Ohio
Department of Medicaid
John R. Kasich, Governor
Barbara R. Sears, Director

Hospital Handbook Transmittal Letter (HHTL) 3352-18-01

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

FROM: **Barbara R. Sears, Director**

SUBJECT: **Hospital Updates Effective January 1, 2018**

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes effective January 1, 2018.

Hospital Inpatient Services

Rule 5160-2-65 entitled Inpatient hospital reimbursement, sets forth the methodology for determining the relative weights and hospital average cost per discharge that is used to reimburse hospitals for inpatient services under prospective payment. In accordance with the provisions of this rule, the hospital specific Diagnosis Related Group (DRG) base rates that were in effect on December 31, 2017 remain unchanged except for hospitals penalized for Potentially Preventable Readmissions (additional information below).

Rule 5160-2-66 entitled Capital costs, sets forth the methodology for inpatient hospital capital reimbursement for those hospitals paid under the prospective payment methodology. Capital costs are reimbursed on a prospective basis at eighty-five percent of historical costs. A separate letter dated December 18, 2017 was sent to all hospitals operating within Ohio, with their hospital specific capital rates effective January 1, 2018.

Relative Weights

Effective for discharges on or after October 1, 2017, 3M deleted 10 Diagnosis Related Groups (DRG) and added 18 new DRGs to its APR-DRG grouper system that Ohio Medicaid (the Department) uses to reimburse inpatient hospital claims for hospitals subject to prospective payment. The new DRGs are the result of reassigning procedure and diagnosis codes from the deleted DRGs and existing DRGs to increase specificity and to incorporate ICD-10 code updates. 3M split the deleted DRGs into new DRGs and moved some procedures and diagnoses out of existing DRGs, which required the Department to recalculate the weight for DRGs 073, 082, 091, 098, 263 and 483 (See HHTL 3352-17-11). The relative weights and Average Length of Stay (ALOS) for the new and recalculated DRGs were determined using a combination of national weights and Ohio-specific relative weights.

The relative weight tables may be accessed through the Department's website: http://www.medicaid.ohio.gov/ > Providers > Fee Schedules and Rates > "I Agree" > Inpatient Hospital Services. The current weights are those that were in effect for discharges on or after October 1, 2017. There are no changes for January 1, 2018.

Classification of Hospitals

Effective July 1, 2017, OAC Rule 5160-2-05, Classifications of Hospitals, was amended to include a provision to reclassify any hospital that has been designated as reclassified in the Inpatient Prospective Payment System (IPPS) case-mix and wage index table as published by the Centers for Medicare and Medicaid Services (CMS), effective October 1 of the calendar year prior to the rate year. In accordance with paragraph (C), 19 hospitals were reclassified from the Rural to Urban peer group. Each reclassed hospital's rate letter, dated December 18, 2017 indicates that the hospital was reclassed and reflects the hospital's peer group and base rate effective January 1, 2018.

Detoxification Services Provided in Psychiatric Hospitals

Effective July 1, 2017 five detoxification DRGs were added to the list of reimbursable DRGs for freestanding psychiatric hospitals. For more information see HHTL 3352-17-12.

Potentially Preventable Readmissions (PPR)

Rule 5160-2-14 entitled Potentially Preventable Readmissions, sets forth a readmission policy which includes a possible penalty of a one percent reduction to the hospital-specific base rate. The penalty is determined by the annual PPR report cards. A rate letter dated December 18, 2017 was sent to all hospitals and indicated whether the hospital is subject to the readmission penalty. The penalty will be effective for the entire 2018 calendar year.

Pre-certification & Prior Authorization

Pre-certification requirements on ICD-10 surgical procedures will remain suspended for calendar year 2018. The Department has no plans to re-instate the medical/surgical pre-certification program at this time. However, all psychiatric admissions will still require pre-certification, and prior authorization requirements have not changed.

Hospital Outpatient Services

Rule 5160-2-75 entitled Outpatient hospital reimbursement, describes the outpatient payment policies for hospitals that are subject to DRG prospective payment.

As a result of the 2018 Current Procedural Terminology (CPT) and Healthcare Common Procedural Coding System (HCPCS) updates, the Enhanced Ambulatory Patient Groups (EAPG) covered codes list for outpatient hospitals and ambulatory surgical centers has been updated. The updated covered codes list has been published on the Department's website: http://www.medicaid.ohio.gov/ > Providers > Fee Schedules and Rates > "I Agree" > Outpatient Hospital Services. The EAPG grouper version has not changed. The Department will continue using EAPG grouper version 3.9.

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, 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.

Outpatient hospital behavioral health (OPHBH) services were made available to hospitals for dates of service on or after August 1, 2017 and are reimbursed outside of the EAPG prospective payment system. OPHBH services are a specific set of services modeled on the Community Mental Health Centers Behavioral Health Redesign project. With the exception of MyCare recipients, hospitals opting to provide OPHBH services should submit the OPHBH services to fee-for-service Medicaid until the managed care roll-in on July 1, 2018.

In addition to the OPHBH services, there are Behavioral Health CPT codes that may be provided in the outpatient setting of any hospital. These services are reimbursed using the EAPG prospective payment system. Please refer to the Outpatient Hospital Covered Codes List for those services that are available.

Other Updates

Use of 340B Drugs by Hospital 340B Entities

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

Beginning January 1, 2018, providers should 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 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. The SE modifier must be listed within the first four modifiers submitted with that drug. Use of the SE modifier will inform the Department that a 340B purchased drug was used and the Department will automatically exclude those drug details from the Department's rebate request. If a non-340B entity submits the SE modifier, edit 3203 – 'modifier restriction, 340B providers' post on their claims.

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

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 cross over directly to the Department from Medicare, the Department will appropriately request rebates for eligible drugs. However, if a provider submits a claim for a dually eligible individual directly to the Department, the Department will expect proper reporting of the SE modifier in accordance with the Department's guidelines.

Please note, 340B reporting is not applicable for inpatient claims.

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2018. The Medicare Part A inpatient hospital deductible amount is $1,340.00. The daily coinsurance amounts are updated as follows: (a) $335.00 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $670.00 for lifetime reserve days; and (c) $167.50 for the 21st through 100th day of extended care services in a skilled nursing facility in a benefit period. The Medicare Part B deductible amount is $183.00.

Access to Rules and Related Material

Information about the services and programs of the Department may be accessed through the Department's main web page: http://www.medicaid.ohio.gov .

- Stakeholders wanting to receive notification when the Department original or final files a rule package may visit JCARR's 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 BIA is posted for public comment on the Ohio Business Gateway here: http://business.ohio.gov/reform/enotify/subscription.aspx

Information about hospital payment policies may be accessed through the Department's main web page (http://medicaid.ohio.gov > Providers > Fee Schedule and Rates > "I Agree").

Additional Information

Questions pertaining to this letter should be addressed to:

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or

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