5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Physicians' services are covered by Ohio Medicaid in accordance with 42 CFR § 440.50.

Services determined by the department as not medically necessary will not be covered.

A limited number of physicians' services (e.g., surgical removal of supernumerary teeth) are covered under the Ohio Medicaid program upon the provider obtaining prior authorization from the Medicaid agency or its designee before the provider renders the services.

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. (Continued)

Beneficiaries younger than age twenty-one can access physicians' services without limitation when medically necessary.

2. a. Outpatient Hospital Services

Outpatient hospital services shall be based upon fee-schedule payments and prospectively determined rates for procedures performed in the outpatient hospital setting. Fee-schedule payments based upon both the Healthcare Common Procedure Coding System (HCPCS) and Physician's Current Procedural Terminology (CPT) codes are established for most outpatient hospital procedures for dates of service on or after January 1, 2012. Except as otherwise noted in the plan, state-developed fee schedule rates of the same for both governmental and private providers. All rates are published on the agency's website at jfs.ohio.gov/OHP/provider.stm.

Reimbursement for some outpatient hospital services such as chemotherapy, emergency room trauma treatment, and unlisted laboratory services, are made at the hospital specific cost to charge ratio. Unlisted surgical procedures, unlisted ancillary and radiology procedures, independently billed pharmacy and medical supplies, and pharmacy billed with IV therapy are based upon a fixed percent of charges for dates of service on or before December 31, 2011. For dates of service on or after January 1, 2012, reimbursement for unlisted surgical procedures, unlisted ancillary and radiology procedures, independently billed pharmacy and medical supplies, and pharmacy billed with IV therapy will be based upon multiplying the hospital specific outpatient cost to charge ratio from the interim settled Medicaid cost reports during the calendar year preceding the rate year by charges associated with claims processed through MMIS.

For dates of services on or after January 1, 2006, hospitals will be required to charge a $3.00 co-payment to Medicaid patients utilizing the emergency department for non-emergency services. As a result, for claims submitted for services indicated as non-emergent use of the emergency department, hospitals will receive reimbursement based upon their FFS payment minus any applicable co-payment.

3. Other laboratory and x-ray services.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for other laboratory and x-ray services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

5. a. Physicians' services.

Physicians' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.50.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule. Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for physicians' services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

Non-covered services are identified on the state developed Medicaid fee schedule (jfs.ohio.gov/OHP/provider.stm) by "NC" as the current price.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agenc staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

The maximum reimbursement for surgical procedures performed under the in-office surgery program is the lesser of the billed charge or the Medicaid maximum for the particular service, plus a $15, $25, or $50 additional payment. The criteria that trigger the payment are place of service and procedure code.

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

The maximum reimbursement for physician evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere. (Continued)

Optometrists' Services

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for physicians' (including optometrists') services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

This service is subject to a co-payment as referenced in Attachment 4.18-A of the State Plan.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for podiatrists' services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

The following payment scenarios also exist:

The maximum reimbursement for surgical procedures performed under the in-office surgery program is the lesser of the billed charge or the Medicaid maximum for the particular service, plus a $15, $25, or $50 additional payment. The criteria that trigger the payment are place of service and procedure code.

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

The maximum reimbursement for services delivered by a physician assistant employed by or under contract with a physician is the lesser of the provider's billed charge or eighty-five per cent of the Medicaid maximum, except for services delivered by a physician assistant when a physician also provided distinct and identifiable services during the visit or encounter and services that are usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations), which are reimbursed at the lesser of the billed charge or an amount based on the Medicaid maximum for the particular service.

The maximum reimbursement for podiatrists' evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum:

Reimbursement for multiple surgical procedures performed on the same patient by the same provider is the lesser of billed charges or one hundred per cent of the Medicaid maximum allowed for the primary procedure (the primary procedure is the surgical procedure that has the highest Medicaid maximum listed on the fee schedule); fifty per cent of the Medicaid maximum allowed for the secondary procedure; or twenty-five per cent of the Medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Reimbursement for bilateral procedures, when performed bilaterally, on the same patient by the same provider, is the lesser of billed charges or one hundred fifty per cent of the Medicaid maximum allowed for the same procedures performed unilaterally.

9. Clinic services.

a. Free-standing ambulatory health care clinics (AHCCs).

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule. Payment scenarios applicable to specific provider types (e.g., physicians) apply.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for free-standing ambulatory health care clinics' services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, State-developed fee schedules and rates are the same for both governmental and private providers.

9. Clinic services, continued.

b. Outpatient health facilities (OHFs).

OHF services are provided in accordance with 42 CFR 440.90. OHFs are freestanding.

1. Payment for authorized services in an OHF is calculated on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Rates are calculated on a clinic's cost of allowable items and services, and thus may vary from clinic to clinic, subject to the tests of reasonableness described in paragraphs (4) to (8). While payments under a prospective system are not subject to audit and retroactive settlement or adjustment, the historical costs upon which prospective rates are based are audited. Adjustments to the paid rate will be made if costs are found to be overstated or misrepresented in a manner which resulted in an overstatement of the previously determined prospective rate (see paragraph (11)). Retroactive adjustments may also occur to reconcile payments made to new facilities on the basis of an interim rate as provided in paragraph (3) or in accordance with paragraph (1)(b).

   a. Rates will be established for each of the following types of services rendered by a participating OHF:

      (i) medical services
      (ii) laboratory services
      (iii) radiology services
      (iv) dental services
      (v) speech therapy and audiology services
      (vi) mental health services
      (vii) physical therapy services
      (viii) transportation services
      (ix) vision care services

10. Dental services.

Payment is the lesser of the billed charges or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for dental services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Effective for dates of service on and after January 1, 2006, selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

17. Nurse-midwife services.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for nurse-midwife services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

The following payment scenarios also exist:

The maximum reimbursement for certified nurse-midwife services is the lesser of the provider's billed charge or the percentage listed below, multiplied by the site differential percentage rate, whichever is less:

eighty-five per cent of the medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.

The maximum reimbursement for nurse-midwife evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.

23. Certified pediatric and family nurse practitioners' services.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's fee schedule.

Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

The agency's fee schedule rate was revised with new fees for certified pediatric and family nurse practitioners' services effective:

For services on or after 1/1/2012. The fee schedule was posted on 12/22/2011 and 12/30/2011.
For services on or after 3/29/2012. The fee schedule was posted on 3/29/2012.

Except as otherwise noted in the plan, state-developed fee schedules and rates are the same for both governmental and private providers.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

The following payment scenarios also exist:

The maximum reimbursement for certified pediatric and family nurse practitioners' services is the lesser of the provider's billed charge or the percentage listed below, multiplied by the site differential percentage rate, whichever is less:

eighty-five per cent of the medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.

The maximum reimbursement for certified pediatric and family nurse practitioners' evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.