Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

Maureen M. Corcoran, Director

Hospital Handbook Transmittal Letter (HHTL) 3352-20-01

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

FROM: **Maureen M Corcoran, Director**

SUBJECT: **Hospital Updates Effective January 1, 2020**

Summary

This Hospital Handbook Transmittal Letter (HHTL) provides information regarding changes that, based on existing rules or policies, generally take effect at the beginning of each calendar year.

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 standard base rates that were in effect on December 31, 2019 will not change. A rate letter was mailed to hospitals operating in Ohio on December 16, 2019 detailing hospital-specific rates.

Annual ICD-10 Updates

The Department has implemented the new 2019 International Classification of Diseases, Tenth Revision (ICD-10) diagnosis and procedure codes for inpatient hospital reimbursement effective October 1, 2019. Obsolete diagnosis and procedure codes have been deleted. Providers are required to use diagnosis and procedure codes that were in effect on the date of discharge. While few new inpatient procedure codes will require prior authorization, the Department did not identify any procedure or diagnosis codes that will not be covered. The list of inpatient procedures that require prior authorization has been updated.

Inpatient hospital claims with dates of discharge on or after October 1, 2019 will be processed under the All Patient Refined Diagnosis Related Groups (APR-DRG) version 37. APR-DRG version 37 contains new, deleted and revised DRGs. Relative weights have been developed for the 10 new DRGs. The current APR-DRG relative weights are those that were in effect for discharges on or after October 1, 2019, please see Hospital Handbook Transmittal Letter (HHTL) 3352-19-06. There are no changes for January 1, 2020. 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.

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 16, 2019 was sent to all hospitals operating within Ohio, with their hospital specific capital rates effective January 2, 2020.

Potentially Preventable Readmissions Program

Rule 5160-2-14 entitled "Potentially preventable readmissions," sets forth general provisions regarding the implementation of the Potentially Preventable Readmissions (PPR) program, which reduces payment for clinically-related and clinically-preventable readmissions. In its continuing effort to pay hospitals back for incorrectly assessing PPR penalties, the Department will continue to honor the one percent increase in inpatient hospital base rates for those hospitals that were incorrectly assessed a PPR penalty in both calendar years (CY) 2017 and CY 2018 under the PPR logic at the time but would not have been penalized under the revised PPR logic in both years. For those hospitals that received a one percent increase in their inpatient base rate effective January 1, 2019 because they were incorrectly assessed a PPR penalty in either CY 2017 or CY 2018 under the PPR logic at the time but would not have been penalized under the revised PPR logic in either year, will no longer receive the one percent increase to their base rate as their PPR penalty has been paid back to them. The PPR report cards have been published on the Department's website. The Department has suspended the Potentially Preventable Readmissions (PPR) penalty.

Hospital Outpatient Services

Rule 5160-2-75, entitled "Outpatient hospital reimbursement," sets forth the Medicaid hospital reimbursement methodology for hospitals subject to the Enhanced Ambulatory Patient Grouping (EAPG) prospective payment. For outpatient services provided on or after January 2, 2020, the Department is migrating from EAPG version 3.9 to version 3.14. Hospital-specific outpatient base rates are provided in the rate letters dated December 16, 2019. Please refer to HHTL 3352-19-09 for full details regarding the amendments to OAC 5160-2-75.

Outpatient Hospital Code Sets.

The Common Procedure Terminology (CPT) and the Healthcare Common Procedure Coding System (HCPCS) code sets are updated each January. The January 2020 code changes have been reviewed. Deleted codes have been end dated and new codes that will be covered in the outpatient hospital setting have been added to the covered EAPG covered code list. The updated relative weights and EAPG covered codes are published on the Department's website: http://www.medicaid.ohio.gov/ > Providers > Fee Schedules and Rates > "I Agree" > Outpatient Hospital Services.

Outpatient Claims Submission and Payment Information

Effective with EAPG Version 3.14, only HCPCS code G0378 will be recognized for observation flat payment. Use of 992XX observation CPT codes are treated as a medical visit in Version 3.14 and processed accordingly.

As standard practice and due to the January 1 CPT and HCPCS, code updates, providers cannot submit outpatient claims that span across December 31 and January 1. In addition, for 2020, ODM will be implementing both EAPG Version 3.14 and the Cost Coverage Add-on effective January 2, 2020. Therefore, it will be necessary that providers submit up to three separate claims for services occurring between December 31, 2019 through January 2, 2020 for the same recipient.

- Claim 1 – Outpatient Services on or before December 31;
- Claim 2 – Outpatient Services on January 1;
- Claim 3 – Outpatient Services on or after January 2.

Prior Authorization, Pre-Certification and Utilization Reviews

The list of inpatient and outpatient services that require prior authorization is available on the Department's 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.

Pre-certification requirements on ICD-10 surgical procedures will remain suspended for calendar year 2020. The Department currently has no plans to re-instate the medical/surgical pre-certification program. However, all psychiatric admissions will still require pre-certification.

Cost Coverage Add-On

Rule 5160-2-60 entitled "Cost Coverage Add-on," sets forth the methodology with which the Department will provide hospitals an additional reimbursement methodology, to ensure continued access to hospital services for Medicaid recipients, in the form of a cost coverage add-on rate. The case-mix adjusted cost coverage add-on will be added to a hospital's inpatient and outpatient base rates for each inpatient discharge or outpatient service on or after January 2, 2020 for those hospitals paid under APR-DRG and EAPG. For those hospitals excluded from the prospective payment systems, the cost coverage add-on will be a percentage increase to their prospective inpatient and outpatient cost-to-charge ratios for discharges or services on or after January 2, 2020. Please see HHTL 3352-19-10 for more information

Other Updates

National Drug Codes

Outpatient claims containing details for covered outpatient drugs must be billed in accordance with National Drug Code (NDC) guidelines. Additionally, details containing Revenue Center Codes (RCC) 25X (either with or without) a CPT/HCPCS code require an NDC. For dates of service on or after January 1, 2019, if an NDC is not submitted for any detail that requires an NDC, edit 4893 (NDC code missing) will post on the detail line, denying the detail. Similarly, the corresponding NDC must be valid on the date of service and correspond to the procedure code the NDC is submitted with, otherwise, edit 4891 (invalid NDC/HCPCS combination) will post on the detail line, denying the detail. Although these edits only apply to fee-for-service claims, the NDC guidelines apply to both fee-for-service and managed care claims. Therefore, the Department expects that the managed care plans will employ similar edits for their claims.

Medicare Coinsurance and Deductible

The coinsurance and deductible amounts for Medicare's hospital insurance program (Part A) have been updated effective January 1, 2020. The Medicare Part A inpatient hospital deductible amount is $1,408.00. The daily coinsurance amounts are updated as follows: (a) $352.00 coinsurance for the 61st through 90th day of hospitalization in a benefit period; (b) $704.00 for lifetime reserve days; and (c) $176.00 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 $198.00.

Access to Rules and Related Material

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

- Stakeholders who want 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 main web page (http://medicaid.ohio.gov > Providers > Fee Schedule and Rates >Click "I Agree").

Additional Information

Questions pertaining to this letter should be addressed to:

hospital_policy@medicaid.ohio.gov

or

Ohio Department of Medicaid
Bureau of Health Plan Policy
Hospital Services
P.O. Box 182709
Columbus, OH 43218-2709
Telephone (800) 686-1516