FEDERAL MEDICAID NOTICE AND PUBLIC HEARING NOTICE
OHIO OFFICE OF MEDICAL ASSISTANCE

DATE: **February 13, 2013**
TIME: **10:00 a.m.**
LOCATION: **Room 3110B, Rhodes State Office Tower**
30 East Broad St., Columbus, Ohio 43215-3414

Pursuant to section 5111.02 and Chapter 119. of the Ohio Revised Code, and 42 CFR 447.205, the director of the Office of Medical Assistance (OMA) gives notice of the office's intent to consider the amendment of the rules as identified below and of a public hearing thereon.

These rules are being amended to implement the new Healthcare Common Procedure Coding System (HCPCS) codes that are effective for dates of service on and after January 1, 2013, and to make other changes described further below.

The HCPCS, which includes Current Procedural Technology (CPT) codes, is a medical procedure coding system that is the national standard for reporting medical services for billing and claims payment purposes. It is also used by Medicare, private health insurance plans, and managed care plans, as well as state workers' compensation programs and state Medicaid programs.

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association and other professional groups, updates the HCPCS on an annual basis. OMA must implement the HCPCS updates for the Medicaid program to comply with the federal Health Insurance Portability and Accountability Act (HIPAA), which requires the use of a nationally standardized coding system (45 CFR 162.1000 and 45 CFR 162.1002). The updates to these codes require OMA to make changes in the Ohio Administrative Code (OAC) because HCPCS codes are included in OAC rules or their appendices that guide the Medicaid program.

The following types of HCPCS code changes will be effective for dates of service on and after January 1, 2013: new codes added, obsolete codes deleted, revised codes implemented, changes in definition, and associated reimbursement changes. New HCPCS codes correspond to services without existing codes or services with existing codes that have been simultaneously rendered obsolete. New HCPCS codes that correspond to services without prior existing codes require coverage and payment decisions that are reflected in the rules and/or their appendices. Revised HCPCS codes correspond to services that have a revised definition.

Rules being amended to comply with HCPCS updates are as follows:

Rule 5101:3-1-60, entitled "Medicaid reimbursement," sets forth the Medicaid reimbursement policies for all professional providers. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete HCPCS codes, revise definitions, and

update reimbursement amounts associated with the codes. A new payment status indicator has also been developed. This new status indicator (B) will be used to signify bundled procedures. No separate payment will be made for bundled procedures as these services are incidental to the primary procedure. Some of the coding changes require amendments to existing policy on coverage. No changes are being made to the rule body itself. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-2-21, entitled "Policies for outpatient hospital services," sets forth polices and payment rates for outpatient services delivered by hospitals that are subject to prospective payment based on diagnosis related groups (DRGs). The appendix to this rule is being updated to add new HCPCS codes, delete obsolete HCPCS codes, and update the fee schedules associated with the codes. No changes are being made to the rule body itself. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-06, entitled "Physician visits," sets forth coverage and reimbursement policies for physician visits provided in a variety of settings. Changes include the addition of codes for transitional care management services as distinct, covered services for which eligible providers of physician services may obtain reimbursement. The changes are driven only by HCPCS code updates. Changes also include updates to rule references. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-12, entitled "Immunizations," sets forth coverage and reimbursement policies for immunization services. Changes to Appendix A of the rule, which contains vaccines covered under the federal vaccines for children program, include the addition of a new influenza virus vaccine code and the deletion of codes for tetanus and diphtheria vaccine. Changes to Appendix B of the rule, which sets forth vaccines that are covered for adults, include the addition of a code for Hepatitis B vaccine and the deletion of codes for tetanus and diphtheria vaccine. Medicaid coverage is not changing as a result of these code changes, as tetanus and diphtheria vaccines will continue to be covered for children and adults using different HCPCS codes. No changes are being made to the rule body itself. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-19, entitled "Allergy services," sets forth coverage and reimbursement policies for allergy sensitivity tests performed by eligible providers of physician services, and immunotherapy. Changes include the addition of new HCPCS codes and deletion of obsolete HCPCS codes related to ingestion challenge testing. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-22, entitled "Surgical services," sets forth coverage and billing practices for surgical services delivered by physician providers of Medicaid services. The appendix of the rule is being updated based on current values contained in the Relative Value Unit file that the Centers for Medicare and Medicaid releases annually for surgical procedures subject to multiple, bilateral, or assistant at surgery procedure pricing. No changes are being made to the rule body itself. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-29, entitled "Services provided for the diagnosis & treatment of mental and emotional disorders," sets forth coverage and reimbursement policy for services that are provided by physician providers for the diagnosis and treatment of mental and emotional disorders. The changes to this rule update rule references that have become obsolete because outdated procedure codes in OAC 5101:3-8-05 have been replaced. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-4-33, entitled "Coverage of fluoride varnish by non-dental providers," sets forth the coverage and limitations of the application of fluoride varnish by non-dental providers. The changes to this rule replace an outdated procedure code and an outdated rule reference. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-5-04, entitled "Dental program: covered preventive services & limitations," sets forth the coverage and limitations of preventive dental services. The change to this rule replaces outdated procedure code nomenclature for the topical application of fluoride. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-8-05, entitled "Covered psychology services & limitations," sets forth the coverage and limitations of services provided by independent psychologists. The rule is being changed to replace outdated procedure codes, update procedure code nomenclature, update outdated rule references, and describe coverage for a new code, interactive complexity, which must be billed as an add-on code to several new psychotherapy codes as a result of the HCPCS updates. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-21-02.3, entitled "Limited family planning benefit," sets forth coverage and reimbursement policies for procedures and services that are covered under this benefit. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete codes, and update the fee schedule. Anesthesia provided during tubal ligations, vasectomies, and hysterectomies have been added to the appendix to this rule. No changes are being made to the rule body itself. OMA estimates that there is no fiscal impact resulting from these changes.

Rule 5101:3-35-04, entitled "Reimbursement for Services Provided by Medicaid School Program (MSP) Providers," sets forth Medicaid reimbursement policies that apply to MSP providers as defined in Chapter 5101:3-35 of the Administrative Code. The appendix to this rule is being updated to add new HCPCS codes, delete obsolete HCPCS codes, and update reimbursement amounts associated with the codes. No changes are being made to the rule body itself. OMA estimates that there is no fiscal impact resulting from these changes.

A copy of each proposed rule is available at the address listed below, without charge, to any person affected by the rule. The proposed 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 hearing will be treated as testimony.

Requests for a copy of the proposed rules or comments on the rules should be submitted by mail to the Office of Medical Assistance, c/o Ohio Department of Job and Family Services, Office of Legal and Acquisition Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43215-0414, by fax at (614) 752-8298, or by e-mail at rules@jfs.ohio.gov. Comments received may be reviewed upon request.