



Office of Benefits

Hospital Billing

Guidelines

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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). Hospital rules can be found in Chapter 5160-2 of the OAC, and can be accessed by visiting the following websites:

<http://emanuals.odjfs.state.oh.us/emanuals>

Select "Medicaid – Provider;" then "Hospital Handbook;" then "Hospital Services Ohio Administrative Code."

Or, Law Writer 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 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	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 (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	IP
13	Admission Hour (Required on all IP claims except for Type of Bill 021X.)	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 (Required on all bill types except 014X. See Appendix C for additional notes regarding Point of Origin for Admission code use for Ohio Medicaid.)	IP, OP
16	Discharge Hour (Required on all final IP claims except for 021X; this includes claims with a Frequency Code of 1, 4 and 7.)	IP
17	Patient Discharge Status (See Appendix D for additional notes regarding Patient Discharge Status code use for Ohio Medicaid.)	IP, OP

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	
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; 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 rejected. If value code 31 is used, the room differential must appear in Form Locator 48 (Non-Covered Charges).)	IP, OP
43	Revenue Description (If the revenue center code in Form Locator 42 indicates room and board charges, enter the daily rate in Form Locator 44 and the number of days in Form Locator 46.)	
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 B of OAC rule 5160-2-21.)	
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
47	Total 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.)	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.)	

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	
70 a-c	Patient’s Reason for Visit	
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	
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 PRE-CERTIFICATION AND PRIOR AUTHORIZATION REQUIREMENTS

These are two different types of authorization hospitals may be required to obtain. The pre-certification requirement is for all psychiatric admissions, and for covered surgical procedures that are normally performed in an outpatient setting but the provider is requesting approval to perform in an inpatient setting. 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.

ODM contracts with a utilization review vendor, Permedion, 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.

When an admission requires both pre-certification and prior authorization, only a prior authorization must be obtained.

2.1.1 PRE-CERTIFICATION

Specifications related to pre-certification are defined in OAC rule 5160-2-40. There are two types of services that require pre-certification for inpatient admissions, surgical procedures and psychiatric admissions.

Surgical Procedures

Surgical procedures that require pre-certification are established and published by ODM. The list of procedures requiring pre-certification can be found on Permedion's website at: <http://hmspermedion.com/oh-medicaid/>

Surgical procedures requiring pre-certification must be obtained prior to the inpatient admission unless it meets one of the exemptions listed in Paragraph (C) of OAC rule 5160-2-40. If the admission does NOT meet one of these requirements, the pre-certification cannot be retrospectively issued; therefore the claim cannot be billed to the Department and no payments will be made. For claims that include a procedure on the pre-certification list, but is exempt due to provisions in Paragraph (C) of OAC rule 5160-2-40, include the condition code "AN" on the

claim to indicate the exemption to precertification. The condition code "AN" cannot be used with psychiatric admissions or procedures requiring prior authorization.

Psychiatric Admissions

For psychiatric admissions, if the admitting International Classification of Diseases, 9th Revision (ICD-9) diagnosis code falls between the ranges of 290.00 - 316.00, the admission requires pre-certification.

Pre-certification is required for all psychiatric admissions; the pre-certification must be obtained prior to the admission or within two business days of the admission. 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.

2.1.2 PRIOR AUTHORIZATION

There is not a published list of services that require prior authorization for inpatient procedures, but OAC rule 5160-2-03 describes the types of 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. In addition, Appendix C of OAC rule 5160-2-21 identifies outpatient surgical procedures that require prior authorization with a PA indicator next to the CPT code. More information regarding Medicaid's prior authorization policy can be found in OAC rule 5160-1-31.

Effective August 2, 2011, all requests for prior authorization, except for transplant services, must be submitted through the ODM MITS Web Portal. See section on Transplants for prior authorization information.

The prior authorization number assigned should be entered into Form Locator 63 - Treatment Authorization Number.

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.

Transplant prior authorizations must be obtained through the appropriate consortium:

Ohio Solid Organ Transplantation Consortium

1-614-504-5705

Ohio Hematopoietic Stem Cell Transplant Consortium

1-440-585-0759

Once the applicable transplant consortium has approved the PA request, the information is entered 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.

2.1.3 UTILIZATION REVIEW

Per OAC rule 5160-2-40, upon retrospective review, the medical review agency may determine that the location of service was not medically necessary, but the services rendered were medically necessary. In this instance, 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 5160-2-21. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed on the outpatient claim.

When resubmitting the claim, if the dates of service would be past the timely filing requirements, the following must be attached to the outpatient bill:

- 1) A copy of the remittance advice recouping payment for the medically unnecessary admission;
- 2) A copy of the original Permedion letter stating their findings;
- 3) Condition Code C3 recorded on the outpatient claim in one of the Form Locators 18-28; and
- 4) A copy of the reconsideration and/or the administrative decision affirming the original decision (only if the original decision was appealed)

The outpatient bill with attachments must be submitted within 60 days of the date of the remittance advice recouping payment for the admission through the ODM MITS Web Portal.

2.2 TRANSFER BILLING

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

2.2.1 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 DRGs 425 – 437 or APR-DRGs 750 – 760 (psychiatric DRGs); or
 - The DRGs for both episodes of care fall outside the range of DRGs 425 – 437 or APR-DRGs 750 – 760 (non-psychiatric DRGs)

In these situations, the hospital must combine the two episodes of care into one admit to 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 (DRG 1 – 424 and 439 – 498, or APR-DRG 1 – 740 and 770 – 952) as well as for psychiatric services provided in the psychiatric distinct part unit (DRG 425 –437 or 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
- Use Patient Discharge Status 65

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.

2.2.2 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 non-covered charges.

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 the both stays in the unit for the Statement Covers Period
- Covered days: 5
- Non-covered days: 2
- In the claim detail, report covered and non-covered days and charges on separate lines.
- 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

2.2.3 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.

2.3 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. All claims for advance interim payment can be submitted via EDI or through the ODM MITS Web Portal.

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 bill can be submitted. The interim bills can be voided/reversed through an EDI transaction or through the ODM MITS Web Portal. The final bill must be a complete admit through discharge bill (111 bill type) 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).

2.4 BILLING FOR SERVICES REQUIRING SPECIAL DOCUMENTATION

2.4.1 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.

In cases of medical procedures, which include abortions, in which the life of the mother would be endangered if the fetus was carried to term, the Department must receive written certification from the physician attesting that the life of the mother would be endangered if the fetus was carried to term before any payment may be made. If space permits, the certification should be placed in the "Remarks" column of the claim. The certification can either be in typewritten or stamped form along with the physician's signature. All certifications must contain the address of the recipient.

The certification must be as follows:

"I certify that, on the basis of my professional judgment, this service was necessary because the life of the mother would be endangered if the fetus were carried to term."

Invoices for abortion services subject to the above requirements must be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately. 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.

2.4.2 STERILIZATION

Please refer to OAC rule 5160-21-01 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. 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.

2.4.3 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. 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 an 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.

2.5 TRANSPLANTS

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. The following table summarizes the payment methodology for transplant services performed on or before June 30, 2013:

Transplant Service	Prior Authorization (PA) Required	Payment Method on or before 6/30/13
Heart	Ohio Solid Organ Transplant Consortium and	DRG
	ODM PA Unit	
Liver	Ohio Solid Organ Transplant Consortium and	DRG
	ODM PA Unit	
Bone Marrow (Stem Cell)	Ohio Bone Marrow Transplantation Consortium and	DRG
	ODM PA Unit	
Single/Double Lung	Ohio Solid Organ Transplant Consortium and	DRG
	ODM PA Unit	
Kidney	No PA required	DRG
Heart/Lung	Ohio Solid Organ Transplant Consortium and	Cost-to-Charge Ratio
	ODM PA Unit	
Liver/Small Bowel	Ohio Solid Organ Transplant Consortium and	Cost-to-Charge Ratio
	ODM PA Unit	
Pancreas	Ohio Solid Organ Transplant Consortium and	Cost-to-Charge Ratio
	ODM PA Unit	

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.

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

Transplant claims can be submitted via EDI or through the ODM MITS Web Portal. The assigned prior authorization number must be included on the claim.

2.6 PARTIAL ELIGIBILITY

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.

Per diem payments are calculated by multiplying the hospital-specific average cost per discharge 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 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 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 as listed below.

Co-payments must not be charged if the consumer is:

- Under the age of 21, or
- In a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF IID), or
- A female who is pregnant, or
- A person seeking family planning services, or
- Receiving hospice care.

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.

2.8 OUTLIER PAYMENTS

2.8.1 SERVICES PROVIDED ON OR AFTER JULY 1, 2013

For services provided 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
 - Trach DRGs (004 & 005), Neonate DRGs (580 - 639) \$42,900.00
 - Hospitals in either the Major Teaching or Children's peer groups \$54,400.00
 - All other DRGs/peer groups \$68,000.00
 - A claim qualifies for only one threshold as determined in the order shown.
- 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)] * 95%
 - Cost of Case = [(Covered Charges – RCC 810) * Hospital-Specific CCR]
 - Effective January 1, 2014, the outlier multiplier was updated to 90% from 95%.
- 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(N)(3) for ODM requirements regarding transfer pricing.
 - Please refer to OAC rule 5160-2-65(N)(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 1, 2, & 6 with SOIs
 - Transplants with 100% Cost application for RCC 810: APR-DRG 3 with SOIs

2.8.2 SERVICES PROVIDED ON OR BEFORE JUNE 30, 2013

For services provided on or before June 30, 2013 the following outlier methodology applies, as described in OAC rule 5160-2-07.9. Additional payments will be made for cases that qualify as cost outliers. Outlier payments are automatically calculated by the Department; therefore, no special billing is required by the provider. Claims for discharges that may qualify for outlier payment may be billed only after discharge, unless the claim also qualifies for interim payment. A claim qualifies as a cost outlier if the total allowable claim charges exceed the charge high trim for the DRG.

- 1) Exceptional Cost Outlier Methodology - Before a claim is considered a cost outlier, it should

be considered for exceptional cost outlier status.

The table below lists the exceptional cost outlier threshold for each calendar year.

Calendar Year	Exceptional Cost Outlier Threshold
2013 (to 6/30/13)	\$642,176
2012	\$630,202
2011	\$608,303
2010	\$590,013
2009	\$579,580
2008	\$551,456
2007	\$531,268
2006	\$514,794
2005	\$493,098
2004	\$477,346

Claim cost is calculated by multiplying total allowable claim charges by the hospital-specific, inpatient cost-to-charge ratio. All DRGs at all Ohio prospective payment hospitals are eligible for payment under the exceptional cost outlier methodology.

Example:

Total Allowable Claim Charges:	\$650,000.00
Hospital-Specific Inpatient Cost-to-Charge Ratio:	X <u> .88</u>
Claim Cost:	=\$572,000.00

If claim cost exceeds the threshold, the claim is paid at cost. If it does not exceed the threshold, the claim should be analyzed according to the other cost outlier methodologies.

- 2) Cost Outlier Methodology – This cost outlier methodology does not apply: (1) to hospitals identified by ODM as having high outlier experience coupled with high Medicaid volume, and (2) to DRGs 488 – 490 for hospitals identified as having an exceptionally high volume of HIV inpatient discharges. For these exceptions, see section C below.
 - a. Compare total allowable claim charges to the DRG charge high trim (charge high trims can be found on the relative weight table on the ODM website). If the total allowable claim charges exceed the charge high trim, calculate the difference.
 - b. Multiply the outlier charges, calculated in step one above, by the hospital-specific cost-to-charge ratio to determine the cost outlier payment.
 - c. To calculate the claim's TOTAL DRG PAYMENT: Add the Cost Outlier Payment to the hospital's standard DRG payment (DRG Base Price + Medical Education Add-On + Capital Add-On).

- 3) Cost Outlier Methodology – Use this methodology for: (1) hospitals identified by ODM as having high outlier experience coupled with high Medicaid volume, and (2) DRGs 488 –

490 for hospitals identified as having an exceptionally high volume of HIV inpatient discharges.

- a. Compare total allowable claim charges to the DRG charge high trim, same as above. If the total allowable claim charges exceed the charge high trim, calculate total claim cost by multiplying total allowable claim charges by the hospital-specific inpatient cost-to-charge ratio.
- b. Multiply total claim cost, calculated in step one above, by 85 percent to determine total reimbursement amount. This amount constitutes the total outlier and DRG final payment.

4) Day Outlier Methodology

Note: If a claim qualifies for cost outlier and day outlier, then payment is based on the cost outlier.

- a. Compare the number of covered days of the stay to the DRG day high trim (day high trims can be found on the relative weight table on the ODM website). If the total covered days exceed the day high trim, compute the difference.

Example:

Number of Covered Days	99
Day High Trim	<u>- 72</u>
Outlier Days	= 27

- b. Outlier days are reimbursed on a per diem basis. The per diem amount is calculated by dividing the DRG base price by the DRG geometric mean length of stay.

Example:

Hospital Base Rate	\$2,000.00
Relative Weight	X <u>4.47598</u>
DRG Base Price	\$8,951.96
Geometric Mean Length of Stay	<u>÷ 10.4705</u>
Per Diem Amount	\$854.97

- c. Multiply the number of outlier days by the per diem amount, calculated in step two above, to compute the day outlier cost.

Example:

Outlier Days	27
Per Diem Amount	X <u>\$854.97</u>
Day Outlier Cost	\$23,084.19

- d. Multiply the day outlier cost, calculated in step three above, by 60 percent* to determine the day outlier payment.

Example:

Day Outlier Cost	\$23,084.19
	X <u> .60</u>
Day Outlier Payment	\$13,850.51

* Multiply by 80 percent for DRGs 388 – 390 and 892 – 898.

* Multiply by 80 percent for hospitals identified by ODM as having high outlier experience coupled with high Medicaid volume.

* Multiply by 80 percent for DRGs 488 – 490 for hospitals identified as having an exceptionally high volume of HIV inpatient discharges.

- 5) Total DRG Payment Calculation: Add the Day Outlier Payment to the hospital's standard DRG payment (DRG Base Price + Medical Education Add-On + Capital Add-On)

2.9 MEDICARE CROSSOVER

2.9.1 MEDICARE PART A EXHAUSTED DURING STAY

Please refer to OAC rule 5160-2-25 for ODM requirements regarding reimbursement for an inpatient stay, in which a patient's Medicare Part A exhausts during the stay and Medicaid becomes primary with Medicare Part B.

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

- 1) Medicare Part A, Bill Type 111 (cost sharing claim)
 - a. Medicare Part A is billed first, and then the claim is submitted to Medicaid for payment.
- 2) Medicare Part B, Bill Type 121 (cost sharing claim)
 - a. After Medicare Part A is exhausted, Part B must be billed for all covered services.
 - b. The claim is then submitted to Medicaid for payment.
- 3) Medicare Part A has been exhausted and Medicaid is now primary, Bill Type 111
 - a. "Admit through discharge" is for the entire stay
 - b. Covered days are the days in which Medicaid was primary
 - c. Non-covered days are the days in which Medicare part A was primary
 - i) At the detail level, each non-covered day must have a separate detail line with matching units to indicate total charges and non-covered charges.
 - d. Covered days are billed as usual, according to the billing instructions, at the detail level.
 - e. Any charges submitted to Medicare Part A or Part B must be reported at the detail level as non-covered charges, OR they must be removed from the claim completely.
 - i) However, charges reflecting non-covered days must be reported as mentioned in (3)(c)(i) and cannot be removed from the claim.
 - f. Do not include any other payer information or payments.

2.9.2 MEDICARE EXHAUSTED BEFORE STAY OR NEVER HAD PART A

Please refer to OAC rule 5160-2-25 for ODM requirements regarding reimbursement for an inpatient stay in which a patient's Medicare Part A exhausted before the stay or never had Part A, and Medicaid is primary with Medicare Part B.

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

- 1) Medicare Part B cost sharing, Bill Type 121 (normal crossover claim)
- 2) For all other charges in which Medicaid is primary, 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 non-covered charges, OR remove the charges submitted to Medicare Part B from the 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.

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.

2.9.3 MEDICARE EFFECTIVE DURING STAY

Please refer to OAC rule 5160-2-25 for ODM requirements regarding reimbursement for an inpatient stay in which a patient's Medicare coverage becomes effective during the stay.

Example:

DOS 09/17/xxxx to 10/06/xxxx. Medicare becomes effective 10/01/xxxx. Medicare has paid on the 10/01/xxxx to 10/06/xxxx. How do you bill Medicaid?

- 1) List the admit through discharge for the entire stay.
- 2) Covered days are the days in which Medicaid was primary.
- 3) Non-covered days are the days in which Medicare Part A was primary.
- 4) In the claim detail, report covered and non-covered days and charges on separate lines.
- 5) Covered days are billed as usual, according to the billing instructions, at the detail level.
- 6) Any charges submitted to Medicare Part A or Part B must be reported at the detail level as non-covered charges, OR they must be removed from the claim completely.
 - a. However, charges reflecting non-covered days must be reported as mentioned in (4) and cannot be removed from the claim.
- 7) Medicaid will receive a separate crossover claim for the Medicare Part A stay.

2.9.4 QMB EXHAUSTS MEDICARE PART A

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

2.9.5 THIRD PARTY LIABILITY/COORDINATION OF BENEFITS

Please refer to OAC rule 5160-2-25 for further clarification regarding Medicaid reimbursement policies for hospital services subject to reimbursement from other payers, including Medicare.

Effective January 1, 2012, Medicaid reimbursement for hospital services covered by Medicare Part B will be equal to the lesser of:

- 1) The sum of the deductible, coinsurance, and co-payment amount as provided by Medicare part B; OR
- 2) The Medicaid maximum allowed amount, minus the total prior payment, not to equal less than zero.

2.10 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.

2.11 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 before he/she is discharged from the inpatient stay, the inpatient hospital should submit an invoice 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 them void their paid claim for the outpatient service. The inpatient hospital should then resubmit the claim to ODM so that it includes inpatient and outpatient services.

2.12 NURSING FACILITY

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

2.12.1 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.*

*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.

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) 01/01/2012 – 01/04/2012 Revenue Center Code (RCC) 101
Line 2) 01/05/2012 – 01/17/2012 RCC 185 (hospital leave days)
Line 3) 01/18/2012 – 01/31/2012 RCC 101

1B) Resident in NF for eight hours or more on date of transfer to hospital
Line 1) 01/01/2012 – 01/05/2012 RCC 101
Line 2) 01/06/2012 – 01/17/2012 RCC 185 (hospital leave days)
Line 3) 01/18/2012 – 01/31/2012 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) 03/01/2012 – 03/12/2012 RCC 101
Line 2) 03/13/2012 – 03/13/2012 RCC 185 (hospital leave day)
Line 3) 03/14/2012 – 03/31/2012 RCC 101

2B) Resident in NF eight hours or more on date of transfer to hospital
Line 1) 03/01/2012 – 03/13/2012 RCC 101
Line 2) 03/14/2012 – 03/31/2012 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) 01/01/2012 – 01/04/2012 RCC 160
Line 2) 01/05/2012 – 01/17/2012 RCC 185*
Line 3) 01/18/2012 – 01/31/2012 RCC 160

3B) Waiver Consumer in NF eight hours or more on date of transfer to hospital
Line 1) 01/01/2012 – 01/05/2012 RCC 160
Line 2) 01/06/2012 – 01/17/2012 RCC 185*
Line 3) 01/18/2012 – 01/31/2012 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) 03/01/2012 – 03/12/2012 RCC 160
Line 2) 03/13/2012 – 03/13/2012 RCC 185*
Line 3) 03/14/2012 – 03/31/2012 RCC 160

4B) Resident is in NF eight hours or more on date of transfer to hospital
Line 1) 03/01/2012 – 03/13/2012 RCC 160
Line 2) 03/14/2012 – 03/31/2012 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 (3/13/12). 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.

2.12.2 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 1/1/12 and is discharged to a NF on 1/5/12, then re-admitted to the hospital on 1/6/12, the hospital must report one non-covered day for the first date of discharge (1/5/12) at the header, and one non-covered day at the detail level.

If the hospital claim denies as a duplicate against the corresponding NF claim due to the overlapping date of service (1/5/12 in this example), the hospital should contact the Ohio Medicaid Ombudsman Unit for a review of their claim. The Ombudsman will review the claims

submitted by both providers to ensure proper billing, and if so, they will send an email to the Ohio Medicaid Adjustment Unit telling them to override the duplicate edit so the hospital claim can be paid.

2.12.3 NURSING FACILITY 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. Please note that wheelchairs, transportation, and oxygen are no longer bundled into the NF per diem rate. 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	

2.13 CHANGES IN PATIENT’S MEDICAID COVERAGE

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.*

2.14 MODIFIERS

2.14.1 MODIFIER 59

Modifier 59 is an accepted modifier on hospital claims. However, it is informational only, and will not affect reimbursement of the procedure or the claim.

2.14.2 MODIFIER 73

Modifier 73 should be used when a surgery is canceled prior to the administration of anesthesia.

2.14.3 MODIFIER 74

Modifier 74 should be used when a surgery is canceled after the administration of anesthesia.

2.15 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.

2.15.1 INPATIENT HOSPITAL SETTING

When LARC services are provided in an inpatient hospital setting following a delivery, the hospital should use an ICD-9 diagnosis code [or, for deliveries with inpatient discharge dates on or after October 1, 2015, ICD-10] delivery diagnosis code on the inpatient claim as well as the appropriate ICD-9/ICD-10 surgical procedure code to indicate an insertion of a contraceptive device in accordance with OAC rule 5160-2-02(C). 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	Z30013, Z30014, Z30018, Z30019, Z30430, Z30432, Z30433, Z01411, Z01419, Z30431	0UH97HZ, 0UH98HZ, 0UHC7HZ, 0UHC8HZ, 0UPD7HZ, 0UPD8HZ
Birth Control Implant	V25.5, V25.02, V72.31, V25.43	99.23, 99.24, 86.09*	Z3049, Z30013, Z30014, Z30018, Z30019, Z01411, Z01419	OJHD0HZ, OJHD3HZ, OJHF0HZ, OJHF3HZ, OJHGOHZ, OJHG3HZ, OJHH0HZ, OJHH3HZ, OJHLOHZ, OJHL3HZ, OJHMOHZ, OJHM3HZ, OJHNOHZ

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

2.15.2 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-9/ICD-10 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, J7300, J7302
Birth Control Implant	11981-11983, J7301, J7307

Notes:

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

2.15.3 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 located in Appendix C of OAC rule 5160-2-21. 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	Z30013, Z30014, Z30018, Z30019, Z30430, Z30432, Z30433, Z01411, Z01419, Z30431	58300, 58301, J7300, J7302
Birth Control Implant	V25.5, V25.02, V72.31, V25.43	Z3049, Z30013, Z30014, Z30018, Z30019, Z01411, Z01419	11981-11983, J7301, 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. Per OAC rule 5160-2-21(L), reimbursement for the independently billed drug/device are currently paid at sixty percent of the hospital's specific Medicaid outpatient cost-to-charge ratio.

3. CLAIMS PROCESSING

3.1 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>

3.2 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.

3.3 CLAIMS SUBMISSION AND PROVIDER ENROLLMENT

All claims must be submitted to the Department either through EDI or the ODM MITS Web Portal. Paper claims are not accepted for hospital reimbursement, except for hospitals that are in a hold and review status.

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>.

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.

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.

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	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
AN	Preadmission Screening Not Required*	Yes	Yes
C3	Partial Approval**	No	Yes

* Use this condition code to report claims exempt from pre-certification when the services would otherwise require pre-certification.

** This code should only be used when billing on an outpatient basis for an admission that upon retrospective review, the location of service was determined by the medical review entity to not be medically necessary, but the services rendered were medically necessary.

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.	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 (Required for all newborns as well as any neonates that group to DRG 385) 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.

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 (NPPES). 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
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 (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
Note: See rule 5160-2-03 for coverage limitations pertaining to private rooms.					
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
		4 -	Psychiatric	C	C
		5 -	Hospice	N	N
		6 -	Detoxification	C	C
		7 -	Oncology	C	C
		8 -	Rehabilitation	C	C
		9 -	Other	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
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
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

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.

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
		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
Incremental Nursing Charge Rate	023	0 - General Classification	C	N
		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

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
		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
		1 - Infusion Pump	C	C
		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
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
		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
		9 - Other Oncology	C	C
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
		1 - Chemistry	C	C
		2 - Immunology	C	C
		3 - Renal Patient (home)	N	N
		4 - Non-routine Dialysis	C	C
		5 - Hematology	C	C
		6 - Bacteriology & Microbiology	C	C
		7 - Urology	C	C
		9 - Other Laboratory	C	C
Laboratory Pathological	031	0 - General Classification	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
		1 - Cytology	C	C
		2 - Histology	C	C
		4 - Biopsy	C	C
		9 - Other Laboratory Pathological	C	C
Radiology - Diagnostic	032	0 - General Classification	C	C
		1 - Angiocardiology	C	C
		2 - Arthrography	C	C
		3 - Arteriography	C	C
		4 - Chest X-ray	C	C
		9 - Other Radiology - Diagnostic	C	C
Radiology - Therapeutic and/or Chemotherapy Administration	033	0 - General Classification	C	C
		1 - Chemotherapy Administration - Injected	C	C
		2 - Chemotherapy Admin. - Oral	C	C
		3 - Radiation Therapy	C	C
		5 - Chemotherapy Admin. - IV	C	C
		9 - Other Radiology - Therapeutic	C	C
Nuclear Medicine	034	0 - General Classification	C	C
		1 - Diagnostic Procedures	C	C
		2 - Therapeutic Procedures	C	C
		3 - Diagnostic Radiopharmaceutical	C	C
		4 - Therapeutic Radiopharmaceutical	C	C
		9 - Other	C	C
CT Scan	035	0 - General Classification	C	C
		1 - Head Scan	C	C
		2 - Body Scan	C	C
		9 - Other CT Scan	C	C
Operating Room Services	036	0 - General Classification	C	C
		1 - Minor Surgery	C	C
		2 - Organ Transplant-Other Than Kidney	C	N
		7 - Kidney Transplant	C	N
		9 - Other Operating Room Services	C	C
Anesthesia	037	0 - General Classification	C	C
		1 - Anesthesia Incident to Radiology	C	C
		2 - Anesthesia Incident to Other Diagnostic Services	C	C
		4 - Acupuncture	N	N
		9 - Other Anesthesia	C	C
Blood	038	0 - General Classification	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
		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 (Cyropricipitates)	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
		9 -	Other Processing and Storage	C	C
Other Imaging Services	040	0 -	General Classification	C	C
		1 -	Diagnostic Mammography	C	C
		2 -	Ultrasound	C	C
		3 -	Screening Mammography	C	C
		4 -	Positron Emission Tomography	C	C
		9 -	Other Imaging Service	C	C
Respiratory Services	041	0 -	General Classification	C	C
		2 -	Inhalation Services	C	C
		3 -	Hyperbaric Oxygen Therapy	C	C
		9 -	Other Respiratory Services	C	C
Physical Therapy	042	0 -	General Classification	C	C
		1 -	Visit Charge	C	C
		2 -	Hourly Charge	C	C
		3 -	Group Rate	C	C
		4 -	Evaluation or Re-evaluation	C	C
		9 -	Other Physical Therapy	C	C
Occupational Therapy	043	0 -	General Classification	C	C
		1 -	Visit Charge	C	C
		2 -	Hourly Charge	C	C
		3 -	Group Rate	C	C
		4 -	Evaluation or Re-evaluation	C	C
		9 -	Other Occupational Therapy	C	C
Speech-Language Pathology	044	0 -	General Classification	C	C
		1 -	Visit Charge	C	C
		2 -	Hourly Charge	C	C
		3 -	Group Rate	C	C
		4 -	Evaluation or Re-evaluation	C	C
		9 -	Other Speech-Language Pathology	C	C

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
Emergency Room	045	0 -	General Classification	C	C
		1 -	EMTALA Emergency Medical Screening Services	C	C
		2 -	ER Beyond EMTALA Screening Services	C	C
		6 -	Urgent Care	C	C
		9 -	Other Emergency Room	C	C
Pulmonary Function	046	0 -	General Classification	C	C
		9 -	Other Pulmonary Function	C	C
Audiology	047	0 -	General Classification	C	C
		1 -	Diagnostic	C	C
		2 -	Treatment	C	C
		9 -	Other Audiology	C	C
Cardiology	048	0 -	General Classification	C	C
		1 -	Cardiac Cath Lab	C	C
		2 -	Stress Test	C	C
		3 -	Echocardiography	C	C
		9 -	Other Cardiology	C	C
Ambulatory Surgical Care	049	0 -	General Classification	C	C
		9 -	Other Ambulatory Surgical Care	C	C
Outpatient Services	050	0 -	General Classification	N	N
		9 -	Other Outpatient Service	N	N
Clinic	051	0 -	General Classification	C	C
		1 -	Chronic Pain Center	C	C
		2 -	Dental Clinic*	C	C
		3 -	Psychiatric Clinic	C	C
		4 -	OB-GYN Clinic	C	C
		5 -	Pediatric Clinic	C	C
		6 -	Urgent Care Clinic	C	C
		7 -	Family Practice Clinic	C	C
		9 -	Other Clinic	C	C
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

*Note: See rule 5160-2-03 for coverage limitations pertaining to dental services provided in a hospital facility.

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		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
Osteopathic Services	053	0 - General Classification	C	C
		1 - Osteopathic Therapy	C	C
		9 - Other Osteopathic Services	C	C
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

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
Home Health - Units of Service	059	0 -	General Classification	N	N
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
		1 -	MRI - Brain (Including Brainstem)	C	C
		2 -	MRI - Spinal Cord (Incl. Spine)	C	C
		4 -	MRI - Other	C	C
		5 -	MRA - Head and Neck	C	C
		6 -	MRA - Lower Extremities	C	C
		8 -	MRA - Other	C	C
		9 -	Other MRT	C	C
		Medical/Surgical Supplies - Extension of 027X	062	1 -	Supplies Incident to Radiology
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
		6 -	Drugs Requiring Detailed Coding	N	C
		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

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
		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
		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
		2 -	Contracted	N	N
		9 -	Other Special Residence Charge	N	N
Trauma Response (Charge for Trauma Team Activation)	068	1 -	Level I	N	N
		2 -	Level II	N	N
		3 -	Level III	N	N
		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
		3-	Consultation and Education	N	N
		5-	Inpatient Care	N	N
		6-	Physician Services	N	N
		7-8	RESERVED	N	N

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
		9-	Other Pre-Hospice/Palliative Care Services	N	N
Cast Room	070	0 -	General Classification	C	C
Recovery Room	071	0 -	General Classification	C	C
Labor Room/Delivery	072	0 -	General Classification	C	C
		1 -	Labor	C	C
		2 -	Delivery	C	C
		3 -	Circumcision	C	C
		4 -	Birthing Center	C	C
		9 -	Other Labor Room/Delivery	C	C
EKG/ECG (Electrocardiogram)	073	0 -	General Classification	C	C
		1 -	Holter Monitor	C	C
		2 -	Telemetry	C	C
		9 -	Other EKG/ECG	C	C
EEG (Electroencephalogram)	074	0 -	General Classification	C	C
Gastro-Intestinal Services	075	0 -	General Classification	C	C
Treatment/Observation Room	076	0 -	General Classification	C	C
		1 -	Treatment Room	C	C
		2 -	Observation Room	C	C
		9 -	Other Treatment/Obs. Room	C	C
Preventive Care Services	077	0 -	General Classification	C	C
		1 -	Vaccine Administration	C	C
Note: Use of this revenue code is limited to Medicaid eligible persons from birth through age 20 yrs.					
Telemedicine	078	0 -	General Classification	N	N
Extra-Corporeal Shock Wave Therapy	079	0 -	General Classification	C	C
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

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
		9 -	Other Donor	C	N
Note: Acquisition charges eligible for cost-related reimbursement, as described in rule 5160-2-65, should be reported using revenue code 0810.					
Hemodialysis - Outpatient or Home	082	0 -	General Classification	N	C
		1 -	Hemodialysis/Composite Other Rate	N	C
		2 -	Home Supplies	N	N
		3 -	Home Equipment	N	N
		4 -	Maintenance/100%	N	N
		5 -	Support Services	N	N
		9 -	Other Outpatient Hemodialysis	N	C
Peritoneal Dialysis - Outpatient or Home	083	0 -	General Classification	N	C
		1 -	Peritoneal Dialysis/Composite or Other Rate	N	C
		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
Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	084	0 -	General Classification	N	C
		1 -	CAPD/Composite or Other Rate	N	C
		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
Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home	085	0 -	General Classification	N	C
		1 -	CCPD/Composite or Other Rate	N	C
		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
Miscellaneous Dialysis	088	0 -	General Classification	C	C
		1 -	Ultrafiltration	C	C
		2 -	Home Dialysis Aid Visit	N	N
		9 -	Other Miscellaneous Dialysis	C	C
Behavioral Health Treatments/Services (Also see 091X, an extension of 090X)	090	0 -	General Classification	C	C
		1 -	Electroshock Treatment	N	N
		2 -	Milieu Therapy	N	N
		3 -	Play Therapy	N	N

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General Category	1st Three Digits	4th Digit Detail Description	I/P	O/P
		4 - Activity Therapy	N	N
		5 - IOP - Psychiatric	N	N
		6 - IOP - Chemical Dependency	N	N
		7 - Day Treatment	N	N
Behavioral Health	091	1 - Rehabilitation	N	C
Treatments/Services - Extension of 090X		2 - Partial Hospitalization - Less Intensive	N	N
		3 - Partial Hospitalization - Intensive	N	N
		4 - Individual Therapy	C	C
		5 - Group Therapy	C	C
		6 - Family Therapy	C	C
		7 - Bio Feedback	N	N
		8 - Testing	C	C
		9 - Other Behavioral Health Treatment / Services	C	C
Other Diagnostic Services	092	0 - General Classification	C	C
		1 - Peripheral Vascular Lab	C	C
		2 - Electromyogram	C	C
		3 - Pap Smear	C	C
		4 - Allergy Test	C	C
		5 - Pregnancy Test	C	C
		9 - Other Diagnostic Services	C	C
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
		1 - Recreational Therapy	N	N
		2 - Education/Training	C	C
		3 - Cardiac Rehabilitation	C	C
		4 - Drug Rehabilitation	N	C
		5 - Alcohol Rehabilitation	N	C
		6 - Complex Medical Equipment - Routine	N	N
		7 - Complex Medical Equipment - Ancillary	N	N
		9 - Other Therapeutic Service	C	C
Other Therapeutic Services - Ext. of 094X	095	1 - Athletic Training	N	N
		2 - Kinesiotherapy	C	C
		3 - Chemical Dependency (Drug and Alcohol) CHEMDEP	N	N
		4-9 RESERVED	N	N
	096	0 - General Classification	N	N

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
Professional Fees (Also see 097X and 098X)		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
		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 Accommodations	Health 100	0 -	General Classification	N	N
		1 -	Res.Treatment - Psychiatric	N	N
		2 -	Res. Treatment - Chem. Dep.	N	N
		3 -	Supervised Living	N	N
		4 -	Halfway House	N	N
Alternative Therapy Services	210	5 -	Group Home	N	N
		0 -	General Classification	N	N
		1 -	Acupuncture	N	N

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General Category	1st Three Digits	4th Digit Detail Description	I/P	O/P
		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
		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