FEDERAL MEDICAID NOTICE AND PUBLIC HEARING NOTICE
OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

DATE: October 22, 2010
TIME: 10:00 am
LOCATION: Room 2925, Rhodes State Office Tower, 30 East Broad Street, Columbus, Ohio 43215

Pursuant to section 5111.02 and Chapter 119. of the Ohio Revised Code, and 42 CFR 447.205 of the Social Security Act, the director of the Ohio Department of Job and Family Services (ODJFS) gives notice of the Department's intent to consider the adoption, amendment, or rescission of the rules as identified below and of a public hearing thereon.

Rule 5101:3-1-60, entitled "Medicaid reimbursement," sets forth Medicaid reimbursement policies. This rule is being amended to provide updates and clarification of coverage and reimbursement information, and to make necessary Medicaid Information Technology System (MITS) implementation changes.

Changes to this rule include the addition of a new Professional Component and Technical Component (PCTC) indicator" column in Appendix DD to the rule. This column is intended to give providers additional information about place-of-service restrictions and applicability of the professional and technical modifiers. In addition, Appendix DD has been updated to reflect reimbursement and coverage changes. The reimbursement amounts for 12 Current Procedural Terminology (CPT) codes have been reduced to comply with the mandated Medicaid payment ceiling of not paying more than the Medicare fee schedule. The reimbursement amount for two CPT codes has been increased to reflect changes in cost to physicians. Twenty-nine codes have been changed to "Not Covered" (NC) to reflect the requirement that only valid, HIPAA-compliant codes as determined by the American Medical Association and the Centers for Medicare and Medicaid Services may be covered. Reimbursement amounts have been assigned to two codes previously listed as "By Report." Coverage and reimbursement will begin for two new codes, A4466 and E2377. The annual fiscal impact of these changes will be approximately $312,819.56.

Rule 5101:3-4-01, "Eligible providers of physician services," sets forth the criteria for being an eligible provider of physician services.

This rule is being amended to recognize that physicians may incorporate into or join a professional medical group in accordance with the provisions set forth in rule 5101:3-1-17.

Rule 5101:3-4-02.1, entitled "By-report services," establishes the conditions under which reimbursement for a service requires manual review, as well as the documentation that must be submitted with claims for services designated by Medicaid as by-report services. This rule is being proposed for rescission and replaced by a new rule with the same rule

number and title because more than fifty per cent of this rule is being stricken and a comparable amount of new text is being added.

Rule 5101:3-4-02.1, "By-report services," establishes the conditions under which reimbursement for a service requires manual review, as well as the documentation that must be submitted with claims for services designated by Medicaid as by-report services.

This new rule replaces a rescinded rule of the same number and title. Differences include: a clearer description of the documentation that is required for submission to Medicaid or its designee for coverage determination and reimbursement of by-report services. In addition, limits have been placed on the use of "not otherwise listed" Healthcare Common Procedure Coding System (HCPCS) codes. Existing language has been clarified.

Rule 5101:3-4-02.2, "Site differential payments and place of service," sets forth the criteria for a differential payment due to place of service.

This rule is being amended to clarify language regarding the location of the list of services subject to site differential payments. Language has also been added to clarify that Medicaid uses place-of-service codes maintained by the Centers for Medicare and Medicaid Services. Claim format language has been updated. References to outdated billing instructions have been removed. The annual fiscal impact of these changes will be approximately $47,281.

Rule 5101:3-4-06, "Physician visits," establishes guidelines for reimbursement of physician services by place of service.

This rule is being amended to clarify existing language regarding the surgical follow-up period and outpatient hospital observations. In addition, reimbursement information for nursing facility services has been updated. References to outdated billing instructions have been removed.

Rule 5101:3-4-06.1, "Physician attendance during patient transport," establishes policies regarding the coverage of and reimbursement for physician attendance during patient transport.

This rule is being amended to remove a reference to rescinded rule 5101:3-1-19.3, and clarification of existing language.

Rule 5101:3-4-11, "Diagnostic and therapeutic procedures with professional and technical components," sets forth coverage of diagnostic and therapeutic procedures with professional components and technical components (PCTC).

This rule is being proposed for rescission and replaced by a new rule with the same rule number and title because more than fifty per cent of this rule is being stricken and a comparable amount of new text is being added.

Rule 5101:3-4-11, "Diagnostic and therapeutic procedures with professional and technical components," sets forth coverage of diagnostic and therapeutic procedures with professional components and technical components (PCTC).

This new rule replaces a rescinded rule of the same number and title, and explains the policy for coverage of professional and technical modifiers. Differences include the provision of additional information about place-of-service restrictions and applicability of the professional and technical modifiers. Providers are also directed to Appendix DD to rule 5101:3-1-60, where the codes with a professional and technical modifier and relevant place of service restrictions are identified.

Rule 5101:3-4-13, "Therapeutic injections (including trigger point injections) and prescribed drugs," establishes coverage and reimbursement policies for injections and prescribed drugs administered in a physician's office, a clinic, or a patient's home.

This rule is being amended to include clarification of how miscellaneous drugs should be entered on a claim has been revised. In addition, a clarification has been added to the prohibition against billing CPT codes 20552 and 20553 for the same patient on the same date of service. Language regarding prescribed drugs for take-home use has also been removed.

Rule 5101:3-4-16, "Cardiovascular diagnostic and therapeutic services," establishes guidelines regarding the appropriate use of modifiers to be used by providers when billing for the provision of services for the diagnosis and treatment of cardiovascular system disorders. The rule also addresses place-of-service restrictions that determine when a code may be reimbursed as a physician or laboratory service.

This rule is being proposed for rescission and replaced by a new rule with the same rule number and title because more than fifty per cent of this rule is being stricken and a comparable amount of new text is being added.

Rule 5101:3-4-16, "Cardiovascular diagnostic and therapeutic services," establishes guidelines regarding the appropriate use of modifiers to be used by providers when billing for the provision of services for the diagnosis and treatment of cardiovascular system disorders. The rule also addresses place-of-service restrictions that determine when a code may be reimbursed as a physician or laboratory service.

This new rule replaces a rescinded rule of the same number and title. Difference include the addition of a reference to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60. In addition, information that is duplicative of the "PCTC Indicator" column has been removed. Language specifying the values in the "lab and prof/tech indicator" column of Appendix DD as the determining factor in reimbursement methodology has been removed. Language has been updated to reflect policy changes in the determination of CPT codes with professional and technical components. References

to the billing of evaluation and management services in conjunction with cardiovascular diagnostic and therapeutic procedures have been relocated to the beginning of the rule body.

Rule 5101:3-4-17, "Gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy and special dermatology services," addresses coverage of these services by setting and the appropriate use of associated professional and technical procedural modifiers.

This rule is being proposed for rescission and replaced by a new rule with the same rule number and title because more than fifty per cent of this rule is being stricken and a comparable amount of new text is being added.

Rule 5101:3-4-17, "Gastroenterology, otorhinolaryngology, endocrinology, neurology, photodynamic therapy and special dermatology services," addresses coverage of these services by setting and the appropriate use of associated professional and technical procedural modifiers.

This new rule replaces a rescinded rule of the same number and title. The new rule directs providers to rule 5101:3-4-11 for the appropriate use of professional and technical modifiers and relevant place of service restrictions.

Rule 5101:3-4-18, "Pulmonary services," establishes coverage and place-of-service provisions for pulmonary services.

This rule is being amended to direct providers to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60. Information that is duplicative of the "PCTC Indicator" column has been removed. Existing language has been clarified.

Rule 5101:3-4-19, "Allergy services," establishes coverage and place-of-service provisions for the performance and evaluation of allergy sensitivity tests.

This rule is being amended to provide additional information regarding place-of-service restrictions and to provide instruction on the appropriate use of modifier 25 when an office visit is billed with an allergen immunotherapy service. In addition, providers are directed to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60 and to 3-4-11 for related place of service information. Information that is duplicative of the "PCTC Indicator" column has been removed and existing language has been clarified. A dated reference is also being removed.

Rule 5101:3-4-20, "Chemotherapy treatment," establishes coverage and reimbursement policies for the administration of chemotherapy and the provision of chemotherapeutic agents.

This rule is being proposed for rescission and replaced by a new rule with the same rule number and title because more than fifty per cent of this rule is being stricken and a comparable amount of new text is being added.

Rule 5101:3-4-20, "Chemotherapy treatment," establishes coverage and reimbursement policies for the administration of chemotherapy and the provision of chemotherapeutic agents.

This new rule replaces a rescinded rule of the same number and title. The new rule directs providers to rule 5101:3-4-11 for place of service restrictions. Clarifying language has also been added.

Rule 5101:3-4-22, "Surgical services," establishes conditions under which surgical procedures are reimbursed and addresses reimbursement levels, billing for multiple and bilateral surgeries, and the appropriate use of modifiers associated with CPT surgery codes.

This rule is being amended to include clarifying language regarding the bundling of surgical services incidental to the main procedure and the use of modifier 50 for bilateral procedures. In addition, language has been added to explain the appropriate use of the newly accepted modifiers LT and RT with bilateral codes and the appropriate use of site modifiers when procedures are performed on fingers, toes, eyelids, or coronary arteries. To reduce duplication of information and to clarify the appropriate use of site modifiers for surgery services, additional detail has been added to the appendix to this rule.

Rule 5101:3-4-25, "Laboratory and radiology services," lists services for which physicians and certain other providers may be reimbursed and addresses the use of professional and technical modifiers in association with CPT codes for these services.

This rule is being amended to direct providers to the newly created "PCTC Indicator" column in Appendix DD to rule 5101:3-1-60 and clarification of existing language regarding mammography services.

Rule 5101:3-4-35, "Skin substitutes for wound treatment and healing," establishes coverage policies in an office setting for skin substitutes used in conjunction with standard wound care regimens for the treatment of burns or ulcers. It is a new rule being proposed for adoption.

It delineates the HCPCS codes that may be reimbursed in an office setting and the conditions under which and frequency with which skin substitutes may be used.

Rule 5101:3-9-01, "Eligible providers of pharmacy services," lists the types of providers eligible for reimbursement for pharmacy services.

This rule is being amended to limit eligible providers of pharmacy services to pharmacies, hospitals, and clinics. Other prescribers dispensing medication to their patients to be used at home will not be reimbursed for the "take-home" prescriptions. In addition, existing language has been clarified.

Copies of the proposed rules are available, without charge, to any person affected by the rules at the address listed below and at the county departments of job and family services. The rules are also available on the internet at http://www.registerofohio.state.oh.us/. A public hearing on the proposed rules will be held at the date, time, and location listed at the top of this notice. Either written or oral testimony will be taken at the public hearing. Additionally, written comments submitted or postmarked no later than the date of the public hearing will be treated as testimony.

Copies of the proposed rules or comments on the rules should be submitted by mail to the Ohio Department of Job and Family Services, Office of Legal Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43215-3414, by fax at (614) 752-8298, or by e-mail at rules@jfs.ohio.gov. Comments received may be reviewed at this address.