Methods and Standards for Establishing Payment Rates

2-a. Outpatient Hospital Services

Outpatient hospital services shall be based upon fee-schedule payments and prospectively determined rates for procedures performed in the outpatient hospital setting. Fee-schedule payments based upon both the Healthcare Common Procedure Coding System (HCPCS) and Physician's Current Procedural Terminology (CPT) codes are established for most outpatient hospital procedures for dates of service on or after October 1, 2009. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. All rates are published on the agency's website at jfs.ohio.gov/OHP/provider.stm.

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

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

Methods and Standards for Establishing Payment Rates

2-a. Outpatient Hospital Services (Continued)

The agency's fee schedule increased as of October 1, 2009 for ambulatory surgery groups and emergency room services and is effective for services provided on or after that date. The five percent rate increase was later expanded across all outpatient services performed for dates of service on or after January 1, 2010. Rates and fees can be found by accessing the agency's website at jfs.ohio.gov/OHP/provider.stm. The rates available at this website include all annual or periodic adjustments to the fee schedule.

2-b. Services billed by a RHC are reimbursed through an all-inclusive rate, determined by Medicare, cost related reimbursement system. All RHC services are to be billed on the all inclusive rate basis and include laboratory services furnished by the clinic.

For services rendered on or after January 1, 2001, RHCs shall be paid in accordance with the methodology described in Section III of Attachment 4.19-B, Item 2-C.

STATE OF OHIO

ATTACHMENT 3.1-A
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2-a. Outpatient hospital services.

Outpatient services are those professional services provided to a patient at a hospital facility which is certified by the Ohio Department of Health ~~for Medicare participation~~ and meets Medicare conditions of participation. Outpatient services include services provided to a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission.

Except for hospitals that are approved by Medicare to charge patients a single rate that covers hospital and physicians' services, Medicaid does not cover, as an outpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

~~The number of outpatient visit includes, but is not limited to the following maximums:~~

- ~~The maximum number of outpatient visits covered without prior authorization is four per month per recipient per provider. Additional visits, up to a maximum of ten visits, may be covered for physician services, EPSDT services, family planning, and emergency dental services, subject to prior authorization. A visit includes all services provided for an outpatient on any one date of service.~~

- ~~The maximum number of outpatient visits, when the professional service is rendered by a practitioner whose scope of treatment is less than a physician's (i.e., chiropractor, speech therapist, audiologist, psychologist, etc.), is generally four per month.~~

- ~~Physical therapist services are limited by a specific number of treatments.~~

Certain specific items and services are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; treatment of obesity; cosmetic surgery; acupuncture; services of an experimental nature; dental procedures which can be performed in the dentist's office or other non-hospital setting; and patient convenience items.