



## Department of Medicaid

**John R. Kasich**, Governor

**John B. McCarthy**, Director

### **Hospital Handbook Transmittal Letter (HHTL) No. 3352-15-11**

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**TO: All Hospital Providers  
Directors, County Departments of Job and Family Services**

**FROM: John B. McCarthy, Director**

**SUBJECT: General Provisions and Outpatient Hospital Services**

#### **Summary**

This Hospital Handbook Transmittal Letter (HHTL) provides information pertaining to the revisions to payment policies for hospital services.

Ohio Administrative Code (OAC) rules 5160-2-02, "General provisions: hospital services" and 5160-2-21, "Reimbursement for services provided in an outpatient hospital setting," have been amended to update the respective rule bodies and applicable appendices to reflect updates to the Department's reimbursement methodologies that contributed to the building of the appropriations established in Am. Sub. H.B. 64. The effective date of these changes is January 1, 2016.

#### **Rule Changes**

**Rule 5160-2-02**, "General provisions: hospital services," provides information about the general provisions for covering hospital services.

##### Change:

- The definition of inpatient services has been amended to include all outpatient services rendered to a patient within three calendar days prior to the date of an inpatient admission in hospitals described in OAC rule 5160-2-01. This change is effective for inpatient admissions that begin on or after January 1, 2016.

**Rule 5160-2-21**, "Reimbursement for services provided in an outpatient hospital setting," describes the outpatient payment policies and rates for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRG).

##### Changes:

- The Department has reformed its outpatient hospital reimbursement policy for pharmaceuticals billed with revenue center code (RCC) 025X and/or 0636 with a

provider-administered pharmaceutical HCPCS J-code or Q-code. When applicable for additional payment based on the provisions in OAC rule 5160-2-21, any line item that contains RCC 025X and/or 0636 with a provider-administered pharmaceutical HCPCS J-code or Q-code will pay according to the Department's Provider-Administered Pharmaceuticals fee schedule at the rate in effect on the date of service, as published in paragraph E to OAC rule 5160-4-12.

- Charges on detail lines that carry a HCPCS J-code or Q-code listed on the Provider-Administered Pharmaceuticals fee schedule as “by report,” will be paid at sixty percent of the hospital's specific outpatient cost-to-charge ratio.
- Charges on detail lines that carry RCC 025X and/or 0636 without a provider-administered pharmaceutical HCPCS J-code or Q-code when an applicable J-code or Q-code does not exist for the provider-administered pharmaceutical for the date of service will also be paid at sixty percent of the hospital's specific outpatient cost-to-charge ratio.
- Providers are expected to bill RCC 025X and 636 using the appropriate J-code or Q-code whenever an appropriate code exists. Claims submitted with RCC 025X without a J-code or Q-code will be targeted for retrospective review to determine whether an appropriate HCPCS could have been used.
- With the exception of children's hospitals, the five percent rate increase for outpatient hospital services, as authorized in Am. Sub. H.B. 1 of the 128th General Assembly, will be set to expire on December 31, 2015. The appendices to this rule have been updated to reflect the expiration of the five percent rate increase that was implemented on January 1, 2010.
- CPT code 28236 was deleted from Appendix C as it is obsolete.
- Coverage to bariatric procedure codes (43644-43645, 43770-43775, 43842-43843, 43845-43848, and 43886-43888) were added to Appendix C. Prior authorization is required for these bariatric procedure codes.
- Coverage and reimbursement rates for vaccine-related procedure codes (90620, 90621, 90651, 90644, 90655, 90657, 90669, 90680, 90685, 90687, 90688, 90700, 90702, 90713, 90721, 90723, and 90744) were updated in Appendix F.
- Per OAC rule 5160-2-21, a UB modifier is required for comprehensive vision exams; the UB modifier was added as a note in Appendix F for those procedure codes.
- Descriptions for modifiers U1, U2, and UB were added to Appendix F.
- Appendix H to this rule, which provides reimbursement rates for laboratory services has been eliminated. Laboratory services will pay in accordance to Appendix DD to OAC rule 5160-1-60, at the same rates as indicated in eliminated Appendix H.
- Language regarding payment for claims that carry a surgical procedure code but do not group to an outpatient surgical code group has been removed; and outdated language has also been removed.
- The intellectual disability diagnosis codes that pertain to unlisted dental surgery payments have been updated to include International Classification of Diseases (ICD) -10 diagnosis codes.
- As a result of the 2016 HCPCS update, a fee schedule has been created to reflect coverage of new CPT codes and deletion of obsolete CPT codes. This fee schedule also contains a list of provider-administered pharmaceutical Q-codes that may receive additional payment when billed with RCC 025X and/or 636.

### **Access to Rules and Related Material**

The main web page of the ODM includes links to valuable information about its services and programs; the address is <http://medicaid.ohio.gov/>.

To access ODM Fee Schedule and Rates, go to [medicaid.ohio.gov](http://medicaid.ohio.gov) > Providers > Fee Schedule and Rates > Click “I Agree”:

- For the Outpatient Hospital appendices and 2016 HCPCS Update Payment Table, select “Outpatient Hospital Services.”
- For the Provider-Administered Pharmaceuticals fee schedule, select “Provider-Administered Pharmaceuticals.”
- For Appendix DD, select “Medicaid Non-Institutional Maximum Payment Schedule.”

### **Additional Information**

Questions pertaining to this letter should be addressed to:

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or

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