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State/Territory Name: OH

State Plan Amendment (SPA) #: 20-0003

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group/ Division of Reimbursement Review

April 17, 2020

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Ohio State Plan Amendment (SPA) 20-0003

Dear Ms. Corcoran:

We have reviewed the proposed Ohio State Plan Amendment (SPA) to Attachment 4.19-B 20-0003, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on (January, 30, 2020). This plan amendment updates the Attachment 4.19-B pages to account for new, amended, and/or deleted Healthcare Common Procedure Code System Codes.

Based upon the information provided by the State, we have approved the amendment with an effective date of January, 1, 2020. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any questions, please contact Fredrick Sebree at Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Acting Director

Enclosures
Fredrick Sebree
Deborah Benson

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **20-003**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **January 01, 2020**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Sections 1905(a)(3),(5),(6),(7),(9),(11),(12),(17),(21) & (28) of the Act; 42 CFR 440.30, 440.50, 440.60, 440.70, 440.90, 440.110, 440.120, 440.165, and 440.166	a. FFY 2020 $0 b. FFY 2021 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Item 3 Page 1 of 1	Attachment 4.19-B, Item 3 Page 1 of 1 (TN 19-004)
Attachment 4.19-B, Item 5-a Page 1	Attachment 4.19-B, Item 5-a Page 1 of 3 (TN 17-027)
Attachment 4.19-B, Item 5-a Page 2	Attachment 4.19-B, Item 5-a Page 2 (TN 19-018)
Attachment 4.19-B, Item 6-a Page 1 of 2	Attachment 4.19-B, Item 6-a Page 1 of 2 (TN 19-004)
Attachment 4.19-B, Item 6-d (5) Page 1	Attachment 4.19-B, Item 6-d (5) Page 1 (TN 19-021)
Attachment 4.19-B, Item 6-d-(6) Page 2 of 2	Attachment 4.19-B, Item 6-d-(6) Page 2 of 2 (TN 19-018)
Attachment 4.19-B, Item 6-d-(8) Page 1 of 1	Attachment 4.19-B, Item 6-d-(8) Page 1 of 1 (TN 17-012)
Attachment 4.19-B, Item 7-c Page 1 of 1	Attachment 4.19-B, Item 7-c Page 1 of 1 (TN 19-004) Page 1 of 2 cd
Attachment 4.19-B, Item 9-a Page 1 of 2	Attachment 4.19-B, Item 9-a Page 1 of 2 (TN 17-020)
Attachment 4.19-B, Item 9-a Page 2 of 2	Attachment 4.19-B, Item 9-a Page 2 of 2 (TN 19-018)
Attachment 4.19-B, Item 11-a Page 1 of 1	Attachment 4.19-B, Item 11-a Page 1 of 1 (TN 19-004)
Attachment 4.19-B, Item 11-b Page 1 of 1	Attachment 4.19-B, Item 11-b Page 1 of 1 (TN 19-004)
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Attachment 4.19-B, Item 17 Page 1 of 1	Attachment 4.19-B, Item 17 Page 1 of 2 (TN 17-010)
	Attachment 4.19-B, Item 17 Page 2 of 2 (TN 19-004) (removed)
Attachment 4.19-B, Item 23 Page1 of 2	Attachment 4.19-B, Item 23 Page1 of 2 (TN 17-010)
Attachment 4.19-B, Item 23 Page 2 of 2	Attachment 4.19-B, Item 23 Page 2 of 2 (TN 19-018)
Attachment 4.19-B, Item 28, Page 1 of 1	Attachment 4.19-B, Item 28, Page 1 of 1 (TN 19-004)

10. SUBJECT OF AMENDMENT: Payment for Services: Non-Institutional Payment Schedule Updates

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **MAUREEN M. CORCORAN**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: January 30, 2020	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: 04/17/2020
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01/01/2020	20 [redacted]
21. TYPED NAME: Todd McMillion	22

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

3. Other laboratory and x-ray services.

Other laboratory and x-ray services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.30.

Payment for other laboratory and x-ray services is the lesser of the billed charge or an amount, based on the Medicaid maximum for the service, that is not to exceed the Medicare rate on a per-test basis. The Medicaid maximum for other laboratory services is the amount listed on the Department's laboratory services fee schedule. The Medicaid maximum for x-ray services is the amount listed on the Department's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one advanced imaging procedure is performed by the same provider or provider group for an individual patient in the same session. Payment is made for the primary procedure at 100%, payment for each additional technical component is made at 50%, and payment for each additional professional component is made at 95%. This payment provision took effect on January 1, 2017.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new laboratory or x-ray services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the laboratory services or MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's laboratory services fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

By-report services 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 pricing using a similar service, product, or procedure that has an established reimbursement rate, or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed.

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

Clinical Diagnostic Lab (CDL) rates attestation

The state attests that it complies with section 1903(i)(7) of the Social Security Act and limits Medicaid payments for clinical diagnostic lab services to the amounts paid by Medicare for those services on a per-test basis (or per billing code basis for a bundled/panel of tests).

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

Unless otherwise specified, the maximum payment amount for a physicians' service is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For dates of service on or after July 1, 2017, when a physician acts as an assistant-at-surgery for a covered primary surgical procedure, the maximum payment amount for the physician is the lesser of the provider's submitted charges or 25% of the Medicaid maximum specified in the agency's physician fee schedule found on the MSRIAP fee schedule.

For dates of service on or after July 1, 2017, when a surgical procedure is performed by two co-surgeons, the maximum payment amount for each co-surgeon is the lesser of the provider's submitted charges or 62.5% of the Medicaid maximum specified in the agency's physician fee schedule found on the MSRIAP fee schedule.

For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount listed on the agency's MSRIAP fee schedule is set at 80% of the Medicare allowed amount.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

For dates of service on or after January 1, 2017, payment for anesthesia services furnished by an anesthesiologist is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

Maximum payment amount =
(Base unit value + Time unit value) x Conversion factor x Multiplier

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. The conversion factor and multiplier are effective for dates of service on or after January 1, 2018, and are listed on the agency's Anesthesia fee schedule at https://medicaid.ohio.gov/ProvidersFeeScheduleandRates.aspx.

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

Optometrists' services

Optometrists' services are subject to a co-payment, explained in Attachment 4.18-A of the plan.

The agency's rates for dispensing of ophthalmic materials such as contact lenses, low vision aids, etc. are on the eye care services fee schedule published on the agency's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx. These rates were set as of May 1, 2016, and are effective for services provided on or after that date.

The agency's physicians' rates found on the MSRIAP fee schedule were set as of January 1, 2020, and are effective for services provided on or after that date.

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

Services Provided in a Community Behavioral Health Agency

Payment rates for evaluation and management services rendered by physicians operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after January 1, 2018, the payment for behavioral health evaluation and management services rendered by physicians operating in a community behavioral health agency will be 117.65% of the 2016 Ohio Medicare Region 00 rates.

Rates for physicians' services are listed on the agency's MSRIAP fee schedule published on the agency's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

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 for Podiatrists' services 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 Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new podiatry code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date. The site differential payment was set as of January 1, 2014 and is effective for services provided on or after that date.

By-report services 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 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.

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. (Continued)

d. Other practitioners' services

(5) Physician assistants' services

Payment for physician assistants' services is the lesser of the billed charge or 85% of the Medicaid maximum for the physicians' service specified in the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial Medicaid maximum payment amount is set at 80% of the Medicare allowed amount. Each new physician assistants' code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

The following payment scenarios apply:

When a physician assistant acts as an assistant-at-surgery for a covered primary surgical procedure, the maximum payment amount for the physician assistant is the lesser of billed charges or 25% of the Medicaid maximum specified for physicians' services in the MSRIAP fee schedule.

Payment rates for evaluation and management services rendered by physician assistants operating in a community behavioral health agency certified or licensed by the single state agency or its designee will be a flat fee for each covered service as specified on the established Medicaid fee schedule. These rates are based on a percentage of the Ohio Medicare Region 00 rates allowable for a specified year. Effective for dates of service on or after August 1, 2019, the payment for behavioral health evaluation and management services rendered by physician assistants practicing in a community behavioral health agency will be 100% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

By-report services 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 pricing using a similar service, product, or procedure that has an established reimbursement rate, or a percentage of charges. The specific methodology utilized depends on the service, product, or procedure performed. Physician assistants are reimbursed the lesser of billed charges or 85% of the established price established through this manual review pricing process.

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

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.

d. Other practitioners' services.

(6) Licensed advanced practice nurses' (APNs') services, other than described elsewhere in this plan.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new APNs' services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

The agency's Anesthesia fee schedule was set as of January 1, 2018, and is effective for services provided on or after that date.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is effective for services provided on or after that date.

Additional codes for certain services provided by CRNAs (i.e., trigger-point injections) are located on the State's MSRIAP fee schedule.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

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.

d. Other practitioners' services

(8) Anesthesiologist Assistants' services.

Payment for an anesthesia service furnished by an Anesthesiologist Assistant is the lesser of the provider's submitted charge or the Medicaid maximum, which is determined by the following formula:

Maximum payment amount =
(Base unit value + Time unit value) x Conversion factor x Multiplier

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. The conversion factor and multiplier are effective for dates of service on or after January 1, 2018 and are listed on the agency's Anesthesia fee schedule, which is published on the agency's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

The services of an Anesthesiologist Assistant employed by a hospital are considered to be hospital services, payment for which is made to the hospital.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new anesthesia code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the Anesthesia fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

The agency's Anesthesia fee schedule was set as of January 1, 2018, and is effective for services provided on or after that date.

Additional codes for certain services provided by Anesthesiologist Assistants (i.e., trigger-point injections) are located on the State's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

7. Home health services, continued.

c. Medical supplies, equipment, and appliances suitable for use in the home.

Payment for medical supplies, equipment, and appliances is the lesser of the submitted charge or an amount based on the Medicaid maximum for the item or service.

The Medicaid maxima for blood glucose monitors, test strips, lancets, lancing devices, needles including pen needles, calibration solution/chips, and needle-bearing syringes with a capacity up to three milliliters are 107% of the wholesale acquisition cost (WAC); if the WAC cannot be determined, the Medicaid maximum is 85.6% of the average wholesale price (AWP). The State's Diabetic Testing and Injection Supplies payment schedule (part of the Pharmacy payment schedule) was set as of April 1, 2017.

The Medicaid maxima for oxygen are listed on the State's Oxygen payment schedule, which was set as of July 16, 2018.

The Medicaid maxima for wheelchairs, parts, accessories, and related services are listed on the State's Wheelchair payment schedule, which was set as of January 1, 2017.

The Medicaid maxima for enteral nutrition products are listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule. Where no Medicaid maximum is specified, payment is 77% of the AWP.

The Medicaid maxima for other medical supplies, equipment, and appliances are listed on the State's main DMEPOS payment schedule. Where no Medicaid maximum for a medical supply item is specified, payment is 72% of the list price; if no list price is available, it is 147% of the invoice price.

The State's main DMEPOS payment schedule was set as of January 1, 2019.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new DMEPOS code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the DMEPOS fee schedule.

All Medicaid payment schedules and rates are published on the State's website at https://medicaid.ohio.gov/Providers/FeeScheduleandRates.aspx.

9. Clinic services.

a. Service-Based Ambulatory Health Care Clinic (AHCC) Services.

i. End-Stage Renal Disease (ESRD) Dialysis Clinics

Payment for covered dialysis services rendered by an ESRD dialysis clinic is made as an all-inclusive composite amount per visit. This composite amount includes all related services, tests, equipment, supplies, and training furnished on the same date.

The Medicaid maximum composite payment amount for a covered dialysis service is the product of two figures: (a) The calendar year 2016 ESRD prospective payment system (PPS) base rate published by the Centers for Medicare and Medicaid services (CMS), which can be found on the CMS website at https://www.cms.gov; and (b) The applicable percentage from the following list: (i) chronic maintenance dialysis performed in an ESRD dialysis clinic – fifty-eight and three quarters per cent; (ii) chronic maintenance dialysis performed in a home setting – three sevenths of the percentage for chronic maintenance dialysis performed in an ESRD dialysis clinic; (iii) dialysis support services – thirty-three and three quarters per cent; or (iv) dialysis with self-care training – sixty-seven and three quarters per cent.

Separate payment may be made to an ESRD dialysis clinic for covered professional services of a medical practitioner and for covered laboratory services and pharmaceuticals that are not directly related to dialysis treatment. Payment methods and amounts for such items and services are determined in accordance with paragraph (9)(a)(ii) of this attachment.

ii. All Other Service-Based AHCCs

Medicaid makes a separate payment for each service or item provided at a service-based AHCC.

Unless otherwise specified, the maximum payment amount for an AHCC service is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new AHCC services code will be located on the agency’s CPT and HCPCS Level II Procedure Code Changes

9-a Clinic services, Service-Based Ambulatory Health Care Clinic (AHCC) Services, continued.

payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

11. Physical therapy and related services.

a. Physical therapy.

Physical therapy (PT) services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for PT services provided by outpatient hospitals, physicians, limited practitioners, and clinics 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 Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new PT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

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

Payment for PT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

Payment for PT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for PT services provided to residents of nursing facilities is included in the nursing facility per diem rate.

11. Physical therapy and related services, continued.

b. Occupational therapy.

Occupational therapy (OT) services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for OT services provided by outpatient hospitals, physicians, limited practitioners, and clinics 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 Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new OT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

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

Payment for OT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for OT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for OT services provided to residents of nursing facilities is included in the nursing facility per diem rate.

11. Physical therapy and related services, continued.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Speech-language pathology and audiology (SLPA) services are covered as hospital, home health agency, physician, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (7), and (9) for reimbursement provisions.

Payment for SLPA services provided by outpatient hospitals, physicians, limited practitioners, and clinics 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 Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new SLPA code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020 and is effective for services provided on or after that date.

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

Payment for SLPA services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for SLPA services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for SLPA services provided to residents of nursing facilities is included in the nursing facility per diem rate.

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, continued.

c. Prosthetic devices.

Payment is the lesser of the submitted charge or an amount based on the Medicaid maximum. The Medicaid maximum for a prosthetic device is listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new prosthetic device code can be found on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the DMEPOS fee schedule.

All Medicaid payment schedules and rates are published on the State's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's DMEPOS fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date.

By-report items and services require manual review by appropriate staff members or contractors. Payment for these items and services is determined on a case-by-case basis. The specific method used depends on the item or service (for example, comparison with a similar service that has an established maximum payment rate or application of a percentage of charges). This schema was effective on July 16, 2018.

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

17. Nurse-midwife services.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse-midwife (CNM) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNM will be made to the hospital.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new nurse-midwife code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

23. Certified pediatric and family nurse practitioners' services.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse practitioner (CNP) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

Payment for services rendered by a hospital-employed CNP will be made to the hospital.

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new CNPs' services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/Provider/FeeScheduleandRates/SchedulesandRates#la-1682569-cpt-and-hcpcs-level-ii-procedure-code-changes until it is moved to the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The agency's MSRIAP fee schedule was set as of July 1, 2020, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends

23. Certified pediatric and family nurse practitioners' services, continued.

on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

28. Licensed or otherwise state-approved freestanding birth centers (FBC) and licensed or otherwise state-recognized covered professionals providing services in the freestanding birth center.

Payment for FBC facility services 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 Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

Payment for FBC services is based on a reimbursement rate for each HCPCS code. Maximum reimbursement for facility services is the lesser of the provider's billed charges or one hundred percent of the rate listed on the MSRIAP fee schedule.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/PROVIDERS/FeeSchedulesandRates.aspx.

The agency's MSRIAP fee schedule was set as of January 1, 2020, and is effective for services provided on or after that date.

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

In addition to reimbursement for facility services, an FBC may also be reimbursed for laboratory procedures, radiological procedures, and diagnostic and therapeutic procedures provided in connection with a covered FBC procedure. To be reimbursed for these procedures, FBC providers must bill using appropriate HCPCS codes. An FBC will not be reimbursed separately for the professional component of such services.