regarding transfer pricing.
 - Please refer to OAC rule 5160-2-65(M)(4) for ODM requirements regarding partial eligibility pricing.
 - Per Diem calculation was updated to use Average Length of Stay (ALOS) instead of from Geometric Mean Length of Stay
 - Transfer Payment Logic: Transfers will be paid the lessor of the [Transfer Base or DRG Base] plus Capital Add-On, Medical Education Add-On and Outlier Add-On (if applicable)
 - A) Transfer Base = Transfer Per Diem * Covered Days
 - Transfer Per Diem = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) / DRG/SOI ALOS
 - B) DRG Base = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.)
 - C) Partial Eligibility Base = Transfer Per Diem * Number of Medicaid Eligible Days
 - Total Transfer Payment = Lessor of A or B + Capital Add-On, Medical Education Add-On & Outlier Add-On (if applicable)
 - Partial Eligibility Payment = Lessor of C or B + Capital Add-On, Medical Education Add-On & Outlier Add-On (if applicable)
- 2) Transplant Pricing Logic using RCC 810 (organ acquisition costs/charges) remains unchanged
 - Transplants with 100% Charge application for RCC 810: APR-DRG 001, 002, & 006 with SOIs
 - Transplants with 100% Cost application for RCC 810: APR-DRG 007 with SOIs

3. BILLING GUIDANCE SPECIFIC TO OUTPATIENT HOSPITAL CLAIMS

3.1 REQUIREMENT TO BILL IN SERVICE DATE ORDER

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

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

For example:

1/1 - RCC 250

1/1 - RCC 300

1/1 - RCC 324

1/5 - RCC 250

1/5 - RCC 300

Explanation of benefits (EOB)/edit 912 was implemented in MITS to deny any outpatient hospital claim where details are not billed in service date order and whose RCCs are not in ascending order. Official documentation of this change can be found in our Hospital Handbook Transmittal Letter (HHTL) No. 3352-16-01. The HHTL is located on the ODM website at the following link: <http://medicaid.ohio.gov/Portals/0/Resources/Publications/Guidance/MedicaidPolicy/Hosp/HHTL-3352-16-01.pdf>. The link to the HHTL is under the 'Hospital' heading.

3.2 NON-EMERGENCY CO-PAY

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

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

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

3.3 ENHANCED AMBULATORY PATIENT GROUPS

Effective for dates of service on or after August 1, 2017, outpatient hospital services will be subject to a prospective payment methodology utilizing the enhanced ambulatory patient

grouping (EAPG) system version 3.9 developed and maintained by 3M Health Information Systems. For hospitals subject to EAPG reimbursement, type of bill 135 (outpatient late charge) is no longer permitted.

The EAPG compliance date is August 1, 2017. Providers that submit outpatient claims with from/through dates that span the compliance date of August 1, 2017, should bill these services using two separate claims:

- 1) One claim should be submitted for outpatient services with dates of service prior to 8/1/17; and
- 2) One claim should be submitted for outpatient services with dates of service on or after 8/1/17.

EAPG, HCPCS, and CPT codes will be updated annually on January 1 of each year. Providers that submit outpatient claims with from/through dates that span January 1 of the given year, should bill these services using two separate claims:

- 1) One claim should be submitted for outpatient services with dates of service prior to January 1 of the given year; and
- 2) One claim should be submitted for outpatient services with dates of service on or after January 1 of the given year.

Example remittance advices are provided in [Appendix K](#).

Please note that HCPCS code G0378 (hospital observation service, per hour) is the preferred observation code by the EAPG grouper.

3.3.1 REVENUE CENTER CODES 25X AND 636

Provider-administered pharmaceutical HCPCS J-codes and Q-codes submitted with RCC 25X or 636 will be paid in accordance with the rate listed on the Provider Administered Pharmaceuticals Fee Schedule for that date of service. Provider-administered pharmaceuticals are identified on the EAPG Covered Codes List. If a non-provider-administered pharmaceutical is billed with RCC 25X or 636, that detail will be assigned an EAPG and will be paid in accordance with the standard EAPG reimbursement methodology. Reimbursement for these items are subject to the discounting factors as determined by the EAPG grouper.

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

3.4 INDEPENDENTLY BILLED SERVICES

Hospitals may elect to independently bill the pharmaceutical or medical supply costs and forgo the payment for any dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, and pregnancy related service. To request independently billed payment under EAPG, hospitals must report all services provided on the date of service; and report modifier UB with the primary procedure performed. The provider would bill the pharmaceutical or medical supply using revenue center code RCC 25X, 27X, or 636.

3.5 OUTPATIENT HOSPITAL BEHAVIORAL HEALTH SERVICES

Effective for dates of service on or after August 1, 2017 and in accordance with OAC rule 5160-2-75(G)(2), all hospitals that meet the Medicare Conditions of Participation may provide outpatient hospital behavioral health (OPHBH) services (services beyond those services available through the regular outpatient hospital benefit).

When billed appropriately, OPHBH claim reimbursement rates match those available via the community behavioral health benefit and pay outside of the EAPG grouper. Hospitals wishing to bill for OPHBH services must submit one institutional claim form for the entire OPHBH service (i.e., do not submit a separate professional claim for the same services), as OPHBH reimbursement rates include the professional and facility reimbursement. Other services provided on the same date of service should be included on the same institutional claim form, as Ohio Medicaid accepts one claim per date of service for the same provider.

To trigger OPHBH pricing, an OPHBH diagnosis code must be on the claim and each OPHBH detail line should include:

- The modifier 'HE';
- A modifier signifying the highest level of practitioner who performed the service (where applicable);
- Other required modifiers related to the type and level of service (when necessary); and
- A BH RCC (0671, 0900, 0904, 0906, 0907, 0911, 0912, 0913, 0914, 0915, 0916, 0918, 0919 or 1002; also indicated in [Appendix I](#)).

A list of outpatient hospital OPHBH services accepted modifiers and RCCs, and the rate chart are available at: <http://medicaid.ohio.gov/> > Providers > Fee Schedule and Rates > I Agree > Outpatient Hospital Behavioral Health Services.

OPHBH services are exempt from the three calendar day roll-in policy. Please refer to [Section 2.13](#) for further clarification.

3.5.1 PRIOR AUTHORIZATION FOR OUTPATIENT HOSPITAL BH SERVICES

Some OPHBH services always require prior authorization (PA), some require PA when rendered in conjunction with specific services, and some require PA to exceed benefit limits. PA requirements are listed on the code/rate chart on <http://medicaid.ohio.gov/> > Providers > Fee Schedule and Rates > I Agree > Outpatient Hospital Behavioral Health Services. PA requests will be submitted following usual outpatient hospital PA procedures and by selecting Assignment Type 55 "Hospital OP – Behavioral Health."

3.5.2 MANAGED CARE CARVE-OUT FOR BH SERVICES

BH services described in OAC 5160-2-75(G)(2) are carved out of managed care, except for MyCare plans, until July 1, 2018. Therefore, for dates of service from August 1, 2017 – June 30, 2018, two outpatient claims should be submitted: (1) a claim for the non-OPHBH services will be submitted to the managed care plan; and (2) a separate claim form for OPHBH services will be submitted to Ohio Medicaid. The slideshow on the ODM webpage (<http://medicaid.ohio.gov/> > Providers > Fee Schedule and Rates > I Agree > Outpatient Hospital Behavioral Health Services) includes a chart indicating which entity is responsible for claim payment based on the recipient's enrollment and date of service.

3.6 NATIONAL DRUG CODES

For dates of service on or after July 1, 2017 through September 30, 2018, if a detail line contains a pharmaceutical HCPCS code but the corresponding national drug code (NDC) is not submitted on the same detail line, edit 4893 (NDC code missing) will post on the detail line but the detail line will not deny. Similarly, if an NDC is submitted but that NDC is not on the NDC crosswalk, then edit 4888 (NDC not on file) will post on the detail line but the detail line will not deny. In addition, the corresponding NDC must be valid on the date of service, otherwise edit 4891 (invalid NDC/HCPCS combination) will post on the detail line but the detail line will not deny. However, for dates of service on or after October 1, 2018, edits 4888, 4891 and 4893 are set to deny a detail line if the appropriate NDC is not submitted. Please note that NDCs are also required on Medicaid secondary claims.

When applicable (e.g., compound drugs), providers are permitted to submit multiple NDCs for the same pharmaceutical HCPCS code. If the claim is submitted via EDI, each NDC must be submitted on a separate detail line with the pharmaceutical HCPCS code. However, if the claim is submitted via the MITS Web Portal, multiple NDCs (maximum of 25 NDCs) may be submitted for the same pharmaceutical HCPCS code on one detail line.

For compound drugs that do not have an assigned NDC, the NDC that makes up the greatest component of the compound drug should be submitted with modifier KP. Each subsequent NDC should be submitted with modifier KQ.

3.7 NURSING FACILITY THERAPY BUNDLING

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

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

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

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

3.8 NATIONAL CORRECT CODING INITIATIVE

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

3.8.1 EDITS

NCCI methodologies consists of two types of edits:

- 1) Procedure to Procedure (PTP): Edits that define pairs of HCPCS/CPT codes that should not be reported together. NCCI methodologies for this edit are applied to current and historical claims.
- 2) Medically Unlikely Edits (MUEs): Edits that define, for many HCPCS/CPT codes, the maximum number of units of service that are, under most circumstances, billable by the

same provider, for the same consumer on the same date of service.

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

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

3.8.2 MISCELLANEOUS

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

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

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

Please refer to [Sections 3.9.2](#) and [3.9.3](#) for guidance regarding NCCI-related modifiers.

3.9 MODIFIERS

3.9.1 MODIFIERS THAT AFFECT EAPG REIMBURSEMENT LOGIC

Modifier	Description	EAPG Function
25	Distinct Service	Allows assignment of a medical visit EAPG on the same claim/day as a significant procedure EAPG (Distinct and Separate Medical Visit + Significant Procedure)
27	Multiple E/M Encounters	Allows assignment of additional medical visit/services ancillary EAPG (Distinct and Separate Medical Visit {E&M} + Medical Visit)
50	Bilateral Procedure	Flags a code for additional payment (150%)
52	Terminated Procedure	Flags a code for terminated procedure discounting
59	Separate Procedure	Turns off consolidation – allows separate payment
73	Terminated Procedure	Flags a code for terminated procedure discounting
PA, PB, PC	Never Event Modifiers	Causes line to not pay

3.9.2 NCCI CORRECT CODING MODIFIER INDICATORS

There are two Correct Coding Modifier Indicators (CCMI):

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

PTP edit files include a column which identifies whether the combination of CPT codes billed is allowed with a CCMI (0 = not allowed, 1 = allowed, 9 = not applicable).

3.9.3 NCCI MODIFIERS 59, XE, XS, XP, AND XU

Effective for claims with dates of service on or after January 1, 2016, the following modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported. Modifier 59 is an accepted modifier on hospital claims.

NCCI will eventually require the use of these modifiers rather than modifier 59 with certain edits. The following modifiers may be utilized in lieu of modifier 59 whenever possible:

- 1) XE - "Separate Encounter: A service that is distinct because it occurred during a separate encounter." This modifier should only be used to describe separate encounters on the same date of service.

- 2) XS – “Separate Structure: A service that is distinct because it was performed on a separate organ/structure.”
- 3) XP – “Separate Practitioner: A service that is distinct because it was performed by a different practitioner.”
- 4) XU – “Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.”

3.9.4 CANCELED SURGERY MODIFIER 73 AND MODIFIER 74

Modifier 73 should be used when a surgery is canceled prior to the administration of anesthesia while modifier 74 should be used when a surgery is canceled after the administration of anesthesia. The canceled surgery modifiers are only to be used when the entire scheduled surgery is canceled.

If more than one surgical procedure was scheduled to be performed during the surgery and at least one surgical procedure was performed, then the performed surgical procedure will be reimbursed. If it was determined during the surgery that one of the scheduled surgical procedure(s) was no longer necessary, but another surgical procedure was completed, then the surgery is not recognized as a canceled surgery. In this scenario, it is inappropriate to bill for the surgical procedure that was not performed.

3.9.5 MODIFIER JW – DRUG WASTE

Effective for dates of service on or after July 1, 2017, modifier JW is an accepted modifier on hospital claims. Modifier JW should be used to notify the department of any drug waste that occurred on that date of service. For example, if the entire vial of drugs was not used, providers should report the number of units used on one detail line, and then report the number of units wasted with modifier JW on another detail line. If a claim (one date of service) contains two detail lines with the same RCC, same pharmaceutical HCPCS code, and same NDC but one detail line contains modifier JW, neither detail line will deny as a duplicate. EOB 9951 (discarded drug pricing applied) will post on the detail line containing modifier JW.

3.9.6 MODIFIER SE – 340B DRUGS

Hospitals recognized as a 340B entity are required to notify the Department when 340B purchased drugs are provided to a Medicaid individual so that the Department does not claim a rebate for that drug. Failure to inform the Department that a 340B drug was used leaves the hospital vulnerable to audit findings should the Department submit that drug for a rebate.

The SE modifier may be reported for services provided on or after October 1, 2017 and should also be submitted on 340B drug detail lines that contain a JW modifier, which indicates drug waste. However, for dates of service on or after January 1, 2018, 340B entities are required to

submit the SE modifier on the 340B drug detail line to indicate that a 340B drug was provided to a Medicaid individual. The SE modifier must be listed within the first four modifiers submitted with that drug.

If a non-340B entity submits the SE modifier, edit 3203 – ‘modifier restriction, 340B providers’ will post and pay on their claims for dates of service on or after April 1, 2018 through September 30, 2018. Beginning on October 1, 2018, edit 3203 will deny claims submitted by a non-340B entity that contain the SE modifier.

Use of the SE modifier is appropriate in the following billing examples:

Revenue Code 25X, with a pharmaceutical J- or Q- code and an NDC

Revenue Code 636, with a pharmaceutical J- or Q- code and an NDC

Please note, 340B reporting is not applicable for inpatient claims. Additionally, in the final 2018 Outpatient Prospective Payment System rule, Medicare specified that modifiers JG and TB will be used to signify when a 340B drug was used. For those claims that crossover directly to ODM from Medicare, ODM will appropriately request rebates for eligible drugs. However, if a provider submits a claim for a dually eligible individual directly to ODM, ODM will expect proper reporting of the SE modifier in accordance with ODM guidelines.

APPENDIX A – TYPE OF BILL

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

INPATIENT - Medicaid

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

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

INPATIENT - Medicare Part A (Medicare crossover claim)

- 011X Hospital inpatient admit through discharge

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

INPATIENT - Medicare Part B (Medicare crossover claim)

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

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

INPATIENT - Medicare HMO (Part C) Plan

- 011X Hospital Inpatient Admit Through Discharge

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

OUTPATIENT - Medicaid

- 0131 Outpatient
- 0135 Outpatient late charge

NOTE: Only two late charge bills may be submitted per provider, per recipient, per date of service. Only laboratory, pregnancy services, and radiology services may be included on claims for late charges. As mentioned in [Section 3.3](#), bill type 0135 is not permitted for hospitals subject to EAPG reimbursement.

OUTPATIENT - Medicare Part B (Medicare crossover claim)

- 013X Outpatient

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

OUTPATIENT - Medicare HMO (Part C) Plan

- 013X Outpatient

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

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

- XXX7 Void and Replace a previously paid claim

- XXX8 Void a previously paid claim

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

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

APPENDIX B – PRIORITY (TYPE) OF VISIT

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

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

APPENDIX C – POINT OF ORIGIN FOR ADMISSION OR VISIT

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

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

APPENDIX D – PATIENT DISCHARGE STATUS

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

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

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

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

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

APPENDIX E – CONDITION CODES

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

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

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

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

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

APPENDIX F – OCCURRENCE CODES

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

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

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

APPENDIX G – VALUE CODES

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

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

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

IMPORTANT NOTES regarding Value Code use for Ohio Medicaid:

Medicaid Spend-Down

Some persons are eligible for Medicaid only after they have incurred medical expenses that reduce their income (spend-down) to the Medicaid need standard. Persons eligible for Medicaid through spend-down are responsible for the medical expenses they incur. Medicaid cannot be billed for any unpaid spend-down amounts. The incurred spend-down amount reflected in Form Locator 39a-d, 40a-d, and 41a-d of the UB-04 will be deducted from the applicable Medicaid payment. If

a third-party payment is made in addition to a collected spend-down amount and the third-party payment exceeds the applicable Medicaid payment amount, then the spend-down payment should be refunded to the recipient. If the third-party payment plus the spend-down exceed the applicable Medicaid payment, the spend-down amount in excess of the applicable Medicaid payment amount should be refunded.

Reporting Covered and Non-Covered Days

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

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

APPENDIX H – NATIONAL PROVIDER IDENTIFIER (NPI)

INFORMATION

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

NPI and Claims Submission

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

Billing for Non-Hospital Services

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

APPENDIX I – COVERED AND NON-COVERED REVENUE CODES

Revenue Codes and Descriptions

I/P = Inpatient O/P = Outpatient

C = Covered

N = Non-Covered

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

Revenue Codes and Descriptions

I/P = Inpatient O/P = Outpatient

C = Covered

N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		4 -	Psychiatric	C	C		
		5 -	Hospice	N	N		
		6 -	Detoxification	C	C		
		7 -	Oncology	C	C		
		8 -	Rehabilitation	C	C		
		9 -	Other	C	C		
Room & Board - Private (Deluxe)	014	0 -	General Classification	N	N		
		1 -	Medical/Surgical/Gyn	N	N		
		2 -	OB	N	N		
		3 -	Pediatric	N	N		
		4 -	Psychiatric	N	N		
		5 -	Hospice	N	N		
		6 -	Detoxification	N	N		
		7 -	Oncology	N	N		
		8 -	Rehabilitation	N	N		
		9 -	Other	N	N		
Room & Board - Ward (Medical or General)	015	0 -	General Classification	C	C		
		1 -	Medical/Surgical/Gyn	C	C		
		2 -	OB	C	C		
		3 -	Pediatric	C	C		
		4 -	Psychiatric	C	C		
		5 -	Hospice	N	N		
		6 -	Detoxification	C	C		
		7 -	Oncology	C	C		
		8 -	Rehabilitation	C	C		
		9 -	Other	C	C		
Room & Board - Other	016	0 -	General Classification	C	C		
		4 -	Sterile Environment	C	C		
		7 -	Self-Care	N	N		
		9 -	Other	C	C		
Nursery	017	0 -	General Classification	C	C		
		1 -	Newborn - Level I	C	C		
		2 -	Newborn - Level II	C	N		
		3 -	Newborn - Level III	C	N		
		4 -	Newborn - Level IV	C	N		
		9 -	Other	C	C		

*Note: Subcategory codes 1 through 4 are defined by the National Uniform Billing Committee. Please note that these definitions are different than those recognized by the Ohio Department of Health.

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
Leave of Absence	018	0 -	General Classification	N	N		
		2 -	Patient Convenience	N	N		
		3 -	Therapeutic Leave	N	N		
		5 -	Hospitalization	N	N		
		9 -	Other Leave of Absence	N	N		
Subacute Care	019	0 -	General Classification	N	N		
		1 -	Subacute Care - Level I	N	N		
		2 -	Subacute Care - Level II	N	N		
		3 -	Subacute Care - Level III	N	N		
		4 -	Subacute Care - Level IV	N	N		
9 -	Other Subacute Care	N	N				
Intensive Care	020	0 -	General Classification	C	N		
		1 -	Surgical	C	N		
		2 -	Medical	C	N		
		3 -	Pediatric	C	N		
		4 -	Psychiatric	C	N		
		6 -	Intermediate ICU	C	N		
		7 -	Burn Care	C	N		
		8 -	Trauma	C	N		
		9 -	Other Intensive Care	C	N		
Coronary Care	021	0 -	General Classification	C	N		
		1 -	Myocardial Infarction	C	N		
		2 -	Pulmonary Care	C	N		
		3 -	Heart Transplant	C	N		
		4 -	Intermediate ICU	C	N		
9 -	Other Coronary Care	C	N				
Special Charges	022	0 -	General Classification	N	N		
		1 -	Admission Charge	N	N		
		2 -	Technical Support Charge	N	N		
		3 -	U.R. Service Charge	N	N		
		4 -	Late Discharge, Medically Nec.	N	N		
9 -	Other Special Charges	N	N				
	023	0 -	General Classification	C	N		

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
Incremental Nursing Charge Rate		1 -	Nursery	C	N		
		2 -	OB	C	N		
		3 -	ICU	C	N		
		4 -	CCU	C	N		
		5 -	Hospice	N	N		
		9 -	Other	C	N		
All Inclusive Ancillary	024	0 -	General Classification	C	N		
		1 -	Basic	C	N		
		2 -	Comprehensive	C	N		
		3 -	Specialty	C	N		
		9 -	Other All Inclusive Ancillary	C	N		
		Pharmacy (Also see 063X, an extension of 025X)	025	0 -	General Classification	C	C
1 -	Generic Drugs			C	C		
2 -	Non-Generic Drugs			C	C		
3 -	Take Home Drugs			N	N		
4 -	Drugs Incident to Other Diagnostic Services			C	C		
5 -	Drugs Incident to Radiology			C	C		
6 -	Experimental Drugs			N	N		
7 -	Non-Prescription Drugs			C	N		
8 -	IV Solution			C	C		
9 -	Other Pharmacy			C	C		
IV Therapy	026	0 -	General Classification	C	C	Y	
		1 -	Infusion Pump	C	C	Y	
		2 -	IV Therapy/Pharmacy	C	C		
		3 -	IV Therapy/Drug/Supply/Delivery	C	C		
		4 -	IV Therapy/Supplies	C	C		
		9 -	Other IV Therapy	C	C	Y	
Medical/Surgical Supplies and Devices (Also see 062X, and extension of 027X)	027	0 -	General Classification	C	C		
		1 -	Non Sterile Supply	C	C		
		2 -	Sterile Supply	C	C		
		3 -	Take Home Supplies	N	N		

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		4 -	Prosthetic/Orthotic Devices	C	N		
		5 -	Pacemaker	C	C		
		6 -	Intraocular Lens	C	C		
		7 -	Oxygen-Take Home	N	N		
		8 -	Other Implant	C	C		
		9 -	Other Supplies/Devices	C	C		
Oncology	028	0 -	General Classification	C	C	Y	
		9 -	Other Oncology	C	C	Y	
Durable Medical Equipment (Other than Rental)	029	0 -	General Classification	N	N		
		1 -	Rental	C	N		
		2 -	Purchase of New DME	N	N		
		3 -	Purchase of Used DME	N	N		
		4 -	Supplies/Drugs for DME Effectiveness (HHA only)	N	N		
		9 -	Other Equipment	N	N		
Laboratory	030	0 -	General Classification	C	C	Y	
		1 -	Chemistry	C	C	Y	
		2 -	Immunology	C	C	Y	
		3 -	Renal Patient (home)	N	N		
		4 -	Non-routine Dialysis	C	C	Y	
		5 -	Hematology	C	C	Y	
		6 -	Bacteriology & Microbiology	C	C	Y	
		7 -	Urology	C	C	Y	
		9 -	Other Laboratory	C	C	Y	
Laboratory Pathological	031	0 -	General Classification	C	C	Y	
		1 -	Cytology	C	C	Y	
		2 -	Histology	C	C	Y	
		4 -	Biopsy	C	C	Y	
		9 -	Other Laboratory Pathological	C	C	Y	
Radiology - Diagnostic	032	0 -	General Classification	C	C	Y	
		1 -	Angiocardiology	C	C	Y	
		2 -	Arthrography	C	C	Y	
		3 -	Arteriography	C	C	Y	
		4 -	Chest X-ray	C	C	Y	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		9 -	Other Radiology - Diagnostic	C	C	Y	
Radiology - Therapeutic and/or Chemotherapy Administration	033	0 -	General Classification	C	C	Y	
		1 -	Chemotherapy Administration - Injected	C	C	Y	
		2 -	Chemotherapy Admin. - Oral	C	C	Y	
		3 -	Radiation Therapy	C	C	Y	
		5 -	Chemotherapy Admin. - IV	C	C	Y	
		9 -	Other Radiology - Therapeutic	C	C	Y	
Nuclear Medicine	034	0 -	General Classification	C	C	Y	
		1 -	Diagnostic Procedures	C	C	Y	
		2 -	Therapeutic Procedures	C	C	Y	
		3 -	Diagnostic Radiopharmaceutical	C	C		
		4 -	Therapeutic Radiopharmaceutical	C	C		
		9 -	Other	C	C	Y	
CT Scan	035	0 -	General Classification	C	C	Y	
		1 -	Head Scan	C	C	Y	
		2 -	Body Scan	C	C	Y	
		9 -	Other CT Scan	C	C	Y	
Operating Room Services	036	0 -	General Classification	C	C	Y	
		1 -	Minor Surgery	C	C	Y	
		2 -	Organ Transplant-Other Than Kidney	C	N		
		7 -	Kidney Transplant	C	N		
		9 -	Other Operating Room Services	C	C	Y	
Anesthesia	037	0 -	General Classification	C	C	Y	
		1 -	Anesthesia Incident to Radiology	C	C	Y	
		2 -	Anesthesia Incident to Other Diagnostic Services	C	C	Y	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		4 -	Acupuncture (eff. 9/1/18)	C	C		
		9 -	Other Anesthesia	C	C	Y	
Blood	038	0 -	General Classification	C	C		
		1 -	Packed Blood Cells	C	C		
		2 -	Whole Blood	C	C		
		3 -	Plasma	C	C		
		4 -	Platelets	C	C		
		5 -	Leucocytes	C	C		
		6 -	Other Components	C	C		
		7 -	Other Derivatives (Cryoprecipitate)	C	C		
		9 -	Other Blood	C	C		
Blood and Blood Components Administration, Processing & Storage	039	0 -	General Classification	C	C		
		1 -	Administration (Transfusions)	C	C		
		2 -	Processing and Storage	N	N		
		9 -	Other Blood Handling	C	C		
Other Imaging Services	040	0 -	General Classification	C	C	Y	
		1 -	Diagnostic Mammography	C	C	Y	
		2 -	Ultrasound	C	C	Y	
		3 -	Screening Mammography	C	C	Y	
		4 -	Positron Emission Tomography	C	C	Y	
		9 -	Other Imaging Service	C	C	Y	
Respiratory Services	041	0 -	General Classification	C	C	Y	
		2 -	Inhalation Services	C	C	Y	
		3 -	Hyperbaric Oxygen Therapy	C	C	Y	
		9 -	Other Respiratory Services	C	C	Y	
Physical Therapy	042	0 -	General Classification	C	C	Y	
		1 -	Visit Charge	C	C	Y	
		2 -	Hourly Charge	C	C	Y	
		3 -	Group Rate	C	C	Y	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		4 -	Evaluation or Re-evaluation	C	C	Y	
		9 -	Other Physical Therapy	C	C	Y	
Occupational Therapy	043	0 -	General Classification	C	C	Y	
		1 -	Visit Charge	C	C	Y	
		2 -	Hourly Charge	C	C	Y	
		3 -	Group Rate	C	C	Y	
		4 -	Evaluation or Re-evaluation	C	C	Y	
		9 -	Other Occupational Therapy	C	C	Y	
Speech-Language Pathology	044	0 -	General Classification	C	C	Y	
		1 -	Visit Charge	C	C	Y	
		2 -	Hourly Charge	C	C	Y	
		3 -	Group Rate	C	C	Y	
		4 -	Evaluation or Re-evaluation	C	C	Y	
		9 -	Other Speech-Language Pathology	C	C	Y	
Emergency Room	045	0 -	General Classification	C	C	Y	
		1 -	EMTALA Emergency Medical Screening Services	C	C	Y	
		2 -	ER Beyond EMTALA Screening Services	C	C	Y	
		6 -	Urgent Care	C	C	Y	
		9 -	Other Emergency Room	C	C	Y	
Pulmonary Function	046	0 -	General Classification	C	C	Y	
		9 -	Other Pulmonary Function	C	C	Y	
Audiology	047	0 -	General Classification	C	C	Y	
		1 -	Diagnostic	C	C	Y	
		2 -	Treatment	C	C	Y	
		9 -	Other Audiology	C	C	Y	
Cardiology	048	0 -	General Classification	C	C	Y	
		1 -	Cardiac Cath Lab	C	C	Y	
		2 -	Stress Test	C	C	Y	
		3 -	Echocardiography	C	C	Y	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		9 -	Other Cardiology	C	C	Y	
Ambulatory Surgical Care	049	0 -	General Classification	C	C	Y	
		9 -	Other Ambulatory Surgical Care	C	C	Y	
Outpatient Services	050	0 -	General Classification	N	N		
		9 -	Other Outpatient Service	N	N		
Clinic	051	0 -	General Classification	C	C	Y	
		1 -	Chronic Pain Center	C	C	Y	
		2 -	Dental Clinic*	C	C	Y	
		3 -	Psychiatric Clinic	C	C	Y	
		4 -	OB-GYN Clinic	C	C	Y	
		5 -	Pediatric Clinic	C	C	Y	
		6 -	Urgent Care Clinic	C	C	Y	
		7 -	Family Practice Clinic	C	C	Y	
		9 -	Other Clinic	C	C	Y	
*Note: See rule 5160-2-03 for coverage limitations pertaining to dental services provided in a hospital facility.							
Free-Standing Clinic	052	0 -	General Classification	N	N		
		1 -	Rural Health-Clinic	N	N		
		2 -	Rural Health-Home	N	N		
		3 -	Family Practice Clinic	N	N		
		4 -	Visit by RHC/FQHC Practitioner -SNF (Covered by Part A)	N	N		
		5 -	Visit by RHC/FQHC Practitioner - SNF(not a Covered Part A Stay) or NF or ICF MR or Other Residential Facility	N	N		
		6 -	Urgent Care Clinic	N	N		
		7 -	Visiting Nurse Service(s)- in a Home Health Shortage Area	N	N		
		8 -	Visit by RHC/FQHC Practitioner to Other Site	N	N		
9 -	Other Freestanding Clinic	N	N				

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
Osteopathic Services	053	0 -	General Classification	C	C	Y	
		1 -	Osteopathic Therapy	C	C	Y	
		9 -	Other Osteopathic Services	C	C	Y	
Ambulance	054	0 -	General Classification	N	N		
		1 -	Supplies	N	N		
		2 -	Medical Transport	N	N		
		3 -	Heart Mobile	N	N		
		4 -	Oxygen	N	N		
		5 -	Air Ambulance	N	N		
		6 -	Neonatal Ambulance Service	N	N		
		7 -	Pharmacy	N	N		
		8 -	Telephone Transmission EKG	N	N		
9 -	Other Ambulance	N	N				
Skilled Nursing	055	0 -	General Classification	N	N		
		1 -	Visit Charge	N	N		
		2 -	Hourly Charge	N	N		
		9 -	Other Skilled Nursing	N	N		
Medical Social Services	056	0 -	General Classification	N	N		
		1 -	Visit Charge	N	N		
		2 -	Hourly Charge	N	N		
		9 -	Other Medical Social Services	N	N		
Home Health - Home Health Aide	057	0 -	General Classification	N	N		
		1 -	Visit Charge	N	N		
		2 -	Hourly Charge	N	N		
		9 -	Other Home Health Aide	N	N		
Home Health - Other Visits	058	0 -	General Classification	N	N		
		1 -	Visit Charge	N	N		
		2 -	Hourly Charge	N	N		
		3 -	Assessment	N	N		
		9 -	Other Home Health Visit	N	N		
Home Health - Units of Service	059	0 -	General Classification	N	N		

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
Home Health - Oxygen	060	0 -	General Classification	N	N		
		1 -	Oxygen - State/Equip/Supply/or Cont	N	N		
		2 -	Oxygen - State/Equip/Supply/ under 1 LPM	N	N		
		3 -	Oxygen - State/Equip/Over 4 LPM	N	N		
		4 -	Oxygen - Portable Add-on	N	N		
		9 -	Other Oxygen	N	N		
Magnetic Resonance Technology (MRT)	061	0 -	General Classification	C	C	Y	
		1 -	MRI - Brain (Including Brainstem)	C	C	Y	
		2 -	MRI - Spinal Cord (Incl. Spine)	C	C	Y	
		4 -	MRI - Other	C	C	Y	
		5 -	MRA - Head and Neck	C	C	Y	
		6 -	MRA - Lower Extremities	C	C	Y	
		8 -	MRA - Other	C	C	Y	
		9 -	Other MRT	C	C	Y	
Medical/Surgical Supplies - Extension of 027X	062	1 -	Supplies Incident to Radiology	C	C		
		2 -	Supplies Incident to Other Diagnostic Services	C	C		
		3 -	Surgical Dressings	C	C		
		4 -	FDA Investigational Devices	N	N		
Pharmacy - Extension of 025X	063	1 -	Single Source Drug	N	N		
		2 -	Multiple Source Drug	N	N		
		3 -	Restrictive Prescription	N	N		
		4 -	Erythropoietin (EPO) Less Than 10,000 Units	C	C		
		5 -	Erythropoietin (EPO) 10,000 or More Units	C	C		

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		6 -	Drugs Requiring Detailed Coding	N	C	Y	
		7 -	Self-administrable Drugs	C	C		
Home IV Therapy Services	064	0 -	General Classification	N	N		
		1 -	Nonroutine Nursing, Central Line	N	N		
		2 -	IV Site Care, Central Line	N	N		
		3 -	IV Start/Change, Peripheral Line	N	N		
		4 -	Nonroutine Nurs., Peripheral Line	N	N		
		5 -	Training, Patient/Caregiver, Central Line	N	N		
		6 -	Training, Disabled Patient, Central Line	N	N		
		7 -	Training, Patient/Caregiver, Peripheral Line	N	N		
		8 -	Training, Disabled Patient, Peripheral Line	N	N		
		9 -	Other IV Therapy Services	N	N		
Hospice Service	065	0 -	General Classification	N	N		
		1 -	Routine Home Care	N	N		
		2 -	Continuous Home Care	N	N		
		5 -	Inpatient Respite Care	N	N		
		6 -	General IP Care (Non-respite)	N	N		
		7 -	Physician Services	N	N		
		8 -	Hospice Room & Board - Nursing Facility	N	N		
		9 -	Other Hospice Service	N	N		
Respite Care	066	0 -	General Classification	N	N		
		1 -	Hourly Charge/Nursing	N	N		

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		2 -	Hourly Charge/Aid/Homemaker / Companion	N	N		
		3 -	Daily Respite Charge	N	N		
		9 -	Other Respite Charge	N	N		
Outpatient Special Residence Charge	067	0 -	General Classification	N	N		
		1 -	Hospital Based	N	N		Y
		2 -	Contracted	N	N		
		9 -	Other Special Residence Charge	N	N		
Trauma Response (Charge for Trauma Team Activation)	068	1 -	Level I	<u>C</u>	<u>C</u>		
		2 -	Level II	<u>C</u>	<u>C</u>		
		3 -	Level III	<u>C</u>	<u>C</u>		
		4 -	Level IV	N	N		
		9 -	Other Trauma Response	N	N		
Pre-Hospice/Palliative Care Services	069	0-	General Classification	N	N		
		1-	Visit Charge	N	N		
		2-	Hourly Charge	N	N		
		3-	Evaluation	N	N		
		4-	Consultation and Education	N	N		
		5-	Inpatient Care	N	N		
		6-	Physician Services	N	N		
		9-	Other Pre-Hospice/Palliative Care Services	N	N		
Cast Room	070	0 -	General Classification	C	C	Y	
Recovery Room	071	0 -	General Classification	C	C		
Labor Room/Delivery	072	0 -	General Classification	C	C	Y	
		1 -	Labor	C	C	Y	
		2 -	Delivery Room	C	C	Y	
		3 -	Circumcision	C	C	Y	
		4 -	Birthing Center	C	C	Y	
		9 -	Other Labor Room/Delivery	C	C	Y	
EKG/ECG (Electrocardiogram)	073	0 -	General Classification	C	C	Y	
		1 -	Holter Monitor	C	C	Y	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		2 -	Telemetry	C	C	Y	
		9 -	Other EKG/ECG	C	C	Y	
EEG (Electroencephalogram)	074	0 -	General Classification	C	C	Y	
Gastro-Intestinal Services	075	0 -	General Classification	C	C	Y	
Treatment/Observation Room	076	0 -	General Classification	C	C	Y	
		1 -	Treatment Room	C	C	Y	
		2 -	Observation Room	C	C	Y	
		9 -	Other Treatment/Obs. Room	C	C	Y	
Preventive Care Services	077	0 -	General Classification	C	C		
		1 -	Vaccine Administration	C	C		
Telemedicine	078	0 -	General Classification	N	N		
Extra-Corporeal Shock Wave Therapy	079	0 -	General Classification	C	C	Y	
Inpatient Renal Dialysis	080	0 -	General Classification	C	N		
		1 -	Inpatient Hemodialysis	C	N		
		2 -	Inpatient Peritoneal (Non-CAPD)	C	N		
		3 -	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	C	N		
		4 -	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	C	N		
		9 -	Other Inpatient Dialysis	C	N		
Acquisition of Body Components	081	0 -	General Classification	C	N		
		1 -	Living Donor	C	N		
		2 -	Cadaver Donor	C	N		
		3 -	Unknown Donor	N	N		
		4 -	Unsuccessful Organ Search Donor Bank Charges	N	N		
		5 -	Stem Cells - Allogeneic	C	C	Y	
		9 -	Other Donor	C	N		
	082	0 -	General Classification	N	C	Y	

*Note: Acquisition charges eligible for cost-related reimbursement, as described in rule 5160-2-65, should be reported using revenue code 0810.

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Hemodialysis - Outpatient or Home		1 -	Hemodialysis/Composite or Other Rate	N	C	Y	
		2 -	Home Supplies	N	N		
		3 -	Home Equipment	N	N		
		4 -	Maintenance/100%	N	N		
		5 -	Support Services	N	N		
		6 -	Hemodialysis – Shorter	N	N		
		9 -	Other Outpatient Hemodialysis	N	C	Y	
Peritoneal Dialysis - Outpatient or Home	083	0 -	General Classification	N	C	Y	
		1 -	Peritoneal Dialysis/Composite or Other Rate	N	C	Y	
		2 -	Home Supplies	N	N		
		3 -	Home Equipment	N	N		
		4 -	Maintenance/100%	N	N		
		5 -	Support Services	N	N		
		9 -	Other OP Peritoneal Dialysis	N	C	Y	
Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	084	0 -	General Classification	N	C	Y	
		1 -	CAPD/Composite or Other Rate	N	C	Y	
		2 -	Home Supplies	N	N		
		3 -	Home Equipment	N	N		
		4 -	Maintenance 100%	N	N		
		5 -	Support Services	N	N		
		9 -	Other Outpatient CAPD	N	C	Y	
Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home	085	0 -	General Classification	N	C	Y	
		1 -	CCPD/Composite or Other Rate	N	C	Y	
		2 -	Home Supplies	N	N		
		3 -	Home Equipment	N	N		
		4 -	Maintenance 100%	N	N		
		5 -	Support Services	N	N		
		9 -	Other Outpatient CCPD	N	C	Y	
<u>Magnetoencephalography (MEG)</u>	<u>086</u>	<u>0 -</u> <u>1 -</u>	<u>General Classification</u> <u>MEG</u>	<u>N</u> <u>N</u>	<u>N</u> <u>N</u>		
Miscellaneous Dialysis	088	0 -	General Classification	C	C	Y	

Revenue Codes and Descriptions

I/P = Inpatient O/P = Outpatient

C = Covered

N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		1 -	Ultrafiltration	C	C	Y	
		2 -	Home Dialysis Aid Visit	N	N		
		9 -	Other Miscellaneous Dialysis	C	C	Y	
Behavioral Health Treatments/Services (Also see 091X, an extension of 090X)	090	0 -	General Classification	C	C	Y	Y
		1 -	Electroshock Treatment	N	N		
		2 -	Milieu Therapy	N	N		
		3 -	Play Therapy	N	N		
		4 -	Activity Therapy	N	N		Y
		5 -	IOP - Psychiatric	N	N		
		6 -	IOP - Chemical Dependency	N	N		Y
		7 -	Day Treatment	N	N		Y
Behavioral Health Treatments/Services - Extension of 090X	091	1 -	Rehabilitation	N	C	Y	Y
		2 -	Partial Hospitalization - Less Intensive	N	N		Y
		3 -	Partial Hospitalization - Intensive	N	N		Y
		4 -	Individual Therapy	C	C	Y	Y
		5 -	Group Therapy	C	C	Y	Y
		6 -	Family Therapy	C	C	Y	Y
		7 -	Bio Feedback	N	N		
		8 -	Testing	C	C	Y	Y
		9 -	Other Behavioral Health Treatment/Services	C	C	Y	Y
Other Diagnostic Services	092	0 -	General Classification	C	C	Y	
		1 -	Peripheral Vascular Lab	C	C	Y	
		2 -	Electromyogram	C	C	Y	
		3 -	Pap Smear	C	C	Y	
		4 -	Allergy Test	C	C	Y	
		5 -	Pregnancy Test	C	C	Y	
		9 -	Other Diagnostic Services	C	C	Y	
Medical Rehabilitation Day Program	093	1 -	Half Day	N	N		
		2 -	Full Day	N	N		
Other Therapeutic Services (Also see 095X, an extension of 094X)	094	0 -	General Classification	C	C	Y	
		1 -	Recreational Therapy	N	N		
		2 -	Education/Training	C	C	Y	

Revenue Codes and Descriptions

I/P = Inpatient O/P = Outpatient

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N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		3 -	Cardiac Rehabilitation	C	C	Y	
		4 -	Drug Rehabilitation	N	C	Y	
		5 -	Alcohol Rehabilitation	N	C	Y	
		6 -	Complex Medical Equipment - Routine	N	N		
		7 -	Complex Medical Equipment - Ancillary	N	N		
		<u>8 -</u>	<u>Pulmonary Rehabilitation</u>	<u>C</u>	<u>C</u>	<u>Y</u>	
		9 -	Other Therapeutic Service	C	C	Y	
Other Therapeutic Services - Ext. of 094X	095	1 -	Athletic Training	N	N		
		2-	Kinesiotherapy	C	C	Y	
		3-	Chemical Dependency (Drug and Alcohol) CHEMDEP	N	N		
Professional Fees (Also see 097X and 098X)	096	0 -	General Classification	N	N		
		1 -	Psychiatric	N	N		
		2 -	Ophthalmology	N	N		
		3 -	Anesthesiologist (MD)	N	N		
		4 -	Anesthetist (CRNA)	N	N		
		9 -	Other Professional Fee	N	N		
Professional Fees (Extension of 096X)	097	1 -	Laboratory	N	N		
		2 -	Radiology - Diagnostic	N	N		
		3 -	Radiology - Therapeutic	N	N		
		4 -	Radiology - Nuclear Medicine	N	N		
		5 -	Operating Room	N	N		
		6 -	Respiratory Therapy	N	N		
		7 -	Physical Therapy	N	N		
		8 -	Occupational Therapy	N	N		
		9 -	Speech Pathology	N	N		
Professional Fees (Extension of 096X and 097X)	098	1 -	Emergency Room	N	N		
		2 -	Outpatient Services	N	N		
		3 -	Clinic	N	N		
		4 -	Medical Social Services	N	N		
		5 -	EKG	N	N		
		6 -	EEG	N	N		

Revenue Codes and Descriptions

I/P = Inpatient O/P = Outpatient

C = Covered

N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		7 -	Hospital Visit	N	N		
		8 -	Consultation	N	N		
		9 -	Private Duty Nurse	N	N		
Patient Convenience Items	099	0 -	General Classification	N	N		
		1 -	Cafeteria/Guest Tray	N	N		
		2 -	Private Linen Service	N	N		
		3 -	Telephone/Telegraph	N	N		
		4 -	TV/Radio	N	N		
		5 -	Nonpatient Room Rentals	N	N		
		6 -	Late Discharge Charge	N	N		
		7 -	Admission Kits	N	N		
		8 -	Beauty Shop/Barber	N	N		
		9 -	Other Patient Convenience Item	N	N		
Behavioral Health Accommodations	100	0 -	General Classification	N	N		
		1 -	Res. Treatment - Psychiatric	N	N		
		2 -	Res. Treatment - Chem. Dep.	N	N		Y
		3 -	Supervised Living	N	N		
		4 -	Halfway House	N	N		
		5 -	Group Home	N	N		
		<u>6 -</u>	<u>Outdoor/Wilderness Behavioral Health</u>	<u>N</u>	<u>N</u>		
Alternative Therapy Services	210	0 -	General Classification	N	N		
		1 -	Acupuncture	N	N		
		2 -	Acupressure	N	N		
		3 -	Massage	N	N		
		4 -	Reflexology	N	N		
		5 -	Biofeedback	N	N		
		6 -	Hypnosis	N	N		
		9 -	Other Alternative Therapy	N	N		
Adult Care	310	1 -	Adult Day Care, Medical and Social - Hourly	N	N		
		2 -	Adult Day Care, Social - Hourly	N	N		

Revenue Codes and Descriptions

I/P = Inpatient O/P = Outpatient

C = Covered

N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT / HCPCS Required	Covered BH RCC in O/P
		3 -	Adult Day Care, Medical and Social - Daily	N	N		
		4 -	Adult Day Care, Social - Daily	N	N		
		5 -	Adult Foster Care - Daily	N	N		
		9 -	Other Adult Care	N	N		

APPENDIX J – INCARCERATED INPATIENT HOSPITAL BENEFITS

FREQUENTLY ASKED QUESTIONS

1. Are all services covered under IHSP?
 - a. No. Only services that are provided during an inpatient hospital stay would be reimbursable. This would also allow for separate physician (or other practitioners of physician services) claims to be submitted with the place of service, inpatient hospital. Please note that prior authorization requirements as described in [Sections 2.5.2](#) and [2.5.3](#) apply to IHSP.
2. Would outpatient hospital services be covered prior to the inpatient stay?
 - a. The 72 hour window for outpatient services to be included in the inpatient stay does not apply to IHSP benefit plan. If any outpatient services are provided prior to the date of admission, the hospital would need to submit their claim to the Department of Rehab & Corrections (DRC) or the correctional facility where the inmate is being housed. However, any outpatient services provided on the date of admission, should be included on the inpatient hospital claim if provided at the same facility as the admission.
3. Would coverage include a 24 hour observation? What admission code would need to be used by the hospital?
 - a. Observation services are normally billed as an outpatient service so they would not be covered. However, if observation is provided on the date of admission for a stay that becomes an inpatient stay, those observation services would be covered and therefore should be included on the inpatient claim. There would not be a specific admission code; the claim itself would be submitted as an inpatient claim starting on the day the admission was ordered.
4. Would the emergency room visit preceding the inpatient stay also be covered? What admission code would need to be used by the hospital?
 - a. Emergency services/visits are normally billed as an outpatient service so they would not be covered. However, if emergency room services are provided on the date of admission for a stay that becomes an inpatient stay, those services would be covered and therefore should be included on the inpatient claim. There would not be a specific admission code; the claim itself would be submitted as an inpatient claim starting on the day the admission was ordered.
5. If an individual is transported via EMS to a hospital and it turns into an inpatient stay, will that transportation cost be covered?
 - a. Ambulance services provided to an inmate before an inpatient admission and/or after discharge are not covered (for lack of eligibility), but an inter-hospital transfer may be covered. Ambulance services, if provided during an inpatient stay, are covered in accordance with OAC rule 5160-2-04(E). Any inter-hospital transfer provided during the inpatient stay would be a professional service claimed by the ambulance provider. The services of any hospital personnel on board would be either accounted for as part of a DRG/EAPG payment or claimed as a professional service by the practitioner.

Example:

- Inmate is transferred to hospital on 1/1 for emergency services. The inmate is in observation on 1/2, and the order to admit to inpatient on 1/3. Inmate is discharged on 1/10.
- Outpatient and professional claims for 1/1 and 1/2 are submitted to DRC or the correctional facility where the inmate is housed for all services provided on these dates.
- Inpatient and the physician (or other practitioners of physician) claims are submitted to Medicaid FFS for 1/3 – 1/10 for all services provided during this time including any outpatient services provided on 1/3 before the admission was ordered.
- Transportation claim is submitted to DRC or the correctional facility where the inmate is housed for 1/1 and 1/10.

6. Does Medicaid require pre-certification for services when an inmate is hospitalized for over 24 hours?
 - a. Pre-certification is generally not required for Medicaid FFS inpatient medical admissions. However, pre-certification is required for all Medicaid FFS inpatient psychiatric admissions.
7. Will individuals who are in jail awaiting sentencing for 30 days or more be eligible for IHSP?
 - a. Per OAC rule 5160:1-1-03(B)(3)(a), 'an individual who is residing in a public institution awaiting criminal proceedings, penal dispositions, or other detainment determinations is considered an inmate. The duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.' If an individual is in jail, Medicaid can only pay for inpatient hospitalization of at least 24 hours. This would include an individual who is in jail awaiting sentencing for 30 days or more.
8. An inmate in jail unable to post bond, has been admitted to the hospital, and has been there past 24 hours. Does the coverage for billing actually pay for everything since arrival at the hospital or only the services after 24 hours had passed?
 - a. If the person is still incarcerated and admitted to an inpatient hospital stay on the day of arrival, all services would be covered. However, if a person is considered outpatient the first date then admitted on the second date of service, in this scenario, you would have to separate the dates of service. Claims for the inpatient stay and the physician (or other practitioners of physician) services would go to Medicaid FFS and the other date with the outpatient services would be submitted to DRC or the correctional facility where they are being housed. (Please see below how this would be submitted if the inmate was enrolled in a Medicaid MCP.)
9. If the inmate has Medicare, is Medicaid still primary?
 - a. Yes. Once a person is incarcerated, their Medicare eligibility is no longer effective. If the inmate has been assigned the IHSP benefit with Medicaid, the provider should be able to submit their claim directly to Medicaid FFS or the MCP without first submitting to Medicare.
10. If the inmate has another primary payer (other than Medicare), is Medicaid still primary?
 - a. If the primary payer will not pay due to a valid reason, such as incarceration, then yes

– Medicaid would be primary. However, the claim will need to be submitted to the primary payer first to obtain the denial. Once a denied claim is received, the claim can then be submitted to Medicaid. Claims would still need to be submitted using the coordination of benefits standard/billing guidelines.

11. Medicaid MCPs are refusing to pay for incarcerated inmate care when inpatient hospital stay is required unless the inmate has been in jail less than 15 days. How can prisons/jails know if the MCP on the same page with the Medicaid FFS rules for payment?
- a. Effective 3/1/17, the MCP will be responsible for the inpatient services as detailed in the response for Q12. (See below)
12. During the inmate's release month, eligibility is showing a Medicaid MCP, should the MCP be billed for services?
- a. Yes, for inpatient admission dates on/after 3/1/17 and per the following:
 - For an inmate who is assigned to the IHSP benefit plan upon admission to the inpatient facility and enrolled into an MCP during the inpatient stay, and when the inpatient admission date occurs in a month preceding the inmate's month of release and the stay continues on/after the MCP enrollment effective date:
 1. Medicaid FFS is responsible for the inpatient facility charges through the date of discharge and physician (or other practitioners of physician) services through the last calendar day of the month that immediately precedes the enrollment effective date with the MCP.
 2. The MCP is responsible for physician (or other practitioners of physician) charges incurred only from the inmate's enrollment effective date. Medicaid FFS continues to pay the facility charges for the entire inpatient stay.
 - For an inmate enrolled into an MCP during his/her month of release and who is admitted for an inpatient hospital stay prior to his/her release date, the MCP is responsible for both the inpatient facility and physician (or other practitioners of physician) services.
 - All other services provided during the release month would be submitted to the DRC or the correctional facility where the inmate is housed.
 - b. Prior to 3/1/17, the inpatient facility and physician (or other practitioners of physician) charges would be submitted to Medicaid FFS as normal. All other services would be submitted to DRC or the correctional facility where the inmate is being housed.

Example 1:

Inmate's release date is 8/16/17. On 8/1/17, inmate is enrolled into a Medicaid MCP. On 8/3/17, inmate is transferred to hospital for emergency services. On 8/4/17, the inmate is admitted to inpatient and discharged on 8/8/17.

- Outpatient and the physician (or other practitioners of physician) claims are submitted to DRC or correctional facility for 8/3/17 for all services provided on this date.
- Inpatient claim is submitted to the MCP for 8/4 – 8/8/17 for all services provided during this time including any outpatient services provided on 8/4/17, before the admission was ordered.
- Physician (or other practitioners of physician) claim is submitted to the MCP for the services provided during the inpatient stay, 8/4 – 8/8/17.

Example 2:

Inmate's release date is 8/16/17. On 8/1/17, inmate is enrolled into a Medicaid MCP. On 7/30/17, the inmate is transferred to hospital for emergency services. On 7/31/17, the inmate is admitted to inpatient and discharged on 8/8/17.

- Outpatient and the physician (or other practitioners of physician) claims are submitted to DRC or correctional facility for 7/30/17 for all services provided on this date.
- Inpatient claim is submitted to Medicaid FFS for 7/31 – 8/8/17 for all services provided during this time, including any outpatient services provided on 7/31/17 before the admission was ordered. Since the MCP is effective on 8/1/17, they are not responsible for the inpatient facility claim.
- The physician (or other practitioners of physician) claims for the inpatient stay would then be split into two claims – one would be submitted to Medicaid FFS for 7/31/17, and the claims would be submitted to the MCP for 8/1 – 8/8/17.

13. Are youth at Community Correction Facilities, which are run by Department of Youth Services (DYS), also eligible under the DYS Presumptive Eligibility (PE) initiative?

- a. Yes, youth at Community Correction Facilities and other children (up to age 21) who are within a week of release from DYS custody are identified. The identified individual's information is placed in the PE Portal by a DYS worker. The PE system approves/denies eligibility and the approval/denial letter is printed by DYS worker and given to the child's parole officer. While incarcerated, they would also be eligible for inpatient hospital services as described above.

14. Would IHSP be available for those sent to a Community Based Correctional Facility (CBCF)?

- a. Yes. The offender is still considered incarcerated. If this offender were to receive inpatient hospital services, those services would be covered under this program.

APPENDIX K – EAPG 835 AND REMITTANCE ADVICE EXAMPLES

K.1 FLAT PAYMENT

UB Claim		Top Nav ? A X	
ICN	2217146000029	Claim Type	OUTPATIENT
Prev ICN	[Search]	*Prov ID	[Search]
*Recipient ID	[Search]	Prov Type	01-HOSPITAL
Last Name	[Search]	Prov Spec	005-CHILDRENS HOSPI
First Name	[Search]	Attend Prov	[Search]
DOB	[Search]	Other Prov 1	[Search]
Medicaid ID	[Search]	Other Prov 2	[Search]
Cert #	[Search]	Facility ID	[Search] NPI
ICD Version	10	Signature	YES
Diagnosis	02 - L309	*Type Of Bill	0131 [Search]
Pat Status	01 [Search]	PAN	[Search]
MRN	[Search]	Submitter ID	[Search]
RA Number	70309078	PA Number	[Search]
Referral Number	[Search]		
		*Status	PAID
		*FDOS	08/15/2017
		*TDOS	08/15/2017
		*Date Billed	05/26/2017
		Date Paid	06/05/2017
		Admit Date	[Search]
		Admit Time	00:00
		Admit Type	3 [Search]
		Copay Code	[Search]
		Admit Source	1 [Search]
		Discharge Hour	00:00
		Txn Type	[Search]
		Financial Class	100
		Level of Care	[Search]
		Details	1
		Total Days	0
		Cvd Days	0
		Ncvd Days	0
		Billed Amount	\$100.00
		Submitted PL/SD	\$0.00
		Allowed Amt	\$1,062.00
		Header TPL	\$0.00
		Total Detail TPL	\$0.00
		TPL Rec Amt	\$0.00
		Copay	\$0.00
		Spenddown	\$0.00
		Patient Liability	\$0.00
		Paid	\$1,062.00

EAPG													Top Nav ? A X			
Detail Number /	Detail FDOS	Revenue Code	Procedure	Mod1	Mod2	Mod3	Mod4	Allowed Units	EAPG Version	Initial EAPG	Final EAPG	Type	Category	Pay Action	Weight	Payment Amount
1	08/15/2017	360	D1515					1	3.9.16.4	00351	00351	23	19	02A	0	\$1,062.00
Detail Number	1															
Revenue Code	360 - OR SERVICES															
Mod1	-															
Mod3	-															
Allowed Units	1															
Initial EAPG	00351 - LEVEL II ADJUNCTIVE GENERAL DENTAL SERVICES															
Type	23 - DENTAL PROCEDURE															
Pay Action	02A - FULL PAYMENT															
Payment Amount	\$1,062.00															
Detail FDOS	08/15/2017															
Procedure	D1515 - FIXED BILAT SPACE MAINTAINER															
Mod2	-															
Mod4	-															
EAPG Version	3.9.16.4															
Final EAPG	00351 - LEVEL II ADJUNCTIVE GENERAL DENTAL SERVICES															
Category	19 - DENTAL PROCEDURES															
Weight	0															

Report: CRA-OPPD-R
RA# : 70309078

OHIO DEPARTMENT OF MEDICAID
Medicaid Information Technology System
PROVIDER REMITTANCE ADVICE
OUTPATIENT CLAIMS PAID

Date: 06/05/2017
Page: 3

ICN	PATIENT NUMBER	ATTENDING PROVIDER	SERVICE DATES	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	CO-PAY AMOUNT	PAID AMOUNT	
2217146000029	[REDACTED]	[REDACTED]	081517 081517	100.00	1,062.00	0.00	0.00	1,062.00	
REV CODE	PROC CD	MODIFIERS	SERVICE DATE	UNITS	FINAL EAPG	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	PAID AMOUNT
0360	D1515		081517	1.00	00351	100.00	1,062.00	0.00	1,062.00
DETAIL EOB# 9225									

CLP* [REDACTED] *1062*0*MC*2217146000029*13*1***0~
 NM1*QC*1*[REDACTED]****MR*[REDACTED]~
 NM1*82*1*[REDACTED]***XX*[REDACTED]~
 REF*EA*[REDACTED]~
 DTM*232*20170815~
 DTM*233*20170815~
 SVC*HC:D1515*100*1062*0360*1~
 DTM*472*20170815~
 CAS*CO*45*-962*0~
 REF*1S*00351~
 AMT*B6*1062~
 LQ*HE*M16~

K.2 CLAIM WITH MORE THAN ONE DATE OF SERVICE – PAID

UB Claim			Top Nav ? A X				
ICN	2217146000011	Claim Type	OUTPATIENT	*Status	PAID	Details	7
Prev ICN	[v]	*Prov ID	[REDACTED] [Search] (i)	*FDOS	07/24/2017	Total Days	0
*Recipient ID	[REDACTED] [Search] (i)	Prov Type	01-HOSPITAL	*TDOS	07/25/2017	Cvd Days	0
Last Name	[REDACTED]	Prov Spec	001-GENERAL HOSPITA	*Date Billed	05/26/2017	Ncvd Days	0
First Name	[REDACTED]	Attend Prov	[REDACTED]	Date Paid	06/05/2017	Billed Amount	\$1,989.00
DOB	[REDACTED]	Other Prov 1	[REDACTED]	Admit Date	[REDACTED]	Submitted PL/SD	\$0.00
Medicaid ID	[REDACTED]	Other Prov 2	[REDACTED]	Admit Time	00:00	Allowed Amt	\$211.24
Cert #	[REDACTED]	Facility ID	[REDACTED] NPI (i)	Admit Type	1 [Search] (i)	Header TPL	\$0.00
ICD Version	10	Signature	YES	Copay Code	[REDACTED]	Total Detail TPL	\$0.00
Diagnosis	03 - F17210 [v]	*Type Of Bill	0131 [Search] (i)	Admit Source	1 [Search] (i)	TPL Rec Amt	\$0.00
Pat Status	01 [Search] (i)	PAN	[REDACTED]	Discharge Hour	00:00	Copay	\$0.00
MRN	[REDACTED]	Submitter ID	[REDACTED]	Txn Type	[REDACTED]	Spenddown	\$0.00
RA Number	70309091	PA Number	[REDACTED]	Financial Class	100	Patient Liability	\$0.00
Referral Number	[REDACTED]			Level of Care	[REDACTED]	Paid	\$211.24

[Display Claim XML](#) [Copy](#)

EAPG																Top	Nav	?	X
Detail Number	Detail FDOS	Revenue Code	Procedure	Mod1	Mod2	Mod3	Mod4	Allowed Units	EAPG Version	Initial EAPG	Final EAPG	Type	Category	Pay Action	Weight	Payment Amount			
1	07/24/2017	300	80048					1	3.9.16.4	00403	00403	4	22	02A	0.2470	\$23.52			
2	07/24/2017	300	84550					1	3.9.16.4	00402	00402	4	22	02A	0.0944	\$8.99			
3	07/24/2017	305	85025					1	3.9.16.4	00408	00408	4	22	02A	0.1035	\$9.86			
4	07/24/2017	320	73630	LT				1	3.9.16.4	00471	00471	4	25	02A	0.5667	\$53.97			
5	07/25/2017	450	99283					1	3.9.16.4	00491	00661	3	59	02A	1.2064	\$114.90			
6	07/25/2017	636	J7512					10	3.9.16.4	00496	00496	6	24	06A	0.1111	\$0.00			
7	07/25/2017	636	J7512					40	3.9.16.4	00496	00496	6	24	06A	0.1111	\$0.00			

Detail Number	Detail FDOS
Revenue Code	Procedure
Mod1	Mod2
Mod3	Mod4
Allowed Units	EAPG Version
Initial EAPG	Final EAPG
Type	Category
Pay Action	Weight
Payment Amount	

RECIPIENT ID: ██████████ RECIPIENT NAME: ██████████ COUNTY: 29 GREENE MED REC NUM: ██████████
 CHARGE SOURCE: EAPG
 2217146000011 MCD ██████████ 072417 072517 1,989.00 211.24 0.00 0.00 211.24
 REV ██████████

CODE	PROC	CD	MODIFIERS	SERVICE	DATE	UNITS	FINAL	BILLED	ALLOWED	TPL	PAID
							EAPG	AMOUNT	AMOUNT	AMOUNT	AMOUNT
0300	80048			072417	072417	1.00	00403	290.00	23.52	0.00	23.52
				DETAIL EOBS	9222						
0300	84550			072417	072417	1.00	00402	91.00	8.99	0.00	8.99
				DETAIL EOBS	9222						
0305	85025			072417	072417	1.00	00408	165.00	9.86	0.00	9.86
				DETAIL EOBS	9222						
0320	73630			072417	072417	1.00	00471	418.00	53.97	0.00	53.97
				DETAIL EOBS	9222						
0450	99283			072517	072517	1.00	00661	1,023.00	114.90	0.00	114.90
				DETAIL EOBS	9222						
0636	J7512			072517	072517	10.00	00496	1.00	0.00	0.00	0.00
				DETAIL EOBS	4891 9918 9221						
0636	J7512			072517	072517	40.00	00496	1.00	0.00	0.00	0.00
				DETAIL EOBS	4891 9918 9221						

CLP*1*1989*211.24*0*MC*2217146000011*13*1***0~
NM1*QC*1*~*MR*~
NM1*82*1*~*XX*~
REF*EA*~
DTM*232*20170724~
DTM*233*20170725~
SVC*HC:80048*290*23.52*0300*1~
DTM*472*20170724~
CAS*CO*45*266.48*0~
REF*1S*00403~
AMT*B6*23.52~
LQ*HE*M16~
SVC*HC:84550*91*8.99*0300*1~
DTM*472*20170724~
CAS*CO*45*82.01*0~
REF*1S*00402~
AMT*B6*8.99~
LQ*HE*M16~
SVC*HC:85025*165*9.86*0305*1~
DTM*472*20170724~
CAS*CO*45*155.14*0~
REF*1S*00408~
AMT*B6*9.86~
LQ*HE*M16~
SVC*HC:73630*418*53.97*0320*1~
DTM*472*20170724~
CAS*CO*45*364.03*0~
REF*1S*00471~
AMT*B6*53.97~
LQ*HE*M16~
SVC*HC:99283*1023*114.9*0450*1~
DTM*472*20170725~
CAS*CO*45*908.1*0~
REF*1S*00661~
AMT*B6*114.9~
LQ*HE*M16~
SVC*HC:J7512*1*0*0636*10~
DTM*472*20170725~
CAS*CO*45*1*0~

K.3 CLAIM WITH MORE THAN ONE DATE OF SERVICE – DENIED

UB Claim Top Nav ? A X

ICN 2217146000014	Claim Type OUTPATIENT	*Status DENIED	Details 7
Prev ICN [v]	*Prov ID [Search]	*FDOS 07/30/2017	Total Days 0
*Recipient ID [Search]	Prov Type 01-HOSPITAL	*TDOS 07/31/2017	Cvd Days 0
Last Name	Prov Spec 001-GENERAL HOSPITA	*Date Billed 05/26/2017	Ncvd Days 0
First Name	Attend Prov	Date Paid 06/05/2017	Billed Amount \$1,989.00
DOB	Other Prov 1	Admit Date	Submitted PL/SD \$0.00
Medicaid ID	Other Prov 2	Admit Time 00:00	Allowed Amt \$0.00
Cert #	Facility ID [NPI]	Admit Type 1 [Search]	Header TPL \$0.00
ICD Version 10	Signature YES	Copay Code	Total Detail TPL \$0.00
Diagnosis 03 - F17210 [v]	*Type Of Bill 0131 [Search]	Admit Source 1 [Search]	TPL Rec Amt \$0.00
MRN [Search]	PAN	Discharge Hour 00:00	Copay \$0.00
RA Number 70309091	Submitter ID	Txn Type	Spenddown \$0.00
Referral Number	PA Number	Financial Class 100	Patient Liability \$0.00
		Level of Care	Paid \$0.00

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EAPG Top Nav ? X

Detail Number	Detail FDOS	Revenue Code	Procedure	Mod1	Mod2	Mod3	Mod4	Allowed Units	EAPG Version	Initial EAPG	Final EAPG	Type	Category	Pay Action	Weight	Payment Amount
1	07/30/2017	300	80048					0							0	\$0.00
2	07/30/2017	300	84550					0							0	\$0.00
3	07/30/2017	305	85025					0							0	\$0.00
4	07/30/2017	320	73630	LT				0							0	\$0.00
5	07/31/2017	450	99283					0							0	\$0.00
6	07/31/2017	636	J7512					0							0	\$0.00
7	07/31/2017	636	J7512					0							0	\$0.00

ICN	PATIENT NUMBER	ATTENDING PROVIDER	SERVICE DATES	BILLED AMOUNT	TPL AMOUNT	DUPLICATE ICN	PREV PAID DT
2217146000014	MCD		073017 073117	1,989.00	0.00		
REV CODE	PROC CD	SERVICE MODIFIERS	SERVICE DATES	UNITS	FINAL EAPG	BILLED AMOUNT	TPL AMOUNT
0300	80048		073017	1.00		290.00	0.00
0300	DETAIL EOBS	5000					
0300	84550		073017	1.00		91.00	0.00
0305	DETAIL EOBS	0482					
0305	85025		073017	1.00		165.00	0.00
0320	DETAIL EOBS	5000					
0320	73630		073017	1.00		418.00	0.00
0450	DETAIL EOBS	5000					
0450	99283		073117	1.00		1,023.00	0.00
0636	DETAIL EOBS	5000					
0636	J7512		073117	10.00		1.00	0.00
0636	DETAIL EOBS	5000					
0636	J7512		073117	40.00		1.00	0.00
	DETAIL EOBS	5000					

CLP*[REDACTED]*4*1989*0*0*MC*2217146000014*13*1***0~
NM1*QC*1*[REDACTED]***MR*[REDACTED]~
NM1*82*1*[REDACTED]**XX*[REDACTED]~
REF*EA*[REDACTED]~
DTM*232*20170730~
DTM*233*20170731~
SVC*HC:80048*290*0*0300*0**1~
DTM*472*20170730~
CAS*CO*B13*290*0~
SVC*HC:84550*91*0*0300*0**1~
DTM*472*20170730~
CAS*OA*18*91*0~
SVC*HC:85025*165*0*0305*0**1~
DTM*472*20170730~
CAS*CO*B13*165*0~
SVC*HC:73630*418*0*0320*0**1~
DTM*472*20170730~
CAS*CO*B13*418*0~
SVC*HC:99283*1023*0*0450*0**1~
DTM*472*20170731~
CAS*CO*B13*1023*0~
SVC*HC:J7512*1*0*0636*0**10~
DTM*472*20170731~
CAS*CO*B13*1*0~
SVC*HC:J7512*1*0*0636*0**40~
DTM*472*20170731~
CAS*CO*B13*1*0~
SE*197*0006~
ST*835*0007~

K.4 VACCINE FOR CHILDREN – RECIPIENT AGE 12

UB Claim Top Nav ? A X

ICN	2217115000038	Claim Type	OUTPATIENT	*Status	PAID	Details	1
Prev ICN	[v]	*Prov ID	[Search]	*FDOS	07/10/2017	Total Days	0
*Recipient ID	[Search]	Prov Type	01-HOSPITAL	*TDOS	07/10/2017	Cvd Days	0
Last Name	[Redacted]	Prov Spec	005-CHILDRENS HOSPI	*Date Billed	04/25/2017	Ncvd Days	0
First Name	[Redacted]	Attend Prov	[Redacted]	Date Paid	05/02/2017	Billed Amount	\$100.00
DOB	[Redacted]	Other Prov 1	[Redacted]	Admit Date	[Redacted]	Submitted PL/SD	\$0.00
Medicaid ID	[Redacted]	Other Prov 2	[Redacted]	Admit Time	00:00	Allowed Amt	\$10.00
Cert #	[Redacted]	Facility ID	[Redacted] NPI	Admit Type	3 [Search]	Header TPL	\$0.00
ICD Version	10	Signature	YES	Copay Code	[Redacted]	Total Detail TPL	\$0.00
Diagnosis	01 - G40909	*Type Of Bill	0131 [Search]	Admit Source	1 [Search]	TPL Rec Amt	\$0.00
Pat Status	01 [Search]	PAN	[Redacted]	Discharge Hour	00:00	Copay	\$0.00
MRN	[Redacted]	Submitter ID	[Redacted]	Txn Type	[Redacted]	Spendedown	\$0.00
RA Number	70308427	PA Number	[Redacted]	Financial Class	100	Patient Liability	\$0.00
Referral Number	[Redacted]			Level of Care	[Redacted]	Paid	\$10.00

Claim Detail Top Nav ? A X

Detail Number	1	Status	PAID	Billed Amount	\$100.00
Procedure	90670	Modifier1		Allowed Amt	\$10.00
Revenue Code	320	Modifier2		CoPay Amt	\$0.00
Other Prov2 ID		Modifier3		OI Submitted	\$0.00
Rate Type		Modifier4		OI Applied	\$0.00
Patient Liability	0			System	NO
ClaimCheck	Y - YES			Non-Covered Charges	\$0.00

Select row above to update.

Detail Number	[v]	Status	[v]	Billed Amt	[v]
Procedure Code	[Search]	Modifier 1	[Search]	Allowed Amt	[v]
Revenue Code	[Search]	Modifier 2	[Search]	Copay Amt	[v]
Other Prov2 ID	[Search]	Modifier 3	[Search]	OI Submitted	[v]
Rate Type	[v]	Modifier 4	[Search]	OI Applied	[v]
Patient Liability	[v]			System	NO [v]
ClaimCheck	[v]			Non-Covered Charge	[v]

EAPG Top Nav ? A X

Detail Number	Detail FDOS	Revenue Code	Procedure	Mod1	Mod2	Mod3	Mod4	Allowed Units	EAPG Version	Initial EAPG	Final EAPG	Type	Category	Pay Action	Weight	Payment Amount
1	07/10/2017	320	90670					1	3.9.16.4	00415	00415	4	23	02A	0.3107	\$10.00

Detail Number	[v]	Detail FDOS	[v]
Revenue Code	[v]	Procedure	[v]
Mod1	[v]	Mod2	[v]
Mod3	[v]	Mod4	[v]
Allowed Units	[v]	EAPG Version	[v]
Initial EAPG	[v]	Final EAPG	[v]
Type	[v]	Category	[v]
Pay Action	[v]	Weight	[v]
Payment Amount	[v]		

Location Top Nav ? A X

Location	Financial Payer	Description	Date	Time
96		SYSTEM GENERATED - CLAIM RECEIVED	04/25/2017	14:53:42
97		SYSTEM GENERATED - CLAIM CREATED	04/25/2017	14:53:43
98	DEF	SYSTEM GENERATED - CLAIM PAID/AWAITING FINANCIAL	04/25/2017	14:53:44
99	DEF	SYSTEM GENERATED - CLAIM FINALIZED IN FINANCIAL	04/26/2017	24:00:00

RECIPIENT ID: [REDACTED] RECIPIENT NAME: [REDACTED] COUNTY: 18 CUYAHOGA MED REC NUM: [REDACTED]
 CHARGE SOURCE: MAXFEE
 2217115000038 MCD [REDACTED] 071017 071017 100.00 10.00 0.00 0.00 10.00
 REV [REDACTED]

CODE	PROC CD	MODIFIERS	SERVICE DATE	UNITS	FINAL EAPG	BILLED AMOUNT	ALLOWED AMOUNT	TPL AMOUNT	PAID AMOUNT
0320	90670		071017	1.00	00415	100.00	10.00	0.00	10.00

 DETAIL EOBS 9918

CLP*[REDACTED]*100*10*0*MC*2217115000038*13*1***0
 NM1*QC*1*[REDACTED]***MR*[REDACTED]
 NM1*82*1*[REDACTED]XX*[REDACTED]
 REF*EA*[REDACTED]
 DTM*232*20170710
 DTM*233*20170710
 SVC*HC:90670*100*10*0320*1
 DTM*472*20170710
 CAS*CO*45*90*0
 REF*1S*00415
 AMT*B6*10
 LQ*HE*M16

K.5 VACCINE FOR CHILDREN – RECIPIENT AGE 22

UB Claim		Top Nav ? A X	
ICN 2217114000071	Claim Type OUTPATIENT	*Status PAID	Details 1
Prev ICN [v]	*Prov ID [REDACTED] [Search]	*FDOS 07/09/2017	Total Days 0
*Recipient ID [REDACTED] [Search]	Prov Type 01-HOSPITAL	*TDOS 07/09/2017	Cvd Days 0
Last Name [REDACTED]	Prov Spec 005-CHILDRENS HOSPI	*Date Billed 04/24/2017	Ncvd Days 0
First Name [REDACTED]	Attend Prov [REDACTED]	Date Paid 05/02/2017	Billed Amount \$100.00
DOB [REDACTED]	Other Prov 1 [REDACTED]	Admit Date [REDACTED]	Submitted PL/SD \$0.00
Medicaid ID [REDACTED]	Other Prov 2 [REDACTED]	Admit Time 00:00	Allowed Amt \$34.77
Cert # [REDACTED]	Facility ID [REDACTED] NPI	Admit Type 3 [Search]	Header TPL \$0.00
ICD Version 10	Signature YES	Copay Code [REDACTED]	Total Detail TPL \$0.00
Diagnosis 01 - G40909	*Type Of Bill 0131 [Search]	Admit Source 1 [Search]	TPL Rec Amt \$0.00
Pat Status 01 [Search]	PAN [REDACTED]	Discharge Hour 00:00	Copay \$0.00
MRN [REDACTED]	Submitter ID [REDACTED]	Txn Type [REDACTED]	Spendedown \$0.00
RA Number 70308427	PA Number [REDACTED]	Financial Class 100	Patient Liability \$0.00
Referral Number [REDACTED]		Level of Care [REDACTED]	Paid \$34.77

[Display Claim XML](#) [Copy](#)

Claim Detail							Top	Nav	?	A	X
Detail Number	1	Status	PAID	Billed Amount		\$100.00					
Procedure	90670	Modifier1		FDOS	07/09/2017	Allowed Amt					\$24.77
Revenue Code	320	Modifier2		TDOS	07/09/2017	CoPay Amt					\$0.00
Other Prov2 ID		Modifier3		Units Billed	1.00	OI Submitted					\$0.00
Rate Type		Modifier4		Units Allowed	1.00	OI Applied					\$0.00
Patient Liability	0					System					NO
ClaimCheck	Y - YES					Non-Covered Charges					\$0.00

Select row above to update.

Detail Number	<input type="text"/>	Status	<input type="text"/>	Billed Amt	<input type="text"/>
Procedure Code	<input type="text"/> [Search]	Modifier 1	<input type="text"/> [Search]	Allowed Amt	<input type="text"/>
Revenue Code	<input type="text"/> [Search]	Modifier 2	<input type="text"/> [Search]	Copay Amt	<input type="text"/>
Other Prov2 ID	<input type="text"/> [Search]	Modifier 3	<input type="text"/> [Search]	OI Submitted	<input type="text"/>
Rate Type	<input type="text"/>	Modifier 4	<input type="text"/> [Search]	OI Applied	<input type="text"/>
Patient Liability	<input type="text"/>			System	NO <input type="text"/>
ClaimCheck	<input type="text"/>			Non-Covered Charge	<input type="text"/>

EAPG																Top	Nav	?	A	X													
Detail Number	1	Detail FDOS	07/09/2017	Revenue Code	320	Procedure	90670	Mod1		Mod2		Mod3		Mod4		Allowed Units	1	EAPG Version	3.9.16.4	Initial EAPG	00415	Final EAPG	00415	Type	4	Category	23	Pay Action	02A	Weight	0.3107	Payment Amount	\$34.77
Detail Number		Detail FDOS		Revenue Code		Procedure		Mod1		Mod2		Mod3		Mod4		Allowed Units		EAPG Version		Initial EAPG		Final EAPG		Type		Category		Pay Action		Weight		Payment Amount	

Location					Top	Nav	?	A	X
Location	Financial Payer	Description	Date	Time					
96		SYSTEM GENERATED - CLAIM RECEIVED	04/24/2017	15:45:16					
97		SYSTEM GENERATED - CLAIM CREATED	04/24/2017	15:45:17					
98	DEF	SYSTEM GENERATED - CLAIM PAID/AWAITING FINANCIAL	04/24/2017	15:45:18					
99	DEF	SYSTEM GENERATED - CLAIM FINALIZED IN FINANCIAL	04/26/2017	24:00:00					

RECIPIENT ID: ██████████ RECIPIENT NAME: ██████████ COUNTY: 57 MONTGOMERY MED REC NUM: ██████████

CHARGE SOURCE: EAPG

2217114000071 MCD ██████████ 070917 070917 100.00 34.77 0.00 0.00 34.77

REV	CODE	PROC CD	MODIFIERS	DATE	SERVICE	FINAL	BILLED	ALLOWED	TPL	PAID
							AMOUNT	AMOUNT	AMOUNT	AMOUNT
	0320	90670		070917			1.00 00415 100.00	34.77	0.00	34.77

DETAIL EOBSS 9222

CLP* [REDACTED] *100*34.77*0*MC*2217114000071*13*1***0
NM1*QC*1* [REDACTED] * [REDACTED]
NM1*82*1* [REDACTED] XX* [REDACTED]
REF*EA* [REDACTED]
DTM*232*20170709
DTM*233*20170709
SVC*HC:90670*100*34.77*0320*1
DTM*472*20170709
CAS*CO*45*65.23*0
REF*1S*00415
AMT*B6*34.77
LQ*HE*M16