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WHAT’S NEW?

The Ohio Medicaid Precertification Program is monitored to identify trends in utilization and show patterns and profiles for Ohio Medicaid consumers and providers. Permedion was acquired by HMS as a wholly owned subsidiary in October, 2007 and continues to work jointly with the Ohio Department of Medicaid (ODM) to evaluate the usefulness of the program.

PRECERTIFICATION REQUESTS USING MITS (MEDICAID INFORMATION TECHNOLOGY SYSTEM)

On August 2, 2011, the Ohio Department of Medicaid implemented an automated system called MITS (Medicaid Information Technology System). All precertification requests must now be submitted through MITS. Previous options for precertification, including telephone and fax requests, are no longer available.

As a provider contact person, in order to initiate precertification requests, you will first need to register and set up a user ID and password that will allow access to the secure area of MITS. Once your registration is successfully completed, you will be able to access the MITS Public Portal to submit a precertification request.

Permedion will process MITS precertification requests in the same manner as previous requests (an overview of the process may be found on page 6 and a detailed review process may be found on pages 35-39). Providers can continue to expect a timely response to their precertification requests through MITS.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
MITS USER REGISTRATION

1. Log into the MITS Public Website: http://jfs.ohio.gov/mts/index.htm

2. Click on “Click here to access the MITS Portal” on the right side

3. On the right side of the screen, under the Provider Setup/Registration heading click the “Click here to setup your account” link. Follow the instructions to complete the registration process, including setting up a user ID and password.

MITS REGISTRATION FAQS CAN BE FOUND AT http://jfs.ohio.gov/mts/MITS%20Provider%20Training.htm

For assistance with the MITS Web Portal contact the ODM Provider Call center: 1-800-686-1516.

For User ID and Password Resets, send an email to: MITS_Access_Support@jfs.ohio.gov

Go to http://jfs.ohio.gov/mts/ for the latest information related to MITS.

MITS PRECERTIFICATION REQUEST STEPS

To request a precertification through MITS:

1. Log onto the MITS home page at http://jfs.ohio.gov/mts/index.htm

2. Click on the “Click here to access the MITS Portal” on the right side

3. Click on the “Click Here to Login” at the top right side

4. Enter your user ID and password, read the agreement, check the box that you have read the agreement, and click on the Login box.

Note: if any non-emergency procedures are performed on an emergency basis, you do NOT need precertification.
5. With the mouse, hover over the **Prior Authorization** menu option in the Main Menu. A sub-menu displays. Select the **New** option.

6. The **Prior Authorization - Base Information** screen displays

7. The information for the precertification request can be entered on this screen

For assistance with the MITS Web Portal contact the ODM Provider Call center: 1-800-686-1516.

A detailed review process is located in Section II. This section also includes an explanation of URAC Accreditation, utilization review reconsideration process, provider administrative appeal process, and resources/contact information.

Ohio Administrative Code (OAC) Rules that apply to precertification are located in Section III. Look for OAC rule 5101:3-2-40 that applies to precertification. The rules can also be found at the ODJFS web site: [http://emanuals.odjfs.state.oh.us/emanuals](http://emanuals.odjfs.state.oh.us/emanuals). Click on Ohio Health Plans – Provider, Hospital Handbook, Hospital Services Ohio Administrative Code, and then use the drop-down Table of Contents to find OAC rule 5101:3-2-40 (5160-2-40).

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**Note:** if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.
INFORMATION TO HAVE ON HAND WHEN YOU SUBMIT A PRECERTIFICATION REQUEST:

- Medicaid consumer demographic information
- Physician demographic information
- Facility demographic information
- Clinical information, including diagnosis and procedure codes

Section II of this manual details what is included in these categories.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
OVERVIEW OF PROCESS

Requests for precertification of procedures will be reviewed for both medical necessity and the level of care for the requested services. Registered nurse reviewers will evaluate the clinical information against established, nationally recognized Milliman Care Guidelines. Sources of information for all Milliman Care Guidelines include peer-reviewed medical literature and textbooks, nationally recognized guidelines published in all fields of medicine, practice observation, and database analysis. These guidelines provide a range of best demonstrated practices and help to reduce unnecessary variation in health care practice, and encourage participation in the practice of evidence-based medicine.

Each criterion is clinically specific to the procedure requested. Additional information may be necessary such as clinical co-morbidities, pertinent laboratory and radiology reports, and consultations which can affect the level of care authorized. The setting of the services may also be impacted by the type, route, and time of anesthesia.

When the medical documentation does not meet the criteria, the case information will be sent to an Ohio-based, peer matched physician reviewer. The reviewing physician will make 2 attempts to speak to the provider prior to a denial of coverage for services being made. Permedion will provide notice of the determination within one business day of the receipt of the complete medical information, but in no instance later than the close of the third business day.

Note: If any oe procedures are performed on an emergency basis, you do NOT need precertification.
REQUESTS FOR RECONSIDERATION

If a procedure, or setting for a procedure, is denied, a request for reconsideration may be submitted in writing within 60 days of the date of the original determination. This request for reconsideration should be sent to:

Permedion/Ohio Medicaid Reconsideration
350 Worthington Road, Suite H
Westerville, Ohio 43082

Requests must include:

- Copy of initial determination letter from Permedion
- Patient’s medical record
- Additional supporting documentation

Requests for reconsideration of any determination will be sent to a different, peer-matched physician reviewer. Physician reviewers have up to 30 days to render a decision. Providers will be notified of a decision within one business day of the reconsideration determination.

Note: if any procedures are performed on an emergency basis, you do NOT need precertification.
Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
Medical Admission

Non-surgical, non-psychiatric, and non-maternity admission.

Medically Necessary Services

Services as defined in Paragraph (B) of Rule 5101:3-2-02 of the OAC.

Observation Services

"Observation services" are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

Outpatient Services

"Outpatient services" - Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a physician or dentist which are furnished to an outpatient by a hospital as defined in rule 5101:3-2-01 of the Administrative Code. Outpatient services do not include direct-care services provided by physicians, podiatrists and dentists. Outpatient services exclude direct-care physician services except as provided in rule 5101:3-4-01 of the Administrative Code.

Preadmission Testing

Testing that can be completed prior to an admission.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
Precertification

Process whereby ODJFS (or its contractual designee) assures that covered medical and psychiatric services and covered surgical procedures are medically necessary and are provided in the most appropriate and cost-effective setting. Since it may be determined that an inpatient stay is not required for the provision of that covered medical or covered surgical care, the location of the service delivery may be altered as a result of precertification. Precertification must be obtained prior to the procedure for non-psychiatric procedures. The payment of that non-psychiatric treatment or procedure is contingent upon the acceptance of Permedion’s recommendation on the appropriate location of service and medical necessity of the admission and/or procedure. For psychiatric precertification, contact Permedion at 1-855-974-5393.

Same Day Surgery

Surgery scheduled and completed on the day of admission with inpatient postoperative days required.

Surgical Admission

Admission to a hospital in which surgery is performed as part of the treatment plan.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
EXEMPT CATEGORIES

- Emergency services, with the exception of emergency psychiatric services.

- Substance abuse services.

- Maternity services.

- Medicaid consumers enrolled in Health Maintenance Organizations (HMOs) under contract with ODM for provision of health services to Medicaid consumers.

- Physicians and hospitals located in noncontiguous states.

- Elective care that is performed in a hospital inpatient setting on a patient that is already hospitalized for a medically necessary condition unrelated to the elective care or when an unrelated procedure which does not require precertification is being performed simultaneously (inpatient only).

- Persons whose eligibility is pending at the time of service or who make application for Medicaid subsequent to admission.

- Patients who are jointly eligible for Medicare and Medicaid who are being admitted under the Medicare Part A benefit.

- Patients who are eligible for benefits through third party insurance as the primary payer for the services subject to precertification.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
- Transfers from one hospital to another hospital with the exception of those hospitals identified for inappropriate transfers.

- Elective procedures or diagnoses not found on the Precertification List.

- Patients not identified as Medicaid consumers at the time of elective admission or procedure. However, every effort should be made by both the attending and/or admitting physicians and hospital providers to identify Medicaid consumers before the admission or procedures that required precertification are performed.

Note: if any elective procedures are performed on an emergency basis, you do NOT need precertification.
FREQUENTLY ASKED QUESTIONS

What is the difference between precertification and prior authorization?

- There are two different types of authorization hospitals are required to obtain. The precertification requirement is for all covered surgical procedures that are normally performed in an outpatient setting, but requesting approval to perform in an outpatient setting. The prior authorization (PA) requirement is for procedures that are normally considered non-covered and must be reviewed for medical necessity. Precertification and prior authorization is not required when Medicare is the primary payer. All requests for precertification and prior authorization of procedures are submitted through MITS.

Prior Authorization –

There is not a published list of services that require prior authorization for inpatient procedures, but Ohio Administrative Code (OAC) rule 5101:3-2-03, Conditions and Limitations, describes the types of services that would require prior authorization. Anything that requires prior authorization in the outpatient hospital setting has a PA indicator next to the CPT code on the applicable appendix in OAC Rule 5101:3-2-21, Policies for Outpatient Hospital Services. Prior authorization will be granted if a service that is typically not covered is proven to be medically necessary for a consumer.

Procedures that require prior authorization are never exempt from prior authorization, so a retrospective review for PA may be requested. A claim submitted with a procedure requiring PA will never pay without authorization.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
**Precertification –**

There are two types of service that require precertification for inpatient admissions. The first is for surgical procedures that require precertification. These surgical procedures are established and published by the Ohio Department of Medicaid.

The second is for psychiatric admissions. If the admitting ICD-9 diagnosis code falls between the range of 290.00 – 326.00, the admission requires precertification.

OAC rule 5101:3-2-40 (5160-2-40), Precertification Review, further defines and describes the requirements for precertification.

Surgical procedure requiring precertification must be obtained prior to the inpatient admission unless it meets one of the exemptions listed in Paragraph C of OAC rule 5101:3-2-40 (5160-2-40), Precertification Review. If the admission does NOT meet one of these requirements, the precertification cannot be retrospectively issued. The claim cannot be billed as inpatient. If the surgical admission meets the exemption policy listed in Paragraph C of the rule, you can submit the claim using the ‘AN” Condition Code to indicate they were exempt from precertification. (The ‘AN” Condition Code cannot be used with psychatoytic admissions or procedures requiring precertification.

Psychiatric admissions requiring precertification must be obtained prior to the admission or within the next business day of the admission. If Medicaid eligibility was pending at the time of psychiatric admission, or if Medicaid eligibility was granted retrospectively, the hospital will need to request a retrospective precertification 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’s determined the reason for the care was psychiatric in nature, precertification is not required. The admitting diagnosis codes on these claims will indicate an acute medical condition

*Note:* if any oe procedures are performed on an emergency basis, you do NOT need precertification.
What information should I have available submit a request for precertification?

- Patient’s Medicaid ID (billing number).
- Patient’s demographic information.
  - Name
  - Address
  - Responsible party, if patient is a minor
  - Date of birth

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
- Physician demographic information.
  - Physician’s name
  - Medicaid provider number
  - Address
  - Telephone number
  - Fax number
  - Specialty

- Procedure to be done
  - Date of procedure
  - Name of procedure
  - CPT code

- Patient clinical information.
  - Signs/symptoms
  - ICD-9 diagnosis codes
  - Duration of signs/symptoms
  - Treatment received so far (medications, PT, etc.)
  - Family history, if applicable
  - Other tests done
  - Reason why physician is ordering procedures

**Who do I contact when a precertification has been denied?**

If a procedure, or setting for a procedure, is denied, a request for reconsideration may be submitted in writing within 60 days of the date of the original determination. This request for reconsideration should be sent to:

Permedion/Ohio Medicaid Reconsideration
350 Worthington Road, Suite H
Westerville, Ohio 43082

*Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.*
What is the penalty for not obtaining a precertification before the procedure is performed?

- When precertification is required for a procedure, there will be no financial reimbursement to the hospital if precertification is not obtained, in accordance with OAC Rule 5101:3-2-40 (5160-2-40).

Is there an appeals process when a precertification is not obtained before the procedures?

- There is no appeals process for untimely precertification, in accordance with OAC Rule 5101:3-2-40 (5160-2-40).

Who is responsible to obtain a precertification?

- While the information required is provided by both the hospital and the patient’s physician, the hospital is ultimately responsible for obtaining a precertification as they will receive no payment if precertification is not obtained.

What if the CPT code for the procedure I plan to perform is not listed in Section II?

- Only the CPT codes listed require precertification.

Note: If any oe procedures are performed on an emergency basis, you do NOT need precertification.
**LIST OF PRECERTIFICATION PROCEDURES – EFFECTIVE AS OF OCTOBER 1, 2006**

**INPATIENT AND OUTPATIENT (HYSTERECTOMIES ARE THE ONLY OUTPATIENT PROCEDURE REQUIRING PRECERTIFICATION)**

**Hysterectomy**

<table>
<thead>
<tr>
<th>Service: ICD-9 Code</th>
<th>Hysterectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.31</td>
<td>Laparoscopic supracervical hysterectomy</td>
</tr>
<tr>
<td>68.39</td>
<td>Other subtotal abdominal hysterectomy nos</td>
</tr>
<tr>
<td>68.41</td>
<td>Laparoscopic total abdominal hysterectomy</td>
</tr>
<tr>
<td>68.49</td>
<td>Other and unspecified total abdominal hysterectomy</td>
</tr>
<tr>
<td>68.51</td>
<td>Laparoscopically assisted vaginal hysterectomy (LAVH)</td>
</tr>
<tr>
<td>68.59</td>
<td>Other vaginal hysterectomy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Hysterectomy</th>
</tr>
</thead>
<tbody>
<tr>
<td>51925</td>
<td>Closure of vesicouterine fistula; with hysterectomy</td>
</tr>
<tr>
<td>58150</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58152</td>
<td>Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopyexy (e.g., Marshall-Marchetti-Krantz, Burch)</td>
</tr>
<tr>
<td>58180</td>
<td>Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58200</td>
<td>Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)</td>
</tr>
<tr>
<td>58260</td>
<td>Vaginal hysterectomy, for uterus 250 grams or less;</td>
</tr>
<tr>
<td>58262</td>
<td>Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s)</td>
</tr>
<tr>
<td>58263</td>
<td>Vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s), and/or ovary(s), with repair of enterocele</td>
</tr>
<tr>
<td>58267</td>
<td>Vaginal hysterectomy, for uterus 250 grams or less; with colpo-urethrocystopyexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control</td>
</tr>
<tr>
<td>58270</td>
<td>Vaginal hysterectomy, for uterus 250 grams or less; with repair of enterocele</td>
</tr>
</tbody>
</table>

*Note: if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.*
Service: **Hysterectomy**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58275</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy</td>
</tr>
<tr>
<td>58280</td>
<td>Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele</td>
</tr>
<tr>
<td>58290</td>
<td>Vaginal hysterectomy, uterus greater than 250 grams</td>
</tr>
<tr>
<td>58291</td>
<td>Vaginal hysterectomy, uterus greater than 250 grams, with removal of tube(s) and/or ovaries</td>
</tr>
<tr>
<td>58292</td>
<td>Vaginal hysterectomy, uterus greater than 250 grams, with removal of tube(s) and/or ovaries, with repair of enterocele</td>
</tr>
<tr>
<td>58293</td>
<td>Vaginal hysterectomy, uterus greater than 250 grams, with colpourethrocystopectomy, with or without endoscopic control</td>
</tr>
<tr>
<td>58294</td>
<td>Vaginal hysterectomy, uterus greater than 250 grams, with repair of enterocele</td>
</tr>
<tr>
<td>58541</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58542</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less, with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58543</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams</td>
</tr>
<tr>
<td>58544</td>
<td>Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58550</td>
<td>Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less</td>
</tr>
<tr>
<td>58552</td>
<td>Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)</td>
</tr>
<tr>
<td>58553</td>
<td>Laparoscopy surgical, with vaginal hysterectomy, for uterus greater than 250 grams</td>
</tr>
<tr>
<td>58554</td>
<td>Laparoscopy surgical, with vaginal hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and/or ovary(s)</td>
</tr>
</tbody>
</table>

*Note: if any of procedures are performed on an emergency basis, you do **NOT** need precertification.*
**Note:** if any of the procedures are performed on an emergency basis, you do **NOT** need precertification.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>58570</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less</td>
</tr>
<tr>
<td>58571</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less, with removal of tube(s) and ovary(s)</td>
</tr>
<tr>
<td>58572</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams</td>
</tr>
<tr>
<td>58573</td>
<td>Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 grams, with removal of tube(s) and ovary(s)</td>
</tr>
<tr>
<td>58951</td>
<td>Resection of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy</td>
</tr>
</tbody>
</table>
**Cervical Laminectomy**

<table>
<thead>
<tr>
<th>Service:</th>
<th>Cervical Laminectomy</th>
</tr>
</thead>
</table>
| ICD-9 Code | Other cervical fusion, anterior technique  
| 81.02 | Other cervical fusion, posterior technique  
| 81.03 | |
| CPT Codes | Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression) cervical below C2  
| 22554 | Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression) cervical below C2; thoracic  
| 22556 | Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression) cervical below C2; lumbar  
| 22558 | Arthrodesis, anterior interbody technique, including minimal diskectomy to prepare interspace (other than for decompression) cervical below C2; each additional interspace (List separately in addition to code for primary procedure) (Use 22585 in conjunction with codes 22554, 22556, 22558)  
| 22585 | Arthrodesis, posterior technique, craniocervical (occiput-C2)  
| 22590 | Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment  
| 22600 | Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment; thoracic (with or without lateral transverse technique)  
| 22610 | Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment; each additional vertebral segment (List separately in addition to code for primary procedure) (Use 22614 in conjunction with codes 22600, 22610, 22612)  
| 22614 | Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments  
| 22800 | |

*Note: if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.*
**Service:** Cervical Laminectomy

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22802</td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments</td>
</tr>
<tr>
<td>22808</td>
<td>Arthrodesis, anterior, for spinal deformity, with or without cast; 2 to 3 vertebral segments</td>
</tr>
<tr>
<td>22810</td>
<td>Arthrodesis, anterior, for spinal deformity, with or without cast; 4 to 7 vertebral segments</td>
</tr>
<tr>
<td>22812</td>
<td>Arthrodesis, anterior, for spinal deformity, with or without cast; 8 or more vertebral segments</td>
</tr>
<tr>
<td>22840</td>
<td>Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across one interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)</td>
</tr>
<tr>
<td>22851</td>
<td>Application of intervertebral biomechanical device(s) (eg, synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace</td>
</tr>
<tr>
<td>63075</td>
<td>Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace</td>
</tr>
<tr>
<td>63076</td>
<td>Diskectomy, anterior, with decompression of spinal cord and/or nerve root(s), including osteophyctomy; cervical, single interspace; cervical, each additional interspace (List separately in addition to code for primary procedure)</td>
</tr>
</tbody>
</table>

*Note:* if any of these procedures are performed on an emergency basis, you do **NOT** need precertification.
## Esophagogastroduodenoscopy (EGD)

<table>
<thead>
<tr>
<th>Service:</th>
<th>Esophagogastroduodenoscopy (EGD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>EGD with closed biopsy</td>
</tr>
<tr>
<td>45.16</td>
<td></td>
</tr>
<tr>
<td>CPT Codes</td>
<td>Description</td>
</tr>
<tr>
<td>43235</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>43238</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s), esophagus (includes endoscopic ultrasound examination limited to the esophagus)</td>
</tr>
<tr>
<td>43239</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple</td>
</tr>
<tr>
<td>43242</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)</td>
</tr>
<tr>
<td>44360</td>
<td>Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with transendoscopic ultrasound-guided intramural or transmural fine needle aspiration/biopsy(s) (includes endoscopic ultrasound examination of the esophagus, stomach, and either the duodenum and/or jejunum as appropriate)</td>
</tr>
<tr>
<td>44361</td>
<td>Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, not including ileum; with biopsy, single or multiple</td>
</tr>
</tbody>
</table>

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44376</td>
<td>Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>44377</td>
<td>Small intestinal endoscopy, enteroscopy beyond second portion of duodenum, including ileum; with biopsy, single or multiple</td>
</tr>
<tr>
<td>44385</td>
<td>Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>44386</td>
<td>Endoscopic evaluation of small intestinal (abdominal or pelvic) pouch; with biopsy, single or multiple</td>
</tr>
</tbody>
</table>

**Note:** if any of the procedures are performed on an emergency basis, you do **NOT** need precertification.
### Injection or infusion of cancer chemotherapeutic substance

<table>
<thead>
<tr>
<th>Service:</th>
<th>Injection or infusion of cancer chemotherapeutic substance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>CPT Code</td>
</tr>
<tr>
<td>99.25</td>
<td>36823</td>
</tr>
<tr>
<td></td>
<td>Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation including regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites</td>
</tr>
<tr>
<td></td>
<td>51720</td>
</tr>
<tr>
<td></td>
<td>Bladder instillation of anticarcinogenic agent (including detention time)</td>
</tr>
<tr>
<td>96401</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic</td>
</tr>
<tr>
<td>96402</td>
<td>Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic</td>
</tr>
<tr>
<td>96405</td>
<td>Chemotherapy administration; intrallesional, up to and including 7 lesions</td>
</tr>
<tr>
<td>96406</td>
<td>Chemotherapy administration; intrallesional, more than 7 lesions</td>
</tr>
<tr>
<td>96409</td>
<td>Chemotherapy administration; intravenous, push technique, single or initial substance/drug</td>
</tr>
<tr>
<td>96411</td>
<td>Chemotherapy administration; intravenous, push technique, each additional substance/drug</td>
</tr>
<tr>
<td>96413</td>
<td>Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug</td>
</tr>
<tr>
<td>96415</td>
<td>Chemotherapy administration, intravenous infusion technique; each additional hour, 1 to 8 hours</td>
</tr>
<tr>
<td>96416</td>
<td>Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump</td>
</tr>
<tr>
<td>96417</td>
<td>Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour</td>
</tr>
<tr>
<td>96420</td>
<td>Chemotherapy administration, intra-arterial; push technique</td>
</tr>
</tbody>
</table>

**Note:** if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96422</td>
<td>Chemotherapy administration, intra-arterial; infusion technique, up to one hour</td>
</tr>
<tr>
<td>96423</td>
<td>Chemotherapy administration, intra-arterial; infusion technique, each additional hour up to 8 hours</td>
</tr>
<tr>
<td>96425</td>
<td>Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump</td>
</tr>
<tr>
<td>96521</td>
<td>Refilling and maintenance of portable pump</td>
</tr>
<tr>
<td>96522</td>
<td>Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (eg, intravenous, intra-arterial)</td>
</tr>
</tbody>
</table>

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
## Laparoscopic Cholecystectomy

<table>
<thead>
<tr>
<th>Service: Laparoscopic Cholecystectomy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>51.23</td>
</tr>
<tr>
<td></td>
<td>51.24</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>47562</td>
</tr>
<tr>
<td></td>
<td>47563</td>
</tr>
<tr>
<td></td>
<td>47564</td>
</tr>
</tbody>
</table>

Note: if any of procedures are performed on an emergency basis, you do NOT need precertification.
**Laparoscopy - Diagnostic**

<table>
<thead>
<tr>
<th>Service:</th>
<th>Laparoscopic - Diagnostic</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>54.21 Laparoscopy</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>Laparoscopy, abdomen, peritoneum and omentum; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)</td>
</tr>
<tr>
<td>49320</td>
<td>Laparoscopy, surgical; with biopsy (single or multiple)</td>
</tr>
<tr>
<td>49321</td>
<td>Laparoscopy, surgical; with aspiration of cavity or cyst (e.g., ovarian cyst) (single or multiple)</td>
</tr>
<tr>
<td>49322</td>
<td>Laparoscopy, surgical; with drainage of lymphocele to peritoneal cavity</td>
</tr>
<tr>
<td>49323</td>
<td>Unlisted laparoscopy procedure, abdomen, peritoneum and omentum</td>
</tr>
</tbody>
</table>

*Note: if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.*
### Lumbar Laminectomy - Posterior

<table>
<thead>
<tr>
<th>Service:</th>
<th>Lumbar Laminectomy - Posterior</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>80.51</td>
</tr>
<tr>
<td></td>
<td>81.05</td>
</tr>
<tr>
<td></td>
<td>81.08</td>
</tr>
<tr>
<td></td>
<td>Excision of intervertebral disc</td>
</tr>
<tr>
<td></td>
<td>Dorsal and dorsolumbar fusion, posterior technique</td>
</tr>
<tr>
<td></td>
<td>Lumbar and lumbosacral fusion, posterior technique</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>22610</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment; thoracic (with or without lateral transverse technique)</td>
</tr>
<tr>
<td></td>
<td>22612</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment; lumbar (with or without lateral transverse technique)</td>
</tr>
<tr>
<td></td>
<td>22614</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior or posterolateral technique, single level; cervical below C2 segment; each additional vertebral segment</td>
</tr>
<tr>
<td></td>
<td>22630</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar</td>
</tr>
<tr>
<td></td>
<td>22632</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar; each additional interspace</td>
</tr>
<tr>
<td></td>
<td>22633</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, including laminectomy and/or discectomy, single interspace and segment, lumbar</td>
</tr>
<tr>
<td></td>
<td>22634</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, including laminectomy and/or discectomy, single interspace and segment, lumbar, each add’l interspace and segment</td>
</tr>
<tr>
<td></td>
<td>22800</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; up to 6 vertebral segments</td>
</tr>
<tr>
<td></td>
<td>22802</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; 7 to 12 vertebral segments</td>
</tr>
<tr>
<td></td>
<td>22804</td>
</tr>
<tr>
<td></td>
<td>Arthrodesis, posterior, for spinal deformity, with or without cast; 13 or more vertebral segments)</td>
</tr>
<tr>
<td></td>
<td>22842</td>
</tr>
<tr>
<td></td>
<td>Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments</td>
</tr>
</tbody>
</table>

*(CONTINUED ON NEXT PAGE)*

**Note:** if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.
### Lumbar Laminectomy - Posterior

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>22843</strong></td>
<td>Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 7 to 12 vertebral segments</td>
</tr>
<tr>
<td><strong>22844</strong></td>
<td>Posterior segmental instrumentation (e.g., pedicle fixation, dual rods with multiple hooks and sublaminar wires); 8 or more vertebral segments</td>
</tr>
<tr>
<td><strong>22851</strong></td>
<td>Application of intervertebral biomechanical device(s) (e.g., synthetic cage(s), threaded bone dowel(s), methylmethacrylate) to vertebral defect or interspace</td>
</tr>
<tr>
<td><strong>63030</strong></td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; one interspace, lumbar (including open or endoscopically-assisted approach)</td>
</tr>
<tr>
<td><strong>63035</strong></td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk; each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td><strong>63042</strong></td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; lumbar</td>
</tr>
<tr>
<td><strong>63044</strong></td>
<td>Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disk, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td><strong>63047</strong></td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; lumbar</td>
</tr>
</tbody>
</table>

**Note:** if any oe procedures are performed on an emergency basis, you do NOT need precertification.
### Percutaneous Angioplasty - Noncoronary Vessel

<table>
<thead>
<tr>
<th>Service:</th>
<th>Percutaneous Angioplasty-Non Coronary Vessel</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>39.50 Angioplasty or atherectomy of non-coronary vessel</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>35471 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel; renal or visceral artery</td>
</tr>
<tr>
<td></td>
<td>35472 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel; aortic</td>
</tr>
<tr>
<td></td>
<td>35475 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel; brachiophecal trunk or branches, each vessel</td>
</tr>
<tr>
<td></td>
<td>35476 Transluminal balloon angioplasty, percutaneous; tibioperoneal trunk or branches, each vessel; venous</td>
</tr>
<tr>
<td></td>
<td>37228 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, initial vessel, with transluminal angioplasty</td>
</tr>
<tr>
<td></td>
<td>37229 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, initial vessel, with transluminal angioplasty, with atherectomy</td>
</tr>
<tr>
<td></td>
<td>37230 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, initial vessel, with transluminal angioplasty, with transluminal stent placement</td>
</tr>
<tr>
<td></td>
<td>37231 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, initial vessel, with transluminal angioplasty, with transluminal stent placement and atherectomy</td>
</tr>
<tr>
<td></td>
<td>37232 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, each add’l vessel, with transluminal angioplasty</td>
</tr>
<tr>
<td></td>
<td>37233 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, each add’l vessel, with transluminal angioplasty, with atherectomy</td>
</tr>
<tr>
<td></td>
<td>37234 Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, each add’l vessel, with transluminal angioplasty, with transluminal stent placement</td>
</tr>
</tbody>
</table>

*Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.*
| 37235 | Revascularization, endovascular, open or percutaneous, tibial. Perineal artery, each add’l vessel, with transluminal angioplasty, with transluminal stent placement and atherectomy |

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
**PTCA-Coronary Angioplasty**

<table>
<thead>
<tr>
<th>Service:</th>
<th>PTCA-Coronary Angioplasty</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 Code</td>
<td>00.66 Percutaneous transluminal coronary angioplasty [PTCA] or</td>
</tr>
<tr>
<td></td>
<td>coronary atherectomy</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>92982 Percutaneous transluminal coronary balloon angioplasty;</td>
</tr>
<tr>
<td></td>
<td>single vessel</td>
</tr>
<tr>
<td></td>
<td>92984 Percutaneous transluminal coronary balloon angioplasty;</td>
</tr>
<tr>
<td></td>
<td>each additional vessel</td>
</tr>
<tr>
<td></td>
<td>92995 Percutaneous transluminal coronary atherectomy, by</td>
</tr>
<tr>
<td></td>
<td>mechanical or other method, with or without balloon angioplasty;</td>
</tr>
<tr>
<td></td>
<td>single vessel</td>
</tr>
<tr>
<td></td>
<td>92996 Percutaneous transluminal coronary atherectomy, by</td>
</tr>
<tr>
<td></td>
<td>mechanical or other method, with or without balloon angioplasty;</td>
</tr>
<tr>
<td></td>
<td>each additional vessel</td>
</tr>
</tbody>
</table>

*Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.*
The participating Medicaid Facility, Attending Physician, or Physician Office Staff will:


- Input demographic information:
  - Medicaid consumer demographic data
    - Name
    - Address
    - Sex
    - Date of birth
    - Medicaid consumer ID number
  - Physician demographic data
    - Name
    - Address
    - Telephone number
    - Fax number
    - Medicaid provider number
    - Physician specialty
  - Facility demographic data
    - Name
    - Address
    - Telephone number
    - Medicaid provider number (billing number)

- Input clinical information:
  - Primary and/or secondary diagnosis
  - Planned procedure(s)

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
☑ Service date(s)
☑ Supporting labs, radiology, and consults
☑ Treatment plan/intensity indicator
☑ Contact person

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
The Utilization Management RN will:

- Review clinical information against criteria

  ✔️ Severity

  ✓ Clinically specific to procedure requested
  ✓ Complicating signs and symptoms
  ✓ Acute clinical compromise
  ✓ Chronic clinical symptoms
  ✓ Abnormalities as identified by lab testing
  ✓ Pathology as noted by radiology and/or surgical intervention
  ✓ Clinical specialty consults denoting clinical pathology
  ✓ Psycho-social factors impacting patient’s episode of care
  ✓ Clinical comorbidities
  ✓ Pertinent laboratory, radiology, and consults

  ✔️ Intensity

  ✓ Diagnostic procedures to establish cause or nature of severity indicators
  ✓ Therapeutic treatment indicators
  ✓ Anesthesia-impact of type, route, and time
  ✓ Post-procedure monitoring
  ✓ Therapeutic management of diagnoses and comorbidities

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
The Utilization Management RN will:

- Evaluate whether the clinical information supports medical necessity based upon the application of clinical criteria

  - If no: RN Reviewer refers case to Ohio based Physician Reviewer.

  OR

  - If yes: RN Reviewer certifies procedure and provides authorization number. Written notification is sent to the facility and patient from the MITS system.

- Is medical necessity and appropriateness validated by Ohio Physician Reviewer?

  - Ohio based Physician Reviewer makes a call to the attending physician for peer-to-peer case discussion if a denial of services may be made (minimum of two attempted calls). If reviewer recommends non-certification for lack of established medical necessity, the RN notifies the attending physician within one business day of decision. Written notification of determination and details regarding the reconsideration/appeal or hearing process is sent within one business day to the facility and patient from the MITS system.

  OR

  - Ohio Physician Reviewer recommends certification. Written notification is sent to the facility and patient from the MITS system.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
The Utilization Management RN will:

- Approve the requested procedure or refer to the Ohio Physician Panel:
  - Ohio based physicians in active practice
  - Specialty peer-matching
  - Confidence in appropriateness of decisions
  - Timeliness in rendering decisions
  - Accessibility which facilitates interaction between the panel and key participants
  - An educational, non-adversarial approach to the review process
  - Appeals handled by different sub-specialty, peer-matched physician
  - Specialties, e.g.
    - Gastroenterology
    - ENT
    - Family Practice
    - Cardiology
    - Surgery
    - Neurosurgery
    - Orthopedic surgery
    - Pediatrics
    - Oncology/Hematology
    - Podiatry
    - Ophthalmology
    - Anesthesiology
    - Psychiatry
    - Obstetrics/Gynecology
    - Physical/Rehabilitation Medicine
    - Otolaryngology
    - Cardio Thoracic Surgery

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
The Utilization Management RN will:

- If approved, authorizations numbers may be obtained electronically by the provider(s) through the MITS system. If surgery is scheduled within 1 business day the RN will communicate certification via phone

- ODM will forward written notification to the patient and facility from the MITS system
  - Precertification determinations are completed within 1 business day of the receipt of the complete medical information, but in no instance later than the close of the third business day
  - Appeal decision is communicated within one day business day of determination

- Permedion contact information:
  
  Permedion  
  350 Worthington Road, Suite H  
  Westerville, Ohio 43082  
  Phone- 1-800-772-2179  
  Fax- 1-855-334-0071

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
UTILIZATION REVIEW RECONSIDERATION

- Submit to Permedion within 60 days of the date of the determination

  Permedion /Ohio Medicaid Reconsideration
  350 Worthington Road, Suite H
  Westerville, Ohio 43082
  Fax- 1-855-334-0071

- Request must be in writing and include:
  - Copy of written determination
  - Patient’s medical record
  - Additional supporting documentation

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
RESOURCES/CONTACT INFORMATION

**Permedion**

Michelle Armstrong, MA, CPC, CPC-P  
UM Service Line Manager - Permedion  
1-800-473-0802 or 1-614-895-9900  
Fax –1-855-334-0071

**Ohio Department of Medicaid (ODM) - Policy Related Questions**

hospital_policy@medicaid.oh.gov

*Note:* if any oe procedures are performed on an emergency basis, you do **NOT** need precertification.
URAC GUIDELINES

The Utilization Review Accreditation Commission (URAC) standards support the necessary structures and processes to promote high quality care and preserve patient rights.

The Ohio Medicaid Precertification Program has been under the leadership of Permedion since 1997. In 2013 Permedion received full URAC re-accreditation in utilization management. Permedion’s review personnel meet or exceed all training and qualification requirements in the URAC standards.

This precertification program monitors and complies with all Ohio Medicaid legislative and certification requirements.

Note: if any oe procedures are performed on an emergency basis, you do NOT need precertification.
(A) To participate in the medicaid program, a hospital must have a valid, current provider agreement. A "provider agreement" is a contractual agreement whereby the provider agrees to adhere to conditions of participation as described in rule 5101:3-1-17.2 of the Administrative Code.

All hospitals, except those excluded in paragraphs (A) (1) and (A) (2) of this rule, that meet Medicare (Title XVIII) conditions of participation as described in 42 C.F.R 482, are eligible to participate in the Ohio Medicaid (Title XIX) program upon execution of a provider agreement. Also considered to be eligible is a hospital which is currently determined to meet the requirements for Title XVIII participation and has in effect a hospital utilization review plan applicable to all patients who receive medical assistance under Title XIX. The following hospitals are excluded from participation:

(1) Tuberculosis facilities, and

(2) Facilities that have fifty per cent or more of their beds registered pursuant to Chapter 3701-59 of the Administrative Code as alcohol and/or drug abuse rehabilitation beds, and have no beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code.
(B) The following facilities with more than sixteen beds shall be eligible to participate in Title XIX only for the provision of inpatient psychiatric services to recipients age sixty-five or older in accordance with paragraph (C) of this rule and to recipients under age twenty-one in accordance with paragraph (D) of this rule.

(1) A hospital with fifty per cent or more of its beds registered as alcohol and/or drug abuse rehabilitation beds that also has beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code.

(2) Hospitals that have at least half of their beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code.

(3) Hospitals that have half or more of their discharges in any six-month time period reviewed by the Ohio department of job and family services and determined to be for psychiatric and/or substance abuse treatment.

(C) Hospitals that are eligible to participate only for the provision of inpatient psychiatric services in accordance with paragraph (B) of this rule and are rendering inpatient psychiatric services to recipients age sixty-five or older must be licensed by the Ohio department of mental health in accordance with Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code, and must provide services in accordance with Chapter 5122-14 of the Administrative Code. Hospitals shall operate pursuant to the provisions of 42 C.F.R. 441 subpart C.
(D) Hospitals that are eligible to participate only for the provision of inpatient psychiatric services in accordance with paragraph (B) of this rule and are rendering inpatient psychiatric services for recipients under age twenty-one must:

(1) Provide services under the direction of a physician;

(2) Operate pursuant to the provisions of 42 C.F.R 441 subpart D;

(3) Be a psychiatric hospital or an inpatient program in a psychiatric hospital, either of which is certified by medicare for reimbursement of services and accredited by the "Joint Commission on Accreditation of Hospitals," and must be licensed by the Ohio department of mental health in accordance with Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code, and must provide services in accordance with Chapter 5122-14 of the Administrative Code; and

(4) Provide services before the recipient reaches age twenty-one or, if the recipient was receiving services immediately before he/she reached age twenty-one, before the earlier of the following:

(a) The date he/she no longer requires the services; or

(b) The date he/she reaches age twenty-two.
(E) The following facilities with sixteen or fewer beds shall be eligible to participate in Title XIX only for the provision of inpatient psychiatric services to recipients in accordance with paragraph (F) of this rule.

(1) A hospital with fifty per cent or more of its beds registered as alcohol and/or drug abuse rehabilitation beds that also has beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code.

(2) Hospitals that have at least half of their beds licensed as psychiatric beds pursuant to Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code.

(3) Hospitals that have half or more of their discharges in any six-month time period reviewed by the Ohio department of job and family services and determined to be for psychiatric and/or substance abuse treatment.

(F) Hospitals that are eligible to participate only for the provision of inpatient psychiatric services in accordance with paragraph (E) of this rule and are rendering inpatient psychiatric services to recipients must be licensed by the Ohio department of mental health in accordance with Chapter 5122-14 of the Administrative Code or operated under the authority of the state mental health authority in accordance with section 5119.01 of the Revised Code, and must provide services in accordance with Chapter 5122-14 of the Administrative Code. Hospitals shall operate pursuant to the provisions of 42 C.F.R. 482 subpart E.
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Rule amplifies: RC 5111.01, 5111.02; 5111.021

R.C. 119.032 review dates: 08/01/2006 and 10/1/2011
5101:3-2-02 GENERAL PROVISIONS: HOSPITAL SERVICES.

(A) The Ohio medicaid program provides payment for medically necessary covered inpatient and outpatient services provided to eligible medicaid recipients by an eligible hospital provider as defined in rule 5101:3-2-01 of the Administrative Code, subject to the provisions of this chapter and Chapter 5101:3-1 of the Administrative Code (relating to general provisions).

(B) The following words and terms, when used in this chapter have the following meanings, unless the context clearly indicates otherwise:

(1) "Inpatient" - A patient who is admitted to a hospital based upon the written orders of a physician or dentist and whose inpatient stay continues beyond midnight of the day of admission.

(2) "Inpatient services" - Services which are ordinarily furnished in a hospital as defined in rule 5101:3-2-01 of the Administrative Code for the care and treatment of inpatients. 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. Inpatient hospital services exclude direct-care physician services except as provided in rule 5101:3-4-01 of the Administrative Code. Emergency room services are covered as an inpatient service when a patient is admitted from the emergency room.

(3) "Outpatient" - A patient who is not an inpatient as defined in paragraph (B)(1) of this rule and who receives outpatient services at a hospital or at a hospital's off-site unit which has been extended accreditation by the "Joint Commission of Accreditation of Health Care Organizations," the "American Osteopathic Association" and/or is certified under medicare. Outpatient includes a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission except in instances when, on the day of
admission, a patient dies or is transferred to another inpatient unit within the hospital, to another hospital, or to a state psychiatric facility.

(4) "Outpatient services" - Diagnostic, therapeutic, rehabilitative, or palliative treatment or services furnished by or under the direction of a physician or dentist which are furnished to an outpatient by a hospital as defined in rule 5101:3-2-01 of the Administrative Code. Outpatient services do not include direct-care services provided by physicians, podiatrists and dentists. Outpatient services exclude direct-care physician services except as provided in rule 5101:3-4-01 of the Administrative Code.

(5) "Diagnostic related groups (DRGs)" - DRGs are a patient classification system that reflects clinically cohesive groupings of services that consume similar amounts of hospital resources. The grouping logic used to develop relative weights is described in rule 5101:3-2-07.3 of the Administrative Code. The groupings used to assign cases to a DRG for claims payment are identified in rule 5101:3-2-07.11 of the Administrative Code.

(6) "Average" is the arithmetic mean obtained by dividing a sum by the number of its observations.

(7) "Geometric mean" is the nth root of the product of n factors.

(8) "Psychiatric unit distinct part" is a distinct part recognized by medicare.

(9) "Level I nursery" is a nursery unit within a hospital which is registered with and recognized by the Ohio department of health as a level I nursery.

(10) "Level II nursery" is a nursery unit within a hospital which is registered with and recognized by the Ohio department of health as a level II nursery.

(11) "Level III nursery" is a nursery unit within a hospital that is registered with and recognized by the Ohio department of health as a level III nursery.
(12) "Standard deviation" is the square root of the arithmetic mean of the squares of the deviations from the arithmetic mean.

(13) "Principal diagnosis" is the diagnosis established after study to be chiefly responsible for causing the patient's admission to the hospital.

(14) "Medically necessary services" are services which are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort. A medically necessary service must:

(a) Meet accepted standards of medical practice;

(b) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;

(c) Be appropriate to the intensity of service and level of setting;

(d) Provide unique, essential, and appropriate information when used for diagnostic purposes.

(15) Transfer.
A hospital inpatient is "transferred" when the patient has been moved from one eligible hospital, as described in rule 5101:3-2-01 of the Administrative Code, to another eligible hospital, including state psychiatric facilities.

A patient is said to be "transferred" when he or she:

(a) Is moved from one eligible hospital, as described in rule 5101:3-2-01 of the Administrative Code, to another eligible hospital, including state psychiatric facilities.
(b) Is moved from an eligible hospital to the same hospital's psychiatric unit distinct part.

(c) Is moved to an eligible hospital from the same hospital's psychiatric unit distinct part.

(16) Readmissions.
For hospitals paid under the department's prospective payment system, a "readmission" is an admission to the same institution within thirty days of discharge.

(17) Discharges.
A patient is said to be "discharged" when he or she:

(a) Is formally released from a hospital;

(b) Dies while hospitalized;

(c) Is discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part as described in paragraph (B)(8) of this rule or is discharged within the same hospital, from a bed in a psychiatric unit distinct part to an acute care bed. Rule 5101:3-2-07.11 of the Administrative Code explains the payment methodology for this type of a discharge; or

(d) Signs himself or herself out against medical advice (AMA).

(18) "Observation services" are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for possible admission to the hospital as an inpatient.

(C) Billing: All inpatient and outpatient hospital services must be billed in accordance with national uniform billing requirements for hospital
facilities (available on http://www.nubc.org/). Appendix A of this rule describes revenue codes that are covered under the medicaid hospital benefit.

Effective: 12/16/10


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5101:3-2-07.12 APPEALS AND RECONSIDERATION OF DEPARTMENTAL DETERMINATIONS REGARDING HOSPITAL INPATIENT AND OUTPATIENT SERVICES.

(A) General.

Pursuant to rules 5101:3-1-57 and 5101:6-50-01 of the Administrative Code, hospitals may appeal under Chapter 119. of the Revised Code final settlements that are based upon final audits by the department. Rule 5101:3-2-24 of the Administrative Code describes final fiscal audits and final settlements performed by the department. Rules 5101:3-1-29 and 5101:3-1-27 of the Administrative Code describe the audits performed by the department's surveillance and utilization review section, which are also appealable under Chapter 119. of the Revised Code. Since the scope and substance of these two types of audits differ, in no instance will the conduct and implementation of one type of audit preclude the conduct and implementation of the other.

(B) Utilization review reconsideration.

Pursuant to rule 5101:3-2-07.13 of the Administrative Code, the department or a medical review entity under contract to the department may make determinations regarding utilization review in accordance with the standards set forth in rules 5101:3-2-02, 5101:3-2-07.9, 5101:3-2-07.13, 5101:3-2-40 of the Administrative Code. These determinations are subject to the reconsideration process described in rule 5101:3-1-57 of the Administrative Code as follows:
(1) A written request for a reconsideration must be submitted to the department or the medical review entity, whichever made the initial determination, within sixty days of the date of the determination. The department or the medical review entity shall have thirty working days from receipt of the request for reconsideration to issue a written decision accepting, modifying, or rejecting its previous determination. The request for reconsideration must include:

(a) A copy of the written determination;

(b) A copy of the patient's medical record;

(c) Copies of any and all additional information that may support the provider's position.

(2) The department will conduct an administrative review of the reconsideration decision if the provider submits its request within thirty days of that decision. A request for an administrative review must include:

(a) A letter requesting a review of the reconsideration.

(b) A statement as to why the provider believes that the reconsideration decision was in error.

(c) Any further documentation supporting the provider's position.
(3) The department may extend time frames described in paragraphs (B)(1), and (B)(2) of this rule, where adherence to time frames causes exceptional hardships to a large number of hospitals or where adherence to time frames as described in paragraphs (B)(1), and (B)(2) of this rule causes exceptional hardship to a hospital because potential determinations constitute a large portion of that hospital's total medicaid business.

(C) Reconsideration of inpatient hospital payments.

(1) Except when the department's determination is based on a finding made by medicare, the proper application of rules 5101:3-2-07.1 and 5101:3-2-07.2 of the Administrative Code and the proper calculation of amounts (including source data used to calculate the amounts) determined in accordance with rules 5101:3-2-07.4, 5101:3-2-07.6, and 5101:3-2-07.7 of the Administrative Code are subject to the reconsideration process described in rule 5101:3-1-57 of the Administrative Code as follows:

(a) Requests for reconsideration authorized by paragraph (C)(1) of this rule must be submitted to the department in writing. If the request for reconsideration involves a rate component or determination made at the beginning of the rate year, the request must be submitted within ninety days of the beginning of the rate year. If the request involves an adjustment or a determination made by the department after the beginning of the rate year, the request must be submitted within thirty days of the date the adjustment or determination was implemented. The request must include a statement as to why the provider believes that the rate component or determination was incorrect as well as all documentation supporting the provider's position.
(b) The department shall have thirty days from receipt of the request for reconsideration to issue a final and binding decision.

(2) When a medicare audit finding was used by the department in establishing a rate component and the finding is subsequently overturned on appeal, the provider may request reconsideration of the affected rate component. Such requests must be submitted to the department in writing prior to final settlement as described rule 5101:3-2-24 of the Administrative Code and within thirty days of the date the hospital receives notification from medicare of the appeal decision. The request for reconsideration of a medicare audit finding that has been overturned on appeal must include all documentation that explains the appeal decision. The department shall have thirty days in which to notify the provider of its final and binding decision regarding the medicare audit finding.

(3) Reconsideration may also be requested if a hospital believes that a claim or claims were paid in error because of an incorrect DRG (diagnosis related groups) assignment or incorrect payment calculation. In such an instance, the hospital must resubmit the claim(s) for an adjustment as described in rule 5101:3-1-19.8 of the Administrative Code. Following the adjustment process, if the hospital continues to believe that the department's DRG assignment or payment calculation was in error, the provider may submit a written request for reconsideration that includes all documentation supporting the providers position. In this instance, the department shall have sixty days in which to notify the provider of its final and binding decision.
(D) State hearings for medicaid recipients whose claim for inpatient hospital services is denied.

Any recipient whose claim for inpatient hospital services is denied may request a state hearing in accordance with division 5101:6 of the Administrative Code. The determination of whether outlier payments will be made or the amounts of outlier payments as described in rule 5101:3-2-07.9 of the Administrative Code is not a denial of a claim for inpatient hospital services. Similarly, the determination of amounts payable for inpatient hospital services involving readmissions or transfers is not a denial of a claim for inpatient hospital services.

(E) The following items are not subject to the department's reconsideration process:

1. The use of the DRG classification system and the method of classification of discharges within DRGs.

2. The assignment of relative weights to DRGs based on the methodology set forth in rule 5101:3-2-07.3 of the Administrative Code.

3. The establishment of peer groups as set forth in rule 5101:3-2-07.2 of the Administrative Code.

4. The methodology used to determine prospective payment rates as described in rules 5101:3-2-07.4 and 5101:3-2-07.6 to 5101:3-2-07.8 of the Administrative Code.

5. The methodology used to identify cost and day thresholds for services that may qualify for outlier payments as described in rule 5101:3-2-07.9 of the Administrative Code.
(6) The formulas used to determine rates of payment for outliers, certain transfers and readmissions, and services subject to preadmission certification, as described, respectively, in rules 5101:3-2-07.9, 5101:3-2-07.11, and 5101:3-2-40 of the Administrative Code.

(7) The peer group average cost per discharge for all hospitals except when the conditions detailed in rule 5101:3-2-07.8 of the Administrative Code are met.

(8) Statewide calculations of the direct and indirect medical education threshold for allowable costs per intern and resident as described in rule 5101:3-2-07.7 of the Administrative Code and of the threshold for establishing which hospitals will be recognized as providing a disproportionate share of indigent care as described in rule 5101:3-2-07.5 of the Administrative Code.

Effective Date: 5/1/07

HISTORY: Eff 10-11-84; 7-1-85; 7-3-86; 10-19-87; 7-1-90; 7-1-92; 11-17-92 (Emer.); 2-1-93; 8-1-02

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5101:3-2-40 PRE-CERTIFICATION REVIEW.

Effective date: April 1, 2005

This rule describes the pre-certification review program for inpatient and outpatient services. For the medical/surgical pre-certification program, paragraphs (A) to (C) and (E) to (G) of this rule are to be used. For the psychiatric pre-certification program, paragraphs (A)(12), (B) and (D) to (G) of this rule are to be used as applicable.

(A) Definitions.

(1) An "emergency admission" is an admission to treat a condition requiring medical and/or surgical treatment within the next forty-eight hours when, in the absence of such treatment, it can reasonably be expected that the patient may suffer unbearable pain, physical impairment, serious bodily injury or death.

(2) "Medically necessary services" are defined in paragraph (B) of rule 5101:3-2-02 of the Administrative Code.

(3) "Standards of medical practice" are nationally recognized protocols for diagnostic and therapeutic care. These protocols are approved by the medicaid program. ODJFS will notify providers of the standards of medical practice to be used by the department. If the department should change the protocols, providers will be notified sixty days in advance.

(4) An "elective admission" is any admission that does not meet the emergency admission definition in paragraph (A)(1) of this rule.

(5) "Elective care" is medical or surgical treatment that may be postponed for at least forty-eight hours without causing the patient unbearable pain, physical impairment, serious bodily injury or death.
(6) For purposes of this rule, a "hospital" is a provider eligible under rule 5101:3-2-01 of the Administrative Code.

(7) A "surgical admission" is an admission to a hospital in which surgery is performed as part of the treatment plan.

(8) A "medical admission" is a nonsurgical, nonpsychiatric, and nonmaternity admission.

(9) "Pre-certification" is a process whereby ODJFS (or its contractual designee) assures that covered medical and psychiatric services, and covered surgical procedures are medically necessary and are provided in the most appropriate and cost effective setting. Since it may be determined that an inpatient stay is not required for the provision of that covered medical or covered surgical care, the location of service delivery may be altered as a result of pre-certification. The payment of that treatment or procedure is contingent upon the acceptance of the review agency's recommendation on the appropriate location of service, and medical necessity of the admission and/or procedure. The department will mail the precertification list and standards of medical practice to all providers thirty days in advance of requiring pre-certification.

(B) Guidelines for pre-certification

(1) The decision that the provision of elective diagnostic and/or therapeutic care is medically necessary will be based upon nationally recognized standards of medical practice, derived from indicators of severity of illness and intensity of services. Both severity of illness and intensity of service must be present to justify proposed care. When indicated, determinations will also include a consideration of relevant and appropriate psycho-social factors.

(2) The individual circumstances of each patient is taken into account when making a decision about the appropriateness of a hospital admission. Issues that will be considered in making the decision about whether or not an admission is medically necessary include psycho-social factors and factors related to the home
environment including proximity to the hospital and the accessibility of alternative sites of care; these issues must be fully documented in the medical record in order to be considered as part of the review.

(C) Pre-certification of medical and surgical services provided in an inpatient or outpatient setting.

(1) Admission for individuals who are Medicaid eligible at the time of the admission and who do not meet any of the exemptions in paragraph (C)(2) of this rule must be certified by the reviewing agency (ODJFS or its contractual designee) prior to an admission to a hospital as defined in paragraph (A)(6) of this rule.

(2) Excluded from the pre-certification process are:

(a) Emergency admissions, with the exception of emergency psychiatric admissions.

(b) Substance abuse admissions.

(c) Maternity admissions.

(d) Recipients enrolled in health insuring corporations under contract with the department for provision of health services to recipients.

(e) Services provided in hospitals which are located in noncontiguous states.

(f) Elective care that is performed in a hospital inpatient setting on a patient who is already hospitalized for a medically necessary condition unrelated to the elective care or when an unrelated procedure which does not require pre-certification is being performed simultaneously.

(g) Persons whose eligibility is pending at the time of admission or who make application for Medicaid subsequent to admission.
(h) Patients who are jointly eligible for Medicare and Medicaid and who are being admitted under the Medicare "part A" benefit.

(i) Patients who are eligible for benefits through a third party insurance as the primary payer for the services subject to pre-certification.

(j) Transfers from one hospital to another hospital with the exception of those hospitals identified for intensified review in accordance with paragraph (C)(1) of rule 5101:3-2-07.13 of the Administrative Code.

(k) Admissions for those elective surgical procedures or diagnoses which are not included in the department's pre-certification list.

(l) If the patient is not identified as a Medicaid recipient at the time of an elective admission or procedure. However, every effort should be made by both the attending and/or admitting physicians and hospital providers to identify Medicaid recipients before an admission or procedure that requires precertification.

(3) The provider must request pre-certification for an admission and/or procedure that does not meet the exemption criteria listed in paragraphs (C)(2)(a) to (C)(2)(l) of this rule and is on the department's pre-certification list by contacting the reviewing agency. The reviewing agency is to make a decision on a pre-certification request within three working days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. "Receipt of a properly submitted request" means that all information needed by the reviewing agency to make a decision based upon the guidelines in paragraph (B) of this rule has been provided to the reviewing agency. All negative decisions shall be reviewed by a physician representing ODJFS or its contractual designee. The reviewing agency shall notify in writing the recipient, the requesting physician, the hospital, and ODJFS of all decisions. The reviewing agency must provide that written notice is sent to the requesting physician, recipient, and hospital by the close of the fourth working day after the request is received.
(D) Pre-certification psychiatric.

(1) General information.

The following definitions pertain to psychiatric admissions:
(a) A "psychiatric admission" is an admission of an individual to a hospital with a primary diagnosis of mental illness and not a medical or surgical admission. A discharge from a medical/surgical unit and an admission to a distinct part psychiatric unit within the same facility is considered to be a psychiatric admission and is subject to pre-certification.

(b) An "emergency psychiatric admission" is an admission where the attending psychiatrist believes that there is likelihood of serious harm to the patient or others and that the patient requires both intervention and a protective environment immediately.

(2) All psychiatric admissions for individuals who are medicaid eligible at the time of the admission must be certified by the reviewing agency ODJFS or its contractual designee) prior to an admission to a hospital or by the next working day after the admission has occurred.

(3) The provider must request pre-certification for a psychiatric admission by contacting the reviewing agency. The reviewing agency is to make a decision on a pre-certification request within three working days of receipt of a properly submitted request, which is to include the information addressed in the standards of medical practice. "Receipt of a properly submitted request" means that all information needed by the reviewing agency to make a decision based upon the guidelines set forth in paragraph (B) of this rule has been provided to the reviewing agency. All negative decisions shall be reviewed by a physician representing ODJFS or its contractual designee. The reviewing agency shall notify the recipient, the requesting physician, the hospital, and ODJFS of all decisions in writing by the close of the fourth working day after the request is received.

(E) Decisions made by the medical review entity as described in this rule are
appealable to the medical review entity and are subject to the reconsideration process described in rule 5101:3-2-07.12 of the Administrative Code.

(F) Recipients have a right to a hearing in accordance with division-level 5101:6 of the Administrative Code. This hearing is separate and distinct from the provider’s appeal, as described in paragraph (E) of this rule.

(G) Reimbursement for elective care subject to pre-certification review.

(1) A certification that an inpatient stay is necessary for the provision of care and/or a procedure is medically necessary does not guarantee payment for that service. The individual must be a medicaid recipient at the time the service is rendered and the service must be a covered service.

(2) An elective admission, as defined in paragraph (A)(4) of this rule, is reimbursed according to the rates for inpatient hospital services pursuant to rule 5101:3-2-22 of the Administrative Code for hospital admissions reimbursed on a cost basis and rule 5101:3-2-07.11 of the Administrative Code for hospital admissions reimbursed on a prospective basis. Outpatient hospital services are reimbursed according to rule 5101:3-2-21 of the Administrative Code for hospitals subject to prospective reimbursement, and according to rule 5101:3-2-22 of the Administrative Code for those hospitals reimbursed on a cost basis. Associated physician services are reimbursed according to medicaid maximums for physician services pursuant to appendix DD to rule 5101:3-1-60 of the Administrative Code.

(3) In any instance when an admission or a procedure that requires pre-certification is performed and the admission and/or procedure has not been approved, hospital payments will not be made. If physician payments have been made for services associated with the medically unnecessary procedure, such payments will be recovered by the department. Recipients may not be billed for charges associated with the admission and/or procedure except under circumstances described in paragraph (G)(4) of this rule.

(4) If the pre-certification process is initiated prospectively by the provider and
hospital inpatient services are denied, or if an admission and/or procedure requiring pre-certification is not found to be medically necessary and the recipient chooses hospitalization or to have the medically unnecessary service, these admissions and/or procedures and all associated services would be considered noncovered services and the recipient will be liable for payment of these services in accordance with rule 5101:3-1-13.1 of the Administrative Code.

(5) The medical review entity may determine upon retrospective review, in accordance with rule 5101:3-2-07.13 of the Administrative Code, that the location of service was not medically necessary, but that services rendered were medically necessary. In this instance, the hospital may bill the department on an outpatient basis for those medically necessary services that were rendered on the date of admission in accordance with rule 5101:3-2-21 of the Administrative Code. Only laboratory and diagnostic radiology services rendered during the remainder of the medically unnecessary admission may be billed in accordance with rule 5101:3-2-02 of the Administrative Code on the outpatient claim. The outpatient bill must be submitted with a copy of the reconsideration affirming the original decision and/or the administrative decision issued in accordance with rule 5101:3-2-07.12 of the Administrative Code. The outpatient bill with attachments must be submitted to the department within sixty days from the date on the remittance advice recouping the DRG payment for the medically unnecessary admission.

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