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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 21-0011

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

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

May 24, 2021

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

RE: Ohio State Plan Amendment 21- 0011

Dear Ms. Corcoran:

We have reviewed the proposed Ohio State Plan Amendment (SPA) to Attachment 4.19-B, OH-21-0011, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 23, 2021. This plan updates the Non-Institutional Payment Schedules for 2021.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2021. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any questions or need further assistance, please contact Debi Benson at 1-312-886-0360 or Deborah.Benson@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **21-011**	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, 2021**	

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), (9), (10), (11), (17) and (23) of the Social Security Act; 42 CFR 440.30, 440.50, 440.60, 440.90, 440.100, 440.110, 440.165, and 440.166	a. FFY 2021 $0 b. FFY 2022 $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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: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 1-2 of 2	Attachment 4.19-B Item 3 Page 1 of 1 (TN: 20-003)
Attachment 4.19-B Item 5-a Page 2	Attachment 4.19-B Item 5-a Page 2 (TN: 20-003)
Attachment 4.19-B Item 6-a Page 1 of 2	Attachment 4.19-B Item 6-a Page 1 of 2 (TN: 20-003)
Attachment 4.19-B Item 6-d (5) Page 1 of 1	Attachment 4.19-B Item 6-d (5) Page 1 (TN: 20-003)
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: 20-003)
Attachment 4.19-B Item 9-a Page 2 of 2	Attachment 4.19-B Item 9-a Page 2 of 2 (TN: 20-003)
Attachment 4.19-B Item 10 Page 1 of 2	Attachment 4.19-B Item 10 Page 1 of 2 (TN: 20-005)
Attachment 4.19-B Item 11-a Page 1 of 1	Attachment 4.19-B Item 11-a Page 1 of 1 (TN: 20-003)
Attachment 4.19-B Item 11-b Page 1 of 1	Attachment 4.19-B Item 11-b Page 1 of 1 (TN: 20-003)
Attachment 4.19-B Item 11-c Page 1 of 1	Attachment 4.19-B Item 11-c Page 1 of 1(TN: 20-003)
Attachment 4.19-B Item 17 Page 1 of 1	Attachment 4.19-B Item 17 Page 1 of 1 (TN: 20-003)
Attachment 4.19-B Item 23 Page 1 of 2	Attachment 4.19-B Item 23 Page 1 of 2 (TN: 20-003)

10. SUBJECT OF AMENDMENT: Payment for Services: Non-Institutional Payment Schedule Updates for 2021

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: March 23, 2021	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: **March 23, 2021**	18. DATE APPROVED: May 24, 2021
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: **January 1, 2021**	L OFFICIAL: [redacted]
21. TYPED NAME: **Todd McMillion**	22. TITLE: **Director, Division of Reimbursement Review**

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 submitted charge or an established amount based on the Medicaid maximum for the service. For each clinical diagnostic laboratory test, the established amount is not to exceed the corresponding Medicare allowed amount.

The Medicaid maximum for other laboratory services is the amount listed on the Department's laboratory services fee schedule. For a newly-covered laboratory service, the initial maximum payment amount is set at 75% of the applicable Medicare allowed amount listed in the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule. If the Medicare amount for a covered laboratory service becomes less than the current Medicaid maximum payment amount, then the Medicaid maximum payment amount for that service is reestablished at 75% of the current applicable Medicare allowed amount.

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. For a newly-covered x-ray service represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. 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 reduction provision took effect on January 1, 2017.

Each code representing a newly covered laboratory or x-ray service is located on the agency's CPT and HCPCS Level II Procedure Code Changes 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 fee schedules and maximum payment amounts 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 April 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, 2021, 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 payment amount for these services is determined through the application of one of a variety of different payment methods, such as adopting the maximum payment amount for a similar service, taking the unweighted average of the maximum payment amounts for a group of related services, or using percentage of charges. The specific method used depends on the service.

Except as otherwise noted in the state plan, state-developed fee schedules and maximum payment amounts 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 procedure code basis for bundled tests or test panels).

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 January 1, 2021, 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, 2021, 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, 2021 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, 2021 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, 2021, 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.

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, 2021, 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.

10. Dental services.

Dental services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.100.

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

Effective for dates of service on and after January 1, 2016, the maximum reimbursement for dental services rendered by a provider whose office address is in a rural Ohio county is the lesser of the billed charges or 105 percent of the Medicaid maximum for the particular service.

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

The agency's dental services fee schedule was set as of January 1, 2021 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 plan, state-developed fee schedules and rates are the same for both governmental and private providers.

Selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

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, 2021 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, 2021 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, 2021 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.

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, 2021, 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 January 1, 2021, 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