Chiropractic Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

To receive eMail notifications of policy updates, go to the **ODM Email List Sign-up site** (**http://www.medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx**) and subscribe to the type of communications in which you are interested. eMail notifications are sent as updates are posted to the eManuals site.

eManual Contents				
Please send comments to ePubs_updates@jfs.ohio.gov				
Medicaid Handbook Transmittal Letters	**Miscellaneous Medicaid Handbook Transmittal Letters**	**Medical Assistance Letters**	**Rules Related to Chiropractic Services**	**Billing Instructions**

Notice

A Chiropractic Services provider handbook is currently not available.

Below please find Medical Assistance Letters (MALs) and Ohio Administrative Code (OAC) rules regarding Chiropractic Services and links to the OAC (found in the Legal Services collection).

Medicaid Handbook Transmittal Letters

MHTL 3339-09-01 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3339-09-01

January 8, 2010

TO: All Eligible Chiropractors

Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately $19,736,109.

OAC rule **5101:3-1-60**, entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately $1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately $82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately $16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately $1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately $335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately $569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately $388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately $228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately $4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately $21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from $185.02 to $185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from $202.00 to $210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule **5101:3-4-21.2**, entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately $194,457.

OAC rule **5101:3-5-02**, entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately $200,946.

OAC rule **5101:3-5-04**, entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately $491,720.

OAC rule **5101:3-10-05**, entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately $272,067.

OAC rule **3-10-26**, entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately $285,921.

OAC rule **5101:3-12-05**, entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately $5,676,688.

OAC rule **5101:3-12-06**, entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately $4,231,876.

Web Page:

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

Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate service provider type or handbook;

(3) Selecting the "Table of Contents";

(4) Selecting the desired document type;

(5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule **5101:3-1-60** or in Appendix DD to that rule. Providers may view these rates by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting "General Information for Medicaid Providers";

(3) Selecting "General Information for Medicaid Providers (Rules)";

(4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: **http://www.odjfs.state.oh.us/subscribe/**.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MHTL 3339-08-02

Medicaid Handbook Transmittal Letter (MHTL) 3339-08-02

July 31, 2008

TO: All Providers of Chiropractic Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Medicaid Program Fee increases

Rule change effective July 1, 2008.

Medicaid Reimbursement-OAC 5101:3-1- 60

The Department is pleased to announce that the Medicaid maximums for certain codes will be increased as part of the Governor's biennium budget. An aggregate 3% increase is being implemented for claims with dates of service on and after July 1, 2008 based on the volume of services paid for all CPT codes.

The Medicaid maximums for selected CPT codes have been raised. If the Medicaid maximum was over the Medicare price, the Medicaid maximum was lowered since Ohio Medicaid is prohibited from paying a price that exceeds the Medicare price. For many codes, the Medicaid maximum remains unchanged.

The full text of this rule amendment and the accompanying appendix DD to this rule can be found on the Department's web site at http://emanuals.odjfs.state.oh.us/emanuals in the General Information for Medicaid Providers handbook.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (Medicaid fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule **5101:3-1- 60** will affect them. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution:

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

Providers may view documents online by:

(1) Selecting "Ohio Health Plans - Provider"

(2) Selecting "Chiropractic Services"; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (**http://www.odjfs.state.oh.us/lpc/calendar/**) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (**http://www.odjfs.state.oh.us/lpc/mtl**). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3339-07-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3339-07-01

December 27, 2007

TO: All providers of Chiropractic Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Revision of OAC rule 5101:3-8-11 "Covered chiropractic physician services and limitations"

Rule change effective January 1, 2008.

The purpose of this MHTL is to provide notice of revision to the following rule:

Rule **5101:3-8-11** entitled: "Covered chiropractic physician services and limitations" is being amended in accordance with Am. Sub. House Bill 119 (127th General Assembly) which authorized the restoration of chiropractic benefits for Medicaid consumers 21 years of age and older to a maximum limit of fifteen dates of service per consumer per twelve month period in an outpatient setting.

Coverage of chiropractic services for Medicaid consumers 20 years of age or younger continue up to a maximum limit of thirty dates of service per consumer per twelve month period in an outpatient setting.

Web Page and Paper Distribution:

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

Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

(2) Selecting the appropriate topic from the document list; and

(3) Selecting the desired item from the "Table of Contents" pull-down menu.

Providers may view current reimbursement rates online by:

(1) Selecting the "Legal Services" folder;

(2) Selecting "ODJFS Ohio Administrative Code"; and

(3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions:

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01), is maintained in the General Information e-book.

Click here to view MHTL 3334-09-02, Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01

Medical Assistance Letters

MAL 527

Medical Assistance Letter (MAL) 527

June 7, 2007

To: Group Chiropractors, Group Chiropractors/Mechanotherapists, Group Mechanotherapists, Group Optometrists, Group Physical Therapists, Group Podiatrists and Group Psychologists

Trading Partners and Tape Intermediaries

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI……GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform providers enrolled and billing as group chiropractors, group chiropractors/mechanotherapists, group mechanotherapists, group optometrists, group physical therapists, group podiatrists and group psychologists in the Ohio Medicaid program that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for group provider types is a unique, ten-digit, entity type 2 identifier received from the National Plan and Provider Enumeration System (NPPES). This MAL also provides information on applying for your NPI, disclosing your NPI to ODJFS, and using your NPI when submitting claims to ODJFS.

Group practices will also be required to use unique (entity type 1) NPI numbers for each individual provider rendering services for the group practice on claims* submitted to ODJFS. The group practice should work with the individual providers in the group to determine if the group will obtain the individual provider numbers from NPPES for the practice's providers or if the individual providers will independently obtain their own individual provider numbers from NPPES and then share the numbers with the group practice. For every Ohio Medicaid provider/billing number you currently have and use today for your Medicaid business, your practice must have a corresponding, unique NPI number.

After receiving the provider group NPI and the individual provider NPI numbers and until January 1, 2008, all provider group practices conducting business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their group NPI number and their current group Medicaid provider number (now referred to as the Medicaid legacy number or the Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL. In addition, they must submit both the individual provider's NPI number and the corresponding individual Medicaid legacy number in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* Until January 1, 2008, claims received by ODJFS from provider group practices will continue to be accepted and processed if the claims contain a valid Medicaid legacy number or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields. Prior to January 1, 2008, claims ***submitted without*** an Ohio Medicaid legacy number (i.e., claims submitted only with an NPI number) in the required provider fields will be rejected or denied.*

Provider claims submitted to ODJFS on or after January 1, 2008 will be rejected and/or denied if the group and/or individual NPI number is not in the required field(s) on the claim. Provider claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

Providers and provider group practices must:

- enumerate through NPPES,
- receive their NPI, and

- disclose their NPI to ODJFS immediately.

Providers and provider group practices must be ready to submit both their NPI(s) and Medicaid legacy numbers on claims.*

* *See special instructions for paper and tape claims (below in this MAL).*

I. How do I get an NPI?

Provider group practices can receive an (entity type 2) NPI number for the provider group practice and an individual (entity type 1) NPI number for each provider in the group practice by submitting an application to NPPES. To obtain a National Provider Identifier, providers should contact NPPES directly **at http://nppes.cms.hhs.gov or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY))**. Providers can apply for an NPI electronically or by paper.

When you apply for your group practice NPI, ODJFS encourages you to submit the following information with your NPI application: Ohio Medicare legacy (PIN/UPIN) number, Ohio Medicaid legacy number, taxonomy number, and employer identification number (EIN). It is also very important to make it clear on the NPI application when you are applying for an NPI for the group practice and when you are applying for an individual NPI for one of the providers in your practice.

If you are applying for a group NPI, check the box on the NPI application for "an organization that renders health care." Please submit as the primary taxonomy for the group practice either the taxonomy number **193400000X** (if you are a single specialty practice) or the taxonomy number **193200000X** (if you are a multi-specialty practice). Other provider taxonomy numbers may be given as secondary taxonomy numbers to further describe the practice and the type of specialty services provided by the practice.

If you are applying for an NPI for an individual provider in the group (i.e., an entity type 1 NPI), check the box on the NPI application for "an individual who provides health care." Please submit as the primary taxonomy number for the individual provider the taxonomy code that best describes the provider's specialty. You may submit more than one provider taxonomy number.

A listing of taxonomy codes for providers can be found at

http://www.wpc-edi.com/codes/taxonomy.

II. How do I bill ODJFS using the NPI?

If your practice received this MAL, at least once during the last twelve months you/your practice submitted claim(s) as one of the group practice provider types specified in this MAL.

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist your practice in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The NPI (entity type 2) assigned to the group practice must be sent with the XX qualifier in the NM108 and the group (entity type 2) NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the Medicaid legacy provider number assigned to the group practice must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the group Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The rendering provider loop (2310B loop) must also be completed and contain information about the provider who rendered the service. Group practices must submit the (entity type 1) NPI assigned to the individual provider that provided the service in the NM109 of 2310B with the qualifier value of XX in the NM108 of the 2310B loop and submit the Medicaid legacy number assigned to the individual provider in the REF02 of the 2310B loop with a 1D qualifier in the REF01 of the 2310B loop. When a group practice submits claims, the pay to numbers should always belong to the group and the rendering provider number must always

be a valid individual provider that can provide Ohio Medicaid covered services under that type of provider group practice. Only one individual (entity type 1) NPI number can be associated with a (unique) individual Ohio Medicaid legacy number. An individual provider's NPI should never be submitted to ODJFS with an individual Medicaid legacy number that belongs to another provider or another individual, group or organizational entity.

Instructions for submitting NPI on claims for a provider group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at:

http://jfs.ohio.gov/OHP/providers/npi.stm (see the box titled "Trading Partner").

Billing on Paper Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the new CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the old CMS 1500).

Providers submitting the old CMS 1500 must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old CMS 1500 will cause the claim to reject or may cause the claim to pay inappropriately.

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

III. Is the group practice required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires providers and provider group practices to obtain NPI numbers, to use their NPI on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that provider in a standard transaction, including transactions sent to and received from any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

IV. Is the group practice required to share with ODJFS the NPI numbers assigned to the group and the individual providers that practice in the group?

Yes, the group practice must disclose the NPI number assigned to the group to ODJFS. The group practice must also disclose the NPI numbers assigned to each individual provider that practices in the group to ODJFS, unless the individual provider has independently disclosed his or her individual NPI number to ODJFS.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site:

http://jfs.ohio.gov/OHP/providers/npi.stm.

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

Yes, providers and provider group practices must disclose their NPI, when requested, to any entity that needs the NPI to identify that provider/provider group practice in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans, and any other provider that needs to identify the provider on transactions. You are required to share the appropriate NPI with them.

VI. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

VII. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

VIII. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at http://jfs.ohio.gov/OHP/providers/npi.stm

NPI……GET IT.....SHARE IT.....USE IT

MAL 526

Medical Assistance Letter (MAL) 526

June 7, 2007

To: Individual Chiropractors, Mechanotherapists, Optometrists, Physical Therapists, Podiatrists and Psychologists

Trading Partners and Tape Intermediaries

Directors, County Departments of Job and Family Services

Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI……GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform individual providers and incorporated individual provider practices that are enrolled as providers in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI is a unique, ten-digit, entity type 1 identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008 providers that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their individual NPI number and their current individual Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

Providers MUST enumerate through NPPES, disclose their NPI to ODJFS and bill ODJFS using both the NPI and Medicaid legacy identifiers. This MAL provides direction to providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Provider claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.*

Provider claims submitted to ODJFS on or after January 1, 2008 will be denied if the provider's NPI number is not in the required field(s) on the claim. Provider claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* *See special instructions for paper and tape claims (below in this MAL).*

I. How do I get an NPI?

Individual providers can receive an NPI number by personally submitting an NPI application to NPPES. Or, you may arrange for your employing health care entity or place of practice to obtain an individual provider number for you. To obtain an NPI, providers should contact NPPES directly at **http://nppes.cms.hhs.gov or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY))**. Providers can apply for an NPI electronically or by paper.

When you apply for your individual NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,

- taxonomy number,
- social security number, and/or
- IRS individual tax identification number (TIN).

It is also important that you make it clear that you are applying for an NPI for an individual provider (i.e., an entity type 1 NPI) by checking the box on the NPI application for "an individual who provides health care." A listing of taxonomy codes for providers can be found at **http://www.wpc-edi.com/codes/taxonomy**.

II. How must my NPI relate to my Medicaid legacy number?

If your practice received this MAL, you/your practice submitted claim(s) as an individual provider or as an incorporated individual provider practice to ODJFS at least once during the last twelve months. When providers are doing business with ODJFS as an individual provider or as an incorporated individual provider practice, ODJFS currently only issues an individual provider Medicaid legacy number and expects the billing provider, pay to provider, and rendering provider to be the same.

Services rendered by other practitioners employed by you or under contract with you or your incorporated individual provider practice should be billed under your NPI and/or your Medicaid legacy number (when both numbers are required). This directive applies as soon as you receive your NPI number and remains in effect after January 1, 2008.

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

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for providers who do business with ODJFS as an individual provider or as an incorporated individual provider practice that has not obtained a group (entity 2 type) NPI. If you do business with ODJFS only as a member of a group practice or other provider-based practice, use the appropriate billing instructions as contained in MAL 527.

Instructions for submitting the NPI by either an individual provider or a provider group are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at:

http://jfs.ohio.gov/OHP/providers/npi.stm (see the box titled "Trading Partner").

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The provider's NPI must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the provider's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The EDI standard does not require the rendering provider loop to be completed if the rendering provider is the same as the pay to provider. For individual practices participating in Medicaid, the rendering and pay to provider will always be the same. Do not send NPI information in the NM108 and NM109 nor Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (2310B or 2420B respectively).

Billing on Paper Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the ***new*** CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the ***old*** CMS 1500).

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

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

IV. If my sole proprietary provider practice (practices owned by one provider) is incorporated, do I use my individual NPI number?

Although this is not currently allowed under the Ohio Medicaid program, many other health plans allow sole proprietary practices to be a group practice (of one member). The NPI provisions allow any sole proprietary practice that is incorporated to obtain an entity type 2 (group/organization) NPI and, if the sole proprietary practice is not incorporated, the practice is not eligible for a group/organization (entity type 2) NPI. When the sole proprietary practice is entitled to obtain an entity type 2 NPI, the NPI provisions require the individual provider that owns the practice and each provider employed by or under contract with the practice to also obtain an individual (entity 1) provider NPI number.

You may obtain your group (entity type 2) NPI number from NPPES as instructed in Section I of this MAL. It is important that you make it clear that you are seeking the group NPI by checking the box for "an organization that renders health care." Please submit as the primary taxonomy for the group practice either the taxonomy number **193400000X** (if you are a single specialty practice) or the taxonomy number **193200000X** (if you are a multi-specialty practice). Other provider taxonomy numbers may be given as secondary taxonomy numbers to further describe the practice and the type of specialty services provided by the practice.

If your practice is an incorporated sole proprietary practice that has received, or plans to receive, an entity type 2 (group/organization) NPI, you may not submit that (entity type 2) NPI number on a claim to ODJFS until you have been issued a corresponding group Medicaid legacy number by ODJFS. Once you have received your (entity type 2) NPI for your practice, you may request a group Medicaid legacy number from ODJFS by contacting the Provider Enrollment Unit at P.O. Box 1461 Columbus, Ohio 43216-1461 or by phone at 1-800-686-1516.

Until you receive your group Medicaid legacy number from ODJFS, you must continue to bill as instructed in Section III of this MAL using only your individual NPI and Medicaid legacy number. Once you receive your group Medicaid legacy number you must bill in accordance with the instructions contained in MAL 527.

V. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires providers to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that provider in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

VI. Am I required to share my NPI number with ODJFS?

Yes, the provider must disclose to ODJFS the NPI number that has been assigned to the provider. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site:

http://jfs.ohio.gov/OHP/providers/npi.stm.

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

Yes, as stated in Section V, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the provider in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

VIII. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

IX. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

X. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at http://jfs.ohio.gov/OHP/providers/npi.stm

NPI……GET IT.....SHARE IT.....USE IT

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

Click here to view MAL 516, Employee Education About False Claims Recovery.

MAL 454

Medical Assistance Letter (MAL) No. 454

October 3, 2003

TO: All Providers of Chiropractic Services
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Elimination of Adult Chiropractic Services

BILLING CHANGE EFFECTIVE JANUARY 1, 2004

The purpose of this Medical Assistance Letter (MAL) is to clarify proposed changes for all providers of chiropractic services.

Ohio's biennial budget did not include funding to retain chiropractic services as part of Ohio's Medicaid benefit package for adults age 21 and over. As a result, Medicaid will no longer pay for these services after January 1, 2004. Exceptions to this include children under age 21 and consumers enrolled in Medicaid Managed Care Plan if there plan continues covering these services. Claims for people who are dual eligible for Medicare and Medicaid will continue to be paid as crossover services.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

MAL 432

Medical Assistance Letter (MAL) No. 432

June 5, 2002

TO: All Chiropractic Physicians
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Proposed Chiropractic Policies

SCHEDULED TO BE EFFECTIVE JULY 1, 2002

The purpose of this Medical Assistance Letter (MAL) is to announce the implementation of a new rule pertaining to chiropractic services. Please note that this rule has been proposed and is pending approval by the Joint Committee on Agency Rule Review (JCARR) in June. The proposed rule is scheduled to be effective for services provided on and after July 1, 2002. Should there be a change in the effective date, we will notify all affected providers via a message on a Remittance Advice.

The proposed new rule will be available on the Department's policy web site at http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid in June.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

Rules Related to Chiropractic Services

5160-8-01 Eligible Providers of Limited Practitioner Services

Formerly **5101:3-8-01 Eligible Providers of Limited Practitioner Services**

Click here to view the Ohio Administrative Code rule 5160:8-01, Eligible providers of limited practitioner services

5160-8-11 Covered Chiropractic Physician Services and Limitations

Formerly **5101:3-8-11 Covered Chiropractic Physician Services and Limitations**

MHTL 3339-07-01

Effective Date: January 1, 2008

Most Current Prior Effective Date: **January 1, 2004**

For dates of service ~~beginning on and after~~from January 1, 2004 through December 31, 2007, chiropractic services provided by chiropractic physicians will no longer be covered medicaid services for adults twenty-one years of age and older.

(A) Definitions:

(1) "Subluxation" means an incomplete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae anatomically, and must be demonstrated by x-ray film or other diagnostic test; and

(2) "Maintenance therapy" means therapy that is performed to treat a chronic, stable condition or to prevent deterioration.

(B) Treatment by means of manual manipulation of the spine to correct a subluxation which exceeds normalcy is a covered service. The existence of the subluxation must be demonstrated either by a diagnostic x-ray or by physical examination, as described in paragraph (C) of this rule. Evidence must be retained as a part of the ~~patient's~~consumer's medical record that a subluxation exists. The manual manipulation must have a direct therapeutic relationship to the ~~patient's~~consumer's condition as documented in the medical record. The lack of documentation specifying the relationship between the ~~patient's~~consumer's condition and treatment shall result in the service being nonreimburseable.

(C) At least two of the following criteria must exist and be documented to demonstrate a subluxation by physical examination. One of the two criteria must be asymmetry/misalignment or range of motion abnormality.

(1) Pain/tenderness evaluated in terms of location, quality and intensity;

(2) Asymmetry/misalignment identified on a sectional or segmental level;

(3) Range of motion abnormality; or

(4) Tissue, tone changes in the characteristics of contiguous or associated soft tissues, including skin, fascia, muscle and ligament.

(D) Covered chiropractic services shall be limited to the chiropractic procedures listed in paragraph (D)(1) of this rule and diagnostic x-rays meeting the provisions described in paragraph (D)(2) of this rule. The service must relate to the diagnosis and treatment of a significant health problem in the form of a neuromusculoskeletal condition necessitating manipulative treatment.

(1) The chiropractic procedures listed below are covered under the medicaid program if the service is deemed medically necessary. The limit is one unit of service for each ~~patient~~ consumer for each date of service.

(a) Chiropractic manipulative treatment (CMT); spinal, one to two regions.

(b) Chiropractic manipulative treatment (CMT); spinal, three to four regions.

(c) Chiropractic manipulative treatment (CMT); spinal, five regions.

(2) Diagnostic x-rays to determine the existence of a subluxation are covered with certain limitations. Two units of service, as defined below, will be covered during any six-month period unless otherwise stated. For purposes of this rule, the six-month period begins on the date the diagnostic x-ray is taken and ends one hundred eighty days from the date. The covered units of service are as follows:

(a) Spine, entire; survey study, anterior-posterior, and lateral. Only two units per one year (three hundred and sixty five days) period are covered.

(b) Spine, cervical; antero-posterior, and lateral.

(c) Spine, cervical; antero-posterior, and lateral; minimum of four views.

(d) Spine, cervical; antero-posterior, and lateral; complete, including oblique and flexion and/or extension studies.

(e) Spine, thoracic; anterior-posterior, and lateral views.

(f) Spine, thoracic; complete, including obliques; minimum of four views.

(g) Spine, thoracolumbar; antero-posterior lateral views.

(h) Spine, lumbosacral; antero-posterior, and lateral views.

(i) Spine, lumbosacral; complete, with oblique views; and

(j) Spine, lumbosacral; complete, including bending views.

(E) Limitations of coverage:

(1) Spinal axis aches, strains, sprains, nerve pains, and functional mechanical disabilities of the spine are considered to provide therapeutic grounds for chiropractic manipulative treatment. Most other diseases and disorders do not provide therapeutic grounds for chiropractic manipulative treatment. Examples of non-covered diagnoses are multiple sclerosis, rheumatoid arthritis, muscular dystrophy, sinus problems and pneumonia.

(2) Repeat x-rays or other diagnostic tests in ~~patients~~consumers with chronic, permanent conditions will not be considered medically necessary and are not a covered service.

(3) If there is no reasonable expectation that the continuation of treatment would improve or arrest deterioration of the condition within a reasonable and generally predictable period of time, coverage will be denied.

(4) Continued repetitive treatments without an achievable and clearly defined goal will be considered maintenance therapy and will not be considered covered services.

(5) Once the maximum therapeutic benefit has been achieved for any given condition, ongoing therapy is considered maintenance therapy which is not considered medically necessary.

(6) When services are performed more frequently than generally accepted by peers, chiropractic manipulation will be considered excessive and will be denied as not medically necessary.

(F) There must be documentation to support each service billed. Documentation should exist in the ~~patient's~~consumer's medical record and must verify that the services billed were rendered and that the services were medically necessary.

(1) The following information should be documented in the ~~patient's~~consumer's medical record on the initial visit for a new condition:

(a) ~~Patient's~~Consumer's history;

(b) ~~Patient's~~Consumer's chief complaint;

(c) Subjective findings from physical examination including evaluations of the musculoskeletal and nervous systems;

(d) Objective findings including x-ray results, if given;

(e) Diagnosis;

(f) Treatment plan which includes the following:

(i) Goals;

(ii) Plans for continued treatment including duration and frequency of visits; and

(iii) Objective measures that will be used to evaluate the effectiveness of treatment.

(2) The following information should be documented on periodic reassessments:

(a) ~~Patient's~~ Consumer's status on each visit date including how the ~~patient's~~ consumer's condition has changed since the last treatment;

(b) Review of how the chief complaint has changed since the last visit; and

(c) Results of physical exam.

(3) On each visit, the treatment given on each visit date must be documented including the specific region(s) manipulated.

(G) The following services are not covered:

(1) Visits in excess of thirty dates of service per ~~recipient~~ consumer per twelve-month period in an outpatient setting if the consumer is under the age of twenty- one;

(2) Effective for dates of service on or after January 1, 2008, visits in excess of fifteen dates of service per consumer per twelve-month period in an outpatient setting if the consumer is twenty-one years of age or older.

~~(2)~~(3) Services rendered to ~~patients~~consumers in an inpatient or outpatient hospital setting are not covered in this rule but are covered in Chapter 5101:3-2 of the Administrative Code;

(4) Services unrelated to the treatment of the specific medical complaint, services unnecessary for the treatment of an ailment, and treatment of a preventative medicine nature;

(5) Services determined by another third-party payer (especially medicare Title XVIII) as not medically necessary. Services denied by medicare will be considered medically unnecessary by the department and will not be considered covered services by medicaid;

(6) X-rays, except for those delineated in paragraph (B)(2) of this rule;

(7) Services which are not personally performed by the chiropractic physician with whom the department has a provider agreement:

(a) Services provided by licensed individuals with whom the department does not have an individual provider agreement are not reimbursable even though the covered services are provided under the personal supervision of a licensed chiropractic physician with whom the department does have a provider agreement.

(b) Services provided by unlicensed individuals under the personal supervision of a licensed chiropractic physician are not reimbursable.

(c) Services provided by students during an internship are not covered services.

(8) Any service other than manual manipulation for treatment of subluxation of the spine and x-rays as described in paragraph (D) of this rule are not covered services. The following are examples of services (not an all-inclusive list) that, when performed or ordered by the chiropractor, are excluded from coverage:

(a) Maintenance therapy;

(b) Laboratory test;

(c) Evaluation and management services;

(d) Physical therapy;

(e) Traction;

(f) Supplies;

(g) Injections;

(h) Drugs;

(i) Diagnostic studies;

(j) Orthopedic devices;

(k) Equipment used for manipulation; and

(l) Any manipulation which the x-ray or other tests does not support the primary diagnosis.

~~(9) Services for adults twenty-one years of age and older when provided by a chiropractic physician.~~

Effective: 01/01/2008

R.C. 119.032 review dates: 10/16/2007 and 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.0112, 5111.02, 5111.021, Section 309.30.60 of Am. Sub. House Bill 119, 127th General Assembly

Prior Effective Dates: 1/10/86, 12/31/86 (Emer), 03/22/97, 07/01/02, 1/1/04

Billing Instructions

Click **here** to view the Billing instructions eManual.