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State/Territory Name: Ohio

State Plan Amendment (SPA) #: 23-0042

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Medicaid and CHIP Operations Group

February 23, 2024

Maureen M. Corcoran, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

Re: Ohio State Plan Amendment (SPA) Transmittal Number 23-0042

Dear Director Corcoran:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number 23-0042. This SPA updates provisions for dental services, increases payments for a range of Medicaid covered services, and incorporates updates to Healthcare Common Procedure Code System (HCPCS) codes effective January 1, 2024.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Ohio Medicaid SPA 23-0042 was approved on February 22, 2024, with an effective date of January 1, 2024.

If you have any questions, please contact Christine Davidson at (312) 886-3642 or via email at christine.davidson@cms.hhs.gov.

Sincerely,

[redacted]

James G. Scott, Director
Division of Program Operations

Enclosure

cc: Rebecca Jackson, ODM
Gregory Niehoff, ODM
Tamara Edwards, ODM
Deborah Benson, CMCS
Myla Adams, CMCS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 23-042

2. STATE: OH

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT: (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2024

5. FEDERAL STATUTE/REGULATION CITATION
Sections 1905(a)(3),(4),(5),(6),(7),(10),(11),(12),(13),(17),(19),(23),(2

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2024 $ 30,212,000
b. FFY 2025 $ 40,174,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See addendum

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See addendum

9. SUBJECT OF AMENDMENT

Coverage and Limitations and Payment for Services: Non-Institutional, Behavioral Health, Targeted Case Management, and Care

10. 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

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME: MAUREEN M. CORCORAN

13. TITLE: STATE MEDICAID DIRECTOR

14. DATE SUBMITTED: December 7, 2023

15. RETURN TO

Greg Niehoff
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED: December 7, 2023

17. DATE APPROVED: **02/22/2023**

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2024

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL: James G. Scott

21. TITLE OF APPROVING OFFICIAL: Director, Division of Program Operations

22. REMARKS

CMS-179 Addendum for TN 23-042
"Coverage and Limitations and Payment for Services: Non-Institutional, Behavioral Health, Targeted Case Management, and Care Coordination Payment Schedule Updates"

Fed statutes/regs: Sections 1905(a)(3),(4),(5),(6),(7),(10),(11),(12),(13),(17),(19),(23),(24), and (28) of the Social Security Act; 42 CFR 440.30, .50, .90, .100, .110, .120, .130, .165, and .166

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Attachment 4.19-B, Item 4-b, Page 1	Attachment 4.19-B, Item 4-b, Page 1 (TN 22-031)
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Attachment 4.19-B, Item 6-d-(1), Page 1 of 1	Attachment 4.19-B, Item 6-d-(1), Page 1 of 1 (TN 23-005)
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10. Dental services.

The dental benefit for beneficiaries includes services in the following categories: Diagnostic, Preventive, Restorative, Endodontics, Periodontics, Implant Services, Oral and Maxillofacial Surgery, Orthodontics, and Adjunctive General Services.

Limitations:

- Comprehensive oral evaluation 1 per 5 years per provider per patient;
- Periodic oral evaluation - Patient younger than 21, pregnant, or in other optional eligibility groups as established by Ohio law: 1 per 180 days. Patient 21 or older: 1 per 365 days;
- Comprehensive periodontal evaluation, new or established patient - 1 per 365 days;
- Intraoral images, complete series (including bitewings) - 1 per 5 years per provider;
- Bitewing image, one - 1 per 6 months;
- Bitewing images, two - 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Bitewing images, three - 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Bitewing images, complete series (at least four images) - 1 per 6 months (recommended interval from 6 to 24 months for a complete series);
- Panoramic image - Patient 6 or older: 1 per 5 years;
- Cone beam CT view both jaws with or without cranium: 1 per 5 years per provider;
- Dental prophylaxis, adult - Patient younger than 21: 1 per 180 days. Patient 21 or older: 1 per 365 days;
- Dental prophylaxis, child - 1 per 180 days;
- Topical fluoride treatment - 1 per 180 days;
- Tobacco counseling for control and prevention of oral disease – 2 per 365 days;
- Interim caries arresting medicament application – Application is limited to 3 times per tooth per year;
- Pin retention, in addition to amalgam restoration and resin-based composite restoration – 3 pins per tooth;
- Periodontal maintenance - 1 per 365 days;
- Relining, all dentures - 1 per 3 years;
- Extraction, erupted tooth or exposed root – 1 per tooth
- Extraction, erupted tooth removal of bone and/or sectioning – 1 per tooth
- Alveoplasty, in conjunction with extraction, - 1 per quadrant;
- Alveoplasty, not in conjunction with extraction, - 1 per quadrant.
- Protective restoration, primary or permanent dentition - 1 per 180 days per tooth;
- Interim therapeutic restoration, primary dentition - 1 per 180 days per tooth;
- Counseling for the control and prevention of adverse oral, and systemic health effects associated with high-risk substance use – 2 per 365 days;
- Re-cementing/re-bonding crown – 1 per 5 years per tooth;
- Core buildup, including any pins when required

Prior authorization is required for the following dental services: intraoral tomosynthesis, image capture only procedures, 3D dental scans, panoramic images (younger than 6), porcelain crowns, post and core, gingivectomy, gingivoplasty, scaling and root planing, dentures, removal of non-resorbable barrier, removal of implant body, guided tissue regeneration, replacement of restorative

material, marsupialization of odon cyst, surgical extractions, comprehensive orthodonture, temporomandibular joint therapy, maxillofacial prosthetics, inhalation of nitrous oxide/analgesia (for ages 21 and over), sleep apnea appliances, behavior management, dental case management special needs and unspecified procedures not adequately described by a procedure code.

Dental services may be provided in an amount beyond established frequency limits with prior authorization, upon a demonstration of medical necessity.

Individuals up to age 21 can access dental benefits without limitation when medically necessary.

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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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, 2024, 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.

4-b. Early and Periodic Screening Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Payment is made according to the provider type rendering service as described elsewhere in this attachment except for Intensive Home-Based Treatment (IHBT) and Mobile Response Stabilization Service (MRSS).

Payment for IHBT

Payment for IHBT, as described in Attachment 3.1-A Item 4-b, shall be the lesser of the billed charges or Medicaid maximum for the services.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

The agency's fee schedule for IHBT was set as of January 1, 2024 and is effective for services provided on or after that date. All rates and unit of service definitions are published on the agency's website at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

Payment for MRSS

Payment for MRSS, as described in Attachment 3.1-A Item 4-b, shall be the lesser of the billed charges or Medicaid maximum for the services.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

The agency's fee schedule for MRSS was set as of January 1, 2024 and is effective for services provided on or after that date. All rates and unit of service definitions are published on the agency's website at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

Except as otherwise noted in the Plan, the State-developed fee schedule is the same for both governmental and private providers.

4. d. Tobacco cessation counseling services for pregnant women.

All rates are published on the agency's website at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's tobacco cessation counseling services fee schedule was set as of January 1, 2024, 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.

Payment for pharmacotherapy for cessation of tobacco use by pregnant women is described in Attachment 4.19-B, Item 12-a of this State plan.

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, 2024, 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, 2024, and are listed on the agency's Anesthesia fee schedule at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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

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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

The agency adopts new anesthesia codes in accordance with the anesthesia base unit values assigned by the American Society of Anesthesiologists in its "Relative Value Guide". The anesthesia base unit value files are located at https://www.cms.gov/medicare/payment/fee-schedules/physician/anesthesiologists-center.

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

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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates. These rates were set as of January 1, 2024, 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, 2024, 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.

Rates for physicians' services are listed on the agency's MSRIAP and community behavioral health fee schedules published on the agency's website at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's physicians' rates found on the community behavioral health fee schedule were set as of January 1, 2024, and are effective for services provided on or after that date.

Each new Physicians' code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, 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.

c. Chiropractors' services.

Payment for covered services described in Attachment 3.1-A, Item 6-c 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) payment schedule.

All Medicaid payment schedules and maximum payment amounts are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP payment schedule was set as of January 1, 2024, 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.

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.

(1) Mechanotherapists' 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.

All rates are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's mechanotherapists' services fee schedule was set as of January 1, 2024, 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.

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 Licensed practitioners' services, continued.

(2) Non-Physician Licensed Behavioral Health Practitioners

Payment for services delivered by Non-Physician Licensed Behavioral Health Practitioners (NP-LBHP), as outlined in Attachment 3.1-A, is the lesser of the billed charge or the Medicaid fee schedule established by the State of Ohio.

The agency's fee schedule rate was set as of January 1, 2024 and is effective for services provided on or after that date. The reimbursement rates for non-physician licensed behavioral health practitioner services rendered in a community behavioral health center certified by ODM or its designee shall be a flat fee for each covered service as specified on the established Medicaid fee schedule.

All rates are published on the Ohio Department of Medicaid (ODM) Fee Schedule and Rates website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

Except as otherwise noted in the State Plan, the State-developed fee schedule is the same for both governmental and private individual providers.

If a Medicare fee exists for a defined covered procedure code, the State will pay the following licensed practitioners at 100% of the Medicaid maximum for the service:

- Psychologists

If a Medicare fee exists for a defined covered procedure code, the State will pay the following independent practitioners at 85% of the Medicaid maximum for the service:

- Board-licensed school psychologists;
- Licensed professional clinical counselors (LPCCs);
- Licensed independent social workers (LISWs);
- Licensed independent marriage and family therapists (LIMFTs); and
- Licensed independent chemical dependency counselors (LICDCs).

If a Medicare fee exists for a defined covered procedure code, the State will pay the following practitioners requiring supervision at 85% of the Medicaid maximum for the service:

- Licensed professional counselors;
- Licensed chemical dependency counselors III;
- Licensed chemical dependency counselors II;
- Licensed social workers;
- Licensed marriage and family therapists;

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

(4) Pharmacist services.

For non-enrolled licensed pharmacists employed by a pharmacy that contracts with Ohio Medicaid, payment for administration of an immunization or other drug by injection is the lesser of the provider's charge or the Medicaid maximum payment specified on the agency's provider-administered injectable pharmaceutical fee schedule. This amount is effective for services provided on or after January 25, 2023.

For licensed pharmacists enrolled with the Department, payment for administration of a covered immunization, injection of medication, or provider-administered pharmaceutical, is the lesser of the billed charge or the Medicaid maximum specified in the agency's provider-administered injectable pharmaceutical fee schedule. Payment for managing medication therapy is the lesser of the billed charge or 85% of the Medicaid maximum specified in the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule. These amounts are effective for services provided on or after January 1, 2024.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024 and is effective for services provided on or after that date. The agency's community behavioral health fee schedule was set as of January 1, 2024 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. 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) Advanced practice nurses' (APNs') services, other than described elsewhere in this plan.

For dates of service on or after January 1, 2024, payment for anesthesia services furnished by a certified registered nurse anesthetist (CRNA) 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. Effective for dates of service on or after January 1, 2024, the conversion factor and multiplier are listed on the agency's Anesthesia fee schedule at https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency adopts new anesthesia codes in accordance with the anesthesia base unit values assigned by the American Society of Anesthesiologists in its "Relative Value Guide". The anesthesia base unit value files are located at https://www.cms.gov/medicare/payment/fee-schedules/physician/anesthesiologists-center.

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

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

Unless otherwise specified, the maximum payment amount for a service furnished by a clinical nurse specialist (CNS) or certified nurse practitioner (CNP) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum for physicians' services as 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 CNS or CNP will be made to the hospital.

Payment rates for evaluation and management services rendered by nurse practitioners and clinical nurse specialists 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

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

after August 1, 2019, the payment for behavioral health evaluation and management services rendered by nurse practitioners and clinical nurse specialists practicing in a community behavioral health agency is 100% of the rates Ohio pays to physicians practicing in a community behavioral health agency, as described in Item 5-a of this Attachment.

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 for surgical procedures as listed on 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 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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, and is effective for services provided on or after that date. The agency's community behavioral health fee schedule was set as of January 1, 2024, 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.

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 (continued)

(7) Dietitians' services

Payment for dietitians' services is the lesser of the submitted charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

All Medicaid maximum payment amounts are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, and is effective for services provided on or after that date.

Except as otherwise noted in the plan, state-developed fee schedules and payment amounts 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, 2024, and are listed on the agency's Anesthesia fee schedule, which is published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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

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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency adopts new anesthesia codes in accordance with the anesthesia base unit values assigned by the American Society of Anesthesiologists in its "Relative Value Guide". The anesthesia base unit value files are located at https://www.cms.gov/medicare/payment/fee-schedules/physician/anesthesiologists-center.

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.

The agency's MSRIAP fee schedule was set as of January 1, 2024, and is effective for services provided on or after that date.

All Medicaid payment schedules and rates are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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.

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

(9) Acupuncturists' services

Payment for acupuncturists' services is the lesser of the submitted charge or the Medicaid maximum payment amount listed on Ohio Medicaid's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) payment schedule. The payment amounts were set as of January 1, 2024, and are effective for acupuncturists' services provided on or after that date.

Payment schedules are published on Ohio Medicaid's website at: https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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

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

(10) Licensed registered nurses' (RN) services provided within their scope of practice under State law.

Payment for licensed RN services for home visiting and lactation consulting services is made to the practitioner's employer or designated provider entity and is the lesser of the provider's submitted charge or the Medicaid maximum payment amount listed on Ohio Medicaid's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) payment schedule. The payment amounts were set as of January 1, 2024, and are effective for services provided on or after that date.

Payment schedules are published on Ohio Medicaid's website at: https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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

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 State's DMEPOS payment schedule was set as of January 1, 2024.

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. If no Medicare allowed amount is available, the initial Medicaid maximum payment amount is set at the unweighted average of the current maximum payment amounts for comparable procedures, services, or supplies. Each new DMEPOS code will be located on the State's CPT and HCPCS Level II Procedure Code Changes payment schedule until it is moved to the DMEPOS payment schedule.

Certain home medical items, such as diabetes-related testing and injection supplies, are also listed on the Pharmacy payment schedule. This list, which includes respective Medicaid maximum payment amounts, was set as of April 1, 2017.

For any covered DMEPOS item or service not represented by a new or newly adopted HCPCS procedure code, the payment amount is the lesser of the submitted charge (which is to reflect any discounts or rebates available to the provider at the time of claim submission but need not reflect subsequent discounts or rebates) or the first applicable Medicaid maximum from the following ordered list:

(a) The amount listed in the DMEPOS payment schedule;

(b) For a "by report" DMEPOS item or service, an amount determined on a case-by-case basis (for example, by comparison with a similar service that has an established maximum payment amount or by application of a percentage of charges);

(c) For an item for which payment is determined by prior aurhorization, the relevant amount specified in the following list:
  (i) A supply item, 147% of the provider cost;
  (ii) A wheelchair, wheelchair item, standing frame, gait trainer, or other DMEPOS item that incorporates complex rehabilitation technology, 120% of the base invoice charge;
  (iii) An enteral nutrition product, 185% of the provider cost; or
  (iv) Any other non-supply DMEPOS item or service, an amount determined on a case-by-case basis;

(d) For a bulk item having an overall payment limit per period, the submitted charge;

(e) For the authorized purchase of a DMEPOS item in used condition, 80% of the payment amount for the item in new condition;

(f) For monthly payment for a "rental/purchase" DME item, 10% of the Medicaid maximum specified for purchase; or

(g) For a professional service for which separate payment is made (such as an evaluation), the applicable amount listed in the Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) payment schedule.

All Medicaid payment schedules and rates are published on the State's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

Except as otherwise noted in the plan, state-developed payment 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's dental services fee schedule was set as of January 1, 2024, 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the DMEPOS payment schedule.

All Medicaid payment schedules and rates are published on the State's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's DMEPOS payment schedule was set as of January 1, 2024, and is effective for services provided on or after that date.

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

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

c. Preventive services.

Payment for preventive 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 Department's Preventive services 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 is set at 80% of the Medicare allowed amount.

All rates are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's fee schedule was set as of January 1, 2024, 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.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

1. Mental Health Rehabilitative services.

Payment for mental health rehabilitative services as described in Attachment 3.1-A, Item 13-d-1 shall be the lesser of the billed charge or an amount based on the Medicaid maximum for the service.

A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

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

The agency's mental health rehabilitative services fee schedule rates were set as of January 1, 2024 and are effective for services provided on or after that date.

All rates and unit of service definitions are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200, regarding payments and consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained. Room and board costs are not included in the Medicaid fee schedule. No payments for residents of Institutions for Mental Disease will be made under the Rehabilitation section of the State Plan.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

2. Substance use disorder (SUD) services

Outpatient and Residential Substance Use Disorder services as outlined in Attachment 3.1-A are paid based upon a Medicaid fee schedule established by the single state agency. Payment for rehabilitative services as described in Attachment 3.1-A shall be the lesser of the billed charge or an amount based on the Medicaid maximum for the service. Room and board costs are not included in the Medicaid fee schedule. No payments for residents of Institutions for Mental Disease will be made under the Rehabilitation section of the State Plan.

These reimbursement methodologies will produce rates sufficient to enlist enough providers so that services under the plan are available to beneficiaries at least to the extent that these services are available to the general population, as required by 42 CFR 447.204. These rates comply with the requirements of Section 1902(a)(3) of the Social Security Act and 42 CFR 447.200 regarding payments, and are consistent with economy, efficiency, and quality of care. Provider enrollment and retention will be reviewed periodically to ensure that access to care and adequacy of payments are maintained.

Direct outpatient services by licensed practitioners are paid according to the fee schedule established under the physician, nurse practitioner and non-physician licensed behavioral health practitioner sections of the state plan in Attachment 4.19-B, Items 5, 6 and 23.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

2. Substance use disorder (SUD) services

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

The fee schedule rates for substance use disorder services were set as of January 1, 2024 and are effective for services provided on or after that date. All rates and unit-of-service definitions are published on the single state agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates. A unit of service is defined according to the Healthcare Common Procedure Coding System (HCPCS) approved code set consistent with the National Correct Coding Initiative unless otherwise specified.

13. Other diagnostic, screening, preventive, and rehabilitation services, i.e., other than those provided elsewhere in the plan.

d. Rehabilitative services

3. Acupuncture and evaluation and management services furnished by a chiropractor

Payment for covered services described in Attachment 3.1-A, Item 13-d-3 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) payment schedule.

All Medicaid payment schedules and maximum payment amounts are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP payment schedule was set as of January 1, 2024, 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.

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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024,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.

19. Case management services and Tuberculosis related services.

a. Methods and standards for payment/reimbursement of case management services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A Target Group F: OhioMHAS (in accordance with Section 1905(a)(19) of Section 1915(g) of the Act).

Rate(s):
The unit rate is $ 88.12 per hour and the reimbursement methodology is as follows:

1) If the total number of service units rendered and billed by a provider per date of service to a unique client is less than or equal to 1.5, the Medicaid payment amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units billed or the provider billed amount based upon their established usual and customary charge, whichever is less.

2) If the total number of service units rendered and billed by a provider per date of service to a unique client is greater than 1.5, the Medicaid payment amount is equal to the sum of:

- The unit rate according to the department's service fee schedule multiplied by 1.5; and

- Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units billed minus 1.5.

The number of units that may be billed during a day is equivalent to the total number of minutes of TCM provided during the day from a specific provider for a specific individual divided by sixty plus one additional tenth of a unit if the remaining number of minutes is at least four (4) minutes.

Unit Definition:
A unit of service is equivalent to one hour and may be billed in tenth of an hour (six minute) increments.

A tenth of a unit may be billed if the individual receives more than four (4) minutes of service.

Claims Payment Process:
Providers will submit claims to the Ohio Department of Medicaid (ODM). ODM will process the claims and reimburse the providers at 100%.

19. Case management services and Tuberculosis related services.

a. Methods and standards for payment/reimbursement of targeted case management (TCM) services as defined in, and to the group specified in, Supplement 1 to Attachment 3.1-A of Target Group G: Children with Behavioral Health Needs (in accordance with Section 1905(a)(19) of Section 1915(g) of the Act).

Rate(s):

Payment for TCM as described in Supplement 1 to Attachment 3.1-A, Target Group G: Children with Behavioral Health Needs, pages 1 through 7, has been set to the Medicaid maximum for the services.

The agency's fee schedule for TCM was set as of January 12, 2024 and is effective for services provided on or after that date. All rates are published on the agency's website at: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates

Except as otherwise noted in the Plan, the State-developed fee schedule is 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates 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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, 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

24. Any other medical care or remedial care recognized under State law and specified by the Secretary.

24-a. Transportation.

Payment on a claim is the lesser of the submitted charge or the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the department's fee schedule.

All rates are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's transportation fee schedule was set as of January 1, 2024, 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.

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/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency's MSRIAP fee schedule was set as of January 1, 2024, 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.