5160-2-21 **~~Policies for outpatient hospital services~~ Reimbursement for services provided in an outpatient hospital setting.**

(A) All hospitals that are subject to DRG (diagnosis related group) prospective payment as described in rule 5160-2-07.1 of the Administrative Code and that provide covered outpatient hospital services to eligible medicaid beneficiaries as defined in rule 5160-2-02 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 indicates otherwise.

(1) Outpatient invoice.

An "outpatient invoice" is a bill, submitted in accordance with Chapter 5160-1 of the Administrative Code, to the department for services rendered to one eligible medicaid beneficiary 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 beneficiary 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 current procedural terminology (CPT) codes and healthcare common procedure coding system (HCPCS) as defined in rule 5160-1-19 of the Administrative Code. Guidelines and definitions for level of care determinations and for new and established patient definitions are as published in the CPT and HCPCS volumes. Applicable HCPCS modifiers are listed in appendix A to this rule.~~

~~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.~~

(a) In this rule, a "procedure code" refers to the current procedural terminology (CPT) codes and healthcare common procedure coding

system (HCPCS) as identified in rule 5160-1-19 of the Administrative Code. Guidelines and definitions for level of care determinations and for new and established patient definitions are as published in the CPT and HCPCS volumes. Applicable HCPCS modifiers are listed in appendix A to this rule.

(b) At the beginning of each calendar year, the centers for medicare and medicaid services (CMS) and the American medical association (AMA) may add procedure codes, discontinue (delete) procedure codes, and revise the descriptions of a covered procedure, service, or supply represented by a HCPCS procedure code, that take effect on January first of the following calendar year. Coverage of new CPT and HCPCS codes will be determined by the department. Effective for dates of service on or after January 1, 2016, the initial maximum payment amount is set at seventy-six per cent of the medicare allowed amount but is not to exceed the medicaid allowed amount of similar procedure codes. For convenience, a list of such initial maximum payment amounts shall be posted no later than January first of each year on the department's web site, http://medicaid.ohio.gov/.

(4) Revenue center codes.

"Revenue center codes", as referenced in this rule, are as listed in appendix I of the department's hospital billing guidelines. ~~A to rule 5160-2-02 of the Administrative Code~~.

(5) National drug code

"National drug code" (NDC) is the actual coding used on the pharmaceutical container from which the product was dispensed and that satisfies the medicaid drug rebate requirements.

(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 be billed in accordance with Chapter 5160-1 of the Administrative Code. All revenue centers listed in appendix B to this rule require CPT or HCPCS coding. Additionally, a date of service is required on each line of the invoice for each service rendered. A diagnosis code(s) 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 90951 through 90999.

Dialysis services will be paid according to the fee schedule in appendix F to this rule. Radiology, pregnancy, and laboratory services will continue to be paid in accordance with paragraphs (I) and (K) of this rule. 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, excluding codes 96521, 96522, and 96523. Except for radiology services that will be paid in accordance with paragraph (I) of this rule, and laboratory and pregnancy services that will be paid in accordance with paragraph (K) of this rule, allowable charges submitted on chemotherapy service claims will be paid by multiplying those charges by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 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 chemotherapy, or emergency room codes modified by modifier -22 (as described in paragraphs (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 to 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~~but is not a grouped outpatient surgical code because the procedure is primarily performed on an inpatient basis, the claim will be paid by multiplying those charges by the hospital's specific medicaid outpatient cost-to-charge ratio. The medicaid outpatient cost-to-charge ratio is described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code~~a per cent of charges, to be determined by the medicaid outpatient per cent described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code~~. 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, 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 specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio 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.

For dates of service on or after January 1, 2014: Unlisted surgery codes will be assigned to a surgical group and paid according to the methodology in paragraphs (F)(2)(b) and (F)(2)(c) of this rule, except as provided in paragraph (F)(2)(b)(iii) of this rule.

(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 a hospital is a children's hospital as described in rule 5160-2-07.2 of the Administrative Code, surgeries will be reimbursed in accordance with the level 1 surgical group rates shown in appendix C to this rule. Payments for surgeries for all other hospitals subject to this rule, that are not children's hospitals, will be in accordance with the level 2 surgical group rate shown in appendix C to this rule. If the claim includes one surgical CPT

code, payment will be based upon the surgical payment rate of the group listed in appendix C to 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 to 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) is(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 that 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 to this rule represent payment in full for all services performed in conjunction with outpatient surgery except for radiology, pregnancy, laboratory services and observation services. 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, and observation services will be paid in accordance with appendix F to this rule.

(ii) Surgical claim edits.

Surgical CPT codes that 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 that must be used in conjunction with an anesthesia code are identified in appendix C to this rule.

Certain surgical CPT codes will be reimbursed only when they

appear on a claim that contains no other CPT codes in the surgery range. The CPT codes that 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 to this rule. ~~Certain surgical CPT codes will only be reimbursed if a prior authorization number is obtained from the department in accordance with rule 5160-2-03 of the Administrative Code.~~Certain surgical CPT codes will only be reimbursed if a prior authorization number is obtained from the department; ~~These~~ these codes are identified in appendix C to this rule.

(iii) Special unlisted dental surgery pricing for claims with an intellectual disability diagnosis code.

For hospitals that had a ratio of unlisted dental surgery services provided to patients with an intellectual disability diagnosis to total unlisted dental surgery services greater than the calendar year 2012 Ohio medicaid fee-for-service mean ratio of unlisted dental surgery claims with an ~~intellecutal~~intellectual disability diagnosis to total unlisted dental surgery services plus three standard deviations and also had an average cost for unlisted dental surgery services provided to individuals with intellectual disabilities greater than the calendar year 2012 Ohio medicaid fee-for-service mean cost for unlisted dental surgery services provided to individuals with an ~~intellecutal~~intellectual disability diagnosis: Claims billed with CPT code 41899 and an ICD-9 diagnosis code of 317, 318.0, 318.1, 318.2, or 319 will be paid $5,500 per claim, for dates of service on or between January 1, 2014 and December 31, 2015.

(c) Canceled surgeries.

It is the intent of the department to reimburse hospitals for canceled surgeries that are the result of medical complications arising after the patient is in the operating room.

To qualify for payment for a canceled surgery, the invoice must carry the occurrence code established to report the scheduled date of the canceled surgery and the CPT code for the surgery must be modified by the CPT modifier -73 or -74, as listed in appendix A to this rule, to report the canceled surgery.

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.

(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 to 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 beneficiary, 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 to this rule.

(2) Clinic service claim payment.

Payments for clinic visits will be made in accordance with the fees listed in appendix D to this rule. If a hospital is a teaching hospital or a children's hospital as described in rule 5160-2-07.2 of the Administrative Code, clinic visits will be reimbursed in accordance with the level 1 clinic visit fee schedule shown in appendix D to 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 to this rule. Payments for clinic visits represent payment in full except for the additional payments that 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 F to this rule.

(b) Additional payments may be made for laboratory services in accordance with paragraph (K) of this rule.

(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 to this rule.

(e) 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 specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio 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 specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(f) Additional payments may be made for pregnancy services in accordance with paragraph (K) 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 to 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 beneficiary, 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 is greater than that usually required for the emergency room procedure because the procedure 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 emergency room procedure code should be modified by the CPT modifier -22. This modifier 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 procedure codes with CPT modifier -22 will be made by multiplying claim charges, except for charges for radiology, pregnancy, and laboratory services, by the hospital's specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code. Radiology services reported on those claims 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.

Payment for other emergency room visits will be made in accordance with the fee schedule listed in appendix E to this rule. If a hospital is a teaching hospital, as defined in rule 5160-2-07.2 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 to this rule. If a hospital is a children's hospital, as described in rule 5160-2-07.2 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 to 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 to 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 F to this rule.

(b) Additional payments may be made for laboratory services in accordance with paragraph (K) of this rule.

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

(d) 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 specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio 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 specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(e) Additional payments may be made for pregnancy services in accordance with paragraph (K) of this rule.

(I) Radiology services.

Payments for radiology services will be made in accordance with the fee schedule listed in appendix G to 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 to this rule.

(J) Ancillary services.

As of October 1, 1994, designated free vaccines, as listed in rule 5160-4-12 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 5160-4-12 of the Administrative Code.

Payments for ancillary services, including designated free vaccines and nondesignated vaccines, listed in appendix F to this rule will be made in accordance with appendix F to this rule if the listed codes appear on a claim that does not include chemotherapy, surgery services, or emergency room procedure codes with CPT modifier -22 as described in paragraphs (E), (F), and (H)(1) of this rule. Reimbursement for all immunizations covered under the VFC program will be ~~five dollars for individuals eighteen years of age or younger. For dates of service on or after January 1, 2010, reimbursement for all immunizations covered under the VFC program will be increased to~~ ten dollars for individuals eighteen years of age or younger.

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.

Payments for ancillary services will be made in accordance with appendix F to this rule.

(1) Additional payments may be made for laboratory services in accordance with paragraph (K) of this rule.

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

(3) 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 specific medicaid

outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio 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 specific medicaid outpatient ~~per cent~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(4) Additional payments may be made for pregnancy services in accordance with paragraph (K) of this rule.

(K) Laboratory and pregnancy related services.

Payments for laboratory services will be made in accordance with the fee schedule listed in appendix H to this rule. Reimbursement for outpatient hospital laboratory services shall be the lower of charges or the payment amounts in the outpatient hospital laboratory fee schedule.

Payments for pregnancy related services will be made in accordance with the fee schedules listed in appendices D and F to this rule. When billing for pregnancy related services, bill the appropriate codes as identified in appendix D and/or F to this rule, with modifier -TH to indicate that obstetrical services, prenatal or post-partum, were provided.

(L) Independently billed services:

Claims submitted without dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services as defined in paragraphs (D) to (K) of this rule will be considered independently billed.

(1) Pharmacy.

For dates of service between 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 specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio.

The medicaid outpatient ~~per cent~~ cost-to-charge ratio 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 specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(2) Medical supply.

For dates of service between January 1, 2012 and December 31, 2013: Claims submitted with line items that carry revenue center codes 027X (with no CPT code present) will be paid at the hospital's specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio 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 027X (with no CPT code present) will be paid at sixty per cent of the hospital's specific medicaid outpatient ~~per cent of charges~~cost-to-charge ratio. The medicaid outpatient ~~per cent~~cost-to-charge ratio is ~~the per cent~~ described in paragraph (B)(2) of rule 5160-2-22 of the Administrative Code.

(M) Observation services

Payments for observation services will be made in accordance with appendix F to this rule. Payments for observation services will be made for up to two consecutive days only. 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.

Effective:

Five Year Review (FYR) Dates: 02/13/2015

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5164.02, 5164.70
Prior Effective Dates:	04/01/1988 (Emer), 04/23/1988, 06/30/1989 (Emer), 08/10/1989, 06/29/1990 (Emer), 08/11/1990, 09/03/1991 (Emer), 11/10/1991, 07/01/1992, 10/01/1992 (Emer), 11/17/1992 (Emer), 12/31/1992, 07/01/1993, 07/01/1994, 09/30/1994 (Emer), 12/30/1994, 12/29/1995 (Emer), 03/16/1996, 12/31/1996 (Emer), 03/22/1997, 12/31/1997 (Emer), 03/19/1998, 07/02/1998, 12/31/1998 (Emer), 03/31/1999, 01/04/2000 (Emer), 03/20/2000, 12/29/2000 (Emer), 03/30/2001, 12/31/2001 (Emer), 03/25/2002, 07/01/2003, 09/01/2003 (Emer), 11/27/2003, 01/02/2004 (Emer), 04/01/2004, 01/01/2005, 12/30/2005 (Emer), 03/27/2006, 12/29/2006 (Emer), 03/29/2007, 12/31/2007 (Emer), 03/30/2008, 12/31/2008 (Emer), 03/31/2009, 10/01/2009 (Emer), 12/3/2009, 12/31/2009 (Emer), 03/31/2010, 12/30/2010 (Emer), 03/30/2011, 12/22/2011, 12/30/2011 (Emer), 03/29/12, 12/31/2012 (Emer), 03/28/2013, 12/18/2013 (Emer), 03/31/2014, 12/31/2014 (Emer)