Department of Medicaid

Pediatric Recovery Center Billing Guidelines

Version 1.1

Last Updated 7/31/25

Adapted from Ohio Administrative Code (OAC) Rule 5160-18-02

Department of Medicaid

Pediatric Recovery Centers (PRCs)

The Ohio Department of Medicaid (ODM) has worked in collaboration with the Ohio Department of Children and Youth (DCY) to establish sustainable funding for physical withdrawal care for infants up to twelve months of age, born substance exposed effective July 1, 2025. 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 the Ohio Department of Children and Youth 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.

PRCs are able to 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 thirty 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. If an infant needs to stay at a PRC for longer than 30 consecutive days, the PRC can submit a prior authorization request for additional payment. A lack of post-discharge options alone will not be considered appropriate justification for continued payment for a stay at a PRC.

All PRCs should have an active provider agreement with the Ohio Department of Medicaid (ODM) and a national provider identifier (NPI).

Billing Providers:

The following eligible providers may receive medicaid payment for submitting a claim for a covered PRC service:

Provider Type/Specialty	Provider Description
10	Pediatric Recovery Center
21	Professional Medical Group with a PRC Specialty
100	PRC Specialty

PRCs may be listed as both the billing and rendering provider on a claim.

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The following providers are permitted to affiliate with PRC providers:

Provider Type	Provider Description
07	Registered Dietician Nutritionist
20	Physician/Osteopath Individual
24	Physician Assistant
39	Physical Therapist, Individual
41	Occupational Therapist, Individual

The following independent behavioral health providers affiliated with a professional medical group may affiliate with a PRC:

Provider Type/Specialty	Provider Description
37/370	Social Worker / Licensed Independent Social Worker
37/47i	Social Worker / Clinical Counselor, Independent
37/42L	Social Worker / Licensed Psychologist
37/52i	Social Worker / Independent Marriage and Family Therapist
37/54i	Social Worker / Chemical Counselor, Independent
42/37i	Psychology / Social Worker, Independent
42/47i	Psychology / Clinical Counselor, Independent
42/52i	Psychology / Independent Marriage and Family Therapist
42/54i	Psychology / Chemical Counselor, Independent
42/420	Psychology / Licensed Psychologist
47/474	Clinical Counseling / Licensed Professional Clinical Counselor
47/37i	Clinical Counseling / Social Worker Independent
47/42L	Clinical Counseling / Licensed Psychologist
47/52i	Clinical Counseling / Independent Marriage and Family Therapist
47/54i	Clinical Counseling / Chemical Counselor, Independent
52/37i	Marriage and Family Therapy / Social Worker, Independent
52/42L	Marriage and Family Therapy / Licensed Psychologist
52/47i	Marriage and Family Therapy / Clinical Counselor, Independent
52/520	Marriage and Family Therapy / Licensed Independent Marriage and Family Therapist
52/54i	Marriage and Family Therapy / Chemical Counselor, Independent
54/540	Chemical Dependency / Licensed Independent Chemical Dependency Counselor
54/37i	Chemical Dependency / Social Worker, Independent
54/47i	Chemical Dependency / Clinical Counselor, Independent
54/42L	Chemical Dependency / Licensed Psychologist
54/52i	Chemical Dependency / Independent Marriage and Family Therapist

More information on how to affiliate providers can be found on the Group/Organization/Agency Affiliations Quick Reference Guide.

Provider Enrollment:

ODM is required to enroll and screen all providers who administer services to Ohio Medicaid members. The screening includes verification of good standing with federal and state agencies, National Provider Identifier verification, and appropriate licensure (if applicable). ODM also screens agency and practice owners during initial enrollment, monthly database checks, and revalidation. A PRC must first go through this enrollment process, before performing services for a Medicaid member and seeking reimbursement for those covered services. All provider enrollment applications are submitted electronically in the Provider Network Management (PNM) module. An OH|ID is required for access to the PNM module. If you do not have an existing OH|ID, you will need to create one first. Once an OH|ID is obtained, Administrator and Agent roles for PNM must then be established. Once in the PNM module, a new provider application may be submitted to become a PRC. The provider application will then be processed by ODM. Once the provider application is approved, the PRC may seek contracts with any applicable Managed Care Organization (MCO), which allows for reimbursement from those MCO's managed care members.

Resources to assist with gaining access to the PNM module, can be found on ODM's Next Generation PNM & Credentialing webpage. There are many specific resources available to anyone, without needing to log into PNM, under the PNM Learning tab. Trainings on how to use the PNM module can be accessed via the learning management system (LMS), Absorb. More details and steps on how to access Absorb can be found on ODM's Next Generation Implementation Training and Resources webpage.

Member Eligibility:

The PRC per diem rate may be billed for substance exposed infants, up to twelve months in age, experiencing physical withdrawal symptoms.

Common diagnoses treated at a PRC include:

ICD-10 Code	Description
P04.14	Neonatal opioid exposure
P04.49	Newborn affected by maternal use of other drugs of addiction (chronic)
P04.6	Newborn affected by maternal exposure to environmental chemical substance
P96.1	Neonatal withdrawal symptoms from maternal use of drugs of addiction

PRC per diem rate claims must include one of these four ICD-10 codes as the primary diagnosis code on the claim. A PRC may also bill for services outside of the per diem rate for medicaid eligible parents and caregivers. MyCare and OhioRISE members are not eligible for services provided by a PRC.

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Coverage and Payment:

ODM can reimburse PRCs for covered services provided to substance exposed infants and their medicaid eligible families and caregivers in the table below. Payment can be made to PRCs for services covered in the per diem rate and ODM pays for services rendered to members with Fee For Service (FFS) coverage. PRCs should bill claims for per diem stays in chronological order starting with the first date of service for proper claims adjudication. MCOs must also cover these services at the same rate as ODM FFS through at least 7/1/2027. Each MCO has their own billing procedures. Refer to each MCO's billing manual for instructions on claims submission.

Services Included in the Per Diem Rate	• Activities to encourage caregiver-infant bonding • Advising on caring for infants with physical withdrawal symptoms • Referrals for services and counseling • Direct care costs • Discharge planning • Non-pharmalogical and pharmalogical care for infants with substance exposure resulting in withdrawal • Pediatric medical services (i.e., prescribing medication, administering rectal or intravenous medication, outpatient laboratory services, sick visits, and onsite well child exams • Training on caring for infants	**Billing Code:** S9475 – Ambulatory setting substance (PRC) **Per Diem Rate:** $559.62 **Maximum Unit:** 1 (per diem) unit, per infant, per day **Place of Service:** 99 – Other Place of Service
Services Not Included in the Per Diem Rate for Which a Separate Medicaid Payment May Be Made	• Direct services provided to medicaid eligible parents or caregivers • Healthcare-related transportation services defined in Chapter 5160-14 of the Administrative Code • Services rendered by a practitioner of physician services outside of any pediatric medical services rendered included in the per diem rate • Other services specifically authorized in rule promulgated under agency 5160 of the Administrative Code.	**See ODM Fee Schedule Appendix DD for billing codes and rates.**

There is no code set for the per diem rate. A PRC should bill one per diem rate code per day stay at a PRC per infant. The services listed in the services included in per diem rate table above are the services generally provided daily to all infants during their stay at a PRC. Only services rendered by providers of physician services, transportation and nurse home visits should be billed separately on behalf of the infant. ODM does not have a restriction on what services can be billed for on behalf of the medicaid eligible parent/caregiver. The per diem rate may only be billed for on behalf of the infant. Payment rates are published in Appendix DD of OAC rule 5160-1-60: Medicaid payment. The Appendix DD fee schedule is typically updated annually in January. Any specific rate updates or new code additions that occur mid-year are listed on the CPT and HCPCS Level II Procedure Code

Changes fee schedule that is updated on a quarterly basis (January, April, July, and October) until the Appendix DD fee schedule is updated accordingly.

Please keep in mind that when a fee schedule is updated, it does not mean every rate is updated for every procedure code.

Prior Authorization (PA):

No prior authorization will be required for per diem rate payment on an infant's initial admission to a PRC. A prior authorization will be required for per diem payment for stays in excess of 30 consecutive days and any time there is a break in service within 30 consecutive days. Please see some example scenarios to describe PA necessity below:

First Date of Service (DOS)	PRC Stay Dates	PA Required?
7/1/25	Discharged from PRC: 7/2/25 Readmitted to PRC: 7/4/25 Discharged from PRC: 7/15/25	No PA will be needed for DOS 7/1-7/2/25. PA needed for readmission during break in 30 consecutive days.
7/1/25	Discharged from PRC: 7/15/25 Readmitted to PRC: 7/16/25 Discharged from PRC: 7/30/25	No PA will be needed as there is no break in 30 consecutive days of service.
7/1/25	Discharged from PRC: 7/15/25 Readmitted 7/20/25 Discharged from PRC: 7/31/25	No PA will be required for DOS 7/1-7/15/25. PA needed for 7/20-7/31/25 DOS.
7/1/25	Discharged from PRC: 7/30/25 Readmitted to PRC: 9/1/25 Discharged from PRC: 9/10/25	No PA required for DOS through 7/30/25. PA required for DOS 9/1-9/10/25.
7/1/25	Discharged from PRC: 8/15/25	No PA required for DOS through 7/30/2025. PA required for DOS 7/31-8/15/25.

PRC PAs should include:

- 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.

Reimbursement for other services covered outside the per diem may depend 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 approved by ODM, its designee, or the MCOs before the services are rendered or the items are delivered. 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 exemptions. 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 PA can be found in the Prior Authorization User Guide on the Learning Page of the PNM homepage. PAs should be submitted directly to MCOs.

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:

PRC claims can be submitted via ODM Electronic Data Interchange (EDI) through a trading partner or using the ODM Provider Network Module. 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 PRC 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. 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. 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 Provider Network Module (PNM) "Provider Financials and Remittance Advice" user manual access through the PNM Provider Education & Training Resources page. Fee-For-Service (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.

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 other 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 and OAC rule 5160-26-09.1: Managed care third-party liability and recovery.

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 denied claims can try to troubleshoot denials by reviewing claim denial reason codes in the PNM portal or in their remittance advice (RA). If the denial reason is still unclear, providers should reach out to the Integrated Help Desk (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 Help Desk (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: https://providercomplaints.ohiomh.com/ComplaintForm.aspx?forceredirect=true. ODM will review all concerns submitted along with MCO responses.

Additional Resources:

- Creating OH|ID for IOP PNM Login
- 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

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Questions?

General PRC Policy Questions:

Email ODM at noninstitutional_policy@medicaid.ohio.gov

Claims Submission:

Fee for Service:

Please contact the ODM Integrated Help Desk (IDH) 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.

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PRC Billing Guidance Change Log

Date	Change Description
7/1/25	Creation of PRC Billing Guidance
7/31/25	ODM clarified one of the ICD-10 diagnosis codes listed in this document needs to be included as the primary diagnosis code on a PRC claim billed on behalf of the infant. ODM also corrected a minor error in the rate listed to match Appendix DD, clarified coverage details and added another billing scenario for provider reference.