5101:3-2-21 **Policies for outpatient hospital services.**

(A) All Ohio hospitals that are subject to DRG prospective payment as described in rule 5101:3-2-07.1 of the Administrative Code and that provide covered outpatient hospital services to eligible medicaid recipients as defined in rule 5101:3-2-02 of the Administrative Code are subject to the payment policies described in this rule.

(B) The words and terms described in paragraphs (B)(1) to (B)(4) of this rule have the following meanings, unless the context clearly indicates otherwise.

(1) Outpatient invoice.

An "outpatient invoice" is the UB-92 form, submitted to the department for services rendered to one eligible medicaid recipient on one or more date(s) of service. An invoice encompassing more than one date of service is referred to in this rule as a "cycle bill."

(2) Outpatient claim.

An "outpatient claim" is defined as those outpatient services rendered to one eligible medicaid recipient on one date of service. In the instance of "cycle bills," as indicated in paragraph (B)(1) of this rule, more than one claim may appear on an invoice.

(3) Procedure code.

In this rule, a procedure code refers to the local level codes listed in appendix A of this rule and the current procedural terminology (CPT) codes as defined in rule 5101:3-2-19.3 of the Administrative Code. ~~codes published in the physician's "Current Procedural Terminology (CPT), Fourth Edition, 2002," published by the "American Medical Association."~~ Guidelines and definitions for level of care determinations and for new and established patient definitions are as published in the CPT volume except for CPT codes 92002 and 92014 for vision services, which are covered for eligible medicaid recipients ages twenty-one to fifty-nine years only.

(4) Revenue center codes.

Revenue center codes, as referenced in this rule, are published in "The Ohio UB-92 Instruction Manual," published by the "Ohio Uniform Billing Committee." See appendix A of rule 5101:3-2-02 of the Administrative Code for identification of revenue center codes that are covered under the medicaid program.

(C) Implementation and billing procedures.

The provisions of this rule are effective for claims associated with outpatient hospital services delivered on or after the effective date of this rule.

All outpatient services must continue to be billed on the UB-92. All revenue centers listed in appendix B of this rule require CPT coding. Additionally, a date of service is required on each line of the invoice for each service rendered. A diagnosis code(s) from the ICD-9-CM indicating the reasons for the outpatient treatment is required on each invoice. All physician, home health, and other professional services must continue to be billed separately.

(D) Dialysis service claims.

A dialysis service claim is identified by the presence of a CPT code in the range 90918 through 90999. For claims with dates of services prior to April 1, 2002, except for radiology services which will be paid in accordance with paragraph (I) of this rule, pregnancy services which will be paid in accordance with appendix F of this rule, and laboratory services which will be paid in accordance with Chapter 5101:3-11 of the Administrative Code, allowable charges submitted on dialysis service claims 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 5101:3-2-22 of the Administrative Code.

For claims with dates of services on or after April 1, 2002, dialysis services will be paid according to the fee schedule in appendix F of this rule. Radiology, pregnancy, and laboratory services will continue to be paid in accordance with paragraph (I) and appendix F of this rule and appendix DD of rule 5101:3-1-60 of the Administrative Code. For claims with dates of service on or after April 1, 2002, IV therapy will be paid in accordance with paragraph (G)(2)(e) of this rule and ancillary services will be paid in accordance with paragraph (J) of this rule.

(E) Chemotherapy service claims.

A chemotherapy service claim is identified by the presence of a CPT code in the range 96400 through 96549. Except for radiology services which will be paid in accordance with paragraph (I) of this rule, pregnancy services which will be paid in accordance with appendix F of this rule, and laboratory services which will be paid in accordance with Chapter 5101:3-11 of the Administrative Code, allowable charges submitted on chemotherapy service claims 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 5101:3-2-22 of the Administrative Code.

(F) Outpatient surgical service claims.

(1) Surgical service billing requirements.

An "outpatient surgical service claim" is a claim that does not include dialysis, chemotherapy, or emergency room services billed on claims carrying condition code 87 as described in paragraphs (D), (E), and (H)(1) of this rule and that carries a CPT code that is in the range 10021-69990 and that is also listed in appendix C of this rule as a grouped outpatient surgical code.

If a claim is submitted that carries a CPT code that is in the range 10021-69990 that is not a grouped outpatient surgical code because the procedure is primarily performed on an inpatient basis, the claim will be paid either a percent of charges, to be determined by the medicaid outpatient per cent described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code, or zero dollars. Claims that are paid zero dollars must be submitted hard copy and the reimbursement amount will be determined by the department on a case-by-case basis. Claims for outpatient surgery services must include all outpatient services performed on that date of service.

(2) Surgical services claims payment.

(a) Unlisted surgical procedures.

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, ~~44209,~~ 44238, 44239, 44979, 47379, 47579, 49329, 49659, 50549, 50949, 55559, 58578, 58579, 58679, 59898, 60659, 69949, or 69979.

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 (70010-79999), pregnancy codes (X5400-X5432), or laboratory CPT codes (80048-89399) will be paid by multiplying .69 times the line item charges. Radiology service line items will be paid in accordance with paragraph (I) of this rule, pregnancy service line items will be paid in accordance with appendix F of this rule, and laboratory service line items will be paid in accordance with Chapter 5101:3-11 of the Administrative Code.

(b) Surgical procedure codes that are not unlisted.

(i) When a claim carries a CPT surgery code and no unlisted surgical procedures, the claim will be assigned to a surgical grouping. If the claim includes one surgical CPT code, payment will be based

upon the surgical payment rate of the group listed in appendix C of this rule to which that CPT code is assigned.

If the claim includes two or more surgical procedure codes that are not identical, payment will be based on one hundred per cent of the surgical payment rate of the highest group listed in appendix C of this rule to which one of the surgical CPT procedure codes is assigned. Additional payment will be made by multiplying .50 times the surgical payment rate of the group(s) to which the other surgical CPT code(s) are assigned.

If the claim includes identical surgical procedure codes, and the identical codes occur in conjunction with the same revenue center code, payment for the first surgery will be based on one hundred per cent of the surgical payment rate of the group to which that CPT code is assigned. Each additional occurrence of that identical surgical procedure code will be reimbursed by multiplying .50 times the group payment rate.

If the claim includes identical surgical CPT codes but those codes are not in conjunction with identical revenue center codes or if those CPT codes represent procedures which would not be performed more than one time on the same patient on the same day, no surgical group payments in addition to the one payment of one hundred per cent of the group rate will be made.

The payment rates shown in appendix C of this rule represent payment in full for all services performed in conjunction with outpatient surgery except for radiology, pregnancy, laboratory services and observation for admission determination code X7100. Radiology service line items will be paid in accordance with paragraph (I) of this rule, pregnancy service line items will be paid in accordance with appendix F of this rule, and laboratory service line items will be paid in accordance with Chapter 5101:3-11 of the Administrative Code, and ancillary service code X7100 will be paid in accordance with appendix F of this rule.

(ii) Surgical claim edits.

Surgical CPT codes which include the administration of anesthesia in the description of that CPT code will only be reimbursed when an anesthesia CPT code in the range 00100-01999 is also coded on the claim. These surgical CPT codes which must be used in conjunction with an anesthesia code are identified in appendix C of this rule.

Certain surgical CPT codes will be reimbursed only when they appear on a claim which contains no other CPT codes in the surgery range. The CPT codes which must appear alone for reimbursement are those in the surgical range that are usually performed as part of another surgery. These codes are identified in appendix C of this rule. Certain surgical CPT codes will only be reimbursed if a prior authorization number is obtained from the department in accordance with rule 5101:3-2-03 of the Administrative Code. These codes are identified in appendix C of this rule.

(3) Canceled surgeries.

It is the intent of the department to reimburse hospitals for canceled surgeries which are the result of medical complications arising after the patient is in the operating room. In order to qualify for payment for canceled surgery, the invoice must carry the occurrence code established by the Ohio uniformed billing committee to report canceled surgery. The claim must also carry one of the local level codes listed in appendix A of this rule that indicates either that medical complications arose after the patient was prepared for surgery and taken to the operating room but before anesthesia was induced or that medical complications arose after the patient was anesthetized.

When a canceled surgery meeting these definitions is billed, the provider must indicate the surgery that was scheduled by listing the scheduled surgery CPT code in conjunction with the appropriate revenue center code and must repeat the canceled surgery local level code on another line in conjunction with the same revenue center code in which the scheduled surgery is listed.

If the code indicating that medical complications arose after patient prepping but before anesthesia is used, the payment will be based upon fifty per cent of the scheduled surgery group payment rate. If the code indicating that medical complications arose after anesthesia was induced is used, payment will be based upon one hundred per cent of the scheduled surgery group payment rate.

If a multiple surgery had been scheduled, the appropriate percentage (fifty or one hundred per cent) will be applied to the highest surgery payment group to which the scheduled surgery codes are assigned. Unlisted surgical procedures, when used to bill a canceled surgery, must be billed hard copy with a description of 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.

(G) Clinic service claims.

(1) Clinic service billing requirements.

A claim is identified as a clinic claim if it carries one of the clinic visit codes listed in appendix D of this rule and does not include dialysis, chemotherapy, or surgical services as described in paragraphs (D), (E), and (F) of this rule.

More than one clinic visit per recipient, per provider, per day is permissible and reimbursable if each clinic visit occurs in a distinct and separate clinic or if the patient visits the clinic, leaves the hospital, and subsequently returns on the same date of service. If the patient had a clinic visit on the same day as a visit to the emergency room of the same hospital, the emergency room visit may also qualify for payment as listed in appendix E of this rule.

(2) Clinic service claim payment.

Payments for clinic visits will be made in accordance with the fees listed in appendix D of this rule. If a hospital is a teaching hospital or a children's hospital as described in rule 5101:3-2-07.2 of the Administrative Code, clinic visits will be reimbursed in accordance with the level 1 clinic visit fee schedule shown in appendix D of this rule. Payments for clinic visits for all other hospitals subject to this rule will be in accordance with the level 2 clinic visit fee schedule shown in appendix D of this rule. Payments for clinic visits represent payment in full except for the additional payments which may be made for services described in paragraphs (G)(2)(a) to (G)(2)(f) of this rule.

(a) Additional payments may be made for ancillary services listed in appendix A and appendix F of this rule.

(b) Additional payments may be made for laboratory services in accordance with Chapter 5101:3-11 of the Administrative Code.

(c) Additional payments may be made for radiology services in accordance with paragraph (I) of this rule.

(d) Additional payments may be made for emergency room visits in accordance with appendix E of this rule.

(e) Additional payments will be made for charges listed in line items which carry revenue center code 25X with no CPT code present when the claim carries IV therapy CPT code 90780, 90781, or 90784. These additional payments will be calculated by multiplying .65 times the charges listed in those line items which carry revenue center code 25X with no CPT code present.

(f) Additional payments may be made for pregnancy services in accordance with appendix F of this rule.

(H) Emergency room visit claims.

(1) Emergency room visit billing requirements.

(a) A claim is identified as an emergency room visit claim if it carries one of the emergency room visit codes listed in appendix E of this rule and does not include dialysis, chemotherapy, surgical, or clinic services as described in paragraphs (D), (E), (F), and (G) of this rule.

(b) More than one emergency room visit per recipient, per provider, per day is permissible and reimbursable if the patient visits the emergency room, leaves the hospital, and subsequently returns to the emergency room on the same date of service.

(c) If the service provided in the emergency room involved stabilizing a patient in a life-threatening condition prior to transferring the patient to another hospital or if the patient died in the emergency room following treatment or resuscitation efforts, the invoice should carry condition code 87 in the appropriate field on the UB-92. This condition code is not to be used when the hospital does not provide active treatment for the patient (for example, when a patient does not require stabilization prior to transfer or when a patient dies prior to treatment or resuscitation efforts being made).

(2) Emergency room claim payment.

Payments for emergency room visits for claims carrying condition code 87 will be made by multiplying claim charges, except for charges for radiology, pregnancy, and laboratory services, by the hospital's medicaid outpatient per cent. The medicaid outpatient per cent is the per cent described in paragraph (B)(2) of rule 5101:3-2-22 of the Administrative Code. Radiology services reported on those claims will be paid in accordance with paragraph (I) of this rule, and pregnancy services reported on those claims will be paid in accordance with appendix F of this rule, laboratory services reported on those claims will be paid in accordance with Chapter 5101:3-11 of the Administrative Code.

Payment for other emergency room visits will be made in accordance with the fee schedule listed in appendix E of this rule. If a hospital is a teaching

hospital, as defined in rule 5101:3-2-07.2 of the Administrative Code, payments for emergency room visits will be made in accordance with the level 1 emergency room fee schedule listed in appendix E of this rule. If a hospital is a children's hospital, as described in rule 5101:3-2-07.2 of the Administrative Code, emergency room visits will be reimbursed in accordance with the level 2 emergency room visit fee schedule shown in appendix E of this rule.

Payments for emergency room visits for all other hospitals subject to this rule will be made in accordance with the level 3 emergency room visit fee schedule shown in appendix E of this rule. Payments for emergency room visits represent payment-in-full except for the additional payments which may be made for services described in paragraphs (H)(2)(a) to (H)(2)(e) of this rule.

(a) Additional payments may be made for ancillary services listed in appendix A and appendix F of this rule.

(b) Additional payments may be made for laboratory services in accordance with Chapter 5101:3-11 of the Administrative Code.

(c) Additional payments may be made for radiology services in accordance with paragraph (I) of this rule.

(d) Additional payments will be made for charges listed in line items which carry revenue center code 25X with no CPT code present when the claim carries IV therapy CPT code 90780, 90781, or 90784. These additional payments will be calculated by multiplying .65 times the charges listed in line items which carry revenue center code 25X with no CPT code present.

(e) Additional payment may be made for pregnancy services in accordance with appendix F of this rule.

(I) Radiology services.

Payments for radiology services will be made in accordance with the fee schedule listed in appendix G of this rule. Reimbursement for outpatient hospital radiology services shall be the lower of charges or the payment amounts in the outpatient hospital radiology fee schedule as published in appendix G of this rule.

(J) Ancillary services.

As of October 1, 1994, designated free vaccines, as listed in rule 5101:3-4-12 of the Administrative Code, shall include all immunizations covered under the federal "Vaccines for Children" (VFC) program. All designated free vaccines and nondesignated vaccines shall be administered in accordance with the requirements described in rule 5101:3-4-12 of the Administrative Code.

Payments for ancillary services, including designated free vaccines and nondesignated vaccines, listed in appendix F of this rule will be made in accordance with appendix F of this rule if the listed codes appear on a claim that does not include chemotherapy, surgery services, or emergency room services billed on claims carrying condition code 87 as described in paragraphs (D),(E),(F), and (H)(1) of this rule.

Payments for ancillary services, including nondesignated vaccines, listed in appendix A of this rule will be made in accordance with appendix F of this rule.

(K) Independently billed medical supply, pharmacy, or laboratory, or pregnancy services.

Claims submitted with line items which carry revenue center code 25X or 27X with no CPT code present and which do not include dialysis, chemotherapy, surgical, clinic, emergency room, radiology, or ancillary services as defined in paragraphs (D) to (J) of this rule will be paid by multiplying .60 times charges associated with revenue center code 25X and by multiplying .50 times charges associated with revenue center code 27X. Payments for pregnancy services will be made in accordance with appendix F of this rule. Payments for laboratory services will be made in accordance with Chapter 5101:3-11 of the Administrative Code.

(L) Observation services

Payments for local level code X7100, observation for admission determination, will only be made when documentation supports that the patient was actively observed. This code is to be billed when a decision as to the medical necessity of admission cannot be made immediately. Payments for this code will be made for up to eleven units on either one date of service or two consecutive dates of service only. One unit is equal to two hours of observation. In order to receive payment for a third consecutive date of service, the patient must have been discharged and for medically necessary reasons, readmitted as an outpatient.

Payments for local level code X7500, test/procedure requiring more than six hours, will be made for two hour increments after the first six hours of testing. This code is only to be used when a test or procedure requires more than six hours to complete and may be billed in two hour increments for the remaining time required to complete the test only.

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