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State/Territory Name: Ohio

State Plan Amendment (SPA): OH-25-0001

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
230 South Dearborn
Chicago, Illinois 60604

Financial Management Group

May 15, 2025

Maureen Corcoran
State Medicaid Director
Ohio Department of Medicaid
P.O. BOX 182709 Columbus, Ohio 43218

RE: TN OH-25-0001

Dear Director Corcoran:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Ohio state plan amendment (SPA) to Attachment 4.19-B OH-25-0001, which was submitted to CMS on February 24th, 2025. This plan amendment accounts for new, amended, and/or deleted Healthcare Common Procedure Code System (HCPCS) codes on the Ohio Department of Medicaid (ODM) fee schedules.

We reviewed your SPA submission for compliance with statutory requirements including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of January 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Robert Bromwell at (410)-786-5914 or via email at Robert.Bromwell@cms.hhs.gov.

Sincerely,

[redacted]

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

REVISED

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 25-0001

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
01/01/2025

5. FEDERAL STATUTE/REGULATION CITATION
See addendum

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

Payment for Services: Non-Institutional Payment Schedule Updates for 2025

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
February 24, 2025

15. RETURN TO

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

FOR CMS USE ONLY

16. DATE RECEIVED
February 24, 2025

17. DATE APPROVED
May 15, 2025

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
January 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Todd McMillion

21. TITLE OF APPROVING OFFICIAL
Director Division of Reimbursement Review

22. REMARKS

On May 5th, 2025, Ohio made a pen and ink change to the addendum for blocks 7 and 8. The changes are as follows:

Block 7- Added Attachment 4.19-B, Item 5-a, Page, Attachment 4.19-B Item 7-c Page 2 of 2, and Attachment 4.19-B Item 23 Page 2 of 2.

Block 8- Added Attachment 4.19-B, Item 5-a, Page 1 TN: 23-042, Attachment 4.19-B Item 7-c Page 2 of 2 TN: 23-042 and Attachment 4.19-B Item 23 Page 2 of 2 TN: 20-003.

Instructions on Back

REVISED

CMS-179 Addendum for TN 25-001
"Payment for Services: Non-Institutional Payment Schedule Updates for 2025"

Fed statutes/regs: Sections 1905(a)(3),(5),(6),(7),(9),(10),(12),(13),(17),(21), and (28) of the Social Security Act; 42 CFR 440.30, .50, .60, .70, .90, .100, .120, .130, .165, and .166

Block 7	Block 8
Attachment 4.19-B, Item 3, Page 1 of 2	Attachment 4.19-B, Item 3, Page 1 of 2 (TN 23-042)
Attachment 4.19-B, Item 5-a, Page 1	Attachment 4.19-B, Item 5-a, Page 1 (TN 23-042)
Attachment 4.19-B, Item 5-a, Page 2	Attachment 4.19-B, Item 5-a, Page 2 (TN 23-042)
Attachment 4.19-B, Item 6-a, Page 1 of 2	Attachment 4.19-B, Item 6-a, Page 1 of 2 (TN 23-042)
Attachment 4.19-B, Item 6-d-(2), Page 1 of 2	Attachment 4.19-B, Item 6-d-(2), Page 1 of 2 (TN 23-042)
Attachment 4.19-B, Item 6-d-(4), Page 1 of 1	Attachment 4.19-B, Item 6-d-(4), Page 1 of 1 (TN 23-042)
Attachment 4.19-B, Item 6-d-(5), Page 1 of 1	Attachment 4.19-B, Item 6-d-(5), Page 1 of 1 (TN 23-042)
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 23-042)
Attachment 4.19-B, Item 6-d-(8), Page 1 of 1	Attachment 4.19-B, Item 6-d-(8), Page 1 of 1 (TN 23-042)
Attachment 4.19-B, Item 7-c, Page 1 of 2	Attachment 4.19-B, Item 7-c, Page 1 of 2 (TN 24-003)
Attachment 4.19-B, Item 7-c, Page 2 of 2	Attachment 4.19-B, Item 7-c, Page 2 of 2 (TN 23-042)
Attachment 4.19-B, Item 9-a, Page 2 of 2	Attachment 4.19-B, Item 9-a, Page 2 of 2 (TN 23-034)
Attachment 4.19-B, Item 10, Page 1 of 2	Attachment 4.19-B, Item 10, Page 1 of 2 (TN 23-042)
Attachment 4.19-B, Item 12-c, Page 1 of 1	Attachment 4.19-B, Item 12-c, Page 1 of 1 (TN 23-042)
Attachment 4.19-B, Item 13-c, Page 1 of 1	Attachment 4.19-B, Item 13-c, Page 1 of 1 (TN 24-017)
Attachment 4.19-B, Item 13-d-(1), Page 1 of 1	Attachment 4.19-B, Item 13-d-(1), Page 1 of 1 (TN 24-009)
Attachment 4.19-B, Item 17, Page 1 of 1	Attachment 4.19-B, Item 17, Page 1 of 1 (TN 23-042)
Attachment 4.19-B, Item 23, Page 1 of 2	Attachment 4.19-B, Item 23, Page 1 of 2 (TN 23-042)
Attachment 4.19-B, Item 23, Page 2 of 2	Attachment 4.19-B, Item 23, Page 2 of 2 (TN 20-003)
Attachment 4.19-B, Item 28, Page 1 of 1	Attachment 4.19-B, Item 28, Page 1 of 1 (TN 23-042)

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, 2025, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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.

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 a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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, 2025, 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, 2025, 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, 2025, 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, 2025, 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 a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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, 2025 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, 2025.

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, 2025 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, 2025 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 a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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.

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, 2025, 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, 2025, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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

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

d. Other practitioners' services

(8) Anesthesiologist Assistants' services.

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

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

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. The conversion factor and multiplier are effective for dates of service on or after January 1, 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, 2025, 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 a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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 Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule was set as of January 1, 2025.

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.

Eligible pharmacy providers may dispense and receive payment for certain medical supply items without enrolling in Medicaid as DMEPOS providers. For these items dispensed beginning 02/16/2024, payment is the sum of two figures:

(1) The lesser of submitted cost or the National Average Drug Acquisition Cost (NADAC) and
(2) The appropriate professional dispensing fee (PDF) specified in Attachment 4.19-B, Item 12-a, for compounded drugs other than non-sterile compounds and total parenteral nutrition compounds.

If no NADAC has been published for an item, payment is the sum of two figures:

(1) The least of the submitted cost, the Ohio Average Acquisition Cost (OAAC), or the wholesale acquisition cost (WAC) and
(2) The appropriate professional dispensing fee (PDF) specified in Attachment 4.19-B, Item 12-a, for compounded drugs other than non-sterile compounds and total parenteral nutrition compounds.

For purposes of determining the PDF, newly enrolled pharmacies located within Ohio are deemed to have filled fewer than 50,000 prescriptions per year, and newly enrolled pharmacies located outside Ohio are deemed to have filled 100,000 or more prescriptions per year.

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) An amount for a "by report" DMEPOS item or service. By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a;

(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.

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

ii. All Other AHCCs

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

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

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new AHCC services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes 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, 2025, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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/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, 2025, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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.

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, 2025, 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 agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

For a 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.

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, 2025, 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, 2025 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.

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, 2025, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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/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, 2025, and is effective for services provided on or after that date.

By-report services require a manual review by the designated staff of the single state agency. The reimbursement methods for by-report services include using the rate of a

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

similar service, product, or procedure, gap filling, applying a percentage of the provider's billed charges, and, when applicable, the Ohio Department of Medicaid (ODM) will utilize the National Drug Code to develop a rate based on the methodologies outlined in Attachment 4.19-B, Item 12-a.

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, 2025, 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.