Ohio | Department of Medicaid

Ohio medicaid QUALITY MONITOR

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Ohio House Bill 59 (H.B. 59)

Summary

Ohio Administrative Code rule 5160-2-21, Policies for outpatient hospital services, is being amended to implement provisions of Am. Sub. H.B 59 of the 130th General Assembly and to add certain HCPCS codes to the laboratory fee schedule. Specifically, the changes set fixed prices for most outpatient services currently reimbursed at cost. Unlisted surgeries, radiology services, and ancillary procedures will now have published fees. Reimbursement for drugs administered with IV therapy, independently billed drugs and medical supplies will be set at 60 percent of cost. Additionally, the hospital laboratory fee schedule will be recalibrated to align payment rates to prescribed Medicare ceilings. Finally, the rule adds codes and reimbursement rates for molecular pathology services. The reimbursement change in this rule was effective January 1, 2014.

Rule

Rule 5160-2-21, "Policies for outpatient hospital services", describes the outpatient payment rates and policies for hospitals that are subject to diagnosis related groups (DRG) prospective payment.

Changes

Language is added to paragraph (B)(3) to clarify the use of the UB modifier.

CPT codes 92004 and 92014 for comprehensive vision exams are covered for eligible Medicaid beneficiaries, and must be billed with HCPCS modifier -UB, as listed in appendix A to this rule, to indicate Medicaid beneficiaries who are age twenty or younger or sixty or older. Comprehensive vision examinations are subject to the limitations defined in rule 5160-6-04 of the Administrative Code.

Surgical Services Claims

The language in paragraph (F) for the pricing methodology for unlisted procedure codes is being changed to pay unlisted surgeries at the surgical group rates, and to subject these codes to the existing surgery bundling methodology, including the methodology for cancelled surgeries.

A surgical procedure is defined as "unlisted" if the CPT code ends in "99" and is defined as an "unlisted procedure" in the description or is surgical CPT code number 23929, 26989, 37501, 38589, 43289, 43659, 44238, 44979, 47379, 47579, 49329, 49659, 50549, 50949, 55559, 58578, 58579, 58679, 59897, 59898, 60659, 69949, or 69979.

For dates of service between January 1, 2012 and December 31, 2013: When a surgical service claim carries an unlisted surgical procedure code, line item charges on the claim, except for those line items that carry radiology CPT codes (36251, 36252, 36253, 36254, 70010 to 79999), pregnancy codes, or laboratory CPT codes (36415, 36416, 80047 to 89399), will be paid by multiplying those charges by the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code. Radiology service line items will be paid in accordance with paragraph (I) of this rule; laboratory and pregnancy service line items will be paid in accordance with paragraph (K) of this rule; observation services will be paid in accordance with appendix F of this rule.

Unlisted surgical procedures, when used to bill a canceled surgery, must be billed with an attachment describing the surgical procedure(s) that were canceled. These unlisted canceled surgeries will be reviewed by the department and the reimbursement amount will be determined on a case-by-case basis.

Clinic Service Claims

The language in paragraph (G) for the pricing methodology for revenue center codes 025X present with an IV therapy code is being changed to pay 60% of the hospital specific outpatient cost-to-charge ratio.

For dates of service between January 1, 2012 and December 31, 2013: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid

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HCPCS J code) by sixty per cent of the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

Emergency Room Service Claims

The language in paragraph (H) for the pricing methodology for revenue center codes 025X present with an IV therapy code is being changed to 60% of the hospital specific outpatient cost-to-charge ratio.

For dates of service between January 1, 2012 and December 31, 2013: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 066 (with a valid HCPCS J code) by sixty per cent of the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

Ancillary Service Claims

The language in paragraph (J) clarifies existing policy regarding the pricing methodology for revenue center codes 025X present with an IV therapy code, is paid at cost for claims between 1/1/2012 and 12/31/2012, and it also changes this methodology for claims on or after 1/1/2014 so that revenue center codes 025X present with an IV therapy code will pay 60% of the hospital specific outpatient cost-to-charge ratio for claims on or after 1/1/2014.

For dates of service between January 1, 2012 and December 31, 2013: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Additional payments will be made for charges listed in line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) when the claim carries IV therapy CPT code 96365, 96366, 96367, or 96368. These additional payments will be calculated by multiplying those charges listed in those line items that carry revenue center code 025X (with no CPT code present) and/or revenue center code 0636 (with a valid HCPCS J code) by sixty per cent of the hospital's Medicaid outpatient per cent. The Medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

Independently Billed Service Claims

The language in paragraph (L) for the pricing methodology for independently billed revenue center codes 025X, 636, and 027X is being changed to pay 60% of the hospital specific outpatient cost-to-charge ratio.

For dates of service January 1, 2012 and December 31, 2013: Claims submitted with line items that carry revenue center codes 025X (with no CPT code present) and/or 0636 (with a valid HCPCS J code) will be paid at the hospital's medicaid outpatient per cent of charges The medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

For dates of service on or after January 1, 2014: Claims submitted with line items that carry revenue center codes 025X (with no CPT code present) and/or 0636 (with a valid HCPCS J code) will be paid at sixty per cent of the hospital's medicaid outpatient per cent of charges. The medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

Appendices

Appendix C is being updated to reflect unlisted procedure codes being reimbursed at the surgical group rates.

	Level 1	Level 2
Group A	$131.00	$147.00
Group B	$233.00	$236.00
Group 1	$408.00	$445.00

Appendix F is updated to set fee schedule prices for ancillary service codes previously paid at cost.

Ex: (1) 36400 = $29.53 (2) 90371 = $119.43 (3) 90880 = $17.12

Appendix H is updated to set fee schedule prices for lab codes previously pat at cost, to recalibrate and align payment rates to prescribed Medicare ceilings, and to add codes and reimbursement rates for molecular pathology services.

EX: (1) 36415 = $2.91 (2) 80150 = $20.21 (3) 86340 = $20.21

Molecular Pathology services:

Level 1 (CPT codes 81200 – 81383)

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Level 2 (CPT codes 81400-81408)

Appendix G is updated to set fee schedule prices for radiology codes previously paid at cost

EX: (1) 36251 - $249.70 (2) 70150 = $55.78 (3) 72080 = $46.34

Access to Rules and Related Material

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

Information about hospital payment policies may be accessed through the "Provider Payment Policies & Relative Weight Tables' link on the Hospital Provider Information web page, http://www.medicaid.ohio.gov/ohp/bhpp/bhfm.stm.

ODM maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is http://emanuals.mdicaid.state.oh.us/emanuals/.

From the "eManuals" page, providers may view documents online by following these steps:

1. Select the 'Ohio Health Plans – Provider' collection
2. Select the appropriate service provider type or handbook
3. Select the desired document type
4. Select the desired item from the 'Table of Contents' pull-down menu.

The Legal/Policy Central – Calendar site, http://www.medicaid.state.oh.us/lpc/mtl/. The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODM e-mail subscription service at http://www.medicaid.state.oh.us/subscribe/.

Questions

Questions pertaining to this letter should be addressed to:

Department of Medicaid
Bureau of Health Plan Policy
Hospital Services
PO Box 182709
Columbus, OH 43218-2709

Telephone (800) 686-1516

Or

Hospital_policy@medicaid.ohio.gov

The information provided above is for informational use only. If there is any discrepancy the Ohio Administrative Rules take precedence.

CODING CORNER

ICD-10-CM Coding Guidelines for Acute Myocardial Infarction

In this article of the Coding Corner, we would like to review an example of one of the changes to the Official Coding Guidelines that will take effect with the implementation of ICD-10-CM in October 2015.

In the Official Coding Guidelines for ICD-9-CM, when selecting the appropriate code to identify an acute myocardial infarction, (410.XX) a fifth digit of 0, 1, or 2 is to be selected to identify the episode of care.

0 = episode of care
1= initial episode of care for newly diagnosed Myocardial Infarction regardless of the times that the patient may be transferred during the initial episode of care.
2= subsequent episode of care - for an episode of care following the initial episode when the patient is admitted for further observation, evaluation or treatment for a Myocardial Infarction that has received initial treatment, but is still less than 8 weeks old.

In the Official Coding Guidelines for ICD-10-CM when selecting the appropriate code to identify an acute myocardial infarction (I21.0X - I21.4), the encounter or episode of care is based on 4 weeks or less. As you can see, the time frame for acute myocardial infarction has changed from 8 weeks or less in ICD-9-CM to 4 weeks or less in ICD-10-CM.

For encounters occurring while the myocardial infarction is equal to or less than 4 weeks old, including transfers to another acute setting, or postacute setting, and the patient requires continued care for the myocardial infarction.

For encounters after the 4 week time frame and the patient is still receiving care related to the myocardial infarction, the appropriate aftercare code should be assigned rather than a code from the category (I21).

For old or healed myocardial infarction not requiring further care, code (I25.2) (old Myocardial Infarction) may be assigned.

EXAMPLE:

A 60 year old male is being treated for a acute Non-ST anterior wall myocardial infarction which he suffered 4 days ago. What is the correct diagnosis code? (Answer (I21.4)).

It will be imperative that the ICD-10-CM Coding Guidelines be reviewed for any possible changes to ensure the guidelines are utilized in obtaining the appropriate code assignment.

Medical Director *dialogue*

By Anthony J. Beisler, MD, MBA, FACS
Medical Director, Permedion

Bariatric surgery, or weight loss surgery, includes a variety of procedures performed on patients with the diagnosis of morbid obesity. Weight loss is achieved by reducing the size of the stomach with an implanted medical device (gastric banding) or by resecting and re-routing the small intestines to a small stomach pouch (gastric bypass surgery) or through removal of a portion of the stomach (biliopancreatic diversion with duodenal switch) or through a combination of the above procedures as a staged surgical intervention (sleeve gastrectomy with follow-on gastric bypass).

Recent long-term studies have confirmed that these procedures result in significant long-term loss of weight, recovery from diabetes, improvement in cardiovascular risk factors, and a reduction in mortality of 23% from 40%.

The U.S. National Institutes of Health recommends bariatric surgery for obese people with a body mass index (BMI) of at least 40, and for people with BMI 35 with a serious coexisting medical conditions, such as diabetes or hypertension. However, research is emerging that suggests bariatric surgery could be appropriate for those with a BMI of 35 to 40 with no comorbidities or a BMI of 30 to 35 with significant comorbidities.

Clinical studies have demonstrated that the best results for enrollees undergoing bariatric surgery are observed in the patient population which fulfills the required pre-surgical regimen. Thus, a rigorous pre-certification procedure is in place prior to surgical intervention. The design of this pre-surgical regimen is a combination of lifestyle modifications along with medical and psychological evaluations. The pre-certification regimen is designed to ensure that the candidates for this surgery are fully evaluated, adequately prepared and have the ability to adapt and modify their lifestyles to meet the post-operative lifestyle changes and ensure long term success.

The patient must be committed to the appropriate work-up for the procedure and for continuing long-term postoperative medical management, and must understand, and be adequately prepared for, the potential complications of the procedure. An individual's understanding of the procedure and ability to comply with life-long follow-up and life-style changes (e.g., as exemplified by compliance with previous medical care) are necessary for the success of the procedure. The patient's ability to lose weight prior to surgery makes surgical intervention easier and also provides an indication of the likelihood of compliance with the severe dietary restriction imposed on patients following surgery.

Recent improvements in morbidity and mortality rates have been attributed to improved patient selection through adherence to the pre-certification criteria, the improvement in choice of operation and the introduction of staged surgical intervention. Historical rates of mortality were noted to be 1.4% - 2%; more recent data has indicated that overall mortality rates, with completion of appropriate pre-operative work-ups and evaluations, have decreased to 0.05%.

A recent position statement from the American Society of Metabolic and Bariatric Surgeons (ASMBS) Clinical Issues Committee determined that staged procedures for the super obese are a standard of care in the bariatric surgical community. Thus, the ASMBS has accepted "Sleeve Gastrectomy" as a recommended bariatric surgical procedure primarily because of its potential value as the first-stage of a multi-staged operative intervention for high-risk patients.

Therefore, Sleeve Gastrectomy is not approved as a stand-alone procedure as it is noted that it is considered to be the appropriate "first step" procedure for a staged intervention. Patients who are initially treated with Sleeve Gastrectomy, after sufficient weight loss and with the subsequent improvement in overall health, are then appropriately converted to a traditional roux-en-y gastric bypass.

A review of the prior 12 month period of our pre-certification process finds the following:

Total number of beneficiaries requesting bariatric procedures via pre-certification process	48
Approvals after first request	9
Secondary Approvals after supplemental information/ completed criteria provided	24
Outstanding cases lacking satisfaction of approval criteria	5
Approvals for staged procedures	9
Number of denials	1

In order for our beneficiaries to continue to receive the highest levels of care with the best possible outcomes, it is imperative that the nationally recognized criteria for bariatric surgery continue to be applied in a prospective fashion through the pre-certification process.

2014 Permedion Holiday Closures

Monday, May 26
Memorial Day

Friday, July 4
Independence Day

Monday, September 1
Labor Day

Thursday, November 27
Thanksgiving

Friday, November 28
Day after Thanksgiving

Thursday, December 25
Christmas

Inpatient Updates Effective 1/1/2014

Rule 5160-2-65 (formerly 5101:3-2-65) entitled Inpatient hospital reimbursement sets forth the methodology for determining the relative weights and hospital average cost per discharge that is used to reimburse hospitals for services provided to Medicaid recipients enrolled in both traditional Medicaid and Medicaid Managed Care under prospective payment. The methodology is in effect for inpatient hospital discharges occurring on or after July 1, 2013. The proposed change to the rule is to: terminate a temporary five percent inpatient rate increase that was built into the hospital base payments and medical education payments for all hospitals except children's hospitals; and reduce the percent of outlier eligible costs from ninety-five to ninety percent for all hospitals.

Rule 5160-2-07.6 (formerly 5101:3-2-07.6) entitled Capital costs sets forth the methodology for inpatient hospital capital reimbursement for those hospitals paid under prospective payment. The proposed change to the rule is to reduce interim capital payments to eighty five percent of cost and to eliminate cost settlement of capital-related costs to all hospitals paid by Medicaid under prospective payment.

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