



Department of
Medicaid

Maternal and Infant Support Program (MISP) Services

Version 2.0

Last Updated 1/22/2026

The Ohio Department of Medicaid (ODM) is Ohio’s largest payer of births in the state. As such, ODM has an important goal of eliminating adverse outcomes, especially for high-risk mothers and their infants. ODM has implemented the Maternal and Infant Support Program (MISP), built on the foundation laid by Governor DeWine’s Children’s Initiative program, focused on providing services and supporting our members to achieve better birth outcomes based on input from a wide variety of stakeholder feedback across the state.

The MISP program includes:

- 12-month postpartum Medicaid coverage extension
- Report of Pregnancy (ROP)
- Perinatal Risk Assessment Form (PRAF)
- Group Pregnancy Education
- Group Prenatal Care
- Lactation Consultation and Lactation Supplies
- Doula Services
- Freestanding Birth Centers
- Maternal and Infant Support Grant Funding
- Comprehensive Maternal Care (CMC)
- Nurse Family Partnership (NFP) Nurse Home Visiting (NHV)
- Family Connects (FC) Nurse Home Visiting (NHV)
- Pediatric Recovery Centers (PRCs)

MISP Ohio Administrative Code (OAC) Rules:

Service / Program	OAC Rule
Comprehensive Maternal Care (CMC)	5160-19-03
Doulas	5160-8-43
Freestanding Birth Centers	5160-18-01
Group Pregnancy Education / Group Prenatal Care	5160-21-04
Lactation Consultation	5160-8-42
Nurse Home Visiting – Nurse Family Partnership	5160-21-05
Nurse Home Visiting – Family Connects	5160-21-06
Pediatric Recovery Centers (PRC)	5160-18-02
Perinatal Risk Assessment Form (PRAF)	5160-21-04 : Pregnancy Related Services
Report of Pregnancy (ROP)	5160-21-04 : Pregnancy Related Services

MISP Services Implementation Timeline

2021

- ODM enhanced coverage for lactation consulting services and breast pumps and supplies.
- ODM established payment for the Report of Pregnancy (ROP) form.
- ODM increased PRAF reimbursement from \$30 to \$90.

2023

- ODM launched the Comprehensive Maternal Care (CMC) program on 1/1.
- ODM clarified coverage and payment provisions for facility and professional services at freestanding birth centers (FBC) and added intrapartum care to FBC provisions.

2025

- ODM adds new Medicaid eligible provider type (PT) Pediatric Recovery Centers (PRCs) effective in the summer of 2025.
- ODM adds the Family Connect NHV program to the MISP suite effective in the summer of 2025.
- ODM extended the Doula specialty to additional provider types.
- ODM updated the PRAF to allow for up to 6 submissions, including during the postpartum period.

2022

- ODM set forth coverage and payment provisions for group pregnancy education and Nurse Family Partnership nurse home visiting services for women experiencing medically complex conditions at high risk for preterm birth.
- ODM allowed practitioners more flexibility in providing group pregnancy education services using evidence-based or evidence-informed curriculum.
- ODM released a request for applications for Maternal and Infant Support Grant Funding.
- ODM began requiring group pregnancy education to be evidence-based. Evidence informed education is no longer eligible for enhanced reimbursement.

2024

- ODM added Doulas as a Medicaid provider type in October 2024.
- ODM added additional practitioners with the IBCLC certification to provide lactation consultation services in Fall 2024.
 - ODM updated the “Pregnancy Risk Assessment Form” to “Perinatal Risk Assessment Form” to allow for submissions during the postpartum period.



**Procedure Code and
FFS Reimbursement
Rate:**

Service Limitations:

OAC Rule Citation:

Effective Date:

Additional Resources:

- 54/540 – Chemical Dependency
- 39 – Physical Therapists (PTs)
- 41 – Occupational Therapists (OTs)
- 40 – Speech Language Pathologists (SLPs)
- 30 – Dentists
- 43 – Audiologist
- 09 – Doula

- Procedure Code: T1023 – Report of pregnancy (ROP)
- FFS Reimbursement Rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule 5160-1-60 for rates

- One ROP may be submitted per pregnancy.

- OAC Rule [5160-21-04](#): Pregnancy related services
- 7/1/21: ODM established payment for the Report of Pregnancy (ROP) form
- 10/1/2025: ODM updated policy to allow Doulas to bill for ROPs.
- [ODM Form 10257](#)
- [Nurture Ohio](#)

Perinatal Risk Assessment Form (PRAF)

Description:

Eligible Providers:

ODM reimburses for PRAFs – a perinatal risk screen used to screen a woman for medical and social factors that may place a woman at risk for adverse pregnancy or postpartum outcomes and to substantiate the woman’s need for enhanced pregnancy-related services and other support services during the perinatal period. The PRAF is connected to our Ohio Benefits eligibility system and submitted PRAFs ensure new mothers retain their Medicaid eligibility through pregnancy and postpartum care. The PRAF also notifies the MCOs of the pregnancy and serves as a home visiting and WIC referral.

The following Medicaid providers are eligible to submit PRAFs:

- 20 – Physicians
- 24 – Physician Assistants
- Advanced Practice Registered Nurse (APRN)
 - » 65 – Clinical Nurse Specialist
 - » 71 – Certified Nurse Midwife
 - » 72 – Certified Nurse Practitioner
- 50 – Clinics
- 84– Community Mental Health Providers
- 95 – Substance Use Treatment Providers
- 01 – Outpatient Hospitals



**Procedure Code and
FFS Reimbursement
Rate:**

- Procedure Code: H1000 33* – Web-based Pregnancy Risk Assessment
- FFS Reimbursement Rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule 5160-1-60 for rates

Service Limitations:

Effective 4/1/2025, providers may submit up to six (6) PRAFs per member per pregnancy throughout the pregnancy and postpartum period.

OAC Rule Citation:

OAC Rule [5160-21-04](#): Pregnancy related services

Effective Date:

- 1/1/17: ODM consolidated pregnancy-related services rules into one new rule, OAC rule 5106-21-04.
- 12/16/24: ODM changed the PRAF from “Pregnancy Risk Assessment Form” to “Perinatal Risk Assessment Form” to allow for PRAFs to be submitted in the postpartum period as well.
- 4/1/25: The number of assessments for which a separate payment may be made increased from one to six.
- Fall 2025 or early 2026: ODM is planning to add the PRAF as a telehealth eligible service.

Additional Resources:

- [ODM Form 10207](#)
- [PRAF Instructions](#)
- [Nurture Ohio](#)

Group Pregnancy Education

Description:

ODM covers group pregnancy education face-to-face presentations by a medical professional to a group of 2-20 participants. The group pregnancy education classes may cover subjects such as childbirth preparation (i.e., Lamaze), childbirth refreshers, nutrition, parenting, infant safety and other evidence-based or evidence-informed curriculum.

Eligible Providers:

The following providers can bill for group pregnancy education services:

- 20 – Physicians
- 24 – Physician Assistants
- Advanced Practice Registered Nurse (APRN)
 - » 65 – Clinical Nurse Specialist
 - » 71 – Certified Nurse Midwife
 - » 72 – Certified Nurse Practitioner
- 01 – Outpatient Hospitals
- 07 – Dietitians

**Procedure Code and
FFS Reimbursement
Rate:**

- Procedure codes and FFS reimbursement rates for Group Pregnancy and Childbirth Educational Services:
 - S9436 TH* – Childbirth prep/Lamaze



Service Limitations:

OAC Rule Citation:

Effective Date:

Additional Resources:

- S9437 TH* – Childbirth refresher
- S9444 TH* – Baby parenting class
- S9447 TH* – Infant safety class
- S9452 TH* – Prenatal nutrition class
- S9453 TH* – Smoking cessation class
- S9470 TH* – Prenatal nutrition counseling

FFS Reimbursement Rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule 5160-1-60 for rates

Reimbursement for Outpatient Hospitals follows the [Enhanced Ambulatory Patient Groups \(EAPG\) payment methodology](#).

There are currently no limits to group pregnancy education services.

OAC Rule [5160-21-04](#): Pregnancy related services

- 1/1/22: ODM established coverage and payment provisions for group pregnancy education.
- Early 2026: ODM is currently working on updating our policy and systems to allow Group pregnancy education to be a telehealth eligible service.
- [ODM MISP Webpage](#)

Group Prenatal Care

Description:

Eligible Providers:

ODM also reimburses for group prenatal care (i.e., Centering Pregnancy or another evidence-based curriculum) which includes group prenatal visits paired with facilitated discussion and activities.

The following providers can bill for group prenatal care services:

- 20 – Physicians
- 24 – Physician Assistants
- Advanced Practice Registered Nurse (APRN)
 - » 65 – Clinical Nurse Specialist
 - » 71 – Certified Nurse Midwife
 - » 72 – Certified Nurse Practitioner
- 01 – Outpatient Hospitals

**Procedure Code and
FFS Reimbursement
Rate:**

Service Limitations:

OAC Rule Citation:

Effective Date:

Additional Resources:

Group prenatal care should be billed as group pregnancy education with an E&M code.

- Procedure code: 99078 TH* – Group prenatal care
- FFS Reimbursement rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule for rate
- Covered E&M codes are listed in [Appendix DD](#) of OAC rule [5160-1-60](#): Medicaid payment and coverage *and payment* is subject to change.

Reimbursement for Outpatient Hospitals follows the [Enhanced Ambulatory Patient Groups \(EAPG\) payment methodology](#).

Group prenatal care services are limited to 12 visits per person per nine (9) months.

OAC Rule [5160-21-04](#): Pregnancy related services

1/1/22: ODM established coverage and payment provisions for group prenatal care.

Early 2026: ODM is currently working on updating our policy and systems to allow Group prenatal care to be a telehealth eligible service.

- [ODM MISP Webpage](#)
- [Centering Pregnancy](#)

Lactation Consultation and Lactation Supplies

Description:

Eligible Providers:

Breastfeeding has been shown to be one of the most effective preventive measures mothers can take to protect their children’s health. Evidence shows that breastfeeding is a low-cost, preventive health strategy that can prevent or address many acute and chronic health issues for mother and baby. These services are intended to narrow Ohio’s population differences in infant and maternal deaths and lower Ohio’s overall infant mortality rate.

The following Medicaid providers are eligible to bill for lactation consulting services:

- 20 – Physicians
- 24 – Physician Assistants
- Advanced Practice Registered Nurse (APRN)
 - » 65 – Clinical Nurse Specialist
 - » 71 – Certified Nurse Midwife
 - » 72 – Certified Nurse Practitioner



Procedure Codes and FFS Reimbursement Rates:

Service Limitations:

OAC Rule Citation:

Additional healthcare providers who hold the International Board of Lactation Consultant (IBCLC) credential may provide lactation consultation services:

- 38 – Non-Agency Nurse – RN
- 38 – Non-Agency Nurse without supervision – RN
- 39 – Physical Therapists (PTs)
- 41 – Occupational Therapists (OTs)
- 40 – Speech Language Pathologists (SLPs)
- 30 – Dentists
- 07 – Dietitians
- 69 – Pharmacists
- 09 – Doula

Physicians, Physician Assistants, and APRNs are required to bill with an E/M code; they will not receive a separate payment for lactation consulting services. The E/M code would be inclusive of time spent.

When services are provided by a RN, PT, OT, SLP, Dentist, Pharmacist, or Doula, payment is made separately from payment for other professional services.

A RN, PT, OT, SLP, Dentist, Pharmacist, or Doula will use the following procedure codes:

- S9443 – Lactation consulting
- S9443 with SY modifier – Lactation consulting provided at person’s residence

FFS Reimbursement rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule for rates

When services are provided by a dietitian in accordance with OAC rule 5160-8-41 the following coding guidelines apply:

- S9452 TH* – Prenatal nutrition class
- 97802 TH* – Lactation counseling by a dietitian
- 97803 TH* – Lactation counseling by a dietitian
- 97804 TH* – Lactation counseling by a dietitian, group

FFS Reimbursement rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule for rates

Reimbursement for Outpatient Hospitals follows the [Enhanced Ambulatory Patient Groups \(EAPG\) payment methodology](#)

No separate payment may be made for a lactation consultation service provided in conjunction with nurse home visiting services.

OAC Rule [5160-8-42](#): Lactation consultation services and [OAC rule 5160-8-41](#): Services provided by a dietitian.



Effective Date:

- 1/1/22: ODM established Medicaid payment for lactation consulting services when provided by physicians, physician assistants, advanced practice registered nurses, and registered nurses for breastfeeding education, support, and assistance with complex breastfeeding problems. ODM also amended OAC rule [5160-10-25: DMEPOS: lactation pumps](#) to loosen restrictions on medical necessity of breast pumps and to add coverage and payment criteria for breast pump supplies.
- 10/1/24: ODM allowed practitioners in a professional setting with an International Board of Lactation Consultant (IBCLC) credential to bill for lactation consultation services including RNs without supervision, LPNs, PTs, OTs, SLPs, dentists, dietitians, pharmacists, and doulas.

Additional Resources:

- [ODM Lactation Consultants](#)
- [ODM MISP Webpage](#)
- [MTL No. 3336-21-13](#)
- [MTL No. 3336-24-09](#)

Doula Services

Description:

Doula services have been shown to improve birth outcomes, maternal experiences, and reduce racial disparities in maternal and infant outcomes. Doulas provide advocacy, physical, educational, and emotional support during pregnancy and childbirth. Doula services provided by community-based doulas have been shown to be effective interventions in reducing health equity gaps and improving birth outcomes. ODM has a statewide recommendation for all members to have access to a doula.

Doulas serving Ohio Medicaid recipients are required to hold a doula certification issued by the Ohio Board of Nursing (OBN) and submit verification to ODM at the time of enrollment. The [OBN website](#) has an e-license search function for which doula certifications may be reviewed.

The following Medicaid providers are eligible enroll as doulas:

- 09 – Doula

Eligible Providers:

The following independent billing provider type / specialty combinations can add the Doula specialty (090) as a secondary specialty in the provider network management (PNM) system:

- 07 – Registered Dietitian Nutritionist
- 25/250 – Non-agency Personal Care Aide



Procedure Codes and FFS Reimbursement Rates:
Service Limitations:
OAC Rule Citation:
Effective Date:
Additional Resources:

- 26/260 – Non-agency Home Care Attendant
• 37/370 – Licensed Independent Social Worker
• 38 – Non-agency Nurse – RN or LPN (380, 381, 382, and 383)
• 47/474 – Clinical Counseling
• 52/520 – Marriage and Family Therapy
• 54/540 – Chemical Dependency
• 55 – Waivered Services Individual (455, 454, 453, 451, and 45A)
• Advanced Practice Registered Nurse (APRN)
» 65 – Clinical Nurse Specialist
» 71 – Certified Nurse Midwife
» 72 – Certified Nurse Practitioner

Notes:

- Providers not included in the above list are currently not eligible to enroll as doulas under the Ohio Medicaid program.
➤ Department of Developmental Disabilities (DODD) and Ohio Department of Aging (ODA) providers cannot hold a 090 Doula specialty unless they have been approved for another ODM provider type.

- T1032 – Services provided by a doula birth worker, per 15 min unit: \$12.50 per unit
• T1033 – Services provided by a doula birth worker, per diem: \$600 per birth, regardless of how long labor lasts

MCOs are required to cover doula services and reimburse at least the FFS rate through October 2026.

- T1032 – Services provided by a doula birth worker, per 15 min unit
o Up to 48 units without a PA
o Doulas may submit a PA to bill for visits should the mother require additional services beyond the allowable 48 units.
• T1033 – Services provided by a doula birth worker, per diem
o No PA needed
o T1033 can be billed once per ten (10) months

Max Reimbursement: \$1,200 per pregnancy and postpartum period

OAC Rule 5160-8-43: Doulas

10/3/2024

- ODM Doula Stakeholder Meeting and Training Session Recordings
• E-License Ohio – Find a Doula
• Doula Medicaid Transmittal Letter No. 3336-24-12

Freestanding Birth Centers (FBCs)

<p>Description:</p>	<p>FBCs are licensed health care facilities or parts of facilities that provide care to women and infants during the pregnancy, delivery, and immediate postpartum period to low-risk expectant mothers and their newborns. Licensed by the Ohio Department of Health (ODH), FBCs are not considered hospitals and are not considered an entity reviewed for hospital accreditation or certification. Any FBC owned and operated by a religious entity providing services exclusively to women who are members of that religious denomination are exempt from ODH FBC licensure. All FBCs should have an active provider agreement with the Ohio Department of Medicaid (ODM) and a national provider identifier (NPI).</p> <p>"Freestanding birth center (FBC)" is an entity defined in 42 U.S.C. 1396d(l)(3)(B) (in effect as of January 1, 2023) that is operated in conformity with rules 3701-83-33 to 3701-83-42 of the Administrative Code</p>
<p>Eligible Providers:</p>	<p>A physician (PT 20) or a certified nurse midwife (PT 71) in collaboration with a physician can direct FBC patient services.</p>
<p>Procedure Codes:</p>	<p>Please see “Freestanding Birth Center Billing Guidelines” on the MISP webpage for a list of procedure codes a FBC can bill for.</p>
<p>FFS Reimbursement Rate:</p>	<p>Please see “Freestanding Birth Center Billing Guidelines” on the MISP webpage for a list of reimbursement rates for services a FBC can bill for. Payment amounts are published in Appendix DD of OAC rule 5160-1-60: Medicaid payment and are subject to change.</p>
<p>Service Limitations:</p>	<p>Please see Appendix DD of OAC rule 5160-1-60: Medicaid payment for specific FBC service limitations. Limitations are subject to change.</p>
<p>OAC Rule Citation:</p>	<p>OAC Rule 5160-18-01: Freestanding birth centers</p> <ul style="list-style-type: none"> 1/1/2018: 5160-18-01 was renumbered from 5101:3-18-01. ODM explicitly stated that a separate professional payment amount, distinct from and in addition to the facility payment amount, could be made for the services of professionals working in FBCs. The actual FBC payments remained the same. ODM also removed the appendix to the rule and added all codes to Appendix DD of OAC rule 5160-1-60: Medicaid payment.
<p>Effective Date(s):</p>	<ul style="list-style-type: none"> 1/1/2023: ODM reorganized and streamlined rule language and coverage of intrapartum care was added. The Freestanding Birth Center Billing Guidelines can be found on the MISP webpage.
<p>Additional Resources:</p>	<ul style="list-style-type: none"> MTL No. 3346-17-01 MTL No. 3346-23-01

Maternal and Infant Support Grant Funding:

As part of Ohio Medicaid’s continuing commitment to improve the health of pregnant and postpartum women and their babies, ODM and its Managed Care Organizations offer a funding opportunity to reduce infant mortality and improve health outcomes in ten of Ohio’s counties with high rates of infant mortality: Butler, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Stark, and Summit. More detail on the Maternal and Infant Support Funding can be found on the [ODM website](#).

Comprehensive Maternal Care (CMC)

<p>Description:</p>	<p>The CMC program is Ohio’s maternal care Alternative Payment Model (APM). The CMC program is a team-based care delivery model led by a CMC entity who is responsible for comprehensively managing the health needs of pregnant and postpartum individuals and ensuring that their infants are receiving appropriate pediatric care. This program is similar to the Ohio Comprehensive Primary Care (CPC) however, it targets a different population of Medicaid covered individuals. Participation is voluntary for eligible Ohio Medicaid providers and for eligible Medicaid covered individuals.</p>
<p>Eligible Providers:</p>	<p>The following Medicaid providers are eligible to participate and receive program payments:</p> <ul style="list-style-type: none"> • 21 – Professional medical groups • 12 – Federally qualified health centers • 05 – Rural health centers • 50 – Clinics • 01 – Professional medical groups billing under hospital provider types
<p>Payment Structure:</p>	<p>CMC entities are eligible to receive a per-member per-month (PMPM) payment and based on performance, may qualify for additional quality and health equity add-on payments on top of typical pregnancy and postpartum service claim submission. The PMPM payment is prospective and will be calculated for each attributed Medicaid individual utilizing two risk tiers with varying PMPM payments. The quality add-on payment will be made after each performance year to CMC practices who meet quality add-on payment requirements.</p>
<p>OAC Rule Citation:</p>	<p>Ohio Administrative Code Rule 5160-19-03: Comprehensive maternal care program</p>



Effective Date:

- 11/18/22: ODM established the CMC program.
- 12/12/24: ODM made rule updates to reflect program year 2025 updates.

Additional Resources:

- [ODM CMC website](#)
- [CMC Program Requirements](#)
- [CMC Program Payments](#)

Nurse Family Partnership Nurse Home Visiting

Description:

Nurse home visits are home visiting services provided by an APRN or an RN to provide services such as prenatal, and postpartum visits, training in pediatric care, nursing examinations, health education, maternal depression screening and lactation consultations. ODM currently covers nurse home visits through the Nurse Family Partnership (NFP) program for mothers with medically complex conditions. The Department of Children and Youth (DCY) will periodically release requests for applications to select NFP NHV providers and manages the NFP certification process for all NFP providers. Providers who are interested in receiving additional information on how to become a NFP provider may reach out to DCY Home Visiting at Homevisiting@childrenandyouth.ohio.gov and the subject line should include the county name and NFP Inquiry.

The following Medicaid providers are eligible to provide NFP services:

- 38 – Non-agency nurse, RN
- Advanced Practice Registered Nurse (APRN)
 - » 65 – Clinical Nurse Specialist
 - » 71 – Certified Nurse Midwife
 - » 72 – Certified Nurse Practitioner

Eligible Providers:

NFP providers need to hold an NFP certification through the Ohio Department of Children and Youth (DCY) that must be uploaded in PNM when the provider enrolls. Providers must request specialty 386 (NHV) when completing an enrollment application. Providers already enrolled with Ohio Medicaid, who receive an NFP certification, will need to complete a change to their provider specialty in PNM.

Procedure Codes and FFS Reimbursement Rate:

- Procedure code: H1005 TH* – Prenatal care enhanced service package
- FFS Reimbursement rate: See ODM Fee Schedule [Appendix DD](#) of OAC rule for rate

Service Limitations:

ODM will reimburse for up to 30 visits per year for NFP NHVs.

OAC Rule Citation:

OAC Rule [5160-21-05](#): Nurse home visiting services

Effective Date:	<ul style="list-style-type: none"> • 1/1/22: ODM established coverage and payment provisions for nurse home visiting services. • 1/1/24: ODM removed the requirement that nurse home visiting services are performed at the order of a practitioner. ODM also removed regulatory restrictions.
Additional Resources:	<ul style="list-style-type: none"> • DCY Nurse Home Visiting Models • Nurse Family Partnership

Family Connect Nurse Home Visiting – effective 7/1/25

Description:	<p>ODM began covering nurse home visits through the Family Connects (FC) program in July 2025. The FC NHV program is not limited to high-risk mothers. DCY will periodically release requests for applications to select FC NHV providers and manages the FC certification process for all FC providers. Providers who are interested in receiving additional information on how to become a FC provider may reach out to DCY Home Visiting at Homevisiting@childrenandyouth.ohio.gov and the subject line should include the county name and FC Inquiry. The following Medicaid providers are eligible to provide FC services:</p> <ul style="list-style-type: none"> • 38 – Non-agency nurse, RN or LPN • Advanced Practice Registered Nurse (APRN) <ul style="list-style-type: none"> » 65 – Clinical Nurse Specialist » 71 – Certified Nurse Midwife » 72 – Certified Nurse Practitioner • 387 – FM specialty code
Eligible Providers:	
Procedure Codes and FFS Reimbursement Rate:	<p>FC providers need to hold an FC certification through DCY that must be uploaded to the ODM PNM when the provider enrolls.</p> <ul style="list-style-type: none"> • T1030 – RN home care, per diem • T1023 – Report of pregnancy (ROP) <p>FFS Reimbursement rate: See ODM Fee Schedule Appendix DD of OAC rule for rates</p>
Service Limitations:	<p>No prior authorization is required for the FC payment. The FC program is limited to three (3) visits per rolling six-month time period.</p>
OAC Rule Citation:	<p>OAC rule 5160-21-06: Family connects (effective 7/1/25)</p>
Effective Date:	<p>7/1/2025</p>
Additional Resources:	<ul style="list-style-type: none"> • DCY Family Connects webpage • DCY Family Connects Ohio Provider Resources • Family Connects Referrals

Pediatric Recovery Centers (PRCs) – effective 7/1/25

<p>Description:</p>	<p>PRCs are health care facilities that provide care to infants experiencing physical withdrawal symptoms and their Medicaid eligible families and caregivers. PRCs must also be certified by DCY as Residential Infant Care Centers (RICCs) as outlined in Ohio Revised Code Section 5103.6010. Visit DCY’s website to learn more about becoming a certified RICC.</p> <p>PRCs can bill ODM and Managed Care Organizations (MCOs) a per diem rate which includes medically necessary services provided to an infant during their stay at a PRC for up to 30 consecutive days. A PRC can also bill for services not included in the per diem reimbursement rate including but not limited to direct services provided to Medicaid eligible parents or caregivers, healthcare-related transportation services defined in Chapter 5160-15 of the Administrative Code, services rendered by a provider of physician services and other services specifically authorized in rule promulgated under agency 5160 of the Administrative Code.</p> <p>The following Medicaid providers are eligible enroll as PRCs:</p>
<p>Eligible Providers:</p>	<ul style="list-style-type: none"> • 10 – Pediatric Recovery Center • 21 – Professional Medical Group with a PRC specialty • 100 – PRC specialty
<p>Procedure Codes and FFS Reimbursement Rates:</p>	<p>Per Diem:</p> <ul style="list-style-type: none"> • <u>Procedure Code:</u> S9475 – Ambulatory setting substance (PRC) • <u>FFS Reimbursement Rate:</u> \$559.62 • <u>Maximum Unit:</u> 1 (per diem) unit, per infant, per day • <u>Place of Service:</u> 99 – Other Place of Service <p>MCOs are required to cover doula services and reimburse at least the FFS rate through June 2027.</p> <p>Services not included in the per diem rate for which a separate Medicaid payment may be made. See ODM Fee Schedule Appendix DD for billing codes and rates.</p>
<p>Service Limitations:</p>	<p>No prior authorization (PA) will be required for per diem rate payment on an infant’s initial admission to a PRC. A PA will be required for per diem payment for stays in excess of 30 consecutive days. PRC PAs should include:</p> <ul style="list-style-type: none"> • A documented medical diagnosis related to significant substance exposure resulting in withdrawal. • A description of the infant’s condition including on-going physical withdrawal symptoms. • A detailed care plan with the anticipated period of time for treatment goals to be met.

OAC Rule Citation:**Effective Date:****Additional Resources:**

A lack of post-discharge options alone will not be considered appropriate justification for a continued stay at a PRC.

OAC Rule 5160-18-02: Pediatric recovery centers (effective 7/1/25)

7/1/2025

- The PRC Billing Guidelines can be found on the [MISP](#) webpage
- [DCY Licensing and Certification](#)

Prior Authorization (PA):

PA standards are specific to each particular item or service. For example, diaphragms for contraceptive use require a PA when more than one diaphragm is needed in the same year. This is called a “limit-based” PA. Reimbursement for certain items and services covered is dependent on obtaining prior authorization from ODM, its designee, or the MCOs. [ODM fee schedules](#) note if a PA is required for a specific service. PA requests must be submitted in accordance with OAC 5160-1-31 and approved by ODM, its designee, or the MCOs before the services are rendered or the items are delivered. Each MCO has their own PA requirements. Please reach out to the MCOs for PA guidance. Paper PA requests cannot be processed except as authorized in [ORC 5160.34](#). Prior authorization exceptions include:

- Situations where the provider believes delaying a service requiring PA to be detrimental to the health of the patient
- In cases of emergency for prescribed drugs requiring PA
- In discretion of and as instructed by ODM

A retroactive PA can be sought for these situations. Providers can also request reconsideration of any denied PA request. Additional PA and reconsideration detail can be found in OAC rule [5160-1-31: Prior authorization](#).

[Step by step guidance](#) on how to submit a fee-for-service (FFS) PA can be found in the [Prior Authorization User Guide](#) on the Learning Page of the PNM homepage. PAs should be submitted directly to the Medicaid member’s MCO.

Documentation Detail:

Medical service documentation helps ODM understand what, why and how a service was delivered to a patient. All Medicaid providers are required to keep appropriate records to establish conditions for payment for all medical services. Some services require specific supporting documents to be attached to the claim. Additional detail on claim documentation requirements can be found in OAC rule [5160-1-27: Review of provider records](#).

Provider Compliance:

ODM reimburses providers for services that are medically necessary. Conditions of medical necessity include meeting generally accepted standards of medical practice and providing services that are clinically appropriate in the right place, for the right amount of time, at the right intensity of care. Services are expected to treat the condition the service is provided for and are expected to be provided in order to produce the anticipated, desired outcome. Additional detail on how ODM defines medical necessity can be found in OAC rule [5160-1-01: Medicaid medical necessity: definitions and principles](#).

ODM regularly reviews submitted claims for fraud, waste and abuse patterns. When suspected fraudulent behavior is detected, providers will be subject to a review by ODM, and the case will be referred to the Ohio Attorney General's (AG) Medicaid Fraud Control Unit (MFCU). If waste or abuse is suspected or apparent, ODM, the office of the AG, or both will take action to recoup inappropriate or excess payments. To ensure compliance and prevent audit findings, providers should understand Medicaid program requirements and ensure medical documentation supports all services billed and that the services are truly medically necessary. Additional detail can be found in [OAC rule 5160-1-29: Medicaid fraud, waste, and abuse](#).

Billing and Claims Submission:

MISP claims can be submitted via ODM Electronic Data Interchange (EDI) through a trading partner or using the ODM PNM provider portal. A trading partner is an entity that providers can contract with to take information from their Electronic Health Records system or other medical records to submit claims to ODM and the MCOs.

All MISP claims should be submitted according to national accepted coding standards using the healthcare common procedure coding system (HCPCS) or current procedural terminology codebook (CPT) codes. FFS claims are expected to be received by ODM within 365 days of the actual date of service. Provider-reported underpaid claims should be adjusted within 365 days of the date of service. The MCOs may have a different contracted billing timeline. Exceptions to timely filing of claims and additional detail on claim submission requirements are outlined in OAC rule [5160-1-19: Submission of Medicaid claims](#).

The claims payment schedule is located in the PNM "Provider Financials and Remittance Advice" user manual accessible through the PNM [Provider Education & Training Resources](#) page. FFS claims are adjudicated daily, and payments are made weekly in accordance with established ODM policies. Each MCO has its own payment calendar. For a claim to be included in the current week's payment cycle, the claim must be submitted by the appropriate deadline. Claims suspended for manual intervention are not guaranteed to be included in that week's payment cycle. More detail on the electronic data interchange can be found on the [ODM website](#) and in the [ODM EDI FAQ](#).

FFS Coordination of Benefits:

Coordination of benefits is the process of determining which health insurance payer will pay first or determine the payment obligations of each payer covering the same benefits for a Medicaid covered individual. Providers are responsible for reviewing the patient's Ohio Medicaid card for evidence of third-party benefits and billing the other insurance company prior to billing ODM.

Generally, Medicaid is the payer of last resort, with few exceptions. When a member has multiple insurance plans, the payment and adjudication information from the other payers is also taken into consideration when calculating Medicaid payment. Payment methodology used to calculate total reimbursement can vary depending on the claim type (i.e., institutional vs. professional) and payer type (i.e., Medicare vs. commercial). If a member does not have coverage from another plan the provider can submit a claim directly to ODM. Additional detail on ODM coordination of benefits and third-party liability can be found in OAC rule [5160-1-08: Coordination of benefits](#) (for FFS claims) and OAC rule [5160-26-09.1: Managed care third-party liability and recovery](#) (for managed care claims).

Denied Claims:

Common reasons for claim denials include coding errors, service limitations, lack of required prior authorizations, claim filing delays, and billing for non-covered services. Providers experiencing FFS denied claims can try to troubleshoot by reviewing claim denial reason codes in the PNM portal or in their electronic remittance advice (ERA). If the denial reason is still unclear, providers should reach out to the Integrated Helpdesk (IHD) for assistance. Representatives are available 8 a.m.- 4:30 p.m. ET, Monday-Friday and can be reached by calling 800-686-1516. A representative will address the claim and provide instructions on how to update or correct the claim for resubmission.

For questions regarding Managed Care claims, please contact the MCO directly. If you have already tried that route with no resolution, please use the online [managed care provider complaint form](#). ODM will review all concerns submitted along with MCO responses.

Payment Questions:

If there's a disagreement with the processing of a fee for service claim, please contact the Integrated Helpdesk (IHD). Representatives are available 8 a.m.- 4:30 p.m. ET, Monday-Friday and can be reached by calling 800-686-1516. A representative will address the claim and provide instructions on how to update or correct the claim for resubmission.

For questions regarding Managed Care claims, please contact the MCO directly. If you have already tried that route with no resolution, please use the online managed care provider complaint form located here: [Provider Complaint Form](#) ODM will review all concerns submitted along with MCO responses.

Additional Resources:

- [Creating OH|ID for IOP PNM Login](#)



Department of Medicaid

- [PNM Login/Access](#)
- [Identifying Your Role Within PNM](#)
- [New Provider Application](#)
- [Absorb LMS & Training Sign Up](#)
- [ODH Freestanding Birthing Centers Licensure](#)
- [ODM Submission of Medicaid Claims](#)
- [ODM Managed Care Claims and Prior Authorization](#)
- [ODM Provider Enrollment and Support](#)
- [ODM Provider Network Module](#)
- [ODM PNM Provider Education and Training Resources](#)
- [ODM Claim and Prior Authorization Submission FAQ](#)
- [ODM PNM Fee-For-Service Prior Authorization User Guide](#)
- [ODM Fee Schedule and Rates](#)
- [ODM Integrated Help Desk](#)
- [Anthem Provider Resource](#)
- [Amerihealth Caritas of Ohio Provider Resource](#)
- [Aetna OhioRISE Provider Resource](#)
- [Buckeye Provider Resource](#)
- [CareSource Provider Resource](#)
- [Humana Provider Resource](#)
- [Molina Provider Resource](#)
- [United Healthcare Provider Resource](#)

Questions?

General MISP Policy Questions:

Email ODM at MISP@medicaid.ohio.gov

Claims Submission:

Fee-For-Service:

Please contact the ODM Integrated Helpdesk (IHD) at 800-686-1516 or IHD@medicaid.ohio.gov. The IHD also provides 24/7 access to information regarding patient eligibility, claim and payment status, and provider information.

Managed Care:

If you are having issues with managed care claims, please contact the plan directly.