Ohio
Department of Medicaid

Office of Benefits

Hospital Billing Guidelines

Applies to dates of discharge and dates of service on or before July 31, 2017

Revised 7/1/2017

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NEW CHANGES FOR 7/1/2017

Underlined text indicates new language.

- The sections of this document have been rearranged for easier readability.
- Language was clarified regarding prior authorization and services rendered by out-of-state providers. In addition, as of July 1, 2017, KEPRO is the contracted vendor responsible for reviewing medical prior authorization requests. (Refer to Section 2.5.2)
- Language was added to provide clarification regarding third party liability. (Refer to Section 2.7.1)
- Language was added to provide clarification regarding inpatient admission orders. (Refer to Section 2.10)
- Language was added to provide billing guidance for individuals with the Inpatient Hospital Services Program (IHSP) benefit plan. (Refer to Section 2.11, Section 2.13 and Appendix J)
- Effective for dates of discharge on or after 7/6/2017, reimbursement for a LARC device when provided in an inpatient hospital setting postpartum and prior to the patient's discharge, the hospital may submit an outpatient claim for the LARC device. The tables in the LARC section have also been updated. (Refer to Section 2.16)
- The outlier thresholds used to calculate outlier payments for dates of discharge on or after July 6, 2017 have been updated. (Refer to Section 2.17)
- Language was added to clarify the requirements regarding the submission of a NDC with a pharmaceutical HCPCS code. (Refer to Section 3.4)
- Modifier information provided in Appendix A to OAC rule 5160-2-21 was added. (Refer to Section 3.7.1)
- Language was added to clarify the use of canceled surgery modifiers. (Refer to Section 3.7.5)
- Language was added to clarify the use of modifier JW. (Refer to Section 3.7.6)
- Per the National Uniform Billing Committee, the implementation date of revenue center code 826 has been delayed. The new effective date is to be determined. (Refer to Appendix I)
- A list of inpatient and outpatient services that require prior authorization was added. (Refer to Appendix K)
- The use of the 'AN' condition code is no longer permitted.

1. HOSPITAL BILLING OVERVIEW

The Ohio Department of Medicaid (ODM) Hospital Billing Guidelines contain basic billing information for Ohio Medicaid hospital providers regarding inpatient and outpatient claims. It is intended to be a supplemental guide to assist providers with specific Medicaid policy from a billing perspective when submitting a claim electronically or through the web portal.

ODM Hospital Billing Guidelines are based on rules of the Ohio Administrative Code (OAC). Effective July 1, 2015, ODM is no longer publishing transmittal letters or utilizing eManuals, including the Ohio Department of Job and Family Services (ODJFS) Legal Policy Central Calendar.

Stakeholders who want to receive notification when ODM original or final files a rule package may visit the Ohio Joint Committee on Agency Rule Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by rule number or department.

Stakeholders can subscribe to receive notification when a clearance or business impact analysis (BIA) is posted for public comment on the Ohio Business Gateway here: http://business.ohio.gov/reform/enotify/subscription.aspx

OAC rules are available at Lawriter at http://codes.ohio.gov/oac/5160-2

Per OAC rule 5160-1-19, all claims must be submitted to ODM through one of the following formats:

> (1) Electronic Data Interchange (EDI) in accordance with standards established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996; or
> (2) The Medicaid Information Technology System (MITS) web portal.

Providers submitting claims electronically to ODM must use the most current version of the EDI 837 Institutional (I) format. The official EDI standards for all EDI transactions are developed and maintained by the Accredited Standards Committee (ASC) X12. The ODM 837I Companion Guide has been created as a supplemental guide and can be accessed through the ODM website at:

http://medicaid.ohio.gov/PROVIDERS/MITS/HIPAA5010Implementation.aspx

Many of the code sets used within the EDI 837I standards are set by the National Uniform Billing Committee (NUBC) for the UB-04 claim form. A complete document containing all current UB-04 billing codes may be accessed at the NUBC website:

http://www.nubc.org/

For additional information, please contact the Interactive Voice Response System (IVR) at 1-800-686-1516, or visit the Ohio Department of Medicaid website:

http://www.medicaid.ohio.gov

1.1 PROVIDER ENROLLMENT

All provider enrollments must be initiated through the ODM MITS Web Portal. More information regarding provider enrollment may be found at: http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx.

Per OAC rule 5160-1-17.9, ODM requires any ordering, referring or prescribing (ORP) providers to be screened and enrolled as participating providers with the Medicaid program. ODM cannot reimburse the eligible rendering provider for any healthcare service requiring a referral, order, or prescription from a physician or other healthcare professional unless the ORP provider is enrolled with Ohio Medicaid. If a claim fails to include the provider's National Provider Identifier (NPI) or the legal name of the physician or healthcare professional that ordered or prescribed the service, or referred the client for the service, Medicaid reimbursement will not be allowed. Providers can choose to enroll as a Medicaid ORP only provider, which allows the provider to order, refer, or prescribe services to Medicaid consumers, but the provider cannot submit a claim to ODM for reimbursement. Claims submitted to an Ohio Medicaid MCP are exempt from ORP requirements.

If a claim was denied because the ORP provider was not enrolled as a provider in the Ohio Medicaid program, the ORP provider is permitted to retroactively enroll up to 12 months prior to the date of enrollment. Retroactive enrollment is permitted under the condition that the enrolling provider is appropriately licensed and the enrollment complies with program integrity provisions established by ODM. Once the ORP provider is enrolled, the denied claim can be resubmitted by the billing provider for payment as long as the resubmission occurs within 365 days from the date of service.

When an existing Medicaid provider's contract is about to expire, ODM has an automated process that sends out letters warning providers of the approaching expirations, both 90 days and 30 days prior to the expiration date of the provider contract. If the provider fails to revalidate, the provider's agreement is terminated. If an ORP provider's contract is terminated for failure to revalidate the Medicaid provider contract prior to the expiration date, any claims submitted with that provider as the ORP for the inactive time period will be denied and cannot be backdated.

1.2 UB-04 INSTRUCTIONS FOR HOSPITAL PROVIDERS

NOTE: This guide is structured using the UB-04 claim form layout, but claims are required to be submitted through EDI or the MITS web-portal.

Form Locator #	Field	Required
1	Billing Provider Name, Address and Telephone Number	IP, OP
2	Billing Provider's Designated Pay-to Name and Address (The address listed here will not be recognized. Payment will be sent to the address listed on the provider application.)	
3a	Patient Control Number	IP, OP
3b	Medical/Health Record Number	
4	Type of Bill (See Appendix A for additional notes regarding Bill Type use for Ohio Medicaid.)	IP, OP
5	Federal Tax Number	IP, OP
6	Statement Covers Period The span of service dates included on this particular claim. The 'from date' is the earliest date of service on the claim and it may not match the 'admission date'. (For Medicare crossover claims this should match the "from date" and "through date" as it appears on the Medicare remittance advice.)	IP, OP
7	Reserved for Assignment by the NUBC	
8a	Patient Identifier	
8b	Patient Name (Name must correspond to the name on the Medical Assistance I.D. card. No punctuation or abbreviation may be used.)	IP, OP
9	Patient Address	IP, OP
10	Patient Birth Date (An unknown birth date is not acceptable.)	IP, OP
11	Patient Sex (An unknown sex is not acceptable.)	IP, OP
12	Admission/Start of Care Date This is the date the inpatient admission is ordered.	IP
13	Admission Hour	IP
14	Priority (Type) of Admission or Visit (See Appendix B for additional notes regarding Priority (Type) of Visit code use for Ohio Medicaid.)	IP, OP
15	Point of Origin for Admission or Visit (See Appendix C for additional notes regarding Point of Origin for Admission code use for Ohio Medicaid.)	IP, OP
16	Discharge Hour (This includes claims with a Frequency Code of 1, 4 and 7 when the replacement is for a prior final claim.)	IP
17	Patient Discharge Status (See Appendix D for additional notes regarding Patient Discharge Status code use for Ohio Medicaid.)	IP, OP

Form Locator #	Field	Required
18-28	Condition Codes (See Appendix E for additional notes regarding Condition Code use for Ohio Medicaid. Form Locator 81 for additional codes will not be used.)	
29	Accident State	
30	Reserved for Assignment by the NUBC	
31-34	Occurrence Codes and Dates (See Appendix F for additional notes regarding Occurrence Codes for Ohio Medicaid. Form Locator 81 for additional codes will not be recognized.)	
35-36	Occurrence Span Codes and Dates	
37	Reserved for Assignment by the NUBC	
38	Responsible Party Name and Address (Claim Address)	
39-41	Value Codes and Amounts (See Appendix G for additional notes regarding Value Code use for Ohio Medicaid. Form Locator 81 for additional codes will not be recognized)	
42	Revenue Code (See Appendix I for a listing of covered revenue codes. The Medicaid program will reimburse private room rates only under the following conditions: a.) When a private room is medically necessary; b.) When a hospital has no semi-private room; c.) When the patient chooses a private room and agrees, in advance in writing, to pay the difference between the private and semi-private rates. When submitting a bill to Medicaid with a private room revenue center code (RCC), either condition code 39 (medical necessity), value code 31 (patient liability-patient chooses private room and agrees to pay room differential), or value code 02 (hospital has no semi-private rooms) must be present or the claim will be denied. If value code 31 is used, the charges related to the private and semi-private room differential must appear in Form Locator 48 (Non-Covered Charges).)	IP, OP
43	Revenue Description (If the revenue center code (RCC) in Form Locator 42 indicates room and board, enter the daily rate in Form Locator 44 and the number of days in Form Locator 46. The number of units for room and board for covered and non-covered days must be reported on separate lines in the claim details and need to match the header level covered and non-covered.)	
44	HCPCS/Accommodation Rates/HIPPS Rate Codes (For most outpatient services, a Current Procedural Terminology (CPT) code must be reported. Services requiring CPT coding are detailed in Appendix B of OAC rule 5160-2-21.)	
45	Service Date	OP
46	Service Units (See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board.)	IP, OP

Form Locator #	Field	Required
47	Total Charges The total amount of charges related to the revenue code and/or CPT/ HCPCS code, include both covered and non-covered charges. (See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board.) The difference between Total Charges and Non-Covered Charges would be the Total Medicaid Covered Charges. The Total Medicaid Covered Charges are used for outlier calculations.	IP, OP
48	Non-Covered Charges (See Appendix G for additional notes regarding how units and charges should be reported for covered and non-covered days for revenue center codes indicating room and board. Any charges that should be reported as non-covered should be listed here.) The difference between Total Charges and Non-Covered Charges would be the Total Medicaid Covered Charges. The Total Medicaid Covered Charges are used for outlier calculations.	
49	Reserved for assignment by the NUBC	
50	Payer Name	IP, OP
51	Health Plan Identification Number	IP, OP
52	Release of Information Certification Indicator	IP, OP
53	Assignment of Benefits Certification Indicator	IP, OP
54	Prior Payments – Payer	
55	Estimated Amount Due	
56	National Provider Identifier – Billing Provider (See Appendix H for additional notes regarding NPI use for Ohio Medicaid.)	
57	Other (Billing) Provider Identifier (Can be used to report the Ohio Medicaid legacy number.)	
58	Insured's Name	IP, OP
59	Patient's Relationship to Insured	IP, OP
60	Insured's Unique Identifier (Enter the patient's twelve (12) digit billing number exactly as it appears on the Medical Assistance I.D. card.)	IP, OP
61	Insured's Group Name	
62	Insured's Group Number	
63	Authorization Code/Referral Number	
64	Document Control Number (DCN)	
65	Employer Name (of the Insured)	
66	Diagnosis and Procedure Code Qualifier (ICD Revision Indicator) (Qualifier Code "9" or "0" is required on all claims.)	IP, OP
67	Principal Diagnosis Code and Present on Admission Indicator	IP, OP
67 A-Q	Other Diagnosis Codes	
68	Reserved for Assignment by the NUBC	
69	Admitting Diagnosis Code (Required on 011X and 012X)	IP

Form Locator #	Field	Required
70 a-c	Patient's Reason for Visit (Required on Type of Bill 013X, 078X, and 085X when: (1) Form Locator 14 codes 1, 2, or 5 are reported; AND (2) Revenue codes 045X, 0516, or 0762 are reported on Form Locator 42.)	OP
71	Prospective Payment System (PPS) Code	
72 a-c	External Cause of Injury (ECI) Code and Present on Admission Indicator	
73	Reserved for Assignment by the NUBC	
74	Principal Procedure Code and Date	
74 a-e	Other Procedure Codes and Dates	
75	Reserved for Assignment by the NUBC	
76	Attending Provider Name and Identifiers	
77	Operating Physician Name and Identifiers	
78-79	Other Provider Name and Identifiers	
80	Remarks Field (For all emergency department visits determined to be non-emergent enter COPAY_NEMR (note: _ indicates space).)	
81	Code – Code Field (This field will not be used.)	

2. SPECIAL CASES BILLING INSTRUCTIONS

2.1 TRANSFER BILLING

Please refer to OAC rule 5160-2-65 for ODM requirements regarding transfer billing.

2.1.1 TRANSFER BETWEEN ACUTE CARE AND MEDICARE DISTINCT PART PSYCHIATRIC UNITS

When a transfer occurs between an acute care unit and a Medicare-approved distinct part psychiatric unit within the same hospital, one of the following billing situations will occur:

1) The stay in the two units will be considered one admission for payment purposes if either of the following is true:

   - The DRGs for both episodes of care fall within the range of APR-DRGs 750 – 760 (psychiatric DRGs); or
   - The DRGs for both episodes of care fall outside the range of APR-DRGs 750 – 760 (non-psychiatric DRGs)

In either of these situations, the hospital must combine the two episodes of care into one admit through discharge claim.

2) If the stay in the two units does not meet the criteria in the above paragraph, the two stays will be treated as two separate admissions for payment purposes and should be submitted as separate claims. A payment will be made for services rendered in the acute care section (APR-DRG 1 – 740 and 770 – 952) as well as for psychiatric services provided in the psychiatric distinct part unit (APR-DRG 750 – 760).

   Complete a separate claim for each stay according to the billing instructions except for the following:

   For the acute care stay:

   - Use Type of Bill 111
   - Enter the beginning and ending service dates to reflect the stay in the unit for the Statement Covers Period
   - Complete Patient Discharge Status as appropriate (example: use Patient Discharge Status 65 if leaving the acute care stay to be admitted to the psychiatric stay.)

   For the psychiatric stay:

   - Use Type of Bill 111
   - Enter the beginning and ending service dates to reflect the stay in the unit as the Statement Covers Period
     - The "from" date must equal the date of discharge on the acute care stay claim
   - Complete Patient Discharge Status as appropriate
   - Please note that a pre-certification is required for all psychiatric stays, regardless of the patient's acute care stay.

2.1.2 MULTIPLE TRANSFERS BETWEEN ACUTE CARE AND MEDICARE DISTINCT PART PSYCHIATRIC UNITS

When a patient stay involves more than one transfer to or from a distinct part psychiatric unit, providers will need to combine the two separate stays of the same unit. In such cases, there are at least two separate episodes of care in either the acute or psychiatric unit, and possibly in both (e.g., 3 days in acute unit - 2 days in psychiatric unit - 2 days in acute unit). Using this example, the two separate stays in the acute unit can be combined into one claim, reporting the days in the psychiatric unit as non-covered days and including the charges as both total and non-covered.

Complete a separate claim for each stay according to the billing instructions except for the following:

For the acute care stay (using the example noted above):

- Use Type of Bill 111
- Enter the beginning and ending service dates to reflect both stays in the unit for the Statement Covers Period
- Covered days: 5
- Non-covered days: 2 (while in psychiatric unit)
- In the claim detail, report covered days with associated charges on one line, and non-covered days (RCC 180) along with the associated charges included as total charges and non-covered charges on a separate line.
- Complete Patient Discharge Status as appropriate

For the psychiatric stay:

- Use Type of Bill 111
- Enter the beginning and ending service dates to reflect the stay in the unit as the Statement Covers Period
    - The "from" date must equal the date of discharge on the acute care stay claim
- Complete Patient Discharge Status as appropriate

2.1.3 TRANSFERS BETWEEN ACUTE AND DISTINCT PART REHABILITATION UNITS

Medicaid does not recognize distinct part rehabilitation units as a separate unit of the hospital. A complete admit through discharge claim must be submitted to ODM when a patient is transferred between the acute care unit and rehabilitation unit within the same hospital. For hospitals that internally generate two claims for these stays, collapse them into one claim prior to submission to ODM.

2.2 INTERIM BILLING INSTRUCTIONS

According to OAC rule 5160-2-65, claims qualify for advance interim payment on the 30th day of a consecutive inpatient stay and at 30-day intervals thereafter.

To receive an interim payment, complete the claim for submission to Medicaid according to the following guidelines:

For hospitals paid under the prospective payment system (DRG):

- Use Type of Bill 112 or 113 (as defined by the NUBC)
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type
    - For 113 bill types, the admission date is not required to fall within the "Statement Covers Period" date span

- Covered days must be equal to or greater than 30 days
- Use Patient Status Code 30 (still patient)

Once the patient is discharged, all interim bills must be voided before the final admit through discharge claim can be submitted. The interim bills can be voided/reversed through an EDI transaction or through the ODM MITS Web Portal. The final claim must be a complete admit through discharge bill type 111 reiterating all charges submitted on prior advance interim bills.

For hospitals that are exempt from DRG-based reimbursement:

- Use Type of Bill 112 or 113 (as defined by the NUBC)
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type
    - For 113 bill types, the admission date is not required to fall within the "Statement Covers Period" date span
- Covered days must be equal to or greater than 30 days
- Use Patient Status Code 30 (still patient)

As a final bill, DRG exempt providers are to submit a Type of Bill 114 with the remaining days and charges since the last interim bill (it would not have to be 30 days).

2.3 ADJUSTMENTS TO PAID CLAIMS

If a provider feels that an improper assignment of a DRG has occurred through omission of information and/or submittal of incorrect claims data, an adjustment can be completed. Through the ODM MITS Web Portal, the paid claim can be voided so the corrected claim can be submitted; this process can also be submitted through EDI.

Information pertaining to electronic adjustments submitted via EDI 837 transactions can be found on the Department's EDI website:

http://medicaid.ohio.gov/PROVIDERS/Billing/TradingPartners.aspx

When adjusting a claim, the code set originally used to submit the claim will be the code set used when adjusting the claim. For example, if the claim was submitted using the ICD-9 code set and date of service/date of discharge was prior to 10/1/2015, the ICD-9 code set will be used for adjusting the claim. If the claim was submitted using the ICD-10 code set and date of service/date of discharge was on or after 10/1/2015, the ICD-10 code set will be used for adjusting the claim.

2.4 DENIED/PROBLEM CLAIMS

Denied or problem claims should be resubmitted to the Department through the ODM MITS Web Portal for reprocessing (indicate that the ODM 06653 Medical Claim Review Request Form is attached).

The following are some examples of when this process must be used:

- Denied claims for clinical editor rejections (age/diagnosis conflicts) – also attach a copy of the Medicaid remittance advice showing the denial. On the ODM 06653 Medical Claim Review Request Form, indicate why the diagnosis code in question is used.
- Medicare Crossover/TPL primary denials – also attach the primary payer's remittance advice for the denied claim, which will indicate the reason for the denial.
- Timely filing denials – also attach a copy of the remittance advice highlighting the claim in question as well as documentation to support timely filing as stated in OAC rule 5160-1-19.

2.5 PRE-CERTIFICATION, PRIOR AUTHORIZATION REQUIREMENTS, AND UTILIZATION REVIEW

These are two different types of authorization hospitals may be required to obtain – pre-certification and prior authorization. The pre-certification requirement is for all psychiatric admissions. The prior authorization (PA) requirement is for procedures that are normally considered non-covered in accordance with OAC rule 5160-2-03, and must be reviewed for medical necessity (except transplants, these are covered but still require prior authorization).

Pre-certification and prior authorization is not required when Medicare is the primary payer.

The use of the condition code "AN" is no longer recognized. If it is added to a claim to by-pass precertification and prior authorization requirements, the result will be a denied claim.

ODM contracts with a utilization review vendor that reviews all submitted pre-certification and PA requests on behalf of the Department.

Effective August 2, 2011, all pre-certification and prior authorization requests (except transplants) must be submitted through the ODM MITS Web Portal. The pre-certification/PA number is issued by MITS and must be submitted on the claim for the services for which the number was rendered.

2.5.1 PRE-CERTIFICATION – PSYCHIATRIC ADMISSIONS

Specifications related to pre-certification are defined in OAC rule 5160-2-40. Providers are required to get pre-certification on psychiatric admissions.

For psychiatric admissions, if the diagnosis related group (DRG) assigned to the claim is DRG 750 to 760 and admitting International Classification of Diseases, 10th Revision (ICD-10) diagnosis code is F0150-F99, G4700, G479, H9325, Q900-Q902, Q909-Q917, Q933-Q935, Q937, Q9388-Q9389, Q939, Q992, R37, R4181, R41840-R41841, R41843-R41844, R440, R442-R443, R450-R457, R4581-R4582 R45850-R45851, R4586-R4587, R4589, R4681, R4689, R480-R482, R488-R489, R54, Z72810-Z72811, Z87890 or Z9183, the admission requires pre-certification.

The pre-certification must be obtained prior to the admission or within two business days of the admission. Pre-certification is required for all payers, unless Medicare is the primary payer. If Medicaid eligibility was pending at the time of psychiatric admission, or if Medicaid eligibility was granted retrospectively, the hospital will need to submit a pre-certification request through the ODM MITS Web Portal to request a retrospective pre-certification number. The hospital should provide proof or reasonable assurance that eligibility was checked at the time of admission, so that their request may be processed in accordance with OAC guidelines.

If a person is admitted for medical reasons but after admission and medical evaluation, it is determined the reason for the care was psychiatric in nature, pre-certification is not required. The admitting diagnosis codes on these claims will indicate an acute medical condition rather than a psychiatric condition, so the claim will process without pre-certification.

Pre-certification requirements for surgical procedures were discontinued effective 10/1/2015.

2.5.2 PRIOR AUTHORIZATION – MEDICAL

Pursuant to Ohio Revised Code (ORC) 5160.34, a list of inpatient and outpatient services that require prior authorization is included as Appendix K of the Hospital Billing Guidelines and is also available on the ODM website. In addition, OAC rule 5160-2-03 describes the types of inpatient and outpatient services that would require prior authorization. Examples of services that would require prior authorization include investigational/experimental procedures, plastic surgery, and organ transplants (except kidney). Prior authorization will be granted if a service that is typically not covered is proven to be medically necessary for a consumer. Per OAC rule 5160-1-11, Ohio Medicaid will cover medically necessary services rendered by out-of-state providers if those services are not available within Ohio; the services must be prior authorized to be performed by the out-of-state provider. More information regarding Medicaid's prior authorization policy can be found in OAC rule 5160-1-31.

Procedures that require prior authorization are never exempt from prior authorization, so a retrospective review for PA can be requested. A claim submitted with a procedure code that requires a PA will never pay without an approved authorization.

As of July 1, 2017, KEPRO is the contracted vendor responsible for reviewing medical prior authorization requests. KEPRO's toll-free phone number is 844-854-7281 and toll-free fax number is 844-262-8990.

2.5.3 PRIOR AUTHORIZATION – TRANSPLANTS

Prior Authorization for transplants must be requested directly from the appropriate consortium:

Ohio Solid Organ Transplantation Consortium
9200 Memorial Dr.
Plain City, Ohio 43064
Telephone: 614-504-5705
FAX: 614-504-5707

Ohio Hematopoietic Stem Cell Transplant Consortium
9500 Euclid Avenue, Desk R32
Cleveland, Ohio 44195
Telephone: 440-585-0759
FAX: 440-943-6877

Once the applicable transplant consortium has approved the PA request, ODM enters the information into MITS and an approval letter is generated to the hospital and the consumer. Hospitals may also log into MITS to check for transplant approvals and authorization numbers. The assigned prior authorization number must be included on the claim. Transplant claims can be submitted via EDI or through the ODM MITS Web Portal.

Effective with the implementation of the APR-DRGs and in accordance with OAC rule 5160-2-65, all transplant services are subject to DRG prospective payment.

In order to receive reimbursement for organ acquisition charges, the charges must be reported using revenue center code "810 - Organ Acquisition, General Classification." Please note that kidney transplants are not subject to additional reimbursement for organ acquisition.

2.5.4 UTILIZATION REVIEW AND ASSOCIATED CLAIM RESUBMISSION

Per OAC rule 5160-02-07.13, on behalf of ODM, a medical review entity performs utilization review for Medicaid inpatient and outpatient services (both acute and psych) regardless of the payment methodology used for reimbursement of those services. During the course of its analyses, the medical review entity may request information or records from the hospital and may conduct on-site medical record reviews.

Upon retrospective review, the medical review agency may determine billing errors, the wrong procedure code was used, or that the location of service was not medically necessary, but the

services rendered were medically necessary. In the instance where the inpatient setting was not medically necessary, the hospital may bill Medicaid on an outpatient basis for those medically necessary services rendered on the date of admission in accordance with OAC rule 5160-2-21. In addition, only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be submitted on the outpatient claim.

1) Payments for inpatient acute stays that have been recouped due to utilization review will include adjustment reason codes (ARC), which will indicate the reason for the recoupment.

    a. ARC 8008 permits the provider to resubmit the claim for the same Type of Bill within 180 days of the voided claim. If a voided claim is assigned ARC 8008, the provider must submit the new claim, along with the letter from the utilization review entity, and include Condition Code C3 and/or the ICN of the voided claim. The new claim must be submitted within 180 days of the voided date of the original claim (the date the payment was taken back by ODM) to allow for the timely filing edits to be bypassed. If the provider fails to resubmit the claim in accordance with the criteria set forth in ARC 8008, audit 5045 (UR-DENY CLAIM WHEN 180 DAY FILING LIMIT EXCEEDED) will post to deny the claim. Do not use the 6653 form process when resubmitting the claim. When resubmitting the claim through the MITS web portal, click on the dropdown box and select "support data for claim", then upload your attachment and click on the submit button.

    b. ARC 8010 is assigned when the payment is recouped and the provider is never allowed to resubmit the claim for this consumer for these dates of service. If a provider attempts to resubmit a claim after the original paid claim is voided, audit 5042 (UR-DENY NEW DAY CLAIM IF HIST PAID CLAIM ADJ TO $0) or audit 5043 (UR-DENY ADJ CLAIM IF HIST PAID CLAIM ADJ TO $0) will post to deny the claim.

    c. ARC 8012 permits the provider to resubmit the claim as an outpatient claim within 60 days of the voided claim. If a voided claim is assigned ARC 8012, the provider must submit the new outpatient claim, along with the letter from the utilization review entity, and include Condition Code C3 and/or the ICN of the voided claim. The new outpatient claim must be submitted within 60 days from the voided date of the original claim (the date the payment was taken back by ODM) to allow for the timely filing edits to be bypassed. If the voided claim contains multiple dates of service, the provider can bill for all services rendered on the date of admission, but the provider can only bill for laboratory and radiology services rendered on dates of service subsequent to the date of admission. If the provider fails to resubmit the claim in accordance with the criteria set forth in ARC 8012, audit 5044 (UR-DENY INPATIENT CLM IF RESUBMIT AS OUTPATIENT), audit 5046 (UR-DENY CLAIM WHEN 60 DAY FILING LIMIT EXCEEDED), or audit 5048 (UR-INVALID INPATIENT PROCEDURE/DOS COMB BILLED) will post to deny the claim. Do not use the 6653 form or process when resubmitting the claim. When resubmitting the claim through the MITS web portal, click on the dropdown box and select "support data for claim", then upload your attachment and click on the submit button.

NOTE: If the original claim was voided due to utilization review using ARC 8008 or 8012 but the provider failed to resubmit the claim with attachments, audit 5047 (UR-RESUBMITTED CLAIM WITH NO ATTACHMENTS) will post to deny the claim.

2) Payments for inpatient psych stays that have been recouped due to utilization review will NOT be assigned ARC 8008 or 8012. When resubmitting the claim after the payment recoupment, please include Condition Code C3 on the claim along with the following attachments:
   a. ODM 06653 Medical Claim Review Request Form
   b. Letter from utilization review entity
   c. Remittance Advice indicating recoupment of payment

Effective for services rendered on or after January 1, 2016, per OAC rule 5160-2-07.13, upon utilization review of Medicaid inpatient hospital services, for those claims recouped for a technical denial (ARC 8010), ODM or its medical review entity may recover physician payments for services associated with the recouped inpatient claim payment that resulted from utilization review.

2.5.5 UTILIZATION REVIEW – THIRD PARTY LIABILITY POST PAYMENT REVIEW

The Department has contracted with Health Management Systems, Inc. (HMS) to supplement its Medicaid third party liability (TPL) recovery activities. Following their claim review, HMS will issue a notice of its findings. Hospitals have 90 days from the date of the notice to:

1) Review its records;
2) Bill the respective commercial carrier, if it has not already done so; and
3) Forward documentation to HMS to either refute the impending recoupment action for every claim the commercial carrier denies or confirm receipt of payment from the third party to validate the impending recoupment.

Failure to respond to or provide proper justification for removing a claim from this initiative will result in the payment being recouped via the claims down adjustment process at the close of the cycle. In order to resubmit the claim(s), providers must first seek authorization through HMS to validate the request. Providers who have repeatedly neglected to respond to recoupment cycles may be prevented from resubmitting claims. The following documentation should be provided to HMS, when seeking to resubmit the claim to the Department for refund or payment as secondary:

1) A copy of the cycle detail, highlighting the recipient name and date of service; and
2) A copy of the explanation of medical benefits (EOMB) letter from the third party, reflecting the status of the claim(s).

This information should sent, by fax, to the HMS Recoupment Team at (877) 256-1226 with the subject line "Refund" or "Payment as Secondary," whichever applies. Please note that the list of valid requests is sent to ODM for action on the last Friday of each month. The list of ICNs is then removed by ODM from the table and will be given a new ICN number that starts with the region

code 56. This new ICN number will be on a remittance advice and is to be put on the claim in the Portal when reprocessing.

When submitting your new claim to the Department via the web portal, put the ICN number with the region n code 56 from your remittance advice in the supporting data for delayed resubmission field. When submitting via EDI, you must include the ICN number of the recoupment claim in the REF Segment P4. The claim will deny for timely filing if this is not included. After those steps are complete, follow the prompts until completion of your claim.

In the event you are still experiencing problems, complete the ODM 06653 form. In section 6 of this form ("Explanation of the Request"), put the statement "This is part of the HMS takeback process." Include the takeback EOMB/letter from HMS with the submission of the ODM 6653 form. When selecting the 'ATTACHMENTS' panel in the MITS Web Portal, locate the 'TYPE OF DOCUMENT' field and choose 'REFERRAL FORM (OHIO 6653)' from the dropdown menu. This will allow the provider's attachments to connect to the claim record, and suspend as designed for manual review.

For all claims, which includes hospital claims that are reviewed for another primary payer, HMS determines if a provider is allowed to resubmit a claim to the Department for payment. The following EOBs will be assigned accordingly when the payment is recouped, and will only allow claims to be resubmitted as indicated.

1) EOB 8200: TPL Contractor recovery because Medicare is primary. Provider is not able to adjust claim and must contact TPL Contractor.
2) EOB 8201: TPL Contractor recovery because a Commercial Insurance is primary. Provider is not able to adjust claim and must contact TPL Contractor.
3) EOB 8210: TPL Contractor take reversal – Provider is able to resubmit for Medicare Cost Sharing.
4) EOB 8211: TPL Contractor take reversal – Provider is able to resubmit for Commercial Insurance Cost Sharing.

NOTE: When a claim is allowed to be resubmitted, and EOB 8210 or 8211 has been assigned, the resubmitted claims MUST include the ICN of the recoupment claim in the REF Segment P4. The resubmitted claim will deny for timely filing if this is not included.

2.6 BILLING FOR SERVICES REQUIRING SPECIAL DOCUMENTATION

2.6.1 ABORTIONS

Please refer to OAC rule 5160-17-01 for ODM requirements regarding reimbursement of abortion procedures. The requirements of OAC rule 5160-17-01 apply only to those abortions, which are induced, and not to those of a spontaneous nature which are normally otherwise defined as miscarriages.

Reimbursement for abortion services is restricted to the following circumstances:

1) Instances in which the mother suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself; or
2) Instances in which the pregnancy was the result of an act of rape; or
3) Instances in which the pregnancy was the result of an act of incest.

In cases of medical procedures, which include abortions, in which the life of the mother would be endangered if the fetus was carried to term, the Department must receive written certification from the physician attesting that the life of the mother would be endangered if the fetus was carried to term before any payment may be made. If space permits, the certification should be placed in the "Remarks" column of the claim. The certification can either be in typewritten or stamped form along with the physician's signature. All certifications must contain the address of the recipient.

The certification must be as follows:

> "I certify that, on the basis of my professional judgment, this service was necessary because the life of the mother would be endangered if the fetus were carried to term."

Invoices for abortion services subject to the above requirements must be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately. Reimbursement will not be made for hospital services, associated services, or laboratory tests if the abortion service is not eligible for reimbursement, regardless of whether or not the abortion itself is billed to the Department.

2.6.2 STERILIZATION

Please refer to OAC rule 5160-21-02.2 for ODM requirements regarding reimbursement of sterilization procedures. The OMB 0937-0166 Consent for Sterilization Form must be attached to all claims for sterilization procedures. The Consent for Sterilization Form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. In order for the sterilization services to be reimbursed, the date of the informed consent must occur at least 30 days, but not more than 180 days, prior to the date of the sterilization; this is not applicable in cases of premature delivery or emergency abdominal surgery. These claims can be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

2.6.3 HYSTERECTOMY SERVICES

Please refer to OAC rule 5160-21-02.2, which describes the requirements regarding reimbursement for hysterectomy services. All invoices submitted to the Department for hysterectomies (whether performed as a primary or secondary procedure) or for medical procedures directly related to such hysterectomies, must include a copy of the ODM 03199 Acknowledgement of Hysterectomy Information Form. A consent form must be completed when a recipient is eligible for both the Medicare and Medicaid programs and requires a hysterectomy. However, a hysterectomy consent form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. The completed consent form does not have to be submitted with the Medicare crossover claim, but must be forwarded separately to Medicaid as an attachment. If the claim is rejected by Medicare, submit a Medicaid claim with the Medicare rejection attached. In the "Provider Remarks" section of the invoice, enter the following: Consent form submitted (date submitted).

All hysterectomies (inpatient and outpatient) also require prior authorization. Prior authorization allows all providers the opportunity to submit a prior authorization request, even retrospectively. Please note that condition code "AN" will not bypass the prior authorization requirement.

All invoices for hysterectomies, along with an attached ODM 03199 Acknowledgement of Hysterectomy Information Form, can be submitted through the ODM MITS Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

2.7 COORDINATION OF BENEFITS / THIRD PARTY LIABILITY

2.7.1 THIRD PARTY LIABILITY

In order for Medicaid to pay secondary or tertiary, the primary payer's conditions of participation must be followed. For example, if the primary payer denies a claim because the patient went out of network or the services did not meet the primary payer's medical necessity requirements, Medicaid will not be responsible for those charges. Please refer to OAC rules 5160-1-05 and 5160-1-08 for further information regarding Medicaid coordination of benefits policies.

For claims where another payer is primary, Medicaid's reimbursement for hospital services will be no more than the Medicaid Maximum. If the prior payer has already paid more than the Medicaid Maximum, Medicaid's payment will be $0.00. Please refer to OAC rule 5160-2-25 for further clarification regarding Medicaid reimbursement policies for hospital services subject to reimbursement from other payers.

2.7.2 PARTIAL ELIGIBILITY / COVERED VS NON-COVERED DAYS

In the case of patients whose Medicaid eligibility does not cover the entire hospitalization, payment for the stay will be made on a per diem basis. However, the entire stay must be reflected in the Statement Covers Period. The covered and non-covered days must also be correctly completed to reflect the date span of the stay that is shown in Statement Covers Period/Dates of Service. Days the patient is not Medicaid eligible should be reported as non-covered.

Example for partial eligibility stay:

- Use Type of Bill 11X
- Enter the beginning and ending service dates to reflect the entire stay in the Statement Covers Period
- The date of discharge is never counted in covered or non-covered days
- Covered days: Number of days eligible
- Non-covered days: Number of days not eligible
- In the claim detail, report covered days with associated charges on one line, and on a separate line include non-covered days (RCC 180) along with the associated charges included as total charges and non-covered charges

Per diem payments are calculated by multiplying the hospital-specific base rate times the relative weight for the DRG, and dividing that value by the average length of stay for that DRG. Payment for the stay is the per diem amount times the number of days of the stay for which the patient was Medicaid eligible, plus applicable medical education (medical education times the DRG relative weight) and capital add-on amounts, not to exceed the DRG maximum. Partial eligibility cases may also qualify for additional payment in the form of outlier payments.

2.7.3 NON-COOPERATIVE PATIENTS

Providers must bill third-party insurance companies prior to billing Medicaid. Providers who are attempting to work with "uncooperative" consumers also have the option to contact the administrative agency (County Department of Job and Family Services or CDJFS) and speak with the consumer's case worker about the consumer's lack of cooperation in regards to complying with requests regarding third party insurance. If the consumer's caseworker is unresponsive to the provider's request for assistance for a TPL issue, the provider may contact the caseworker's supervisor to address the issue.

OAC rule 5160-1-13.1, Medicaid Consumer Liability, describes circumstances under which a provider may "bill" Ohio Medicaid consumers. In accordance with OAC rule 5160-1-13.1(C), "Providers are not required to bill the Ohio department of medicaid (ODM) for medicaid-covered services rendered to eligible consumers. However, providers may not bill consumers in lieu of ODM unless:

1) The consumer is notified in writing prior to the service being rendered that the provider will not bill ODM for the covered service; and
2) The consumer agrees to be liable for payment of the service and signs a written

statement to that effect prior to the service being rendered; and
3) The provider explains to the consumer that the service is a covered medicaid service and other medicaid providers may render the service at no cost to the consumer."

In addition, there are recent updates to OAC rules that may help encourage consumers to comply with the required requests from providers and third party payers.

1) OAC rule 5160:1-2-10, Medicaid: Conditions of Eligibility and Verifications
    a. OAC rule 5160:1-2-10(B)(7)(a): The consumer must cooperate with requests from a third-party insurance company to provide additional information that is required to authorize coverage or obtain benefits through the third party insurance company.
    b. OAC rule 5160:1-2-10(B)(7)(b): The consumer must cooperate with requests from a Medicaid provider, managed care plan, or a managed care plan's contracted provider to provide additional information that is required for the provider or plan to obtain payments from a third-party insurance company for Medicaid covered services.
2) OAC rule 5160:1-2-01, Medicaid: Administrative Agency Responsibilities
    a. If information needed to determine an individual's initial or continuing eligibility for a medical assistance program must be verified, but was not submitted with the application, the administrative agency must deny an application for medical assistance or terminate eligibility if an individual fails or refuses, without good cause, to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verifications.

Providers may communicate with consumers about their responsibility to provide information that is required in order to maintain their eligibility in the medical assistance program, such as verifying third party coverage.

2.7.4 MEDICARE PRIMARY

For claims where Medicare is primary, Medicaid reimbursement for hospital services covered by Medicare Part A and Part B will be equal to the lesser of:

1) The sum of the deductible, coinsurance, and co-payment amount as provided by Medicare; OR
2) The Medicaid maximum allowed amount, minus the total prior payment, not to equal less than $0.00.
3) If Medicare has already paid more than the Medicaid Maximum, Medicaid's payment will be $0.00.

Please refer to OAC rule 5160-2-25, Coordination of benefits: hospital services, for further details on how Medicaid will process claims with Medicare as the primary payer.

2.7.5 MEDICARE PART A EXHAUSTED DURING STAY OR MEDICARE BECOMES EFFECTIVE DURING ADMISSION

For an inpatient stay, in which a patient's Medicare Part A exhausts during the stay and Medicaid becomes primary with Medicare Part B, OR Medicare Part A eligibility starts after an admission and Medicaid is primary with Part B before Part A eligibility starts.

In this situation, three claims will be submitted to Medicaid:

1) Medicare Part A cost sharing, Bill Type 111 (normal crossover claim)
   a. Using Medicare billing guidelines, Medicare Part A is billed first, and then the claim is submitted to Medicaid for cost sharing.
2) Medicare Part B cost sharing, Bill Type 121 (normal crossover claim)
   a. After Medicare Part A is exhausted, using Medicare billing guidelines, all covered services under Part B are submitted to Medicare Part B. The claim is then submitted to Medicaid for cost sharing.
3) Medicaid as primary for days Medicare Part A is exhausted or not eligible, Bill Type 111
   a. The Statement Covers Period/"Admit through discharge" is for the entire stay.
   b. Include Occurrence Code A3 with the Medicare Part A exhaust date.
   c. Covered days are the days in which Medicaid was primary.
   d. Non-covered days (RCC 180) should equal the days Medicare Part A was primary.
      i) At the detail level, any days listed as non-covered must have a separate line with matching units indicating total charges and listed again as non-covered charges. (Covered days would be billed as normal at the detail.)
   e. Any charges submitted to Medicare Part A or Part B, must be reported at the detail as non-covered charges OR they must be removed from the claim completely. (Except for charges reflecting non-covered days, these must be reported as mentioned above and cannot be removed from the claim.)
   f. Since Medicaid is primary, do not include any other payer information or any other payments. Do not include any payments received from Medicare Part A or Part B on this claim.

2.7.6 MEDICAID PRIMARY WITH MEDICARE PART B ONLY

For an inpatient stay, in which a patient has Medicaid primary and only has Medicare Part B. The patient could have had Medicare Part A but it exhausts prior to the inpatient stay.

In this situation, two claims may be submitted to Medicaid:

1) Medicare Part B Cost sharing, Bill Type 121 (normal crossover claim):
   a. Medicare Part B is billed first, and then the claim is submitted to Medicaid for cost sharing.
2) Medicaid as primary for all other charges, Bill Type 111:
   a. If Medicare Part A exhausted before the inpatient stay, please include Occurrence Code A3 with the exhaust date.

b. Report all charges submitted to Medicare Part B as total charges and non-covered charges, OR remove the charges submitted to Medicare Part B from the Medicaid claim entirely (these charges were submitted to Medicare Part B on Bill Type 121).
c. Submit the claim to Medicaid as usual, according to the billing guidelines.
d. Since Medicaid is primary, do not include any other payer information or any other payments. If there is another payer besides Medicare Part B, then Medicaid is not primary. Do not include any payments received from Medicare Part B on this claim.

2.7.7 QMB Exhausts Medicare Part A

QMB members do not have Medicaid coverage; therefore, Medicaid has no payment liability until a 'QMB Beneficiary' is determined eligible for Medicaid.

2.8 Medicaid and Medicaid Managed Care Plan Split Claims

Please refer to OAC rule 5160-26-02(D) for ODM requirements regarding payment responsibility for a patient whose Medicaid coverage changes during an inpatient hospital stay.

Admit Plan	Enrollment Change	Responsible Plan*
FFS	FFS -> MCP	FFS
MCP	MCP -> FFS	MCP
MCP_1	MCP_1 -> MCP_2	MCP_1

** Responsible for the inpatient facility charges through the date of discharge. All other medically necessary services, i.e., Physicians & other Professionals, are the responsibility of the enrolled plan based on the date of service by the professional.*

In the situation where there are outpatient services within three days of the admission date and the patient also changes Medicaid coverage on the same day as the admission, the outpatient services would not be bundled into the inpatient claim. Refer to Section 2.13 for additional details.

2.9 Hospital and Nursing Facility Split Claims

Please refer to OAC rule 5160-3-16.4 for ODM requirements regarding nursing facility (NF) reimbursement.

2.9.1 Hospital Leave Days

NFs may be paid for Hospital Leave Days at a reduced daily rate to reserve a bed for the resident who intends to return to that facility following a hospitalization. If a resident is in the NF for eight hours or more on the day they were transferred to the hospital or readmitted from the hospital,

the NF is eligible for reimbursement at the full per diem rate instead of the Leave Day rate. Medicaid NF residents are eligible for up to 30 Leave Days per calendar year.

Claim Denials – Possible Duplicates:

When billed correctly, the Hospital and NF Leave Days billed in common will bypass the duplicate claim edit, except for HCBS Waiver consumers in a short-term NF stay.*

*Please note that MITS was not initially designed to cover Leave Days for HCBS Waiver Consumers in a NF for a short-term stay. Revisions to the applicable OAC rule and MITS are underway to allow for future coverage of such Hospital Leave Days. NFs must continue to bill all Hospital Leave Days with RCC 185 even though this code is not currently set to pay for Waiver Consumers. NFs must not bill Leave Days with RCC 160, as doing so will result in overpayment to the NF at 100% of the per diem rate and the corresponding hospital claim will deny.

NF Billing Scenarios:

Scenario 1: NF resident to Hospital for more than two days

A NF resident who is hospitalized on the 5th of January and returns to the NF on the 18th

1A) Resident in NF less than eight hours on date of transfer to hospital
Line 1) 01/01/2015 – 01/04/2015 Revenue Center Code (RCC) 101
Line 2) 01/05/2015 – 01/17/2015 RCC 185 (hospital leave days)
Line 3) 01/18/2015 – 01/31/2015 RCC 101

1B) Resident in NF for eight hours or more on date of transfer to hospital
Line 1) 01/01/2015 – 01/05/2015 RCC 101
Line 2) 01/06/2015 – 01/17/2015 RCC 185 (hospital leave days)
Line 3) 01/18/2015 – 01/31/2015 RCC 101

Scenarios 1A and 1B illustrate the difference in billing for a full day versus a Leave Day on the day of hospital admission. A full covered day may be billed (RCC 101) for the day the resident returns to the NF if they are in the NF for eight hours or more that day. Billing properly allows the duplicate edit to be bypassed so that both the NF and hospital can be paid appropriately for the covered days they bill in common.

Scenario 2: NF resident to Hospital for overnight stay

A NF resident who is hospitalized on the 13th of March and returns to the NF on the 14th

2A) Resident in NF less than eight hours on date of transfer to hospital
Line 1) 03/01/2015 – 03/12/2015 RCC 101

Line 2) 03/13/2015 – 03/13/2015 RCC 185 (hospital leave day)
Line 3) 03/14/2015 – 03/31/2015 RCC 101

2B) Resident in NF eight hours or more on date of transfer to hospital
Line 1) 03/01/2015 – 03/13/2015 RCC 101
Line 2) 03/14/2015 – 03/31/2015 RCC 101

Scenario 2B illustrates that the dates must be split into two different detail lines, even though no Leave Days are being billed. A full covered day may be billed (RCC 101) for the day the resident returns to the NF if they are in the NF for eight hours or more that day. Splitting the covered days into two different lines allows the duplicate edit to be bypassed so that both the NF and hospital can be paid appropriately for the covered days they bill in common.

Scenario 3: Waiver Consumer in NF for short-term stay to Hospital for more than two days: Consumer is hospitalized on the 5th of January and returns to the NF on the 18th.

3A) Waiver Consumer in NF less than eight hours on date of transfer to hospital
Line 1) 01/01/2015 – 01/04/2015 RCC 160
*Line 2) 01/05/2015 – 01/17/2015 RCC 185**
Line 3) 01/18/2015 – 01/31/2015 RCC 160

3B) Waiver Consumer in NF eight hours or more on date of transfer to hospital
Line 1) 01/01/2015 – 01/05/2015 RCC 160
*Line 2) 01/06/2015 – 01/17/2015 RCC 185**
Line 3) 01/18/2015 – 01/31/2015 RCC 160

Scenarios 3A and 3B illustrate the difference in billing for a full day versus a Leave Day on the day of hospital admission. RCC 160 must be billed instead of RCC 101 for HCBS Waiver consumers in a short-term NF stay (i.e., consumers with an active waiver span for DOS billed by NF). Hospital Leave Days must be billed with RCC 185.

Scenario 4: Waiver Consumer in NF for short-term stay to Hospital for an overnight stay: Consumer is hospitalized on the 13th of March and returns to the NF on the 14th

4A) Resident in NF less than eight hours on date of transfer to hospital
Line 1) 03/01/2015 – 03/12/2015 RCC 160
*Line 2) 03/13/2015 – 03/13/2015 RCC 185**
Line 3) 03/14/2015 – 03/31/2015 RCC 160

4B) Resident is in NF eight hours or more on date of transfer to hospital
Line 1) 03/01/2015 – 03/13/2015 RCC 160
Line 2) 03/14/2015 – 03/31/2015 RCC 160

Scenario 4B illustrates that the dates must be split into two different detail lines, even though no Leave Days are being billed. Splitting the covered days into two different lines allows the duplicate edit to be bypassed so that both the NF and hospital can be paid for the date of admission (3/13/2015). RCC 160 must be billed instead of RCC 101 for HCBS Waiver consumers in a short-term NF stay (i.e., consumers with an active waiver span for DOS billed by NF). Hospital Leave Days must be billed with RCC 185.

2.9.2 READMISSIONS TO A HOSPITAL

If a consumer is an inpatient in a hospital, is discharged, then subsequently re-admitted to the same hospital within a day, the hospital must collapse the two inpatient stays into one admit through discharge claim. The hospital must report one non-covered day at the header, and use Revenue Code 180 to report a non-covered day at the detail.

For example, if the consumer is hospitalized 1/1/2015 and is discharged to a NF on 1/5/2015, then re-admitted to the hospital on 1/6/2015, the hospital must report one non-covered day for the first date of discharge (1/5/2015) at the header, and one non-covered day at the detail level, RCC 180.

If the hospital claim denies as a duplicate against the corresponding NF claim due to the overlapping date of service (1/5/2015 in this example), the hospital should contact Provider Assistance at 1-800-686-1516.

2.10 INPATIENT HOSPITAL ADMISSION ORDERS

Per ORC 3727.06, a doctor, dentist, podiatrist, clinical nurse specialists (CNS), certified nurse-midwives (CNM), certified nurse practitioners (CNP), and physician assistants (PA) may admit a patient to a hospital. Due to this revision in the ORC, the term "physician" in OAC rule 5160-2-02 include these other practitioners of physician services (i.e., CNS, CNM, CNP, and PA) and therefore are permitted to order an inpatient hospital admission per their scope of practice and their hospital credentials.

2.11 INPATIENT HOSPITAL SERVICES PROGRAM BENEFIT PLAN

If an individual is Medicaid eligible, incarcerated, and receives inpatient hospital services while admitted to a hospital for 24 hours or more, then Medicaid would pay for the claim using the Inpatient Hospital Services Program (IHSP) benefit plan. The IHSP benefit plan was established on August 1, 2016. Per OAC rule 5160:1-1-03, an exception to the prohibition against Medicaid payment for services is permitted during the part of the month in which an individual is not an inmate of a public institution. An individual is not an inmate of a public institution during such time as he/she is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility,

or ICF-IID. In addition, there is no time limit on Medicaid payment for services as long as the individual continues to be eligible for Medicaid and is receiving services as an inpatient in the medical facility. Please refer to Appendix J of the Hospital Billing Guidelines for responses to frequently asked questions.

2.12 Inpatient Hospital Stay with Outpatient Services

Please refer to OAC rule 5160-2-02 for ODM requirements regarding reimbursement for outpatient services during an inpatient stay. Inpatient services include all covered services provided to patients during the course of their inpatient stay, whether furnished directly by the hospital or under arrangement, except for direct-care services provided by physicians, podiatrists, and dentists. If a patient receives outpatient services from another hospital before he/she is discharged from the inpatient stay, the inpatient hospital should submit a claim that includes both inpatient and outpatient services. Although the inpatient hospital submits the claim, the outpatient hospital will be reimbursed by the inpatient hospital for those outpatient services.

If the outpatient hospital submits the claim separately to ODM before the inpatient hospital submits their claim, the inpatient claim will be deemed as a duplicate claim and will be denied payment. The inpatient hospital will need to work with the outpatient hospital to pay the outpatient visit and to have them void their paid claim for the outpatient service. The inpatient hospital should then resubmit the claim to ODM so that it includes inpatient and outpatient services.

2.13 Three Calendar Day Roll-In

Effective for admissions on or after January 1, 2016, per OAC rule 5160-2-02(B)(2), outpatient services provided within three calendar days prior to the date of admission will be covered as inpatient services; this includes emergency room and observation services. All outpatient services provided within three calendar days prior to the inpatient admission need to be included on the inpatient claim. The 'From Date' (statement covers period) should start with the first date of outpatient services and the 'Through Date' should be the date of discharge. The 'Admit Date' field should have the date the patient was admitted as an inpatient.

Claim Example (Medicaid primary for entire stay):

Dates outpatient services were rendered: 1/8 – 1/9

Dates of inpatient stay: 1/10 – 1/15

1. The Statement Covers Period/'Admit through Discharge' is for the entire stay. This should include the first date of outpatient services and the 'Through Date' should be the date of discharge.
    a. FDOS: 1/8
    b. TDOS: 1/15

2. The admission date is the date the patient was admitted as an inpatient.
    a. Admit Date: 1/10
3. Covered days are the inpatient days.
    a. Covered Days: 5 (the date of discharge is not included, so only count 1/10 – 1/14 as covered days. Outpatient visit days are not included.)
    b. Non-covered Days: 0
4. When reporting room accommodations at the detail, the units should equal the total days (covered + non-covered days) reported at the header. (Note: any days listed as non-covered must have a separate line with matching units indicating total charges and listed again as non-covered charges.)

There are <u>two</u> exceptions to the three calendar day roll-in policy when the outpatient charges are not included with the inpatient claim:

1. When a patient's Medicaid coverage changes between Medicaid Fee-for-Service to a Medicaid Managed Care Plan on the date of an inpatient admission. All outpatient services provided within three calendar days prior to the inpatient admission should be submitted to either Medicaid fee-for-service or the Managed Care Plan depending on the eligibility of the patient for those days. The inpatient claim should be submitted to either Medicaid fee-for-service or the Managed Care Plan depending on the eligibility of the patient on the date of admission.

2. <u>When a patient is admitted under the IHSP benefit plan, the outpatient charges are not included in the inpatient stay. If any outpatient services are provided prior to the date of admission, the hospital would need to submit their claim to the Department of Rehab & Corrections (DRC) or the correctional facility where the inmate is being housed. However, any outpatient services provided on the date of admission, should be included on the inpatient hospital claim if provided at the same facility as the admission.</u>

2.14 PRESENT ON ADMISSION INDICATOR

In accordance with federal regulations (42 CFR § 447.26), payment for provider-preventable conditions are prohibited. Therefore, the NUBC instructions require the collection of Present on Admission (POA) indicators on all claims for inpatient hospital services. Although Medicare exempts certain types of hospitals from POA reporting, OAC rule 5160-1-02 explicitly prohibits payment for hospital acquired conditions. As a result, ODM does not exempt any hospital from reporting POA indicators as the POA indicator is a crucial part of identifying hospital acquired conditions.

A non-reimbursable hospital condition can only be identified in one of two ways:

1) The POA indicator, or
2) The retrospective review process

In the case that a claim is missing a POA indicator and ODM reimburses the hospital for those services, the claim will be recouped during retrospective review as it lacked the POA indicator.

2.15 Pregnancy / Child Birth Delivery

2.15.1 Early Elective Deliveries

Per OAC rule 5160-1-10, caesarean section, labor induction, or any delivery following labor induction is subject to the following criteria: (1) Gestational age of the fetus must be determined to be at least thirty-nine weeks or (2) If a delivery occurs prior to thirty-nine weeks gestation, maternal and/or fetal conditions must indicate medical necessity for the delivery. Cesarean sections, labor inductions, or any deliveries following labor induction that occur prior to thirty-nine weeks gestation that are not considered medically necessary are not eligible for payment.

2.15.2 Gestational Age Diagnosis Codes

ICD-10 has new diagnosis codes available that indicate the weeks of gestation of pregnancy. ODM will require that all claims for a delivery procedure (mother's claim, not child's claim) with a date of service (outpatient and professional), or date of discharge (institutional) on or after October 1, 2015 must include the weeks of gestation ICD-10 diagnosis code. This billing requirement will be effective with the ICD-10 compliance date of 10/1/2015.

The following table displays the ICD-10 diagnosis codes that must be present with a delivery procedure code beginning 10/1/2015. To allow providers six months to adjust to this ICD-10 billing requirement, the system logic to enforce this billing guidance will be set to post and pay starting 10/1/2015, and then set to deny for dates of service (outpatient and professional) or dates of discharge (institutional) on or after 2/1/2017.

ICD-10 Diagnosis Codes	
Z3A.00	Gestation not specified
Z3A.01	Less than 8 weeks Gestation of Pregnancy
Z3A.08	8 weeks gestation of pregnancy
Z3A.09	9 weeks gestation of pregnancy
Z3A.10	10 weeks gestation of pregnancy
Z3A.11	11 weeks gestation of pregnancy
Z3A.12	12 weeks gestation of pregnancy
Z3A.13	13 weeks gestation of pregnancy
Z3A.14	14 weeks gestation of pregnancy
Z3A.15	15 weeks gestation of pregnancy

ICD-10 Diagnosis Codes	
Z3A.16	16 weeks gestation of pregnancy
Z3A.17	17 weeks gestation of pregnancy
Z3A.18	18 weeks gestation of pregnancy
Z3A.19	19 weeks gestation of pregnancy
Z3A.20	20 weeks gestation of pregnancy
Z3A.21	21 weeks gestation of pregnancy
Z3A.22	22 Weeks gestation of pregnancy
Z3A.23	23 Weeks gestation of pregnancy
Z3A.24	24 Weeks gestation of pregnancy
Z3A.25	25 Weeks gestation of pregnancy
Z3A.26	26 Weeks gestation of pregnancy
Z3A.27	27 Weeks gestation of pregnancy
Z3A.28	28 Weeks gestation of pregnancy
Z3A.29	29 Weeks gestation of pregnancy
Z3A.30	30 Weeks gestation of pregnancy
Z3A.31	31 Weeks gestation of pregnancy
Z3A.32	32 Weeks gestation of pregnancy
Z3A.33	33 Weeks gestation of pregnancy
Z3A.34	34 Weeks gestation of pregnancy
Z3A.35	35 Weeks gestation of pregnancy
Z3A.36	36 Weeks gestation of pregnancy
Z3A.37	37 Weeks gestation of pregnancy
Z3A.38	38 Weeks gestation of pregnancy
Z3A.39	39 Weeks gestation of pregnancy
Z3A.40	40 Weeks gestation of pregnancy
Z3A.41	41 Weeks gestation of pregnancy
Z3A.42	42 Weeks gestation of pregnancy
Z3A.49	Greater than 42 weeks Gestation of Pregnancy

This guidance applies to professional and outpatient claims when the following CPT codes are present on the claim:

CPT Codes	
59400 – 59410	Vaginal Delivery, Antepartum and Postpartum Care
59510 – 59515	Cesarean Delivery
59610 – 59622	Delivery After Previous Cesarean Delivery

This guidance applies to institutional claims when the following ICD-10 procedure codes are present on the claim:

ICD-10 Procedure Codes	
10D00Z0	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Classical
10D00Z1	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Low Cervical
10D00Z2	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Open, No Device, Extraperitoneal
10D07Z3	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Low Forceps
10D07Z4	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Mid Forceps
10D07Z5	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, High Forceps
10D07Z6	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Vacuum
10D07Z7	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Internal Version
10D07Z8	Obstetrics, Pregnancy, Pulling or stripping out or off all or a portion of a body part, Product of conception, Via Natural or Artificial Opening, No Device, Other
10E0XZZ	Obstetrics, Pregnancy, Delivery, Assisting the passage of products of conception from the genital canal, Products of Conception, External, No Device, No Qualifier

2.16 LONG-ACTING REVERSIBLE CONTRACEPTIVES

Ohio Medicaid provides coverage for Long-Acting Reversible Contraceptives (LARCs) in the inpatient hospital setting immediately after a delivery or up to the time of the inpatient discharge for postpartum women, or at any time deemed medically necessary. LARC services are also covered by Ohio Medicaid when provided in an outpatient hospital or an independent professional setting. All claims for reimbursement of LARC services should follow correct coding conventions and be supported by the appropriate diagnosis and procedure codes.

2.16.1 INPATIENT HOSPITAL SETTING

Effective for dates of discharge on or after July 6, 2017 and per OAC rule 5160-2-79, when a LARC device or subdermal implant that is covered by Medicaid is provided to a Medicaid recipient in an inpatient hospital setting postpartum and prior to the patient's discharge, the hospital may submit an outpatient claim for the LARC. The claim for the LARC is separate from any claim submitted for other inpatient care the hospital provides to the Medicaid recipient in conjunction with the obstetrical delivery.

In order to receive separate reimbursement for a LARC device or subdermal implant when provided postpartum in an inpatient hospital setting, hospitals must adhere to the following guidelines:

- A paid inpatient obstetrical delivery claim must exist for the recipient.
- The paid inpatient claim must include a secondary ICD-10 CM diagnosis code from the Z37 – Outcome of Delivery range of codes.
- The LARC device or implant must be billed using Type of Bill 131.
- The outpatient claim for the LARC must include one detail line for the LARC device or implant only. No other procedure codes should be listed on the claim. *Note:* Only LARC devices and implants listed on the Department's Provider-Administered Pharmaceuticals Fee Schedule located under the Providers tab on the Ohio Department of Medicaid's website (http://www.medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx) as of the date of service will be eligible for reimbursement.
- The LARC device or implant must be reported using Revenue Center Code 278 – Medical/Surgical Supplies and Devices.
- The date of service on the outpatient claim for the LARC device or implant must fall within the date span on the corresponding paid inpatient claim for the obstetrical delivery excluding the date of discharge.

Reimbursement for the LARC device or implant will be made in accordance with the Medicaid Maximum Payment listed on the Provider-Administered Pharmaceuticals Fee Schedule as of the date of service.

Note: MITS is scheduled to be remediated to accommodate this new claims processing methodology on July 12, 2017. We respectfully request that all outpatient claims for LARC devices

supplied to a Medicaid recipient postpartum in an inpatient hospital setting with dates of service on or after July 6, 2017 and billed separately on an outpatient claim, be submitted for payment after July 12, 2017.

For LARC services furnished prior to July 6, 2017 and provided in an inpatient hospital setting following a delivery, the hospital should use an ICD-10 delivery diagnosis code [or, for deliveries with inpatient discharge dates before October 1, 2015, an ICD-9 delivery diagnosis code] on the inpatient claim as well as the appropriate ICD-10/ICD-9 surgical procedure code to indicate an insertion of a contraceptive device. See the table below for the appropriate diagnostic and procedure codes needed to document that LARC services were provided. Per OAC rule 5160-2-65(E), for DRG hospitals, inpatient claims will process and pay in accordance with the All Patient Refined Diagnosis Related Group (APR-DRG) methodology. The cost of the device or drug implant is captured in the hospital's charges on the inpatient claim. No additional or separate payment will be made to the hospital for LARC inpatient services.

Long Acting Reversible Contraceptive (LARC)				
	Inpatient Hospital Setting			
	ICD-9		**ICD-10**	
Insertion/Removal of:	***Diagnostic***	***Procedural***	***Diagnostic***	***Procedural***
IUD	V25.02, V25.11, V25.12, V25.13, V72.31, V25.42	69.7, 97.71	Z30.013,Z30.014, Z30.018, Z30.019, Z30.430, Z30.432, Z30.433, Z01.411, Z01.419, Z30.431	0UH97HZ, 0UH98HZ, 0UHC7HZ, 0UHC8HZ, 0UPD7HZ, 0UPD8HZ
Birth Control Implant	V25.5, V25.02, V72.31, V25.43	99.23, 99.24, 86.09*	Z30.49, Z30.013, Z30.017, Z30.018, Z30.019, Z01.411, Z01.419	0JHD0HZ, 0JHD3HZ, 0JHF0HZ, 0JHF3HZ, 0JHG0HZ, 0JHG3HZ, 0JHH0HZ, 0JHH3HZ, 0JHL0HZ, 0JHL3HZ, 0JHM0HZ, 0JHM3HZ, 0JHN0HZ, 0JHN3HZ

** ICD-9 Procedural code 86.09 is a generic code that may be billed to capture insertion of a contraceptive implant.*

2.16.2 Physician Billing for LARC Services on a Professional Claim

For the LARC insertion procedure, the attending physician should bill Medicaid on a professional claim utilizing an appropriate ICD-10/ICD-9 diagnosis code and one of the CPT procedure codes listed in the table below. If the procedure is performed in a private physician's office and the practitioner supplies the IUD or other LARC, the practitioner may also bill for the device using the appropriate Healthcare Common Procedure Coding System (HCPCS) Level II procedure code listed below. Reimbursement for the drug/device will be made in accordance with the Medicaid Non-Institutional Maximum Payment Fee Schedule and the Provider Administered Pharmaceuticals Fee Schedule both of which are located under the Providers Tab on the Ohio

Department of Medicaid's website (http://www.medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx).

Long Acting Reversible Contraceptive (LARC)	
	Professional Billing
Insertion/Removal of:	**CPT/HCPCS**
IUD	58300, 58301, J7297, J7298, J7300, J7301, J7302 (no longer available as of 4/1/17), Q9984 (Effective 7/1/17)
Birth Control Implant	11981, 11982, 11983, J7307

Notes:

- *The diagnostic coding will vary, however, codes will usually be selected from the V25 series in ICD-9-CM or Z30 series in ICD-10-CM (Encounter for contraceptive management).*
- *Occasionally, ultrasound is needed to guide IUD insertion. It would be coded with CPT 76998 in an outpatient hospital or professional setting.*

2.16.3 Outpatient Hospital Setting

Ohio Medicaid will reimburse hospitals for the services associated with the insertion or implantation of a LARC device provided in an outpatient hospital setting in accordance with the Outpatient Hospital Fee Schedule, which is located under the Providers Tab on the ODM website. Any drugs, medical supplies (including the cost of the LARC) or routine ancillary services will be rolled into the surgical payment for reimbursement. The hospital would use the appropriate diagnostic and procedure codes listed below to capture the surgical procedure associated with the insertion of the LARC device:

Long Acting Reversible Contraceptive (LARC)			
	Outpatient Hospital Setting		
	ICD-9	**ICD-10**	**CPT/HCPCS**
Insertion/Removal of:	***Diagnostic***	***Diagnostic***	***Procedural***
IUD	V25.02, V25.11, V25.12, V25.13, V72.31, V25.42	Z30.013, Z30.014, Z30.018, Z30.019, Z30.430, Z30.432, Z30.433, Z01.411, Z01.419, Z30.431	58300, 58301, J7297, J7298, J7300, J7301, J7302 (no longer available as of 4/1/17), Q9984 (Effective 7/1/17)
Birth Control Implant	V25.5, V25.02, V72.31, V25.43	Z30.49, Z30.013, Z30.014, Z30.017, Z30.018, Z30.019, Z01.411, Z01.419	11981-11983, J7307

Hospitals may elect to independently bill the pharmaceutical or medical supply costs of the LARC in lieu of billing for the surgical procedure. In such cases, the provider would only bill for the LARC using RCC 636 with one of the valid J-codes listed above, and would not include any other procedures/services on the claim provided on the same date. Reimbursement for the independently billed drug/device is paid in accordance with the Provider-Administered Pharmaceuticals fee schedule rate in effect for the date of service.

2.17 CALCULATING OUTLIER PAYMENTS

For dates of discharge on or after July 1, 2013, the following outlier methodology applies, as described in rule 5160-2-65 of the OAC.

1) Calculate Claim Costs
   - Claim Cost = (Allowed Charges – RCC 810) * Hospital-Specific CCR
     - Allowed Charges = (Billed Charges – Non-Covered Charges)
     - CCR = Cost-to-Charge Ratio
2) Select Fixed Outlier Threshold
   - A claim qualifies for only one threshold as determined in the order below:

	Dates of Discharge on or before 7/5/2017	**Dates of Discharge on or after 7/6/2017**
Trach DRGs (004 & 005), Neonate DRGs (580 - 639)	$42,900.00	$25,000.00
Hospitals in either the Major Teaching or Children's peer groups	$54,400.00	$60,000.00
All other DRGs/peer groups	$68,000.00	$75,000.00

3) Conduct Outlier Qualification Test
   - Is Claim Cost > [(Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + Fixed (Outlier) Threshold]
   - If YES, claim qualifies for an outlier add-on payment
     - See #4 for outlier add-on payment calculation
     - See #5 for total claim payment calculation
   - If NO, calculate standard APR-DRG reimbursement
     - Standard APR-DRG reimbursement = #5 minus Outlier Add-On
   - SOI = Severity of Illness
4) Computation of Outlier Payment
   - Outlier Add-On Payment = [Cost of Case – ((Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + Fixed (Outlier) Threshold)] * 90%
     - Cost of Case = [(Covered Charges – RCC 810) * Hospital-Specific CCR]
5) Total Claim Payment = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) + (Medical Education Add-On * DRG/SOI Rel. Wgt.) + Capital Add-On + Outlier Add-On (if applicable) + Non-Outlier Add-On (Organ Acquisition Costs or Charges, if applicable)

Please note:

1) Transfer/Partial Eligibility Pricing Calculation

- Please refer to OAC rule 5160-2-65(N)(3) for ODM requirements regarding transfer pricing.
- Please refer to OAC rule 5160-2-65(N)(4) for ODM requirements regarding partial eligibility pricing.
- Per Diem calculation was updated to use Average Length of Stay (ALOS) instead of from Geometric Mean Length of Stay
- Transfer Payment Logic: Transfers will be paid the lessor of the [Transfer Base or DRG Base] plus Capital Add-On, Medical Education Add-On and Outlier Add-On (if applicable)
    - A) Transfer Base = Transfer Per Diem * Covered Days
    - Transfer Per Diem = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.) / DRG/SOI ALOS
    - B) DRG Base = (Hospital-Specific Base Rate * DRG/SOI Rel. Wgt.)
    - C) Partial Eligibility Base = Transfer Per Diem * Number of Medicaid Eligible Days
- Total Transfer Payment = Lessor of A or B + Capital Add-On, Medical Education Add-On & Outlier Add-On (if applicable)
- Partial Eligibility Payment = Lessor of C or B + Capital Add-On, Medical Education Add-On & Outlier Add-On (if applicable)

2) Transplant Pricing Logic using RCC 810 (organ acquisition costs/charges) remains unchanged
    - Transplants with 100% Charge application for RCC 810: APR-DRG 1, 2, & 6 with SOIs
    - Transplants with 100% Cost application for RCC 810: APR-DRG 3 with SOIs

3. BILLING GUIDANCE SPECIFIC TO OUTPATIENT HOSPITAL CLAIMS

3.1 REQUIREMENT TO BILL IN SERVICE DATE ORDER

Effective January 1, 2016, ODM expects all outpatient hospital claims billed to ODM (or adjusted) on or after January 1, 2016 to be billed with the details in service date order and the RCC in ascending order within each service date. This requirement applies to every outpatient hospital claim (bill types 131 and 135) that is billed to ODM regardless of mode of submission (portal or EDI). This new requirement does not apply to inpatient claims or any claim billed on a CMS 1500. This requirement also does not apply when Medicare is the primary payer, but does apply to any other outpatient claims where Medicaid is the secondary or tertiary payer.

Per this new requirement, details on each individual outpatient claim must be billed in service date order, and the RCC must be billed in ascending order within each date of service on the claim.

For example:

1/1/2016-RCC 250

1/1/2016-RCC 300

1/1/2016-RCC 324

1/5/2016-RCC 250

1/5/2016-RCC 300

Explanation of benefits (EOB)/edit 912 was implemented in MITS to deny any outpatient hospital claim where details are not billed in service date order and whose RCCs are not in ascending order. Official documentation of this change can be found in our Hospital Handbook Transmittal Letter (HHTL) No. 3352-16-01. The HHTL is located on the ODM website at the following link: http://medicaid.ohio.gov/RESOURCES/Publications/ODMGuidance.aspx#161542-medicaid-policy. The link to the HHTL is under the 'Hospital' heading.

3.2 Non-Emergency Co-Pay

Please refer to OAC rule 5160-2-21.1 for ODM requirements regarding reimbursement of non-emergency co-pay.

Effective for dates of service on or after January 1, 2006, Medicaid consumers are required to pay a co-payment equal to three dollars for non-emergency emergency department services, except as excluded in OAC rule 5160-1-09 as listed below.

Co-payments must not be charged if the consumer is:

- Under the age of 21, or
- In a nursing home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID), or
- Receiving emergency services, or
- A female who is pregnant or has post-partum coverage, or
- Receiving hospice care.

For non-emergency services sought in the emergency department (procedure codes 99281-99285), please indicate a $3.00 co-pay, which is assessed by adding the following in the remarks field on the claims, "COPAY_NEMR" (note: _ indicates space). The Department shall reimburse the emergency department claim the allowable Medicaid payment minus the applicable co-payment and any third party resources available to the patient.

3.3 RCC 25X and/or 636 with HCPCS J-Code or Q-Code

Please note that the Department is not updating how pharmaceuticals qualify for additional payment. Rather, the Department is updating its requirements for billing pharmaceuticals in the outpatient hospital setting.

There are only two instances in which pharmaceuticals qualify for additional payment: (1) The claim contains an IV therapy CPT code (96365, 96366, 96367, or 96368); (2) The claim does not contain dialysis, chemotherapy, surgical, clinic, emergency room, radiology, ancillary, laboratory, or pregnancy related services as defined in paragraphs (D) to (K) of OAC rule 5160-2-21 and therefore is considered independently billed as defined in paragraph (L) of OAC rule 5160-2-21.

Effective for dates of service on or after January 1, 2016, pharmaceuticals must be billed using RCC 25X and/or 636 with a provider-administered pharmaceutical HCPCS J-code or Q-code; those pharmaceutical line items will be paid in accordance with the Provider-Administered Pharmaceuticals fee schedule. Please note that the Provider-Administered Pharmaceuticals fee schedule is only to be used for reimbursement rates of covered J-codes and Q-codes, not coverage policies of services in the outpatient hospital setting.

When an applicable HCPCS J-code or Q-code does not exist for the provider-administered pharmaceutical for the date of service or if the HCPCS J-code or Q-code is listed as "by report" on the Provider-Administered Pharmaceuticals fee schedule, then payment for those line items will be calculated by multiplying the charges on those line items by 60% of the hospital's outpatient cost-to-charge ratio. All HCPCS J-codes are covered in the outpatient hospital setting, but only provider-administered pharmaceutical HCPCS Q-codes are covered in the outpatient hospital setting. Please refer to Appendix I to OAC rule 5160-2-21 for a list of covered Q-codes in the outpatient hospital setting.

The Department recognizes that there may not be an applicable HCPCS J-code or Q-code for certain pharmaceuticals, which resulted in the option to submit RCC 25X without a HCPCS J-code or Q-code. However, the use of detailed billing (e.g., HCPCS J-code or Q-code) is required whenever applicable. If a detail line contains RCC 25X without a corresponding HCPCS J-code or Q-code then that claim may be targeted for retrospective review to determine whether an applicable HCPCS J-code or Q-code should have been submitted on the RCC 25X detail line.

Effective for dates of service on or after January 1, 2016, covered vaccine/toxoid CPT codes are reimbursable when submitted with RCC 25X or 636. Effective for dates of service on or after October 1, 2016, covered immune globulins, serum, and recombinant products CPT codes are reimbursable when submitted with RCC 25X or 636. Please refer to the outpatient ancillary services fee schedule (Appendix F to OAC rule 5160-2-21) for coverage and reimbursement rates for these codes.

3.4 NATIONAL DRUG CODES

For dates of service on or after July 1, 2017 through December 31, 2017, if a detail line contains a pharmaceutical HCPCS code but the corresponding national drug code (NDC) is not submitted on the same detail line, edit 4893 (NDC code missing) will post on the detail line but the detail line will not deny. In addition, the corresponding NDC must be valid on the date of service, otherwise edit 4891 (invalid NDC/HCPCS combination) will post on the detail line but the detail line will not deny. However, for dates of service on or after January 1, 2018, edits 4891 and 4893 is set to deny a detail line if the appropriate NDC is not submitted. Please note that a corresponding valid NDC is still required when a detail line contains RCC 25X without a pharmaceutical HCPCS code.

When applicable, providers are permitted to submit multiple NDCs for the same pharmaceutical HCPCS code. If the claim is submitted via EDI, each NDC must be submitted on a separate detail line with the pharmaceutical HCPCS code. However, if the claim is submitted via the MITS Web Portal, multiple NDCs (maximum of 25 NDCs) may be submitted for the same pharmaceutical HCPCS code on one detail line.

For compound drugs that do not have an assigned NDC, the NDC that makes up the greatest component of the compound drug should be submitted with modifier KP. Each subsequent NDC should be submitted with modifier KQ.

3.5 NURSING FACILITY THERAPY BUNDLING

If a NF resident goes to an outpatient hospital and receives any of the services specified below, then the hospital should bill the NF for those specific services. Since ODM reimburses NFs by a per diem rate, the NFs are responsible for reimbursing the provider for these particular services. If the hospital bills ODM for any of these specific services, the claim will be denied. The hospital should remove the specific service codes from the claim and submit these charges to the NF. Once these specific codes are removed from the claim, then the claim can be resubmitted to ODM for payment for the other services provided on that day.

Specific therapy codes that are included in the NF per diem bundled rate (hospital must not bill ODM):

92502	92507	92508	92521	92522	92523	92524	92526
92551	92552	92555	92556	92557	92610	97001	97002
97003	97004	97010	97014	97016	97018	97022	97024
97026	97028	97032	97033	97034	97035	97036	97110
97112	97113	97116	97124	97140	97150	97530	97532
97533	97535	97542	97750	97760	97761	97762	

Please note that custom wheelchairs, medically necessary wheelchair van and ambulance transportation, and oxygen (except emergency oxygen) are no longer bundled into the NF per diem rate.

3.6 NATIONAL CORRECT CODING INITIATIVE

Effective January 1, 2016, ODM implemented the edit and coding methodologies of the National Correct Coding Initiative (NCCI), which is a national program that consists of coding policies and edits. NCCI policies and edits are applied against claims for procedures/services performed by the same provider for the same consumer on the same date of service. The NCCI analyzes and edits claims based upon HCPCS/CPT codes reported by outpatient providers for procedures/services rendered to Medicaid consumers.

3.6.1 EDITS

NCCI methodologies consists of two types of edits:

1) Procedure to Procedure (PTP): Edits that define pairs of HCPCS/CPT codes that should not be reported together. NCCI methodologies for this edit are applied to current and historical claims.
2) Medically Unlikely Edits (MUEs): Edits that define, for many HCPCS/CPT codes, the maximum number of units of service that are, under most circumstances, billable by the same provider, for the same consumer on the same date of service.

The following EOBs will be reported if a detail line on a claim has denied because of a PTP or MUE edit:

1) EOB 7222: The current procedure is denied based on an NCCI edit because this service is not payable with another service on the same claim for the same date of service.
2) EOB 7223: The current procedure is denied based on an NCCI edit because this service is not payable with another service on a history claim for the same date of service.
3) EOB 7224: A historical procedure for the same date of service would have been denied based on an NCCI edit because that service is not payable with this current service.
4) EOB 7227: The current procedure is denied based on an NCCI edit because the units of service exceed the medically unlikely limit per claim detail for the same date of service.

3.6.2 MISCELLANEOUS

Billed detail claim lines with a unit-of-service value greater than the established MUE value for the HCPCS/CPT code OR a pair of HCPCS/CPT codes that should not be reported together will result in that detail line being denied for payment.

All currently active Medicaid PTP edits and MUEs, as well as information about the NCCI program are published on the Medicaid NCCI webpage at: https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html. These files are updated on a quarterly basis. The PTP edit files contain the effective date of every edit and the deletion date of prior edits. This information can be used to verify whether a particular PTP edit was valid on the date of service of the claim in question and whether use of a PTP-associated modifier would allow the claim to bypass the edit. The MUE edit files are applicable to claims processed in the current quarter and with dates of service in the current quarter. MUE edit files do not contain historical information.

It is important that providers access the Medicaid NCCI edit file at the above webpage and not the Medicare NCCI files on the CMS webpage. Medicaid NCCI edits are significantly different from Medicare NCCI edits.

Please refer to Sections 3.7.2 and 3.7.3 for guidance regarding NCCI-related modifiers.

3.7 MODIFIERS

3.7.1 APPENDIX A TO OAC RULE 5160-2-21

All modifiers are accepted, but only these modifiers listed on Appendix A to OAC rule 5160-2-21 will affect reimbursement.

HCPCS Modifier	Description of Modifiers
U1	Pediatric patient, chronically or severely ill
U2	Adult chronic illness
UB	20 and younger or 60 and older
TH	Obstetrical services, prenatal or post-partum, were provided
22	Unusual procedural services
73	Discontinued surgery procedure prior to anesthesia administration
74	Discontinued surgery procedure after anesthesia administration

3.7.2 NCCI CORRECT CODING MODIFIER INDICATORS

There are two Correct Coding Modifier Indicators (CCMI):

1) CCMI 0: The reported CPT codes should never be reported together by the same provider for the same consumer on the same date of service.
2) CCMI 1: The reported CPT codes may be reported together only in defined circumstances which are identified on the claim by the use of specific NCCI-associated modifiers.

PTP edit files include a column which identifies whether the combination of CPT codes billed is allowed with a CCMI (O = not allowed, 1 = allowed, 9 = not applicable).

3.7.3 NCCI Modifiers 59, XE, XS, XP, and XU

Effective for claims with dates of service on or after January 1, 2016, the following modifiers were developed to provide greater reporting specificity in situations where modifier 59 was previously reported. Modifier 59 is an accepted modifier on hospital claims. However, it is informational only, and will not affect reimbursement of the procedure or the claim.

NCCI will eventually require the use of these modifiers rather than modifier 59 with certain edits. The following modifiers may be utilized in lieu of modifier 59 whenever possible:

1) XE - "Separate Encounter: A service that is distinct because it occurred during a separate encounter." This modifier should only be used to describe separate encounters on the same date of service.
2) XS – "Separate Structure: A service that is distinct because it was performed on a separate organ/structure."
3) XP – "Separate Practitioner: A service that is distinct because it was performed by a different practitioner."
4) XU – "Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service."

3.7.4 Modifier 50

Modifier 50 is an accepted modifier on hospital claims. However, it is informational only and will not affect reimbursement of the procedure or the claim.

When submitting a claim with multiple surgeries, submit the surgical CPT code on two separate detail lines on the claim. Per OAC rule 5160-2-21(F)(2)(b), ODM's payment logic for multiple surgeries is programmed to reimburse the highest paid surgery at 100% of the fee schedule amount and each additional surgery on the claim at 50% of the fee schedule amount. If the multiple surgical procedures are submitted on the same detail line, the multiple surgical procedure payment logic will not be applied to the claim. Please note that for all other procedures (ancillary, labs, etc.), multiple identical procedures must be submitted on one detail line with multiple units, otherwise that date of service will deny due to duplicate procedures.

3.7.5 Modifier 73 and Modifier 74

Modifier 73 should be used when a surgery is canceled prior to the administration of anesthesia while modifier 74 should be used when a surgery is canceled after the administration of anesthesia. The canceled surgery modifiers are only to be used when the entire scheduled surgery is canceled.

If more than one surgical procedure was scheduled to be performed during the surgery and at least one surgical procedure was performed, then the performed surgical procedure will be

reimbursed. If it was determined during the surgery that one of the scheduled surgical procedure(s) was no longer necessary, but another surgical procedure was completed, then the surgery is not recognized as a canceled surgery. In this scenario, it is inappropriate to bill for the surgical procedure that was not performed.

3.7.6 MODIFIER JW

Effective for dates of service on or after July 1, 2017, modifier JW will be an accepted modifier on hospital claims. However, it is informational only, and will not affect reimbursement of the pharmaceutical or the claim. If a claim (one date of service) contains two detail lines with the same RCC, same pharmaceutical HCPCS code, and same NDC but one detail line contains modifier JW, the second detail line will not deny as a duplicate. EOB 9950 (discarded drug pricing applied) will post on the detail line containing modifier JW, which will result in a payment of $0 for that detail line.

3.8 SPECIAL UNLISTED DENTAL SURGERY PRICING METHODOLOGY (1/1/14 – 12/31/15)

Per OAC rule 5160-2-21(F)(2)(b)(iii), 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 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 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 or ICD-10 diagnosis code of F70, F71, F72, F73, F78, or F79 will be paid five thousand five hundred dollars per claim, for dates of service on or between January 1, 2014 and December 31, 2015.

APPENDIX A – TYPE OF BILL

Type of Bill should be used in accordance with the following guidelines.

INPATIENT - Medicaid

0110 Zero Pay Bill
0111 Hospital inpatient admit through discharge
0112 Hospital inpatient first interim bill
0113 Hospital inpatient continuing interim bill
0114 Hospital inpatient last interim bill (only allowable for DRG-exempt hospitals)
0115 Late charges (DRG hospitals will not be reimbursed for late charges)

NOTE: Hospitals subject to DRG payment may submit bill types 112 and 113 in 30 day cycles. However, before the final admit through discharge bill (0111) can be submitted, all interim bills must be voided. These transactions can be submitted EDI or through the ODM MITS Web Portal. These are not handled by the Department's Adjustment Unit.

INPATIENT - Medicare Part A (Medicare crossover claim)

011X Hospital inpatient admit through discharge

NOTE: If an inpatient claim has Medicare coverage for Part A services and Medicaid coverage for the Part A coinsurance and deductible, Medicaid can only be billed directly when the claim for the coinsurance and deductible has not automatically "crossed-over" from Medicare to Medicaid within 90 days of the hospital's receipt of the Medicare payment.

INPATIENT - Medicare Part B (Medicare crossover claim)

012X Hospital inpatient admit through discharge (Use only with Medicare Part B)

NOTE: If an inpatient claim has Medicare coverage for Part B services and Medicaid coverage for the Part B coinsurance and deductible, Medicaid can only be billed directly when the claim for the coinsurance and deductible has not automatically "crossed-over" from Medicare to Medicaid within 90 days of the hospital's receipt of the Medicare payment.

INPATIENT - Medicare HMO (Part C) Plan

011X Hospital Inpatient Admit Through Discharge

NOTE: Unlike traditional Medicare Part A and Part B, claims for patients enrolled in Medicare HMO plans do not automatically "cross-over" from Medicare to Medicaid. To bill Medicaid for the cost-sharing related to a Medicare HMO Claim, the provider must submit a claim directly to Medicaid.

OUTPATIENT - Medicaid

0131 Outpatient
0135 Outpatient late charge

NOTE: Only two late charge bills may be submitted per provider, per recipient, per date of service. Only laboratory, pregnancy services, and radiology services may be included on claims for late charges.

OUTPATIENT - Medicare Part B (Medicare crossover claim)

013X Outpatient

NOTE: If an outpatient claim has Medicare coverage for Part B services and Medicaid coverage for the Part B coinsurance and deductible, Medicaid can only be billed directly when the claim for the coinsurance and deductible has not automatically "crossed-over" from Medicare to Medicaid within 90 days of the hospital's receipt of the Medicare payment.

OUTPATIENT - Medicare HMO (Part C) Plan

013X Outpatient

NOTE: Unlike traditional Medicare Part A and Part B, claims for patients enrolled in Medicare HMO plans do not automatically "cross-over" from Medicare to Medicaid. To bill Medicaid for the cost-sharing related to a Medicare HMO Claim, the provider must submit a claim directly to Medicaid.

VOID and REPLACE OR VOID – Can only be submitted as an Electronic Data Interchange (EDI) claim

XXX7 Void and Replace a previously paid claim

XXX8 Void a previously paid claim

NOTE: Please see the NUBC and EDI guidelines for additional information on how to use these Type of Bills ending in '7' or '8'. These cannot be used in the MITS Web Portal. The MITS Web

Portal has a ‘void’ option and an ‘adjustment’ option once a claim is selected. Therefore, use of Type of Bills XX7 or XX8 in the MITS Web Portal is unnecessary.

APPENDIX B – PRIORITY (TYPE) OF VISIT

The Priority (Type) of Visit Codes should be used in accordance with the following guidelines.

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
1	Emergency	Yes	Yes
2	Urgent	Yes	Yes
3	Elective	Yes	Yes
4	Newborn	Yes	Yes
5	Trauma Center	Yes	Yes
9	Information not available – use of this code will cause claim to deny	Not Allowed	Not Allowed

APPENDIX C – POINT OF ORIGIN FOR ADMISSION OR VISIT

Point of Origin for Admission or Visit Codes should be used in accordance with the following guidelines for Ohio Medicaid.

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
1	Non-Health Care Facility Point of Origin	Yes	Not Applicable
2	Clinic or Physician's Office	Yes	Not Applicable
4	Transfer from a Hospital - excludes transfers from hospital inpatient in the same facility (will be considered a transfer claim for payment purposes)	Yes	Not Applicable
5	Transfer from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), or Assisted Living Facility (ALF)	Yes	Not Applicable
6	Transfer from Another Health Care Facility	Yes	Not Applicable
8	Court/Law Enforcement	Yes	Not Applicable
9	Information not Available – use of this code will result in denied claim	Not Allowed	Not Applicable
D	Transfer from One Distinct Unit of the Hospital to another Distinct Unit of the Same Hospital Resulting in a Separate Claim to Payer	Yes	Not Applicable
E	Transfer from Ambulatory Surgery Center	Yes	Not Applicable
F	Transfer from a Hospice Facility	Yes	Not Applicable
Code	**Code Structure for Newborn**	**IP**	**OP**
5	Born Inside this Hospital: use, as applicable, with Priority (Type) of Visit 4 (Newborn)	Yes	Required only if Priority (Type) of Visit = 4
6	Born Outside of this Hospital: use, as applicable, with Priority (Type) of Visit 4 (Newborn)	Yes	Required only if Priority (Type) of Visit = 4

APPENDIX D – PATIENT DISCHARGE STATUS

Patient Discharge Status Codes should be used in accordance with the following guidelines.

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
1	Discharged to home or self-care (routine discharge)	Yes	Yes
2	Discharged/transferred to a short-term general hospital for inpatient care (will be considered a transfer claim for payment purposes)	Yes	Yes
3	Discharged/transferred to skilled nursing facility	Yes	Yes
4	Discharged/transferred to a facility that provides custodial or supportive care	Yes	Yes
5	Discharged/transferred to a Designated Cancer Center or Children's Hospital (will be considered a transfer claim for payment purposes)	Yes	Yes
6	Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care	Yes	Yes
7	Left against medical advice	Yes	Yes
9	Admitted as an inpatient to this hospital	Not Allowed	Yes
20	Expired NOTE: Please report Occurrence Code 55 to report the patient's date of death.	Yes	Yes
21	Discharged/transferred to court/law enforcement	Yes	Yes
30	Still patient (when billing for inpatient services, use of this code with type of bill other than 112, 113, 122 or 123 will result in a denied claim)	Yes	Yes
40	Expired at home – use of this code will result in a denied claim	Not Allowed	Not Allowed
41	Expired in a medical facility – use of this code will result in a denied claim	Not Allowed	Not Allowed
42	Expired – place unknown – use of this code will result in a denied claim	Not Allowed	Not Allowed
43	Discharged/transferred to a federal health care facility	Yes	Yes
50	Hospice – home	Yes	Yes
51	Hospice – medical facility	Yes	Yes

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
61	Discharged/transferred to a hospital-based Medicare approved swing bed. Note: Use of this code will cause the claim to be processed as a discharge, rather than a transfer for payment purposes.	Yes	Yes
62	Discharged/transferred to an inpatient rehabilitation facility (will be considered a transfer claim for payment purposes) **IMPORTANT NOTE:** Ohio Medicaid does not recognize distinct part rehabilitation units of a hospital as separate providers, therefore, one admit through discharge claim should be submitted to include the stay in both the medical unit and rehabilitation unit of the same hospital in these situations. Use this code only when discharging/transferring patient to a free-standing rehabilitation hospital.	Yes	Yes
63	Discharged/transferred to a Medicare Certified Long-Term Care Hospital (LTCH) (will be considered a transfer claim for payment purposes)	Yes	Yes
64	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare	Yes	Yes
65	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (will be considered a transfer claim for payment purposes)	Yes	Yes
66	Discharged/transferred to a Critical Access Hospital (CAH) (will be considered a transfer claim for payment purposes)	Yes	Yes
69	Discharged/transferred to a designated disaster alternative care site (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes
70	Discharged/transferred to another type of health care institution not defined elsewhere in this Code List (will be considered a transfer claim for payment purposes) - See Code 95 for a discharge with a Planned Acute Care Hospital Inpatient Readmission	Yes	Yes
81	Discharged to home or self-care with a planned acute care hospital inpatient readmission (Effective 10/1/13)	Yes	Yes

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
82	Discharged/transferred to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes
83	Discharged/transferred to a Skilled Nursing Facility (SNF) with Medicare certification with a planned acute care hospital inpatient readmission (Effective 10/1/13)	Yes	Yes
84	Discharged/transferred to a facility that provides custodial or supportive care with a planned acute care hospital inpatient readmission (Effective 10/1/13)	Yes	Yes
85	Discharged/transferred to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes
86	Discharged/transferred to home under care of an organized home health service organization with a planned acute hospital inpatient readmission (Effective 10/1/13)	Yes	Yes
87	Discharged/transferred to court/law enforcement with a planned acute care hospital inpatient readmission (Effective 10/1/13)	Yes	Yes
88	Discharged/transferred to a federal health care facility with a planned acute care hospital inpatient readmission (Effective 10/1/13)	Yes	Yes
89	Discharged/transferred to a hospital-based Medicare approved swing bed with a planned acute care Hospital inpatient readmission (Effective 10/1/13)	Yes	Yes
90	Discharged/transferred to an Inpatient Readmission Facility (IRF) including rehabilitation distinct parts units of a hospital with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes
91	Discharged/transferred to a Medicare Certified Long-Term Care Hospital (LTCH) with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
92	Discharged/transferred to a nursing facility certified under Medicaid but not certified under Medicare with a planned acute care hospital inpatient readmission	Yes	Yes
93	Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes
94	Discharged/transferred to a Critical Access Hospital (CAH) with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes
95	Discharged/transferred to another type of health care institution not defined elsewhere in this code list with a planned acute care hospital inpatient readmission (will be considered a transfer claim for payment purposes; effective 10/1/13)	Yes	Yes

APPENDIX E – CONDITION CODES

Condition Codes should be used in accordance with the following guidelines.

Please note: NUBC condition codes not used by Medicaid for adjudication are not listed here, but will not cause claims to deny when correctly submitted.

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
2	Condition Is Employment Related	Yes	Yes
3	Patient Covered By Insurance Not Reflected Here	Yes	Yes
39	Private Room Medically Necessary	Yes	No
71	Full Care In Dialysis Unit	Yes	Yes
72	Self-Care In Dialysis Unit	Yes	Yes
73	Self-Care Training	Yes	Yes
74	Home Dialysis	Yes	No
75	Home - 100% Reimbursement - Home Dialysis Using a Machine Purchased By Medicare Under The 100% Program	Yes	No
76	Back-Up In-Facility Dialysis (home dialysis patients)	Yes	No
81	C-sections or inductions performed at less than 39 weeks gestation for medical necessity (Effective 10/1/2013)	Yes	No
82	C-sections or inductions performed at less than 39 weeks gestation electively (Effective 10/1/2013)	Yes	No
83	C-sections or inductions performed at 39 weeks gestation or greater (Effective 10/1/2013)	Yes	No
A1	HEALTHCHECK / (EPSDT)	Yes	Yes
A2	Physically Handicapped Children's Program	Yes	Yes
A4	Family Planning	Yes	Yes
AA	Abortion Due to Rape	Yes	Yes
AB	Abortion Performed Due to Incest	Yes	Yes
AC	Abortion Due to Serious Fetal Genetic Defect, Deformity, or Abnormality	Not Covered	Not Covered
AD	Abortion Performed Due to a Life Endangering Physical Condition Caused by, Arising from, or Exacerbated by the Pregnancy Itself	Yes	Yes
AE	Abortion Due to Physical Health of Mother that is not Life Endangering	Not Covered	Not Covered

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
AF	Abortion Performed Due to Emotional/Psychological Health of the Mother	Not Covered	Not Covered
AG	Abortion Due to Social or Economic Reasons	Not Covered	Not Covered
AH	Elective Abortion	Not Covered	Not Covered
AI	Sterilization	Yes	Yes
C3	Partial Approval*	No	Yes

* This code should be included on any claims that are permitted to be resubmitted after a retrospective review by the utilization review vendor.

APPENDIX F – OCCURRENCE CODES

Occurrence Codes should be used in accordance with the following guidelines for Ohio Medicaid.

Please note: Valid codes not used by Medicaid for adjudication are not listed here, but will not cause claims to deny when correctly submitted.

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
1	Auto Accident	Yes	Yes
2	Auto Accident/No Fault Insurance Involved	Yes	Yes
3	Accident/Tort Liability	Yes	Yes
4	Accident/Employment Related	Yes	Yes
5	Accident/No Medical or Liability Coverage	Yes	Yes
6	Crime Victim	Yes	Yes
10	Last menstrual period. The date of the last menstrual period is applicable when the patient is being treated for a maternity related condition. Not required	Yes	Yes
24	Date of Insurance Denied	Yes	Yes
25	Date Benefits Terminated by Primary Payer	Yes	Yes
42	Date of Discharge: To be used when "Through" date in Form Locator 6 is not the actual discharge date and frequency code in Form Locator 4 is that of final bill (when the replacement is for a prior final claim).	Yes	No
43	Scheduled Date of Canceled Surgery (Outpatient only and must report modifier 73 or 74 with the canceled outpatient procedure.)	No	Yes
A3	Benefits Exhausted - Payer A	Yes	Yes
B3	Benefits Exhausted - Payer B	Yes	Yes
C3	Benefits Exhausted - Payer C	Yes	Yes

APPENDIX G – VALUE CODES

Value Codes should be used in accordance with the following guidelines for Ohio Medicaid.

Please note: Valid codes not used by Medicaid for adjudication are not listed here but will not cause claims to deny when correctly submitted.

Code	Description	Used in Medicaid Claims Adjudication	
		IP	OP
01	Most common semi-private rate	Yes	Not Applicable
02	Hospital has no semi-private rooms (do not list dollar amounts)	Yes	Not Applicable
06	Medicare Part A Blood Deductible	Yes	Not Applicable
23	Recurring monthly income (Patient's monthly spend-down responsibility)	Yes	Yes
31	Patient Liability Amount (Required when a patient chooses a private room and agrees to pay the room differential. Differential must also be reported as non-covered charges for revenue code 011X)	Yes	Not Applicable
54	Newborn birth weight in grams Please note: Providers should include decimal points when reporting birth weight. For example, if the birth weight is 1000 grams, then the provider should report 1000.00 along with value code 54.	Yes	Not Applicable
80	Covered Days	Yes	Not Applicable
81	Non-Covered Days	Yes	Not Applicable
82	Co-Insurance Days	Yes	Not Applicable
83	Lifetime Reserve Days	Yes	Not Applicable

IMPORTANT NOTES regarding Value Code use for Ohio Medicaid:

Medicaid Spend-Down

Some persons are eligible for Medicaid only after they have incurred medical expenses that reduce their income (spend-down) to the Medicaid need standard. Persons eligible for Medicaid through spend-down are responsible for the medical expenses they incur. Medicaid cannot be billed for any unpaid spend-down amounts. The incurred spend-down amount reflected in Form Locator 39a-d, 40a-d, and 41a-d of the UB-04 will be deducted from the applicable Medicaid payment. If

a third-party payment is made in addition to a collected spend-down amount and the third-party payment exceeds the applicable Medicaid payment amount, then the spend-down payment should be refunded to the recipient. If the third-party payment plus the spend-down exceed the applicable Medicaid payment, the spend-down amount in excess of the applicable Medicaid payment amount should be refunded.

Reporting Covered and Non-Covered Days

The days being reported as covered should only be the days Medicaid is responsible for payment during the Statement Covers Period (From and Through dates). Any days for which Medicaid is not responsible (i.e., person is ineligible) during the Statement Covers Period (From and Through dates), should be reported as non-covered days. These numbers will also need to be reported separately at the detail level. The number of covered days should also match the number of units and charges being reported for room and board. Non-covered days should have a separate line at the detail level for the matching of the number of units. Any charges related to the non-covered days would be reported under Total Charges and Non-Covered Charges. The discharge date should not be included as a non-covered day.

Effective for admissions on or after January 1, 2016, all outpatient services rendered within three days of an inpatient admission must be submitted on the inpatient claim. As a result, the covered days should reflect the number of days in which the patient was admitted and eligible for Medicaid fee-for-service coverage.

APPENDIX H – NATIONAL PROVIDER IDENTIFIER (NPI) INFORMATION

In accordance with federal regulations (45 CFR § 162.404), all eligible health care providers are required to obtain a ten digit National Provider Identifier (NPI) from the National Plan and Provider Enumeration System. ODM will continue to maintain and assign the seven-digit Medicaid Legacy Provider Identifier upon enrollment.

NPI and Claims Submission

Providers must use the general acute care hospital NPI on all claims submitted directly to Medicaid, including claims where the consumer has Medicare coverage. Medicaid will deny claims submitted directly with NPIs other than the general acute care hospital NPI. However, on claims that automatically "cross-over" from Medicare, Medicaid will accept "secondary" NPIs associated with a psychiatric unit, rehabilitation unit, or renal dialysis services. Providers must report "secondary" NPIs to Medicaid in order to have them accepted on automatic "cross-over" claims from Medicare. They will then be mapped to the general acute care hospital NPI for payment purposes.

Billing for Non-Hospital Services

Hospital providers who obtained unique NPIs for non-hospital services such as ambulance, durable medical equipment (DME), or pharmacy (for take-home drugs) must also obtain unique Medicaid Legacy Provider Identifiers. Unique NPIs associated with non-hospital services will not be mapped to the general acute care hospital Medicaid Legacy Provider Identifier.

APPENDIX I – COVERED AND NON-COVERED REVENUE CODES

Revenue Codes and Descriptions

I/P = Inpatient
O/P = Outpatient

C = Covered
N = Non-Covered

CPT/HCPCS Required?

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
Health Insurance - PPS	002	2 -	Skilled Nursing Facility PPS	N	N
		3 -	Home Health PPS	N	N
		4 -	Inpatient Rehabilitation Facility PPS	N	N
All Inclusive Rate	010	0 -	All-inclusive Room and Board Plus Ancillary	C	N
		1 -	All-Inclusive Room and Board	N	N
Room & Board - Private (Medical or General)	011	0 -	General Classification	C	C
		1 -	Medical/Surgical/Gyn	C	C
		2 -	OB	C	C
		3 -	Pediatric	C	C
		4 -	Psychiatric	C	C
		5 -	Hospice	N	N
		6 -	Detoxification	C	C
		7 -	Oncology	C	C
		8 -	Rehabilitation	C	C
		9 -	Other	C	C
Note: See rule 5160-2-03 for coverage limitations pertaining to private rooms.					
Room & Board - Semi-Private Two Bed (Medical or General)	012	0 -	General Classification	C	C
		1 -	Medical/Surgical/Gyn	C	C
		2 -	OB	C	C
		3 -	Pediatric	C	C
		4 -	Psychiatric	C	C
		5 -	Hospice	N	N
		6 -	Detoxification	C	C
		7 -	Oncology	C	C
		8 -	Rehabilitation	C	C
		9 -	Other	C	C
Room & Board - Semi-Private - Three and Four Beds	013	0 -	General Classification	C	C
		1 -	Medical/Surgical/Gyn	C	C
		2 -	OB	C	C
		3 -	Pediatric	C	C
		4 -	Psychiatric	C	C
		5 -	Hospice	N	N
		6 -	Detoxification	C	C
		7 -	Oncology	C	C
		8 -	Rehabilitation	C	C
		9 -	Other	C	C

Revenue Codes and Descriptions

I/P = Inpatient
O/P = Outpatient

C = Covered
N = Non-Covered

CPT/HCPCS Required?

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
Room & Board - Private (Deluxe)	014	0 -	General Classification	N	N
		1 -	Medical/Surgical/Gyn	N	N
		2 -	OB	N	N
		3 -	Pediatric	N	N
		4 -	Psychiatric	N	N
		5 -	Hospice	N	N
		6 -	Detoxification	N	N
		7 -	Oncology	N	N
		8 -	Rehabilitation	N	N
		9 -	Other	N	N
Room & Board - Ward (Medical or General)	015	0 -	General Classification	C	C
		1 -	Medical/Surgical/Gyn	C	C
		2 -	OB	C	C
		3 -	Pediatric	C	C
		4 -	Psychiatric	C	C
		5 -	Hospice	N	N
		6 -	Detoxification	C	C
		7 -	Oncology	C	C
		8 -	Rehabilitation	C	C
		9 -	Other	C	C
Room & Board - Other	016	0 -	General Classification	C	C
		4 -	Sterile Environment	C	C
		7 -	Self-Care	N	N
		9 -	Other	C	C
Nursery	017	0 -	General Classification	C	C
		1 -	Newborn - Level I	C	C
		2 -	Newborn - Level II	C	N
		3 -	Newborn - Level III	C	N
		4 -	Newborn - Level IV	C	N
		9 -	Other	C	C
Note: Subcategory codes 1 through 4 are defined by the National Uniform Billing Committee. Please note that these definitions are different than those recognized by the Ohio Department of Health.					
Leave of Absence	018	0 -	General Classification	N	N
		2 -	Patient Convenience	N	N
		3 -	Therapeutic Leave	N	N
		5 -	Hospitalization	N	N
		9 -	Other Leave of Absence	N	N
Subacute Care	019	0 -	General Classification	N	N
		1 -	Subacute Care - Level I	N	N
		2 -	Subacute Care - Level II	N	N
		3 -	Subacute Care - Level III	N	N

Revenue Codes and Descriptions

I/P = Inpatient
O/P = Outpatient

C = Covered
N = Non-Covered

CPT/HCPCS Required?

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
		4 -	Subacute Care - Level IV	N	N
		9 -	Other Subacute Care	N	N
Intensive Care	020	0 -	General Classification	C	N
		1 -	Surgical	C	N
		2 -	Medical	C	N
		3 -	Pediatric	C	N
		4 -	Psychiatric	C	N
		6 -	Intermediate ICU	C	N
		7 -	Burn Care	C	N
		8 -	Trauma	C	N
		9 -	Other Intensive Care	C	N
Coronary Care	021	0 -	General Classification	C	N
		1 -	Myocardial Infarction	C	N
		2 -	Pulmonary Care	C	N
		3 -	Heart Transplant	C	N
		4 -	Intermediate ICU	C	N
		9 -	Other Coronary Care	C	N
Special Charges	022	0 -	General Classification	N	N
		1 -	Admission Charge	N	N
		2 -	Technical Support Charge	N	N
		3 -	U.R. Service Charge	N	N
		4 -	Late Discharge, Medically Nec.	N	N
		9 -	Other Special Charges	N	N
Incremental Nursing Charge Rate	023	0 -	General Classification	C	N
		1 -	Nursery	C	N
		2 -	OB	C	N
		3 -	ICU	C	N
		4 -	CCU	C	N
		5 -	Hospice	N	N
		9 -	Other	C	N
All Inclusive Ancillary	024	0 -	General Classification	C	N
		1 -	Basic	C	N
		2 -	Comprehensive	C	N
		3 -	Specialty	C	N
		9 -	Other All Inclusive Ancillary	C	N
Pharmacy (Also see 063X, an extension of 025X)	025	0 -	General Classification	C	C
		1 -	Generic Drugs	C	C
		2 -	Non-Generic Drugs	C	C
		3 -	Take Home Drugs	N	N
		4 -	Drugs Incident to Other Diagnostic Services	C	C

Revenue Codes and Descriptions

I/P = Inpatient
O/P = Outpatient

C = Covered
N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
		5 -	Drugs Incident to Radiology	C	C	
		6 -	Experimental Drugs	N	N	
		7 -	Non-Prescription Drugs	C	N	
		8 -	IV Solution	C	C	
		9 -	Other Pharmacy	C	C	
IV Therapy	026	0 -	General Classification	C	C	Y
		1 -	Infusion Pump	C	C	Y
		2 -	IV Therapy/Pharmacy	C	C	
		3 -	IV Therapy/Drug/Supply/Delivery	C	C	
		4 -	IV Therapy/Supplies	C	C	
		9 -	Other IV Therapy	C	C	Y
Medical/Surgical Supplies and Devices (Also see 062X, and extension of 027X)	027	0 -	General Classification	C	C	
		1 -	Non Sterile Supply	C	C	
		2 -	Sterile Supply	C	C	
		3 -	Take Home Supplies	N	N	
		4 -	Prosthetic/Orthotic Devices	C	N	
		5 -	Pacemaker	C	C	
		6 -	Intraocular Lens	C	C	
		7 -	Oxygen-Take Home	N	N	
		8 -	Other Implant	C	C	
		9 -	Other Supplies/Devices	C	C	
Oncology	028	0 -	General Classification	C	C	Y
		9 -	Other Oncology	C	C	Y
Durable Medical Equipment (Other than Rental)	029	0 -	General Classification	N	N	
		1 -	Rental	C	N	
		2 -	Purchase of New DME	N	N	
		3 -	Purchase of Used DME	N	N	
		4 -	Supplies/Drugs for DME Effectiveness (HHA only)	N	N	
		9 -	Other Equipment	N	N	
Laboratory	030	0 -	General Classification	C	C	Y
		1 -	Chemistry	C	C	Y
		2 -	Immunology	C	C	Y
		3 -	Renal Patient (home)	N	N	
		4 -	Non-routine Dialysis	C	C	Y
		5 -	Hematology	C	C	Y
		6 -	Bacteriology & Microbiology	C	C	Y
		7 -	Urology	C	C	Y
		9 -	Other Laboratory	C	C	Y
Laboratory Pathological	031	0 -	General Classification	C	C	Y

Revenue Codes and Descriptions

I/P = Inpatient
O/P = Outpatient

C = Covered
N = Non-Covered

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
		1 -	Cytology	C	C	Y
		2 -	Histology	C	C	Y
		4 -	Biopsy	C	C	Y
		9 -	Other Laboratory Pathological	C	C	Y
Radiology - Diagnostic	032	0 -	General Classification	C	C	Y
		1 -	Angiocardiography	C	C	Y
		2 -	Arthrography	C	C	Y
		3 -	Arteriography	C	C	Y
		4 -	Chest X-ray	C	C	Y
		9 -	Other Radiology - Diagnostic	C	C	Y
Radiology - Therapeutic and/or Chemotherapy Administration	033	0 -	General Classification	C	C	Y
		1 -	Chemotherapy Administration - Injected	C	C	Y
		2 -	Chemotherapy Admin. - Oral	C	C	Y
		3 -	Radiation Therapy	C	C	Y
		5 -	Chemotherapy Admin. - IV	C	C	Y
		9 -	Other Radiology - Therapeutic	C	C	Y
Nuclear Medicine	034	0 -	General Classification	C	C	Y
		1 -	Diagnostic Procedures	C	C	Y
		2 -	Therapeutic Procedures	C	C	Y
		3 -	Diagnostic Radiopharmaceutical	C	C	
		4 -	Therapeutic Radiopharmaceutical	C	C	
		9 -	Other	C	C	Y
CT Scan	035	0 -	General Classification	C	C	Y
		1 -	Head Scan	C	C	Y
		2 -	Body Scan	C	C	Y
		9 -	Other CT Scan	C	C	Y
Operating Room Services	036	0 -	General Classification	C	C	Y
		1 -	Minor Surgery	C	C	Y
		2 -	Organ Transplant-Other Than Kidney	C	N	
		7 -	Kidney Transplant	C	N	
		9 -	Other Operating Room Services	C	C	Y
Anesthesia	037	0 -	General Classification	C	C	Y
		1 -	Anesthesia Incident to Radiology	C	C	Y
		2 -	Anesthesia Incident to Other Diagnostic Services	C	C	Y
		4 -	Acupuncture	N	N	
		9 -	Other Anesthesia	C	C	Y
Blood	038	0 -	General Classification	C	C	

Revenue Codes and Descriptions

I/P = Inpatient
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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
		1 -	Packed Blood Cells	C	C	
		2 -	Whole Blood	C	C	
		3 -	Plasma	C	C	
		4 -	Platelets	C	C	
		5 -	Leucocytes	C	C	
		6 -	Other Components	C	C	
		7 -	Other Derivatives (Cryoprecipitate)	C	C	
		9 -	Other Blood	C	C	
Blood and Blood Components Administration, Processing & Storage	039	0 -	General Classification	C	C	
		1 -	Administration (Transfusions)	C	C	
		9 -	Other Processing and Storage	C	C	
Other Imaging Services	040	0 -	General Classification	C	C	Y
		1 -	Diagnostic Mammography	C	C	Y
		2 -	Ultrasound	C	C	Y
		3 -	Screening Mammography	C	C	Y
		4 -	Positron Emission Tomography	C	C	Y
		9 -	Other Imaging Service	C	C	Y
Respiratory Services	041	0 -	General Classification	C	C	Y
		2 -	Inhalation Services	C	C	Y
		3 -	Hyperbaric Oxygen Therapy	C	C	Y
		9 -	Other Respiratory Services	C	C	Y
Physical Therapy	042	0 -	General Classification	C	C	Y
		1 -	Visit Charge	C	C	Y
		2 -	Hourly Charge	C	C	Y
		3 -	Group Rate	C	C	Y
		4 -	Evaluation or Re-evaluation	C	C	Y
		9 -	Other Physical Therapy	C	C	Y
Occupational Therapy	043	0 -	General Classification	C	C	Y
		1 -	Visit Charge	C	C	Y
		2 -	Hourly Charge	C	C	Y
		3 -	Group Rate	C	C	Y
		4 -	Evaluation or Re-evaluation	C	C	Y
		9 -	Other Occupational Therapy	C	C	Y
Speech-Language Pathology	044	0 -	General Classification	C	C	Y
		1 -	Visit Charge	C	C	Y
		2 -	Hourly Charge	C	C	Y
		3 -	Group Rate	C	C	Y
		4 -	Evaluation or Re-evaluation	C	C	Y
		9 -	Other Speech-Language Pathology	C	C	Y

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
Emergency Room	045	0 -	General Classification	C	C	Y
		1 -	EMTALA Emergency Medical Screening Services	C	C	Y
		2 -	ER Beyond EMTALA Screening Services	C	C	Y
		6 -	Urgent Care	C	C	Y
		9 -	Other Emergency Room	C	C	Y
Pulmonary Function	046	0 -	General Classification	C	C	Y
		9 -	Other Pulmonary Function	C	C	Y
Audiology	047	0 -	General Classification	C	C	Y
		1 -	Diagnostic	C	C	Y
		2 -	Treatment	C	C	Y
		9 -	Other Audiology	C	C	Y
Cardiology	048	0 -	General Classification	C	C	Y
		1 -	Cardiac Cath Lab	C	C	Y
		2 -	Stress Test	C	C	Y
		3 -	Echocardiography	C	C	Y
		9 -	Other Cardiology	C	C	Y
Ambulatory Surgical Care	049	0 -	General Classification	C	C	Y
		9 -	Other Ambulatory Surgical Care	C	C	Y
Outpatient Services	050	0 -	General Classification	N	N	
		9 -	Other Outpatient Service	N	N	
Clinic	051	0 -	General Classification	C	C	Y
		1 -	Chronic Pain Center	C	C	Y
		2 -	Dental Clinic*	C	C	Y
		3 -	Psychiatric Clinic	C	C	Y
		4 -	OB-GYN Clinic	C	C	Y
		5 -	Pediatric Clinic	C	C	Y
		6 -	Urgent Care Clinic	C	C	Y
		7 -	Family Practice Clinic	C	C	Y
		9 -	Other Clinic	C	C	Y
*Note: See rule 5160-2-03 for coverage limitations pertaining to dental services provided in a hospital facility.						
Free-Standing Clinic	052	0 -	General Classification	N	N	
		1 -	Rural Health-Clinic	N	N	
		2 -	Rural Health-Home	N	N	
		3 -	Family Practice Clinic	N	N	
		4 -	Visit by RHC/FQHC Practitioner - SNF (Covered by Part A)	N	N	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
		5 -	Visit by RHC/FQHC Practitioner - SNF(not a Covered Part A Stay) or NF or ICF MR or Other Residential Facility	N	N	
		6 -	Urgent Care Clinic	N	N	
		7 -	Visiting Nurse Service(s)- in a Home Health Shortage Area	N	N	
		8 -	Visit by RHC/FQHC Practitioner to Other Site	N	N	
		9 -	Other Freestanding Clinic	N	N	
Osteopathic Services	053	0 -	General Classification	C	C	Y
		1 -	Osteopathic Therapy	C	C	Y
		9 -	Other Osteopathic Services	C	C	Y
Ambulance	054	0 -	General Classification	N	N	
		1 -	Supplies	N	N	
		2 -	Medical Transport	N	N	
		3 -	Heart Mobile	N	N	
		4 -	Oxygen	N	N	
		5 -	Air Ambulance	N	N	
		6 -	Neonatal Ambulance Service	N	N	
		7 -	Pharmacy	N	N	
		8 -	Telephone Transmission EKG	N	N	
		9 -	Other Ambulance	N	N	
Skilled Nursing	055	0 -	General Classification	N	N	
		1 -	Visit Charge	N	N	
		2 -	Hourly Charge	N	N	
		9 -	Other Skilled Nursing	N	N	
Medical Social Services	056	0 -	General Classification	N	N	
		1 -	Visit Charge	N	N	
		2 -	Hourly Charge	N	N	
		9 -	Other Medical Social Services	N	N	
Home Health - Home Health Aide	057	0 -	General Classification	N	N	
		1 -	Visit Charge	N	N	
		2 -	Hourly Charge	N	N	
		9 -	Other Home Health Aide	N	N	
Home Health - Other Visits	058	0 -	General Classification	N	N	
		1 -	Visit Charge	N	N	
		2 -	Hourly Charge	N	N	
		3 -	Assessment	N	N	
		9 -	Other Home Health Visit	N	N	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
Home Health - Units of Service	059	0 -	General Classification	N	N	
Home Health - Oxygen	060	0 -	General Classification	N	N	
		1 -	Oxygen - State/Equip/Supply/or Cont	N	N	
		2 -	Oxygen - State/Equip/Supply/ under 1 LPM	N	N	
		3 -	Oxygen - State/Equip/Over 4 LPM	N	N	
		4 -	Oxygen - Portable Add-on	N	N	
		9 -	Other Oxygen	N	N	
Magnetic Resonance Technology (MRT)	061	0 -	General Classification	C	C	Y
		1 -	MRI - Brain (Including Brainstem)	C	C	Y
		2 -	MRI - Spinal Cord (Incl. Spine)	C	C	Y
		4 -	MRI - Other	C	C	Y
		5 -	MRA - Head and Neck	C	C	Y
		6 -	MRA - Lower Extremities	C	C	Y
		8 -	MRA - Other	C	C	Y
		9 -	Other MRT	C	C	Y
Medical/Surgical Supplies - Extension of 027X	062	1 -	Supplies Incident to Radiology	C	C	
		2 -	Supplies Incident to Other Diagnostic Services	C	C	
		3 -	Surgical Dressings	C	C	
		4 -	FDA Investigational Devices	N	N	
Pharmacy - Extension of 025X	063	1 -	Single Source Drug	N	N	
		2 -	Multiple Source Drug	N	N	
		3 -	Restrictive Prescription	N	N	
		4 -	Erythropoietin (EPO) Less Than 10,000 Units	C	C	
		5 -	Erythropoietin (EPO) 10,000 or More Units	C	C	
		6 -	Drugs Requiring Detailed Coding	N	C	Y
		7 -	Self-administrable Drugs	C	C	
Home IV Therapy Services	064	0 -	General Classification	N	N	
		1 -	Nonroutine Nursing, Central Line	N	N	
		2 -	IV Site Care, Central Line	N	N	
		3 -	IV Start/Change, Peripheral Line	N	N	
		4 -	Nonroutine Nurs., Peripheral Line	N	N	

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CPT/HCPCS Required?

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
		5 -	Training, Patient/Caregiver, Central Line	N	N
		6 -	Training, Disabled Patient, Central Line	N	N
		7 -	Training, Patient/Caregiver, Peripheral Line	N	N
		8 -	Training, Disabled Patient, Peripheral Line	N	N
		9 -	Other IV Therapy Services	N	N
Hospice Service	065	0 -	General Classification	N	N
		1 -	Routine Home Care	N	N
		2 -	Continuous Home Care	N	N
		5 -	Inpatient Respite Care	N	N
		6 -	General IP Care (Non-respite)	N	N
		7 -	Physician Services	N	N
		8 -	Hospice Room & Board - Nursing Facility	N	N
		9 -	Other Hospice Service	N	N
Respite Care	066	0 -	General Classification	N	N
		1 -	Hourly Charge/Nursing	N	N
		2 -	Hourly Charge/Aid/Homemaker/ Companion	N	N
		3 -	Daily Respite Charge	N	N
		9 -	Other Respite Charge	N	N
Outpatient Special Residence Charge	067	0 -	General Classification	N	N
		1 -	Hospital Based	N	N
		2 -	Contracted	N	N
		9 -	Other Special Residence Charge	N	N
Trauma Response (Charge for Trauma Team Activation)	068	1 -	Level I	N	N
		2 -	Level II	N	N
		3 -	Level III	N	N
		4 -	Level IV	N	N
		9 -	Other Trauma Response	N	N
Pre-Hospice/Palliative Care Services	069	0-	General Classification	N	N
		1-	Visit Charge	N	N
		2-	Hourly Charge	N	N
		3-	Evaluation	N	N
		4-	Consultation and Education	N	N
		5-	Inpatient Care	N	N
		6-	Physician Services	N	N
		7-8	RESERVED	N	N

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
		9-	Other Pre-Hospice/Palliative Care Services	N	N	
Cast Room	070	0 -	General Classification	C	C	Y
Recovery Room	071	0 -	General Classification	C	C	
Labor Room/Delivery	072	0 -	General Classification	C	C	Y
		1 -	Labor	C	C	Y
		2 -	Delivery	C	C	Y
		3 -	Circumcision	C	C	Y
		4 -	Birthing Center	C	C	Y
		9 -	Other Labor Room/Delivery	C	C	Y
EKG/ECG (Electrocardiogram)	073	0 -	General Classification	C	C	Y
		1 -	Holter Monitor	C	C	Y
		2 -	Telemetry	C	C	Y
		9 -	Other EKG/ECG	C	C	Y
EEG (Electroencephalogram)	074	0 -	General Classification	C	C	Y
Gastro-Intestinal Services	075	0 -	General Classification	C	C	Y
Treatment/Observation Room	076	0 -	General Classification	C	C	Y
		1 -	Treatment Room	C	C	Y
		2 -	Observation Room	C	C	Y
		9 -	Other Treatment/Obs. Room	C	C	Y
Preventive Care Services	077	0 -	General Classification	C	C	
		1 -	Vaccine Administration	C	C	
Telemedicine	078	0 -	General Classification	N	N	
Extra-Corporeal Shock Wave Therapy	079	0 -	General Classification	C	C	Y
Inpatient Renal Dialysis	080	0 -	General Classification	C	N	
		1 -	Inpatient Hemodialysis	C	N	
		2 -	Inpatient Peritoneal (Non-CAPD)	C	N	
		3 -	Inpatient Continuous Ambulatory Peritoneal Dialysis (CAPD)	C	N	
		4 -	Inpatient Continuous Cycling Peritoneal Dialysis (CCPD)	C	N	
		9 -	Other Inpatient Dialysis	C	N	
Acquisition of Body Components	081	0 -	General Classification	C	N	
		1 -	Living Donor	C	N	
		2 -	Cadaver Donor	C	N	
		3 -	Unknown Donor	N	N	
		4 -	Unsuccessful Organ Search Donor Bank Charges	N	N	
		5 -	Stem Cells - Allogeneic	C	C	Y

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
		9 -	Other Donor	C	N	
Note: Acquisition charges eligible for cost-related reimbursement, as described in rule 5160-2-65, should be reported using revenue code 0810.						
Hemodialysis - Outpatient or Home	082	0 -	General Classification	N	C	Y
		1 -	Hemodialysis/Composite or Other Rate	N	C	Y
		2 -	Home Supplies	N	N	
		3 -	Home Equipment	N	N	
		4 -	Maintenance/100%	N	N	
		5 -	Support Services	N	N	
		6 -	Hemodialysis – Shorter	N	N	Y
		9 -	Other Outpatient Hemodialysis	N	C	Y
Peritoneal Dialysis - Outpatient or Home	083	0 -	General Classification	N	C	Y
		1 -	Peritoneal Dialysis/Composite or Other Rate	N	C	Y
		2 -	Home Supplies	N	N	
		3 -	Home Equipment	N	N	
		4 -	Maintenance/100%	N	N	
		5 -	Support Services	N	N	
		9 -	Other OP Peritoneal Dialysis	N	C	Y
Continuous Ambulatory Peritoneal Dialysis (CAPD) - Outpatient or Home	084	0 -	General Classification	N	C	Y
		1 -	CAPD/Composite or Other Rate	N	C	Y
		2 -	Home Supplies	N	N	
		3 -	Home Equipment	N	N	
		4 -	Maintenance 100%	N	N	
		5 -	Support Services	N	N	
		9 -	Other Outpatient CAPD	N	C	Y
Continuous Cycling Peritoneal Dialysis (CCPD) - Outpatient or Home	085	0 -	General Classification	N	C	Y
		1 -	CCPD/Composite or Other Rate	N	C	Y
		2 -	Home Supplies	N	N	
		3 -	Home Equipment	N	N	
		4 -	Maintenance 100%	N	N	
		5 -	Support Services	N	N	
		9 -	Other Outpatient CCPD	N	C	Y
Miscellaneous Dialysis	088	0 -	General Classification	C	C	Y
		1 -	Ultrafiltration	C	C	Y
		2 -	Home Dialysis Aid Visit	N	N	
		9 -	Other Miscellaneous Dialysis	C	C	Y
Behavioral Health Treatments/Services (Also	090	0 -	General Classification	C	C	Y
		1 -	Electroshock Treatment	N	N	
		2 -	Milieu Therapy	N	N	

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General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P	CPT/HCPCS Required?
see 091X, an extension of 090X)		3 -	Play Therapy	N	N	
		4 -	Activity Therapy	N	N	
		5 -	IOP - Psychiatric	N	N	
		6 -	IOP - Chemical Dependency	N	N	
		7 -	Day Treatment	N	N	
Behavioral Health Treatments/Services - Extension of 090X	091	1 -	Rehabilitation	N	C	Y
		2 -	Partial Hospitalization - Less Intensive	N	N	
		3 -	Partial Hospitalization - Intensive	N	N	
		4 -	Individual Therapy	C	C	Y
		5 -	Group Therapy	C	C	Y
		6 -	Family Therapy	C	C	Y
		7 -	Bio Feedback	N	N	
		8 -	Testing	C	C	Y
		9 -	Other Behavioral Health Treatment/Services	C	C	Y
Other Diagnostic Services	092	0 -	General Classification	C	C	Y
		1 -	Peripheral Vascular Lab	C	C	Y
		2 -	Electromyogram	C	C	Y
		3 -	Pap Smear	C	C	Y
		4 -	Allergy Test	C	C	Y
		5 -	Pregnancy Test	C	C	Y
		9 -	Other Diagnostic Services	C	C	Y
Medical Rehabilitation Day Program	093	1 -	Half Day	N	N	
		2 -	Full Day	N	N	
Other Therapeutic Services (Also see 095X, an extension of 094X)	094	0 -	General Classification	C	C	Y
		1 -	Recreational Therapy	N	N	
		2 -	Education/Training	C	C	Y
		3 -	Cardiac Rehabilitation	C	C	Y
		4 -	Drug Rehabilitation	N	C	Y
		5 -	Alcohol Rehabilitation	N	C	Y
		6 -	Complex Medical Equipment - Routine	N	N	
		7 -	Complex Medical Equipment - Ancillary	N	N	
		9 -	Other Therapeutic Service	C	C	Y
Other Therapeutic Services - Ext. of 094X	095	1 -	Athletic Training	N	N	
		2-	Kinesiotherapy	C	C	Y
		3-	Chemical Dependency (Drug and Alcohol) CHEMDEP	N	N	
		4-9	RESERVED	N	N	

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CPT/HCPCS Required?

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
Professional Fees (Also see 097X and 098X)	096	0 -	General Classification	N	N
		1 -	Psychiatric	N	N
		2 -	Ophthalmology	N	N
		3 -	Anesthesiologist (MD)	N	N
		4 -	Anesthetist (CRNA)	N	N
		9 -	Other Professional Fee	N	N
Professional Fees (Extension of 096X)	097	1 -	Laboratory	N	N
		2 -	Radiology - Diagnostic	N	N
		3 -	Radiology - Therapeutic	N	N
		4 -	Radiology - Nuclear Medicine	N	N
		5 -	Operating Room	N	N
		6 -	Respiratory Therapy	N	N
		7 -	Physical Therapy	N	N
		8 -	Occupational Therapy	N	N
		9 -	Speech Pathology	N	N
Professional Fees (Extension of 096X and 097X)	098	1 -	Emergency Room	N	N
		2 -	Outpatient Services	N	N
		3 -	Clinic	N	N
		4 -	Medical Social Services	N	N
		5 -	EKG	N	N
		6 -	EEG	N	N
		7 -	Hospital Visit	N	N
		8 -	Consultation	N	N
		9 -	Private Duty Nurse	N	N
Patient Convenience Items	099	0 -	General Classification	N	N
		1 -	Cafeteria/Guest Tray	N	N
		2 -	Private Linen Service	N	N
		3 -	Telephone/Telegraph	N	N
		4 -	TV/Radio	N	N
		5 -	Nonpatient Room Rentals	N	N
		6 -	Late Discharge Charge	N	N
		7 -	Admission Kits	N	N
		8 -	Beauty Shop/Barber	N	N
		9 -	Other Patient Convenience Item	N	N
Behavioral Health Accommodations	100	0 -	General Classification	N	N
		1 -	Res.Treatment - Psychiatric	N	N
		2 -	Res. Treatment - Chem. Dep.	N	N
		3 -	Supervised Living	N	N
		4 -	Halfway House	N	N
		5 -	Group Home	N	N
Alternative Therapy Services	210	0 -	General Classification	N	N

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CPT/HCPCS Required?

General Category	1st Three Digits	4th Digit	Detail Description	I/P	O/P
		1 -	Acupuncture	N	N
		2 -	Acupressure	N	N
		3 -	Massage	N	N
		4 -	Reflexology	N	N
		5 -	Biofeedback	N	N
		6 -	Hypnosis	N	N
		9 -	Other Alternative Therapy	N	N
Adult Care	310	1 -	Adult Day Care, Medical and Social - Hourly	N	N
		2 -	Adult Day Care, Social - Hourly	N	N
		3 -	Adult Day Care, Medical and Social - Daily	N	N
		4 -	Adult Day Care, Social - Daily	N	N
		5 -	Adult Foster Care - Daily	N	N
		9 -	Other Adult Care	N	N

APPENDIX J – INCARCERATED INPATIENT HOSPITAL BENEFITS

FREQUENTLY ASKED QUESTIONS

1. Are all services covered under IHSP?
    a. No. Only services that are provided during an inpatient hospital stay would be reimbursable. This would also allow for separate physician (or other practitioners of physician services) claims to be submitted with the place of service, inpatient hospital. Please note that prior authorization requirements as described in Sections 2.5.2 and 2.5.3 apply to IHSP.

2. Would outpatient hospital services be covered prior to the inpatient stay?
    a. The 72 hour window for outpatient services to be included in the inpatient stay does not apply to IHSP benefit plan. If any outpatient services are provided prior to the date of admission, the hospital would need to submit their claim to the Department of Rehab & Corrections (DRC) or the correctional facility where the inmate is being housed. However, any outpatient services provided on the date of admission, should be included on the inpatient hospital claim if provided at the same facility as the admission.

3. Would coverage include a 24 hour observation? What admission code would need to be used by the hospital?
    a. Observation services are normally billed as an outpatient service so they would not be covered. However, if observation is provided on the date of admission for a stay that becomes an inpatient stay, those observation services would be covered and therefore should be included on the inpatient claim. There would not be a specific admission code; the claim itself would be submitted as an inpatient claim starting on the day the admission was ordered.

4. Would the emergency room visit preceding the inpatient stay also be covered? What admission code would need to be used by the hospital?
    a. Emergency services/visits are normally billed as an outpatient service so they would not be covered. However, if emergency room services are provided on the date of admission for a stay that becomes an inpatient stay, those services would be covered and therefore should be included on the inpatient claim. There would not be a specific admission code; the claim itself would be submitted as an inpatient claim starting on the day the admission was ordered.

5. If an individual is transported via EMS to a hospital and it turns into an inpatient stay, will that transportation cost be covered?
    a. No. Only services provided during inpatient hospitalization can be paid by Medicaid for incarcerated individuals. Transportation services would not be included.

        Example:
        - Inmate is transferred to hospital on 1/1/2017 for emergency services. The inmate is in observation on 1/2/2017, and the order to admit to inpatient on 1/3/17. Inmate is discharged on 1/10/17.

- Outpatient and professional claims for 1/1/17 and 1/2/17 are submitted to DRC or the correctional facility where the inmate is housed for all services provided on these dates.
- Inpatient and the physician (or other practitioners of physician) claims are submitted to Medicaid FFS for 1/3 – 1/10/17 for all services provided during this time including any outpatient services provided on 1/3/17 before the admission was ordered.
- Transportation claim is submitted to DRC or the correctional facility where the inmate is housed for 1/1/17 and 1/10/17.

6. Does Medicaid require pre-certification for services when an inmate is hospitalized for over 24 hours?
    a. Pre-certification is generally not required for Medicaid FFS inpatient medical admissions. However, pre-certification is required for all Medicaid FFS inpatient psychiatric admissions.

7. Will individuals who are in jail awaiting sentencing for 30 days or more be eligible for IHSP?
    a. Per OAC 5160:1-1-03(B)(3)(a), 'an individual who is residing in a public institution awaiting criminal proceedings, penal dispositions, or other detainment determinations is considered an inmate. The duration of time that an individual is residing in the public institution awaiting these arrangements does not determine inmate status.' If an individual is in jail, Medicaid can only pay for inpatient hospitalization of at least 24 hours. This would include an individual who is in jail awaiting sentencing for 30 days or more.

8. An inmate in jail unable to post bond, has been admitted to the hospital, and has been there past 24 hours. Does the coverage for billing actually pay for everything since arrival at the hospital or only the services after 24 hours had passed?
    a. If the person is still incarcerated and admitted to an inpatient hospital stay on the day of arrival, all services would be covered. However, if a person is considered outpatient the first date then admitted on the second date of service, in this scenario, you would have to separate the dates of service. Claims for the inpatient stay and the physician (or other practitioners of physician) services would go to Medicaid FFS and the other date with the outpatient services would be submitted to DRC or the correctional facility where they are being housed. (Please see below how this would be submitted if the inmate was enrolled in a Medicaid MCP.)

9. If the inmate has Medicare, is Medicaid still primary?
    a. Yes. Once a person is incarcerated, their Medicare eligibility is no longer effective. If the inmate has been assigned the IHSP benefit with Medicaid, the provider should be able to submit their claim directly to Medicaid FFS or the MCP without first submitting to Medicare.

10. If the inmate has another primary payer (other than Medicare), is Medicaid still primary?
    a. If the primary payer will not pay due to a valid reason, such as incarceration, then yes – Medicaid would be primary. However, the claim will need to be submitted to the primary payer first to obtain the denial. Once a denied claim is received, the claim can then be submitted to Medicaid. Claims would still need to be submitted using the coordination of benefits standard/billing guidelines.

11. Medicaid MCPs are refusing to pay for incarcerated inmate care when inpatient hospital stay is required unless the inmate has been in jail less than 15 days. How can prisons/jails know if the MCP on the same page with the Medicaid FFS rules for payment?
    a. Effective 3/1/17, the MCP will be responsible for the inpatient services as detailed in the response for Q12. (See below)

12. During the inmate's release month, eligibility is showing a Medicaid MCP, should the MCP be billed for services?
    a. Yes, for inpatient admission dates on/after 3/1/17 and per the following:
        - For an inmate who is assigned to the IHSP benefit plan upon admission to the inpatient facility and enrolled into an MCP during the inpatient stay, and when the inpatient admission date occurs in a month preceding the inmate's month of release and the stay continues on/after the MCP enrollment effective date:
            1. Medicaid FFS is responsible for the inpatient facility charges through the date of discharge and physician (or other practitioners of physician) services through the last calendar day of the month that immediately precedes the enrollment effective date with the MCP.
            2. The MCP is responsible for physician (or other practitioners of physician) charges incurred only from the inmate's enrollment effective date. Medicaid FFS continues to pay the facility charges for the entire inpatient stay.
        - For an inmate enrolled into an MCP during his/her month of release and who is admitted for an inpatient hospital stay prior to his/her release date, the MCP is responsible for both the inpatient facility and physician (or other practitioners of physician) services.
        - All other services provided during the release month would be submitted to the DRC or the correctional facility where the inmate is housed.
    b. Prior to 3/1/17, the inpatient facility and physician (or other practitioners of physician) charges would be submitted to Medicaid FFS as normal. All other services would be submitted to DRC or the correctional facility where the inmate is being housed.

    Example 1:
    Inmate's release date is 8/16/17. On 8/1/17, inmate is enrolled into a Medicaid MCP. On 8/3/17, inmate is transferred to hospital for emergency services. On 8/4/17, the inmate is admitted to inpatient and discharged on 8/8/17.
        - Outpatient and the physician (or other practitioners of physician) claims are submitted to DRC or correctional facility for 8/3/17 for all services provided on this date.
        - Inpatient claim is submitted to the MCP for 8/4 – 8/8/17 for all services provided during this time including any outpatient services provided on 8/4/17, before the admission was ordered.
        - Physician (or other practitioners of physician) claim is submitted to the MCP for the services provided during the inpatient stay, 8/4 – 8/8/17.

    Example 2:
    Inmate's release date is 8/16/17. On 8/1/17, inmate is enrolled into a Medicaid MCP.

On 7/30/17, the inmate is transferred to hospital for emergency services. On 7/31/17, the inmate is admitted to inpatient and discharged on 8/8/17.

- Outpatient and the physician (or other practitioners of physician) claims are submitted to DRC or correctional facility for 7/30/17 for all services provided on this date.
- Inpatient claim is submitted to Medicaid FFS for 7/31 – 8/8/17 for all services provided during this time, including any outpatient services provided on 7/31/17 before the admission was ordered. Since the MCP is effective on 8/1/17, they are not responsible for the inpatient facility claim.
- The physician (or other practitioners of physician) claims for the inpatient stay would then be split into two claims – one would be submitted to Medicaid FFS for 7/31/17, and the claims would be submitted to the MCP for 8/1 – 8/8/17.

13. Are youth at Community Correction Facilities, which are run by Department of Youth Services (DYS), also eligible under the DYS Presumptive Eligibility (PE) initiative?
    a. Yes, youth at Community Correction Facilities and other children (up to age 21) who are within a week of release from DYS custody are identified. The identified individual's information is placed in the PE Portal by a DYS worker. The PE system approves/denies eligibility and the approval/denial letter is printed by DYS worker and given to the child's parole officer. While incarcerated, they would also be eligible for inpatient hospital services as described above.

14. Would IHSP be available for those sent to a Community Based Correctional Facility (CBCF)?
    a. Yes. The offender is still considered incarcerated. If this offender were to receive inpatient hospital services, those services would be covered under this program.

APPENDIX K – SERVICES THAT REQUIRE PRIOR AUTHORIZATION

K.1 INPATIENT PROCEDURES NORMALLY COVERED BUT REQUIRE PA

Inpatient Procedures: Covered (* Codes that were end dated effective 9/30/16)					
02YA0Z0	02YA0Z1	0BYC0Z0	0BYC0Z1	0BYD0Z0	0BYD0Z1
0BYF0Z0	0BYF0Z1	0BYG0Z0	0BYG0Z1	0BYH0Z0	0BYH0Z1
0BYJ0Z0	0BYJ0Z1	0BYK0Z0	0BYK0Z1	0BYL0Z0	0BYL0Z1
0BYM0Z0	0BYM0Z1	0D13079	0D1307A	0D1307B	0D16079
0D1607A	0D1607B	0D1607L	0D160J9	0D160JA	0D160JB
0D160JL	0D160K9	0D160KA	0D160KB	0D160KL	0D160Z9
0D160ZA	0D160ZB	0D160ZL	0D16479	0D1647A	0D1647B
0D1647L	0D164J9	0D164JA	0D164JB	0D164JL	0D164K9
0D164KA	0D164KB	0D164KL	0D164Z9	0D164ZA	0D164ZB
0D164ZL	0D16879	0D1687A	0D1687B	0D1687L	0D168J9
0D168JA	0D168JB	0D168JL	0D168K9	0D168KA	0D168KB
0D168KL	0D168Z9	0D168ZA	0D168ZB	0D168ZL	0D760DZ
0D760ZZ	0D763DZ	0D763ZZ	0D764DZ	0D764ZZ	0D767DZ
0D767ZZ	0D768DZ	0D768ZZ	0DB60Z3	0DB60ZZ	0DB63Z3
0DB63ZZ	0DB64Z3	0DB64ZZ	0DB67Z3	0DB67ZZ	0DB68Z3
0DB68ZZ	0DF60ZZ	0DF63ZZ	0DF64ZZ	0DF67ZZ	0DF68ZZ
0DM60ZZ	0DM64ZZ	0DN60ZZ	0DN63ZZ	0DN64ZZ	0DN67ZZ
0DN68ZZ	0DP643Z	0DP64CZ	0DP67DZ	0DP68DZ	0DQ60ZZ
0DQ63ZZ	0DQ64ZZ	0DQ67ZZ	0DQ68ZZ	0DT60ZZ	0DT64ZZ
0DT67ZZ	0DT68ZZ	0DU607Z	0DU60JZ	0DU60KZ	0DU647Z
0DU64JZ	0DU64KZ	0DU677Z	0DU67JZ	0DU67KZ	0DU687Z
0DU68JZ	0DU68KZ	0DV60CZ	0DV60DZ	0DV60ZZ	0DV63CZ
0DV63DZ	0DV63ZZ	0DV64CZ	0DV64DZ	0DV64ZZ	0DV67DZ
0DV67ZZ	0DV68DZ	0DV68ZZ	0DW643Z	0DW64CZ	0DY80Z0
0DY80Z1	0DYE0Z0	0DYE0Z1	0FSG0ZZ	0FSG4ZZ	0FY00Z0
0FY00Z1	0FYG0Z0	0FYG0Z1	0UT90ZZ	0UT94ZZ	0UT97ZZ
0UT98ZZ	0UT9FZZ	30230AZ	30230G0	30230G1 *	30230G2
30230G3	30230G4	30230X0	30230X1 *	30230X2	30230X3
30230X4	30230Y0	30230Y1 *	30230Y2	30230Y3	30230Y4
30233AZ	30233G0	30233G1 *	30233G2	30233G3	30233G4
30233X0	30233X1 *	30233X2	30233X3	30233X4	30233Y0
30233Y1 *	30233Y2	30233Y3	30233Y4	30240AZ	30240G0
30240G1 *	30240G2	30240G3	30240G4	30240X0	30240X1 *
30240X2	30240X3	30240X4	30240Y0	30240Y1 *	30240Y2
30240Y3	30240Y4	30243AZ	30243G0	30243G1 *	30243G2
30243G3	30243G4	30243X0	30243X1 *	30243X2	30243X3
30243X4	30243Y0	30243Y1 *	30243Y2	30243Y3	30243Y4
30250G0	30250G1	30250X0	30250X1	30250Y0	30250Y1
30253G0	30253G1	30253X0	30253X1	30253Y0	30253Y1
30260G0	30260G1	30260X0	30260X1	30260Y0	30260Y1
30263G0	30263G1	30263X0	30263X1	30263Y0	30263Y1
3E0G3GC					

K.2 INPATIENT PROCEDURES NORMALLY NON-COVERED AND REQUIRE PA

Inpatient Procedures: Non-covered per OAC 5160-2-03 (considered cosmetic, experimental, etc.)					
0210083	0210088	0210089	0210483	0210488	0210489
0211083	0211088	0211089	0211483	0211488	0211489
0212083	0212088	0212089	0212483	0212488	0212489
0213083	0213088	0213089	0213483	0213488	0213489
021008C	021008F	021008W	021048C	021048F	021048W
021108C	021108F	021108W	021148C	021148F	021148W
021208C	021208F	021208W	021248C	021248F	021248W
021308C	021308F	021308W	021348C	021348F	021348W
021608P	021608Q	021608R	021648P	021648Q	021648R
021708P	021708Q	021708R	021708S	021708T	021708U
021748P	021748Q	021748R	021748S	021748T	021748U
021K08P	021K08Q	021K08R	021K48P	021K48Q	021K48R
021L08P	021L08Q	021L08R	021L48P	021L48Q	021L48R
021P08A	021P08B	021P08D	021P48A	021P48B	021P48D
021Q08A	021Q08B	021Q08D	021Q48A	021Q48B	021Q48D
021R08A	021R08B	021R08D	021R48A	021R48B	021R48D
021V08P	021V08Q	021V08R	021V08S	021V08T	021V08U
021V48P	021V48Q	021V48R	021V48S	021V48T	021V48U
021W08B	021W08D	021W08P	021W08Q	021W08R	021W48B
021W48D	021W48P	021W48Q	021W48R	021X08B	021X08D
021X08P	021X08Q	021X08R	021X48B	021X48D	021X48P
021X48Q	021X48R	024F08J	024G082	024J082	02BK0ZZ
02BK3ZZ	02BK4ZZ	02BL0ZZ	02BL3ZZ	02BL4ZZ	02H400Z
02H430Z	02H440Z	02H600Z	02H630Z	02H640Z	02H700Z
02H730Z	02H740Z	02HL00Z	02HL30Z	02HL40Z	02HS00Z
02HS30Z	02HS40Z	02HT00Z	02HT30Z	02HT40Z	02HV00Z
02HV30Z	02HV40Z	02RF37H	02RF37Z	02RF38H	02RF38Z
02RF3JH	02RF3JZ	02RF3KH	02RF3KZ	02RG37H	02RG37Z
02RG38H	02RG38Z	02RG3JH	02RG3JZ	02RG3KH	02RG3KZ
02RH37H	02RH37Z	02RH38H	02RH38Z	02RH3JH	02RH3JZ
02RH3KH	02RH3KZ	02RX08Z	02UA0JZ	02UA3JZ	02UA4JZ
02UX08Z	02UX38Z	02UX48Z	02VW0DZ	02VW3DZ	02VW4DZ
02YA0Z2	03HK0MZ	03HK3MZ	03HK4MZ	03HL0MZ	03HL3MZ
03HL4MZ	03LG0BZ	03LG3BZ	03LG4BZ	03LH0BZ	03LH3BZ
03LH4BZ	03LJ0BZ	03LJ3BZ	03LJ4BZ	03LK0BZ	03LK3BZ
03LK4BZ	03LL0BZ	03LL3BZ	03LL4BZ	03LM0BZ	03LM3BZ
03LM4BZ	03LN0BZ	03LN3BZ	03LN4BZ	03LP0BZ	03LP3BZ
03LP4BZ	03LQ0BZ	03LQ3BZ	03LQ4BZ	03PY0MZ	03PY3MZ
03PY4MZ	03VG0BZ	03VG3BZ	03VG4BZ	03VH0BZ	03VH3BZ
03VH4BZ	03VJ0BZ	03VJ3BZ	03VJ4BZ	03VK0BZ	03VK3BZ
03VK4BZ	03VL0BZ	03VL3BZ	03VL4BZ	03VM0BZ	03VM3BZ
03VM4BZ	03VN0BZ	03VN3BZ	03VN4BZ	03VP0BZ	03VP3BZ
03VP4BZ	03VQ0BZ	03VQ3BZ	03VQ4BZ	03WY0MZ	03WY3MZ
03WY4MZ	04U03JZ	04U04JZ	04V03DZ	04V04DZ	079T00Z
079T0ZZ	079T30Z	079T3ZZ	079T40Z	079T4ZZ	07DQ0ZZ

Inpatient Procedures: Non-covered per OAC 5160-2-03 (considered cosmetic, experimental, etc.)					
07DQ3ZZ	07DR0ZZ	07DR3ZZ	07DS0ZZ	07DS3ZZ	080N07Z
080N0JZ	080N0KZ	080N0ZZ	080N37Z	080N3JZ	080N3KZ
080N3ZZ	080NX7Z	080NXJZ	080NXKZ	080NXZZ	080P07Z
080P0JZ	080P0KZ	080P0ZZ	080P37Z	080P3JZ	080P3KZ
080P3ZZ	080PX7Z	080PXJZ	080PXKZ	080PXZZ	080Q07Z
080Q0JZ	080Q0KZ	080Q0ZZ	080Q37Z	080Q3JZ	080Q3KZ
080Q3ZZ	080QX7Z	080QXJZ	080QXKZ	080QXZZ	080R07Z
080R0JZ	080R0KZ	080R0ZZ	080R37Z	080R3JZ	080R3KZ
080R3ZZ	080RX7Z	080RXJZ	080RXKZ	080RXZZ	08QN0ZZ
08QN3ZZ	08QNXZZ	08QP0ZZ	08QP3ZZ	08QPXZZ	08QQ0ZZ
08QQ3ZZ	08QQXZZ	08QR0ZZ	08QR3ZZ	08QRXZZ	08RJ30Z
08RK30Z	08SN0ZZ	08SN3ZZ	08SNXZZ	08SP0ZZ	08SP3ZZ
08SPXZZ	08SQ0ZZ	08SQ3ZZ	08SQXZZ	08SR0ZZ	08SR3ZZ
08SRXZZ	08W0X0Z	08W0X3Z	08W0X7Z	08W0XCZ	08W0XDZ
08W0XJZ	08W0XKZ	08W1X0Z	08W1X3Z	08W1X7Z	08W1XCZ
08W1XDZ	08W1XJZ	08W1XKZ	08WJXJZ	08WKXJZ	090007Z
09000JZ	09000KZ	09000ZZ	090037Z	09003JZ	09003KZ
09003ZZ	090047Z	09004JZ	09004KZ	09004ZZ	0900X7Z
0900XJZ	0900XKZ	0900XZZ	090107Z	09010JZ	09010KZ
09010ZZ	090137Z	09013JZ	09013KZ	09013ZZ	090147Z
09014JZ	09014KZ	09014ZZ	0901X7Z	0901XJZ	0901XKZ
0901XZZ	090207Z	09020JZ	09020KZ	09020ZZ	090237Z
09023JZ	09023KZ	09023ZZ	090247Z	09024JZ	09024KZ
09024ZZ	0902X7Z	0902XJZ	0902XKZ	0902XZZ	090K07Z
090K0JZ	090K0KZ	090K0ZZ	090K37Z	090K3JZ	090K3KZ
090K3ZZ	090K47Z	090K4JZ	090K4KZ	090K4ZZ	090KX7Z
090KXJZ	090KXKZ	090KXZZ	09N00ZZ	09N03ZZ	09N04ZZ
09N0XZZ	09N10ZZ	09N13ZZ	09N14ZZ	09N1XZZ	09Q00ZZ
09Q03ZZ	09Q04ZZ	09Q0XZZ	09Q10ZZ	09Q13ZZ	09Q14ZZ
09Q1XZZ	09Q20ZZ	09Q23ZZ	09Q24ZZ	09Q2XZZ	09QK0ZZ
09QK3ZZ	09QK4ZZ	09QKXZZ	09QM0ZZ	09QM3ZZ	09QM4ZZ
09R007Z	09R00JZ	09R00KZ	09R0X7Z	09R0XJZ	09R0XKZ
09R107Z	09R10JZ	09R10KZ	09R1X7Z	09R1XJZ	09R1XKZ
09R207Z	09R20JZ	09R20KZ	09R2X7Z	09R2XJZ	09R2XKZ
09RK07Z	09RK0JZ	09RK0KZ	09RKX7Z	09RKXJZ	09RKXKZ
09RM07Z	09RM0JZ	09RM0KZ	09RM37Z	09RM3JZ	09RM3KZ
09RM47Z	09RM4JZ	09RM4KZ	09S00ZZ	09S04ZZ	09S0XZZ
09S10ZZ	09S14ZZ	09S1XZZ	09S20ZZ	09S24ZZ	09S2XZZ
09SK0ZZ	09SK4ZZ	09SKXZZ	09SM0ZZ	09SM4ZZ	09U007Z
09U00JZ	09U00KZ	09U0X7Z	09U0XJZ	09U0XKZ	09U107Z
09U10JZ	09U10KZ	09U1X7Z	09U1XJZ	09U1XKZ	09U207Z
09U20JZ	09U20KZ	09U2X7Z	09U2XJZ	09U2XKZ	09UK07Z
09UK0JZ	09UK0KZ	09UKX7Z	09UKXJZ	09UKXKZ	09UM07Z
09UM0JZ	09UM0KZ	09UM37Z	09UM3JZ	09UM3KZ	09UM47Z
09UM4JZ	09UM4KZ	09WHX7Z	09WHXDZ	09WHXJZ	09WHXKZ
09WJX7Z	09WJXDZ	09WJXJZ	09WJXKZ	09WKX7Z	09WKXDZ
09WKXJZ	09WKXKZ	0B538ZZ	0B548ZZ	0B558ZZ	0B568ZZ
0B578ZZ	0B588ZZ	0B598ZZ	0B5B8ZZ	0BYC0Z2	0BYD0Z2
0BYF0Z2	0BYG0Z2	0BYH0Z2	0BYJ0Z2	0BYK0Z2	0BYL0Z2
0BYM0Z2	0C00X7Z	0C00XJZ	0C00XKZ	0C00XZZ	0C01X7Z

Inpatient Procedures: Non-covered per OAC 5160-2-03 (considered cosmetic, experimental, etc.)					
0C01XJZ	0C01XKZ	0C01XZZ	0CN40ZZ	0CN43ZZ	0CN4XZZ
0CQ00ZZ	0CQ03ZZ	0CQ0XZZ	0CQ10ZZ	0CQ13ZZ	0CQ1XZZ
0CQ40ZZ	0CQ43ZZ	0CQ4XZZ	0CR00JZ	0CR03JZ	0CR0XJZ
0CR10JZ	0CR13JZ	0CR1XJZ	0CR40JZ	0CR43JZ	0CR4XJZ
0CS00ZZ	0CS0XZZ	0CS10ZZ	0CS1XZZ	0CU007Z	0CU00JZ
0CU00KZ	0CU037Z	0CU03JZ	0CU03KZ	0CU0X7Z	0CU0XJZ
0CU0XKZ	0CU107Z	0CU10JZ	0CU10KZ	0CU137Z	0CU13JZ
0CU13KZ	0CU1X7Z	0CU1XJZ	0CU1XKZ	0CU407Z	0CU40JZ
0CU40KZ	0CU437Z	0CU43JZ	0CU43KZ	0CU4X7Z	0CU4XJZ
0CU4XKZ	0DY80Z2	0DYE0Z2	0FY00Z2	0FYG0Z2	0G560ZZ
0G563ZZ	0G564ZZ	0G570ZZ	0G573ZZ	0G574ZZ	0G580ZZ
0G583ZZ	0G584ZZ	0G590ZZ	0G593ZZ	0G594ZZ	0G5B0ZZ
0G5B3ZZ	0G5B4ZZ	0G5C0ZZ	0G5C3ZZ	0G5C4ZZ	0G5D0ZZ
0G5D3ZZ	0G5D4ZZ	0G5F0ZZ	0G5F3ZZ	0G5F4ZZ	0G9600Z
0G960ZX	0G960ZZ	0G9630Z	0G963ZX	0G963ZZ	0G9640Z
0G964ZX	0G964ZZ	0G9700Z	0G970ZX	0G970ZZ	0G9730Z
0G973ZX	0G973ZZ	0G9740Z	0G974ZX	0G974ZZ	0G9800Z
0G980ZX	0G980ZZ	0G9830Z	0G983ZX	0G983ZZ	0G9840Z
0G984ZX	0G984ZZ	0G9900Z	0G990ZX	0G990ZZ	0G9930Z
0G993ZX	0G993ZZ	0G9940Z	0G994ZX	0G994ZZ	0G9B00Z
0G9B0ZX	0G9B0ZZ	0G9B30Z	0G9B3ZX	0G9B3ZZ	0G9B40Z
0G9B4ZX	0G9B4ZZ	0G9C00Z	0G9C0ZX	0G9C0ZZ	0G9C30Z
0G9C3ZX	0G9C3ZZ	0G9C40Z	0G9C4ZX	0G9C4ZZ	0G9D00Z
0G9D0ZX	0G9D0ZZ	0G9D30Z	0G9D3ZX	0G9D3ZZ	0G9D40Z
0G9D4ZX	0G9D4ZZ	0G9F00Z	0G9F0ZX	0G9F0ZZ	0G9F30Z
0G9F3ZX	0G9F3ZZ	0G9F40Z	0G9F4ZX	0G9F4ZZ	0GB60ZX
0GB60ZZ	0GB63ZX	0GB63ZZ	0GB64ZX	0GB64ZZ	0GB70ZX
0GB70ZZ	0GB73ZX	0GB73ZZ	0GB74ZX	0GB74ZZ	0GB80ZX
0GB80ZZ	0GB83ZX	0GB83ZZ	0GB84ZX	0GB84ZZ	0GB90ZX
0GB90ZZ	0GB93ZX	0GB93ZZ	0GB94ZX	0GB94ZZ	0GBB0ZX
0GBB0ZZ	0GBB3ZX	0GBB3ZZ	0GBB4ZX	0GBB4ZZ	0GBC0ZX
0GBC0ZZ	0GBC3ZX	0GBC3ZZ	0GBC4ZX	0GBC4ZZ	0GBD0ZX
0GBD0ZZ	0GBD3ZX	0GBD3ZZ	0GBD4ZX	0GBD4ZZ	0GBF0ZX
0GBF0ZZ	0GBF3ZX	0GBF3ZZ	0GBF4ZX	0GBF4ZZ	0GC60ZZ
0GC63ZZ	0GC64ZZ	0GC70ZZ	0GC73ZZ	0GC74ZZ	0GC80ZZ
0GC83ZZ	0GC84ZZ	0GC90ZZ	0GC93ZZ	0GC94ZZ	0GCB0ZZ
0GCB3ZZ	0GCB4ZZ	0GCC0ZZ	0GCC3ZZ	0GCC4ZZ	0GCD0ZZ
0GCD3ZZ	0GCD4ZZ	0GCF0ZZ	0GCF3ZZ	0GCF4ZZ	0GHS02Z
0GHS03Z	0GHS32Z	0GHS33Z	0GHS42Z	0GHS43Z	0GJS0ZZ
0GJS3ZZ	0GJS4ZZ	0GN60ZZ	0GN63ZZ	0GN64ZZ	0GN70ZZ
0GN73ZZ	0GN74ZZ	0GN80ZZ	0GN83ZZ	0GN84ZZ	0GN90ZZ
0GN93ZZ	0GN94ZZ	0GNB0ZZ	0GNB3ZZ	0GNB4ZZ	0GNC0ZZ
0GNC3ZZ	0GNC4ZZ	0GND0ZZ	0GND3ZZ	0GND4ZZ	0GNF0ZZ
0GNF3ZZ	0GNF4ZZ	0GPS00Z	0GPS02Z	0GPS03Z	0GPS30Z
0GPS32Z	0GPS33Z	0GPS40Z	0GPS42Z	0GPS43Z	0GQ60ZZ
0GQ63ZZ	0GQ64ZZ	0GQ70ZZ	0GQ73ZZ	0GQ74ZZ	0GQ80ZZ
0GQ83ZZ	0GQ84ZZ	0GQ90ZZ	0GQ93ZZ	0GQ94ZZ	0GQB0ZZ
0GQB3ZZ	0GQB4ZZ	0GQC0ZZ	0GQC3ZZ	0GQC4ZZ	0GQD0ZZ
0GQD3ZZ	0GQD4ZZ	0GQF0ZZ	0GQF3ZZ	0GQF4ZZ	0GT60ZZ
0GT64ZZ	0GT70ZZ	0GT74ZZ	0GT80ZZ	0GT84ZZ	0GT90ZZ

Inpatient Procedures: Non-covered per OAC 5160-2-03 (considered cosmetic, experimental, etc.)					
0GT94ZZ	0GTB0ZZ	0GTB4ZZ	0GTC0ZZ	0GTC4ZZ	0GTD0ZZ
0GTD4ZZ	0GTF0ZZ	0GTF4ZZ	0GWS00Z	0GWS02Z	0GWS03Z
0GWS30Z	0GWS32Z	0GWS33Z	0GWS40Z	0GWS42Z	0GWS43Z
0H0T07Z	0H0T0JZ	0H0T0KZ	0H0T0ZZ	0H0T37Z	0H0T3JZ
0H0T3KZ	0H0T3ZZ	0H0TXZZ	0H0U07Z	0H0U0JZ	0H0U0KZ
0H0U0ZZ	0H0U37Z	0H0U3JZ	0H0U3KZ	0H0U3ZZ	0H0UXZZ
0H0V07Z	0H0V0JZ	0H0V0KZ	0H0V0ZZ	0H0V37Z	0H0V3JZ
0H0V3KZ	0H0V3ZZ	0H0VXZZ	0H82XZZ	0H83XZZ	0HD0XZZ
0HD1XZZ	0HD4XZZ	0HD5XZZ	0HD6XZZ	0HD7XZZ	0HD8XZZ
0HDAXZZ	0HDBXZZ	0HDCXZZ	0HDDXZZ	0HDEXZZ	0HDFXZZ
0HDGXZZ	0HDHXZZ	0HDJXZZ	0HDKXZZ	0HDLXZZ	0HDMXZZ
0HDNXZZ	0HDSXZZ	0HHT0NZ	0HHT3NZ	0HHT7NZ	0HHT8NZ
0HHU0NZ	0HHU3NZ	0HHU7NZ	0HHU8NZ	0HHV0NZ	0HHV3NZ
0HHV7NZ	0HHV8NZ	0HHW0NZ	0HHW3NZ	0HHW7NZ	0HHW8NZ
0HHX0NZ	0HHX3NZ	0HHX7NZ	0HHX8NZ	0HM2XZZ	0HM3XZZ
0HMTXZZ	0HMUXZZ	0HMVXZZ	0HMWXZZ	0HMXXZZ	0HNT0ZZ
0HNT3ZZ	0HNT7ZZ	0HNT8ZZ	0HNTXZZ	0HNU0ZZ	0HNU3ZZ
0HNU7ZZ	0HNU8ZZ	0HNUXZZ	0HNV0ZZ	0HNV3ZZ	0HNV7ZZ
0HNV8ZZ	0HNVXZZ	0HNW0ZZ	0HNW3ZZ	0HNW7ZZ	0HNW8ZZ
0HNWXZZ	0HNX0ZZ	0HNX3ZZ	0HNX7ZZ	0HNX8ZZ	0HNXXZZ
0HQ2XZZ	0HQ3XZZ	0HQT0ZZ	0HQT3ZZ	0HQT7ZZ	0HQT8ZZ
0HQTXZZ	0HQU0ZZ	0HQU3ZZ	0HQU7ZZ	0HQU8ZZ	0HQUXZZ
0HQV0ZZ	0HQV3ZZ	0HQV7ZZ	0HQV8ZZ	0HQVXZZ	0HQW0ZZ
0HQW3ZZ	0HQW7ZZ	0HQW8ZZ	0HQWXZZ	0HQX0ZZ	0HQX3ZZ
0HQX7ZZ	0HQX8ZZ	0HQXXZZ	0HQY0ZZ	0HQY3ZZ	0HQY7ZZ
0HQY8ZZ	0HQYXZZ	0HR2X73	0HR2X74	0HR2XJ3	0HR2XJ4
0HR2XJZ	0HR2XK3	0HR2XK3	0HR2XK4	0HR2XK4	0HR3X73
0HR3X74	0HR3XJ3	0HR3XJ4	0HR3XJZ	0HR3XK3	0HR3XK3
0HR3XK4	0HR3XK4	0HRQX7Z	0HRQXJZ	0HRQXKZ	0HRRX7Z
0HRRXJZ	0HRRXKZ	0HRSX7Z	0HRSXJZ	0HRSXKZ	0HRT075
0HRT076	0HRT077	0HRT078	0HRT079	0HRT07Z	0HRT0JZ
0HRT0KZ	0HRT37Z	0HRT3JZ	0HRT3KZ	0HRTXJZ	0HRU075
0HRU076	0HRU077	0HRU078	0HRU079	0HRU07Z	0HRU0JZ
0HRU0KZ	0HRU37Z	0HRU3JZ	0HRU3KZ	0HRUXJZ	0HRV075
0HRV076	0HRV077	0HRV078	0HRV079	0HRV07Z	0HRV0JZ
0HRV0KZ	0HRV37Z	0HRV3JZ	0HRV3KZ	0HRVXJZ	0HRW07Z
0HRW0JZ	0HRW0KZ	0HRW37Z	0HRW3JZ	0HRW3KZ	0HRWX7Z
0HRWXJZ	0HRWXKZ	0HRX07Z	0HRX0JZ	0HRX0KZ	0HRX37Z
0HRX3JZ	0HRX3KZ	0HRXX7Z	0HRXXJZ	0HRXXKZ	0HSSXZZ
0HSWXZZ	0HSXXZZ	0HUT07Z	0HUT0JZ	0HUT0KZ	0HUT37Z
0HUT3JZ	0HUT3KZ	0HUT77Z	0HUT7JZ	0HUT7KZ	0HUT87Z
0HUT8JZ	0HUT8KZ	0HUTX7Z	0HUTXJZ	0HUTXKZ	0HUU07Z
0HUU0JZ	0HUU0KZ	0HUU37Z	0HUU3JZ	0HUU3KZ	0HUU77Z
0HUU7JZ	0HUU7KZ	0HUU87Z	0HUU8JZ	0HUU8KZ	0HUUX7Z
0HUUXJZ	0HUUXKZ	0HUV07Z	0HUV0JZ	0HUV0KZ	0HUV37Z
0HUV3JZ	0HUV3KZ	0HUV77Z	0HUV7JZ	0HUV7KZ	0HUV87Z
0HUV8JZ	0HUV8KZ	0HUVX7Z	0HUVXJZ	0HUVXKZ	0HUW07Z
0HUW0JZ	0HUW0KZ	0HUW37Z	0HUW3JZ	0HUW3KZ	0HUW77Z
0HUW7JZ	0HUW7KZ	0HUW87Z	0HUW8JZ	0HUW8KZ	0HUWX7Z
0HUWXJZ	0HUWXKZ	0HUX07Z	0HUX0JZ	0HUX0KZ	0HUX37Z

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0HUX3JZ	0HUX3KZ	0HUX77Z	0HUX7JZ	0HUX7KZ	0HUX87Z
0HUX8JZ	0HUX8KZ	0HUXX7Z	0HUXXJZ	0HUXXKZ	0HWT0JZ
0HWT3JZ	0HWU0JZ	0HWU3JZ	0HX2XZZ	0HX3XZZ	0J010ZZ
0J013ZZ	0J040ZZ	0J043ZZ	0J050ZZ	0J053ZZ	0J060ZZ
0J063ZZ	0J070ZZ	0J073ZZ	0J080ZZ	0J083ZZ	0J090ZZ
0J093ZZ	0J0D0ZZ	0J0D3ZZ	0J0F0ZZ	0J0F3ZZ	0J0G0ZZ
0J0G3ZZ	0J0H0ZZ	0J0H3ZZ	0J0L0ZZ	0J0L3ZZ	0J0M0ZZ
0J0M3ZZ	0J0N0ZZ	0J0N3ZZ	0J0P0ZZ	0J0P3ZZ	0JD00ZZ
0JD03ZZ	0JD10ZZ	0JD13ZZ	0JD40ZZ	0JD43ZZ	0JD50ZZ
0JD53ZZ	0JD60ZZ	0JD63ZZ	0JD70ZZ	0JD73ZZ	0JD80ZZ
0JD83ZZ	0JD90ZZ	0JD93ZZ	0JDB0ZZ	0JDB3ZZ	0JDC0ZZ
0JDC3ZZ	0JDD0ZZ	0JDD3ZZ	0JDF0ZZ	0JDF3ZZ	0JDG0ZZ
0JDG3ZZ	0JDH0ZZ	0JDH3ZZ	0JDJ0ZZ	0JDJ3ZZ	0JDK0ZZ
0JDK3ZZ	0JDL0ZZ	0JDL3ZZ	0JDM0ZZ	0JDM3ZZ	0JDN0ZZ
0JDN3ZZ	0JDP0ZZ	0JDP3ZZ	0JDQ0ZZ	0JDQ3ZZ	0JDR0ZZ
0JDR3ZZ	0JH00NZ	0JH03NZ	0JH10NZ	0JH13NZ	0JH40NZ
0JH43NZ	0JH50NZ	0JH53NZ	0JH60AZ	0JH60MZ	0JH60NZ
0JH63AZ	0JH63MZ	0JH63NZ	0JH70MZ	0JH70NZ	0JH73MZ
0JH73NZ	0JH80AZ	0JH80MZ	0JH80NZ	0JH83AZ	0JH83MZ
0JH83NZ	0JH90NZ	0JH93NZ	0JHB0NZ	0JHB3NZ	0JHC0NZ
0JHC3NZ	0JHD0NZ	0JHD3NZ	0JHF0NZ	0JHF3NZ	0JHG0NZ
0JHG3NZ	0JHH0NZ	0JHH3NZ	0JHJ0NZ	0JHJ3NZ	0JHK0NZ
0JHK3NZ	0JHL0NZ	0JHL3NZ	0JHM0NZ	0JHM3NZ	0JHN0NZ
0JHN3NZ	0JHP0NZ	0JHP3NZ	0JHQ0NZ	0JHQ3NZ	0JHR0NZ
0JHR3NZ	0JPT0MZ	0JPT3MZ	0JQ10ZZ	0JQ13ZZ	0JQ40ZZ
0JQ43ZZ	0JQ50ZZ	0JQ53ZZ	0JQ80ZZ	0JQ83ZZ	0JQ90ZZ
0JQ93ZZ	0JR037Z	0JR137Z	0JR437Z	0JR537Z	0JR637Z
0JR737Z	0JR837Z	0JR937Z	0JRB37Z	0JRC37Z	0JRD37Z
0JRF37Z	0JRG37Z	0JRH37Z	0JRJ37Z	0JRK37Z	0JRL37Z
0JRM37Z	0JRN37Z	0JRP37Z	0JRQ37Z	0JRR37Z	0JWT0MZ
0JWT3MZ	0JWTXMZ	0KS10ZZ	0KS14ZZ	0KXK0Z6	0KXK4Z6
0KXL0Z6	0KXL4Z6	0NNX0ZZ	0NNX3ZZ	0NNX4ZZ	0NQB0ZZ
0NQB3ZZ	0NQB4ZZ	0NQBXZZ	0NRB07Z	0NRB0JZ	0NRB0KZ
0NRB37Z	0NRB3JZ	0NRB3KZ	0NRB47Z	0NRB4JZ	0NRB4KZ
0NUB07Z	0NUB0JZ	0NUB0KZ	0NUB37Z	0NUB3JZ	0NUB3KZ
0NUB47Z	0NUB4JZ	0NUB4KZ	0NWBX0Z	0NWBX7Z	0NWBXJZ
0NWBXKZ	0NWWX0Z	0NWWX7Z	0NWWXJZ	0NWWXKZ	0RH00BZ
0RH00CZ	0RH00DZ	0RH03BZ	0RH03CZ	0RH03DZ	0RH04BZ
0RH04CZ	0RH04DZ	0RH10BZ	0RH10CZ	0RH10DZ	0RH13BZ
0RH13CZ	0RH13DZ	0RH14BZ	0RH14CZ	0RH14DZ	0RH40BZ
0RH40CZ	0RH40DZ	0RH43BZ	0RH43CZ	0RH43DZ	0RH44BZ
0RH44CZ	0RH44DZ	0RH60BZ	0RH60CZ	0RH60DZ	0RH63BZ
0RH63CZ	0RH63DZ	0RH64BZ	0RH64CZ	0RH64DZ	0RHA0BZ
0RHA0CZ	0RHA0DZ	0RHA3BZ	0RHA3CZ	0RHA3DZ	0RHA4BZ
0RHA4CZ	0RHA4DZ	0RP004Z	0RP034Z	0RP044Z	0RP104Z
0RP134Z	0RP144Z	0RP404Z	0RP434Z	0RP444Z	0RP604Z
0RP634Z	0RP644Z	0RPA04Z	0RPA34Z	0RPA44Z	0RRJ00Z
0RRK00Z	0RW004Z	0RW034Z	0RW044Z	0RW104Z	0RW134Z
0RW144Z	0RW404Z	0RW434Z	0RW444Z	0RW604Z	0RW634Z
0RW644Z	0RWA04Z	0RWA34Z	0RWA44Z	0SH00BZ	0SH00CZ

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0SH00DZ	0SH03BZ	0SH03CZ	0SH03DZ	0SH04BZ	0SH04CZ
0SH04DZ	0SH30BZ	0SH30CZ	0SH30DZ	0SH33BZ	0SH33CZ
0SH33DZ	0SH34BZ	0SH34CZ	0SH34DZ	0SP004Z	0SP034Z
0SP044Z	0SP304Z	0SP334Z	0SP344Z	0SW004Z	0SW034Z
0SW044Z	0SW304Z	0SW334Z	0SW344Z	0U15075	0U15076
0U15079	0U150J5	0U150J6	0U150J9	0U150K5	0U150K6
0U150K9	0U150Z5	0U150Z6	0U150Z9	0U15475	0U15476
0U15479	0U154J5	0U154J6	0U154J9	0U154K5	0U154K6
0U154K9	0U154Z5	0U154Z6	0U154Z9	0U16075	0U16076
0U16079	0U160J5	0U160J6	0U160J9	0U160K5	0U160K6
0U160K9	0U160Z5	0U160Z6	0U160Z9	0U16475	0U16476
0U16479	0U164J5	0U164J6	0U164J9	0U164K5	0U164K6
0U164K9	0U164Z5	0U164Z6	0U164Z9	0U9500Z	0U9530Z
0U9540Z	0U9570Z	0U9580Z	0U9600Z	0U9630Z	0U9640Z
0U9670Z	0U9680Z	0U9700Z	0U9730Z	0U9740Z	0U9770Z
0U9780Z	0UF50ZZ	0UF53ZZ	0UF54ZZ	0UF57ZZ	0UF58ZZ
0UF60ZZ	0UF63ZZ	0UF64ZZ	0UF67ZZ	0UF68ZZ	0UF70ZZ
0UF73ZZ	0UF74ZZ	0UF77ZZ	0UF78ZZ	0UJ80ZZ	0UJ83ZZ
0UJ84ZZ	0UJ87ZZ	0UJ88ZZ	0UM00ZZ	0UM10ZZ	0UM20ZZ
0UM50ZZ	0UM54ZZ	0UM60ZZ	0UM64ZZ	0UM70ZZ	0UM74ZZ
0UP80JZ	0UP83JZ	0UP84JZ	0UP87JZ	0UP88JZ	0UQ00ZZ
0UQ03ZZ	0UQ04ZZ	0UQ10ZZ	0UQ13ZZ	0UQ14ZZ	0UQ20ZZ
0UQ23ZZ	0UQ24ZZ	0UQ50ZZ	0UQ53ZZ	0UQ54ZZ	0UQ54ZZ
0UQ57ZZ	0UQ58ZZ	0UQ60ZZ	0UQ63ZZ	0UQ64ZZ	0UQ67ZZ
0UQ68ZZ	0UQ70ZZ	0UQ73ZZ	0UQ74ZZ	0UQ77ZZ	0UQ78ZZ
0US00ZZ	0US10ZZ	0US20ZZ	0US50ZZ	0US54ZZ	0US60ZZ
0US64ZZ	0US70ZZ	0US74ZZ	0UU507Z	0UU50JZ	0UU50KZ
0UU547Z	0UU54JZ	0UU54KZ	0UU577Z	0UU57JZ	0UU57KZ
0UU587Z	0UU58JZ	0UU58KZ	0UU607Z	0UU60JZ	0UU60KZ
0UU647Z	0UU64JZ	0UU64KZ	0UU677Z	0UU67JZ	0UU67KZ
0UU687Z	0UU68JZ	0UU68KZ	0UU707Z	0UU70JZ	0UU70KZ
0UU747Z	0UU74JZ	0UU74KZ	0UU777Z	0UU77JZ	0UU77KZ
0UU787Z	0UU78JZ	0UU78KZ	0UW3X0Z	0UW3X3Z	0UW8X0Z
0UW8X3Z	0UW8X7Z	0UW8XCZ	0UW8XDZ	0UW8XJZ	0UW8XKZ
0UWDX0Z	0UWDX3Z	0UWDX7Z	0UWDXCZ	0UWDXDZ	0UWDXHZ
0UWDXJZ	0UWDXKZ	0UWHX0Z	0UWHX3Z	0UWHX7Z	0UWHXDZ
0UWHXJZ	0UWHXKZ	0UWMX0Z	0UWMX7Z	0UWMXJZ	0UWMXKZ
0UY00Z0	0UY00Z1	0UY00Z2	0UY10Z0	0UY10Z1	0UY10Z2
0V5Q4ZZ	0V7N0DZ	0V7N0ZZ	0V7N3DZ	0V7N3ZZ	0V7N4DZ
0V7N4ZZ	0V7P0DZ	0V7P0ZZ	0V7P3DZ	0V7P3ZZ	0V7P4DZ
0V7P4ZZ	0V7Q0DZ	0V7Q0ZZ	0V7Q3DZ	0V7Q3ZZ	0V7Q4DZ
0V7Q4ZZ	0VBQ4ZZ	0VJM0ZZ	0VJM3ZZ	0VJM4ZZ	0VJR0ZZ
0VJR3ZZ	0VJR4ZZ	0VLH4CZ	0VLH4DZ	0VLH4ZZ	0VLN0DZ
0VLN3DZ	0VLN4DZ	0VLP0DZ	0VLP3DZ	0VLP4DZ	0VLQ0DZ
0VLQ3DZ	0VLQ4CZ	0VLQ4DZ	0VLQ4ZZ	0VMF0ZZ	0VMF4ZZ
0VMG0ZZ	0VMG4ZZ	0VMH0ZZ	0VMH4ZZ	0VNF0ZZ	0VNF3ZZ
0VNF4ZZ	0VNG0ZZ	0VNG3ZZ	0VNG4ZZ	0VNH0ZZ	0VNH3ZZ
0VNH4ZZ	0VNJ0ZZ	0VNJ3ZZ	0VNJ4ZZ	0VNK0ZZ	0VNK3ZZ
0VNK4ZZ	0VNL0ZZ	0VNL3ZZ	0VNL4ZZ	0VNN0ZZ	0VNN3ZZ
0VNN4ZZ	0VNP0ZZ	0VNP3ZZ	0VNP4ZZ	0VNQ0ZZ	0VNQ3ZZ

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0VNQ4ZZ	0VQF0ZZ	0VQF3ZZ	0VQF4ZZ	0VQG0ZZ	0VQG3ZZ
0VQG4ZZ	0VQH0ZZ	0VQH3ZZ	0VQH4ZZ	0VQJ0ZZ	0VQJ3ZZ
0VQJ4ZZ	0VQK0ZZ	0VQK3ZZ	0VQK4ZZ	0VQL0ZZ	0VQL3ZZ
0VQL4ZZ	0VQN0ZZ	0VQN3ZZ	0VQN4ZZ	0VQP0ZZ	0VQP3ZZ
0VQP4ZZ	0VQQ0ZZ	0VQQ3ZZ	0VQQ4ZZ	0VR90JZ	0VRB0JZ
0VRC0JZ	0VSF0ZZ	0VSF3ZZ	0VSF4ZZ	0VSG0ZZ	0VSG3ZZ
0VSG4ZZ	0VSH0ZZ	0VSH3ZZ	0VSH4ZZ	0VUF07Z	0VUF0JZ
0VUF0KZ	0VUF47Z	0VUF4JZ	0VUF4KZ	0VUG07Z	0VUG0JZ
0VUG0KZ	0VUG47Z	0VUG4JZ	0VUG4KZ	0VUH07Z	0VUH0JZ
0VUH0KZ	0VUH47Z	0VUH4JZ	0VUH4KZ	0VUJ07Z	0VUJ0JZ
0VUJ0KZ	0VUJ47Z	0VUJ4JZ	0VUJ4KZ	0VUK07Z	0VUK0JZ
0VUK0KZ	0VUK47Z	0VUK4JZ	0VUK4KZ	0VUL07Z	0VUL0JZ
0VUL0KZ	0VUL47Z	0VUL4JZ	0VUL4KZ	0VUN07Z	0VUN0JZ
0VUN0KZ	0VUN47Z	0VUN4JZ	0VUN4KZ	0VUP07Z	0VUP0JZ
0VUP0KZ	0VUP47Z	0VUP4JZ	0VUP4KZ	0VUQ07Z	0VUQ0JZ
0VUQ0KZ	0VUQ47Z	0VUQ4JZ	0VUQ4KZ	0VUS07Z	0VUS0JZ
0VUS0KZ	0VUS47Z	0VUS4JZ	0VUS4KZ	0VUSX7Z	0VUSXJZ
0VUSXKZ	0VWMX0Z	0VWMX3Z	0VWMX7Z	0VWMXCZ	0VWMXJZ
0VWMXKZ	0VWRX0Z	0VWRX3Z	0VWRX7Z	0VWRXCZ	0VWRXDZ
0VWRXJZ	0VWRXKZ	0W0007Z	0W000JZ	0W000KZ	0W000ZZ
0W0037Z	0W003JZ	0W003KZ	0W003ZZ	0W0047Z	0W004JZ
0W004KZ	0W004ZZ	0W0207Z	0W020JZ	0W020KZ	0W020ZZ
0W0237Z	0W023JZ	0W023KZ	0W023ZZ	0W0247Z	0W024JZ
0W024KZ	0W024ZZ	0W0607Z	0W060JZ	0W060KZ	0W060ZZ
0W0637Z	0W063JZ	0W063KZ	0W063ZZ	0W0647Z	0W064JZ
0W064KZ	0W064ZZ	0W0807Z	0W080JZ	0W080KZ	0W080ZZ
0W0837Z	0W083JZ	0W083KZ	0W083ZZ	0W0847Z	0W084JZ
0W084KZ	0W084ZZ	0W0F07Z	0W0F0JZ	0W0F0KZ	0W0F0ZZ
0W0F37Z	0W0F3JZ	0W0F3KZ	0W0F3ZZ	0W0F47Z	0W0F4JZ
0W0F4KZ	0W0F4ZZ	0W0K07Z	0W0K0JZ	0W0K0KZ	0W0K0ZZ
0W0K37Z	0W0K3JZ	0W0K3KZ	0W0K3ZZ	0W0K47Z	0W0K4JZ
0W0K4KZ	0W0K4ZZ	0W0L07Z	0W0L0JZ	0W0L0KZ	0W0L0ZZ
0W0L37Z	0W0L3JZ	0W0L3KZ	0W0L3ZZ	0W0L47Z	0W0L4JZ
0W0L4KZ	0W0L4ZZ	0W0M07Z	0W0M0JZ	0W0M0KZ	0W0M0ZZ
0W0M37Z	0W0M3JZ	0W0M3KZ	0W0M3ZZ	0W0M47Z	0W0M4JZ
0W0M4KZ	0W0M4ZZ	0W4M070	0W4M0J0	0W4M0K0	0W4M0Z0
0W4N071	0W4N0J1	0W4N0K1	0W4N0Z1	0WF30ZZ	0WF33ZZ
0WF34ZZ	0WU207Z	0WU20JZ	0WU20KZ	0WU247Z	0WU24JZ
0WU24KZ	0WU407Z	0WU447Z	0WU507Z	0WU547Z	0WU60JZ
0WU60KZ	0WU64JZ	0WU64KZ	0WY	0WY20Z0	0WY20Z1
0X0407Z	0X040JZ	0X040KZ	0X040ZZ	0X0437Z	0X043JZ
0X043KZ	0X043ZZ	0X0447Z	0X044JZ	0X044KZ	0X044ZZ
0X0507Z	0X050JZ	0X050KZ	0X050ZZ	0X0537Z	0X053JZ
0X053KZ	0X053ZZ	0X0547Z	0X054JZ	0X054KZ	0X054ZZ
0X0607Z	0X060JZ	0X060KZ	0X060ZZ	0X0637Z	0X063JZ
0X063KZ	0X063ZZ	0X0647Z	0X064JZ	0X064KZ	0X064ZZ
0X0707Z	0X070JZ	0X070KZ	0X070ZZ	0X0737Z	0X073JZ
0X073KZ	0X073ZZ	0X0747Z	0X074JZ	0X074KZ	0X074ZZ
0X0807Z	0X080JZ	0X080KZ	0X080ZZ	0X0837Z	0X083JZ
0X083KZ	0X083ZZ	0X0847Z	0X084JZ	0X084KZ	0X084ZZ

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0X0907Z	0X090JZ	0X090KZ	0X090ZZ	0X0937Z	0X093JZ
0X093KZ	0X093ZZ	0X0947Z	0X094JZ	0X094KZ	0X094ZZ
0X0B07Z	0X0B0JZ	0X0B0KZ	0X0B0ZZ	0X0B37Z	0X0B3JZ
0X0B3KZ	0X0B3ZZ	0X0B47Z	0X0B4JZ	0X0B4KZ	0X0B4ZZ
0X0C07Z	0X0C0JZ	0X0C0KZ	0X0C0ZZ	0X0C37Z	0X0C3JZ
0X0C3KZ	0X0C3ZZ	0X0C47Z	0X0C4JZ	0X0C4KZ	0X0C4ZZ
0X0D07Z	0X0D0JZ	0X0D0KZ	0X0D0ZZ	0X0D37Z	0X0D3JZ
0X0D3KZ	0X0D3ZZ	0X0D47Z	0X0D4JZ	0X0D4KZ	0X0D4ZZ
0X0F07Z	0X0F0JZ	0X0F0KZ	0X0F0ZZ	0X0F37Z	0X0F3JZ
0X0F3KZ	0X0F3ZZ	0X0F47Z	0X0F4JZ	0X0F4KZ	0X0F4ZZ
0X0G07Z	0X0G0JZ	0X0G0KZ	0X0G0ZZ	0X0G37Z	0X0G3JZ
0X0G3KZ	0X0G3ZZ	0X0G47Z	0X0G4JZ	0X0G4KZ	0X0G4ZZ
0X0H07Z	0X0H0JZ	0X0H0KZ	0X0H0ZZ	0X0H37Z	0X0H3JZ
0X0H3KZ	0X0H3ZZ	0X0H47Z	0X0H4JZ	0X0H4KZ	0X0H4ZZ
0XU20JZ	0XU20KZ	0XU24JZ	0XU24KZ	0XU30JZ	0XU30KZ
0XU34JZ	0XU34KZ	0XU40JZ	0XU40KZ	0XU44JZ	0XU44KZ
0XU50JZ	0XU50KZ	0XU54JZ	0XU54KZ	0XU60JZ	0XU60KZ
0XU64JZ	0XU64KZ	0XU70JZ	0XU70KZ	0XU74JZ	0XU74KZ
0XU80JZ	0XU80KZ	0XU84JZ	0XU84KZ	0XU90JZ	0XU90KZ
0XU94JZ	0XU94KZ	0XUB0JZ	0XUB0KZ	0XUB4JZ	0XUB4KZ
0XUC0JZ	0XUC0KZ	0XUC4JZ	0XUC4KZ	0XUD0JZ	0XUD0KZ
0XUD4JZ	0XUD4KZ	0XUF0JZ	0XUF0KZ	0XUF4JZ	0XUF4KZ
0XUG0JZ	0XUG0KZ	0XUG4JZ	0XUG4KZ	0XUH0JZ	0XUH0KZ
0XUH4JZ	0XUH4KZ	0XUJ0JZ	0XUJ0KZ	0XUJ4JZ	0XUJ4KZ
0XUK0JZ	0XUK0KZ	0XUK4JZ	0XUK4KZ	0XUL0JZ	0XUL0KZ
0XUL4JZ	0XUL4KZ	0XUM0JZ	0XUM0KZ	0XUM4JZ	0XUM4KZ
0XUN0JZ	0XUN0KZ	0XUN4JZ	0XUN4KZ	0XUP0JZ	0XUP0KZ
0XUP4JZ	0XUP4KZ	0XUQ0JZ	0XUQ0KZ	0XUQ4JZ	0XUQ4KZ
0XUR0JZ	0XUR0KZ	0XUR4JZ	0XUR4KZ	0XUS0JZ	0XUS0KZ
0XUS4JZ	0XUS4KZ	0XUT0JZ	0XUT0KZ	0XUT4JZ	0XUT4KZ
0XUV0JZ	0XUV0KZ	0XUV4JZ	0XUV4KZ	0XUW0JZ	0XUW0KZ
0XUW4JZ	0XUW4KZ	0XY	0XYJ0Z0	0XYJ0Z1	0XYK0Z0
0XYK0Z1	0Y0007Z	0Y000JZ	0Y000KZ	0Y000ZZ	0Y0037Z
0Y003JZ	0Y003KZ	0Y003ZZ	0Y0047Z	0Y004JZ	0Y004KZ
0Y004ZZ	0Y0107Z	0Y010JZ	0Y010KZ	0Y010ZZ	0Y0137Z
0Y013JZ	0Y013KZ	0Y013ZZ	0Y0147Z	0Y014JZ	0Y014KZ
0Y014ZZ	0Y0907Z	0Y090JZ	0Y090KZ	0Y090ZZ	0Y0937Z
0Y093JZ	0Y093KZ	0Y093ZZ	0Y0947Z	0Y094JZ	0Y094KZ
0Y094ZZ	0Y0B07Z	0Y0B0JZ	0Y0B0KZ	0Y0B0ZZ	0Y0B37Z
0Y0B3JZ	0Y0B3KZ	0Y0B3ZZ	0Y0B47Z	0Y0B4JZ	0Y0B4KZ
0Y0B4ZZ	0Y0C07Z	0Y0C0JZ	0Y0C0KZ	0Y0C0ZZ	0Y0C37Z
0Y0C3JZ	0Y0C3KZ	0Y0C3ZZ	0Y0C47Z	0Y0C4JZ	0Y0C4KZ
0Y0C4ZZ	0Y0D07Z	0Y0D0JZ	0Y0D0KZ	0Y0D0ZZ	0Y0D37Z
0Y0D3JZ	0Y0D3KZ	0Y0D3ZZ	0Y0D47Z	0Y0D4JZ	0Y0D4KZ
0Y0D4ZZ	0Y0F07Z	0Y0F0JZ	0Y0F0KZ	0Y0F0ZZ	0Y0F37Z
0Y0F3JZ	0Y0F3KZ	0Y0F3ZZ	0Y0F47Z	0Y0F4JZ	0Y0F4KZ
0Y0F4ZZ	0Y0G07Z	0Y0G0JZ	0Y0G0KZ	0Y0G0ZZ	0Y0G37Z
0Y0G3JZ	0Y0G3KZ	0Y0G3ZZ	0Y0G47Z	0Y0G4JZ	0Y0G4KZ
0Y0G4ZZ	0Y0H07Z	0Y0H0JZ	0Y0H0KZ	0Y0H0ZZ	0Y0H37Z
0Y0H3JZ	0Y0H3KZ	0Y0H3ZZ	0Y0H47Z	0Y0H4JZ	0Y0H4KZ

Inpatient Procedures: Non-covered per OAC 5160-2-03 (considered cosmetic, experimental, etc.)					
0Y0H4ZZ	0Y0J07Z	0Y0J0JZ	0Y0J0KZ	0Y0J0ZZ	0Y0J37Z
0Y0J3JZ	0Y0J3KZ	0Y0J3ZZ	0Y0J47Z	0Y0J4JZ	0Y0J4KZ
0Y0J4ZZ	0Y0K07Z	0Y0K0JZ	0Y0K0KZ	0Y0K0ZZ	0Y0K37Z
0Y0K3JZ	0Y0K3KZ	0Y0K3ZZ	0Y0K47Z	0Y0K4JZ	0Y0K4KZ
0Y0K4ZZ	0Y0L07Z	0Y0L0JZ	0Y0L0KZ	0Y0L0ZZ	0Y0L37Z
0Y0L3JZ	0Y0L3KZ	0Y0L3ZZ	0Y0L47Z	0Y0L4JZ	0Y0L4KZ
0Y0L4ZZ	0YU007Z	0YU00JZ	0YU00KZ	0YU047Z	0YU04JZ
0YU04KZ	0YU107Z	0YU10JZ	0YU10KZ	0YU147Z	0YU14JZ
0YU14KZ	0YU907Z	0YU90JZ	0YU90KZ	0YU947Z	0YU94JZ
0YU94KZ	0YUB07Z	0YUB0JZ	0YUB0KZ	0YUB47Z	0YUB4JZ
0YUB4KZ	0YUC07Z	0YUC0JZ	0YUC0KZ	0YUC47Z	0YUC4JZ
0YUC4KZ	0YUD07Z	0YUD0JZ	0YUD0KZ	0YUD47Z	0YUD4JZ
0YUD4KZ	0YUF07Z	0YUF0JZ	0YUF0KZ	0YUF47Z	0YUF4JZ
0YUF4KZ	0YUG07Z	0YUG0JZ	0YUG0KZ	0YUG47Z	0YUG4JZ
0YUG4KZ	0YUH07Z	0YUH0JZ	0YUH0KZ	0YUH47Z	0YUH4JZ
0YUH4KZ	0YUJ07Z	0YUJ0JZ	0YUJ0KZ	0YUJ47Z	0YUJ4JZ
0YUJ4KZ	0YUK07Z	0YUK0JZ	0YUK0KZ	0YUK47Z	0YUK4JZ
0YUK4KZ	0YUL07Z	0YUL0JZ	0YUL0KZ	0YUL47Z	0YUL4JZ
0YUL4KZ	0YUM07Z	0YUM0JZ	0YUM0KZ	0YUM47Z	0YUM4JZ
0YUM4KZ	0YUN07Z	0YUN0JZ	0YUN0KZ	0YUN47Z	0YUN4JZ
0YUN4KZ	0YUP07Z	0YUP0JZ	0YUP0KZ	0YUP47Z	0YUP4JZ
0YUP4KZ	0YUQ07Z	0YUQ0JZ	0YUQ0KZ	0YUQ47Z	0YUQ4JZ
0YUQ4KZ	0YUR07Z	0YUR0JZ	0YUR0KZ	0YUR47Z	0YUR4JZ
0YUR4KZ	0YUS07Z	0YUS0JZ	0YUS0KZ	0YUS47Z	0YUS4JZ
0YUS4KZ	0YUT07Z	0YUT0JZ	0YUT0KZ	0YUT47Z	0YUT4JZ
0YUT4KZ	0YUU07Z	0YUU0JZ	0YUU0KZ	0YUU47Z	0YUU4JZ
0YUU4KZ	0YUV07Z	0YUV0JZ	0YUV0KZ	0YUV47Z	0YUV4JZ
0YUV4KZ	0YUW07Z	0YUW0JZ	0YUW0KZ	0YUW47Z	0YUW4JZ
0YUW4KZ	0YUX07Z	0YUX0JZ	0YUX0KZ	0YUX47Z	0YUX4JZ
0YUX4KZ	0YUY07Z	0YUY0JZ	0YUY0KZ	0YUY47Z	0YUY4JZ
0YUY4KZ	10A03ZZ	10A04ZZ	10A08ZZ	3E00XKZ	3E00XMZ
3E0102A	3E0132A	3E0300P	3E030GN	3E0330P	3E033GN
3E0400P	3E040GN	3E0430P	3E043GN	3E0500P	3E050GN
3E0530P	3E053GN	3E0600P	3E060GN	3E0630P	3E063GN
3E0C3MZ	3E0C7MZ	3E0CXMZ	3E1N38X	3E1N38Z	3E1N78X
3E1N78Z	3E1N88X	3E1N88Z	3E1P38X	3E1P38Z	3E1P78X
3E1P78Z	3E1P88X	3E1P88Z	5A0512C	5A0522C	8E0H300
8E0H30Z	8E0HXY9	X2RF032	X2RF332	X2RF432	XHRPXL2

K.3 OUTPATIENT PROCEDURES THAT REQUIRE PA

Outpatient Procedures that Require PA					
11970	14020	19300	19316	19318	19340
19342	19350	19357	19366	19370	19371
19380	19396	19499	30400	30410	30420
30430	30435	30450	36468	36470	36471
36473	36474	36475	36476	36478	36479
37765	37766	38230	38232	38240	38241
43644	43645	43770	43771	43772	43773
43774	43775	43842	43843	43845	43846
43847	43848	43886	43887	43888	54406
54408	54410	54415	54416	54660	55200
55300	55400	55970	55980	57155	58260
58262	58263	58270	58290	58291	58292
58294	58541	58542	58543	58544	58550
58552	58553	58554	58570	58571	58572
58573	58660	58674	65130	65135	65140
65150	65155	65765	67900	67901	67902
67903	67904	67906	67908	67911	69300
G0277					