8. Private duty nursing services.

Private Duty Nursing (PDN) is a service provided in the home and in the community for beneficiaries needing continuous periods of nursing to stay in the home rather than an institutional setting. The service is provided in the beneficiary's covered place of residence or in the community due to the beneficiary's medical condition or functional limitation. The level of care is determined by the treating physician signed orders and incorporated into the plan of care. The program allows beneficiaries to access PDN through three different avenues.

The first avenue is a post-hospital service of up to 60 days duration and 56 hours per week for all Medicaid beneficiaries who have a medical necessity for such services as determined by the treating physician upon discharge from a three day or more covered inpatient stay when all of the following conditions apply:

- The 60 days begin once the beneficiary is discharged from the hospital to the beneficiary's place of residence, from the last inpatient stay whether or not it was in an inpatient hospital or inpatient rehabilitation unit of a hospital; and
- The 60 days will begin once the beneficiary is discharged from a hospital to a nursing facility although PDN is not available while residing in a nursing facility; and
- The beneficiary has a skilled level of care (SLOC) as evidenced by a medical condition that temporarily reflects SLOC; and
- PDN must not be for the provision of maintenance care.

The second avenue is for beneficiaries up to age 21 who have a PDN authorization by the Medicaid agency or the agency's designee for the PDN services that are medically necessary for the health and welfare of the beneficiary.

The third avenue is for beneficiaries age 21 or older who have a PDN authorization by the Medicaid agency or the agency's designee for the PDN services that are medically necessary for the health and welfare of the adult beneficiary when all of the following conditions apply:

- The beneficiary requires continuous nursing including the provision of on-going maintenance care; and
- The beneficiary has a comparable level of care (LOC) as evidenced by either enrollment in an HCBS waiver, or a comparable institutional level of care evaluated initially and annually by Medicaid agency or its designee; and
- The beneficiary must have a PDN authorization approved by the Medicaid agency or its designee to establish medical necessity and comparable LOC; and

The service is provided to all Medicaid beneficiaries who meet a skilled level of care for post-hospital service and an institutional level of care for adults and children who do not

have a hospital stay and need to receive continuous nursing care from an independent registered nurse; independent licensed practical nurse; Medicare Certified Home Health Agency; or a home health agency accredited by a national accreditation organization approved by the Centers for Medicare and Medicaid Services (CMS), which may include, but is not limited to, one of the following: the Accreditation Commission for Health Care (ACHC), the Community Health Accreditation Program (CHAP), and the Joint Commission (TJC).

PDN visits are typically continuous nursing visits that are both medically necessary and more than four hours, but less than or equal to 12 hours in length. There must be a lapse of two or more hours between the provision of home health nursing or PDN. The only exceptions to these requirements are as follows:

- An unusual, occasional circumstance requires a medically necessary visit of up to and including 16 hours; or
- Less than a two hour lapse between visits has occurred and the length of the PDN service requires an agency to provide a change in staff; or
- Less than a two hour lapse between visits has occurred and the PDN service is provided by more than one non-agency provider; or
- The Medicaid agency or its designee has authorized PDN visits that are four hours or less in length.

Individuals up to age 21 can access PDN services without limitation when medically necessary.

9. Clinic services, continued.

b. Outpatient health facilities (OHFs).

OHF services are provided in accordance with 42 CFR 440.90. OHFs are freestanding.

According to Ohio law, an outpatient health facility:

- Is a facility that provides comprehensive primary health services by or under the direction of a physician at least five days per week on a forty-hour per week basis to outpatients;
- Is operated by the board of health of a city, general health district, another public agency, nonprofit private agency, or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of one or more such outpatient health facilities; and
- Receives at least seventy-five per cent of its operating funds from public sources, except that it does not include an outpatient hospital facility or a federally qualified health center as defined in Sec. 1905(l)(2)(B) of the "Social Security Act," 103 Stat. 2264 (1989), 42 U.S.C.A. 1396d(l)(2)(B).

For a facility to qualify as an OHF, the facility must:

- Have health and medical care policies developed with the advice of, and subject to review by, an advisory committee of professional personnel, including one or more physicians, one or more dentists if dental care is provided, and one or more registered nurses;
- Have a medical director, a dental director if dental care is provided, and a nursing director responsible for the execution of such policies;
- Have physicians, dentists, nursing, and ancillary staff appropriate to the scope of services provided;
- Require that the care of every patient be under the supervision of a physician, provides for medical care in case of emergency, has in effect a written agreement with one or more hospitals and one or more other outpatient facilities, and has an established system for the referral of patients to other resources and a utilization review plan and program;
- Maintain clinical records on all patients;
- Provide nursing services and other therapeutic services in compliance with applicable laws and rules, and have a registered nurse on duty at all times when the facility is in operation;
- Follow approved methods and procedures for the dispensing and administration of drugs and biologicals;

9. Clinic services, continued.

b. Outpatient health facilities (OHFs), continued.

- Maintain the accounting and record-keeping system required under federal laws and regulations for the determination of reasonable and allowable costs.

"Comprehensive primary health services" means preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that include all of the following:

- Services of physicians, physician assistants, and certified nurse practitioners (limitations are described in Attachment 3.1-A, Items 5, 17, and 23);
- Diagnostic laboratory and radiological services (limitations are described in Attachment 3.1-A, Item 3);
- Preventive health services, such as children's eye and ear examinations, perinatal services, well child services, and family planning services (limitations are described in Attachment 3.1-A, Items 4-b, 4-c, 5, 6, 10, 11, 17, 20, 23);
- Arrangements for emergency medical services;
- Transportation services (limitations are described in Attachment 3.1-A, Item 24-a)

9. Clinic services, continued.

c. Ambulatory surgery centers (ASCs).

An ambulatory surgery center (ASC) is any distinct, freestanding entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization. All ASCs that meet the standards provided in 42 C.F.R. 416.20 to 416.49 (effective dates of these regulations are set forth below) and are certified for Medicare participation by the Ohio Department of Health are eligible to become Medicaid providers upon execution of the "Ohio Medicaid Provider Agreement."

Covered "ASC facility services" are items and services furnished by an ASC in connection with a covered ASC surgical services. ASC facility services include but are not limited to:

Nursing, technician, and related services;

Use of the ASC facility;

Drugs, biologicals (e.g., blood), surgical dressings, splints, casts and appliances, and equipment directly related to the provision of the surgical procedure;

Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

Administrative, recordkeeping, and housekeeping items and services;

Materials for anesthesia;

Intraocular lenses; and

Supervision of the services of an anesthetist by the operating surgeon.

10. Dental services.

Covered services are identified at the following website: jfs.ohio.gov/OHP/provider.stm.

Effective for dates of service on and after July 1, 2008, through December 31, 2009, the dental benefit for beneficiaries 21 years of age and older includes two annual routine exams and cleanings; x-rays; oral surgery services; simple and complex extractions; fillings; denture services; crowns, posts, and related services; general anesthesia; periodontics; orthodontics; and endodontics, including root canal-procedures.

Effective for dates of service on and after January 1, 2010, the dental benefit for beneficiaries 21 years of age and older includes one annual routine exam and cleaning; x-rays; oral surgery services; simple and complex extractions; fillings; denture services; crowns, posts, and related services; general anesthesia; periodontics; orthodontics; and endodontics, including root canal procedures.

Several dental services provided require prior authorization. Dental services may be provided in an amount beyond established limits with prior authorization.

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

3. Other laboratory and x-ray 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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

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

Physician services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.50. Physician services include services delivered by a physician, the physician's employee working within his or her scope of licensure, or the physician's contracted staff working within their scope of licensure.

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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

The following payment scenarios also exist:

The maximum reimbursement for surgical procedures performed under the in-office surgery program is the lesser of the billed charge or the Medicaid maximum for the particular service, plus a $15, $25, or $50 additional payment. The criteria that trigger the payment are place of service and procedure code.

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

The maximum reimbursement for the services listed below, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum:

99201* OFFICE/OP VISIT

99202* OFFICE/OP VISIT

99203* OFFICE/OP VISIT

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

99204* OFFICE/OP VISIT

99205* OFFICE/OP VISIT

99211* OFFICE/OP VISIT

99212* OFFICE/OP VISIT

99213* OFFICE/OP VISIT

99214* OFFICE/OP VISIT

99215* OFFICE/OP VISIT

99241 OUTPATIENT CONSULT

99242 OUTPATIENT CONSULT

99243 OUTPATIENT CONSULT

99244 OUTPATIENT CONSULT

99245 OUTPATIENT CONSULT

90801 PSYCHIATRIC DIAGNOSTIC INTERVIEW

90802 INTERACTIVE PSYCHIATRIC DIAGNOSTIC INTERVIEW 80%

90804 INDIVIDUAL PSYCHOTHERAPY 20 TO 30 MINUTES

90805 WITH MEDICAL EVALUATION AND MANAGEMENT

90806 INDIVIDUAL PSYCHOTHERAPY 45 TO 50 MINUTES

90807 WITH MEDICAL EVALUATION AND MANAGEMENT

90808 INDIVIDUAL PSYCHOTHERAPY 75 TO 80 MINUTES

90809 WITH MEDICAL EVALUATION AND MANAGEMENT

90810 INTERACTIVE PSYCHOTHERAPY 20 TO 30 MINUTES

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

90811 WITH MEDICAL EVALUATION AND MANAGEMENT

90812 INTERACTIVE PSYCHOTHERAPY 45 TO 50 MINUTES

90813 WITH MEDICAL EVALUATION AND MANAGEMENT

90814 INTERACTIVE PSYCHOTHERAPY 75 TO 80 MINUTES

90815 WITH MEDICAL EVALUATION AND MANAGEMENT

90845 PSYCHOANALYSIS

90846 FAMILY PSYCHOTHERAPY (W/O PATIENT PRESENT)

90847 FAMILY PSYCHOTHERAPY (PATIENT PRESENT)

90849 MULTIPLE-FAMILY GROUP PSYCHOTHERAPY

90853 GROUP PSYCHOTHERAPY

90857 INTERACTIVE GROUP PSYCHOTHERAPY

90862 PHARMACOLOGIC MANAGEMENT

The maximum reimbursement for services delivered by a physician assistant employed by or under contract with a physician is the lesser of the provider's billed charge or eighty-five per cent of the Medicaid maximum, except for services delivered by a physician assistant when a physician also provided distinct and identifiable services during the visit or encounter and services that are usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations), which are reimbursed at the lesser of the billed charge or an amount based on the Medicaid maximum for the particular service.

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

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	$49.85
new patient, expanded problem focused visit	$49.85
established patient, evaluation & management by non-physician	$19.73
established patient, evaluation & management by physician	$49.85

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

Psycho-therapy provided by a non-physician employed by or under contract with a physician will be reimbursed as follows:

> Services provided by a clinical psychologist will be reinbursed at eighty-five percent of the Medicaid maximum for an examination personally performed by a licensed psychologist.

Individual and group therapy services provided by other non-physicians will be reimbursed at the lesser of the provider's billed charge or fifty percent of the Medicaid maximum for the therapy code.

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

Reimbursement for multiple surgical procedures performed on the same patient by the same provider is the lesser of billed charges or one hundred per cent of the medicaid maximum allowed for the primary procedure (the primary procedure is the surgical procedure that has the highest medicaid maximum listed on the fee schedule); fifty per cent of the medicaid maximum allowed for the secondary procedure; or twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Reimbursement for bilateral procedures, when performed bilaterally, on the same patient by the same provider, is the lesser of billed charges or one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally.

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

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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 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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

The following payment scenarios also exist:

The maximum reimbursement for surgical procedures performed under the in-office surgery program is the lesser of the billed charge or the Medicaid maximum for the particular service, plus a $15, $25, or $50 additional payment. The criteria that trigger the payment are place of service and procedure code.

The maximum reimbursement for physician groups that contract with a hospital to provide physician hospital clinic services in the physician group practice setting and who provide 40 percent of the Medicaid physician visits in the county of location and 10 percent of the visits in contiguous counties, is the lesser of billed charges or the Medicaid maximum for a particular service according to the Department's fee schedule, plus 40 percent of that fee.

The maximum reimbursement for services delivered by a physician assistant employed by or under contract with a physician is the lesser of the provider's billed charge or eighty-five per cent of the Medicaid maximum, except for services delivered by a physician assistant when a physician also provided distinct and identifiable services during the visit or encounter and services that are usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations), which are reimbursed at the lesser of the billed charge or an amount based on the Medicaid maximum for the particular service.

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.

a. Podiatrists' services, continued.

The maximum reimbursement for the services listed below, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum:

99201* OFFICE/OP VISIT

99202* OFFICE/OP VISIT

99203* OFFICE/OP VISIT

99211* OFFICE/OP VISIT

99212* OFFICE/OP VISIT

99213* OFFICE/OP VISIT

99241 OUTPATIENT CONSULT

99242 OUTPATIENT CONSULT

99243 OUTPATIENT CONSULT

Reimbursement for multiple surgical procedures performed on the same patient by the same provider is the lesser of billed charges or one hundred per cent of the medicaid maximum allowed for the primary procedure (the primary procedure is the surgical procedure that has the highest medicaid maximum listed on the fee schedule); fifty per cent of the medicaid maximum allowed for the secondary procedure; or twenty-five per cent of the medicaid maximum allowed for all subsequent (tertiary, etc.) procedures.

Reimbursement for bilateral procedures, when performed bilaterally, on the same patient by the same provider, is the lesser of billed charges or one hundred fifty per cent of the medicaid maximum allowed for the same procedures performed unilaterally.

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.

b. Optometrists' 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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

Effective for dates of service on and after January 1, 2006, selected optometrists' services are subject to a co-payment as specified in Attachment 4.18-A of the State Plan.

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 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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

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. The agency's fee schedule was set as of January 1, 2010, 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, continued.

(2) Psychologists' services.

Payment for services delivered by a psychologist is the lesser of the billed charge or eighty-five percent of the Medicaid maximum for the service.

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. The agency's fee schedule was set as of January 1, 2010, 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.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

7. Home health services, continued.

b. Home health aide services provided by a home health agency.

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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

7. Home health services, continued.

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

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the service or item. The Medicaid maximum is the amount listed on the Department's fee schedule. Where no Medicaid maximum is specified, the provider must submit either the list price or the invoice price. The Medicaid agency will pay 72 per cent of the list price or 147 per cent of the invoice price.

Payment for enteral nutrition products is the lesser of the billed charge or an amount based on the Medicaid maximum for the product. The Medicaid maximum is the amount listed on the Department's fee schedule. Where no Medicaid maximum is specified, payment is the average wholesale price (AWP) minus 23 per cent.

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. The agency's fee schedule was set as of January 1, 2010, 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.

7. Home health services, continued.

d. Physical therapy, occupational therapy or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

8. Private duty nursing 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.

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. The agency's fee schedule was set as of January 1, 2010, 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.

9. Clinic services.

a. Free-standing ambulatory health care clinics (AHCCs).

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. Payment scenarios applicable to specific provider types (e.g., physicians) apply.

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. The agency's fee schedule was set as of January 1, 2010, 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.

b. Outpatient health facilities (OHFs).

1. Payment for authorized services in an OHF is calculated on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Rates are calculated on a clinic's cost of allowable items and services, and thus may vary from clinic to clinic, subject to the tests of reasonableness described in paragraphs (4) to (8). While payments under a prospective system are not subject to audit and retroactive settlement or adjustment, the historical costs upon which prospective rates are based are audited. Adjustments to the paid rate will be made if costs are found to be overstated or misrepresented in a manner which resulted in an overstatement of the previously determined prospective rate (see paragraph (11)). Retroactive adjustments may also occur to reconcile payments made to new facilities on the basis of an interim rate as provided in paragraph (3) or in accordance with paragraph (1)(b).

a. Rates will be established for each of the following types of services rendered by a participating OHF:

(i) medical services
(ii) laboratory services
(iii) radiology services
(iv) dental services
(v) speech therapy and audiology services
(vi) mental health services
(vii) physical therapy services
(viii) transportation services
(ix) vision care services

9. Clinic services, continued.

12. Based on the filing of calendar quarterly utilization evaluation reports, adjustments will be made in the rates. Quarterly reports for utilization evaluation must be filed within 30 days of calendar quarter end. This filing will result in a utilization adjustment of rates, if variances in utilization would result in a five percent or greater increase or decrease in the prospective rate, with 60 days of due date. The approved rates will be adjusted to reflect the four most current calendar quarters of reported utilization. During the initial four quarters of participation of an OHF, the utilization factors will be adjusted by substituting the reporting quarterly utilization for the average quarterly utilization factors report. Failure to file the quarterly utilization evaluation report (see paragraph (6) will result in suspension of payment for eligible services rendered until such time as the quarterly report is received, evaluated, and adjusted by the Division of Fiscal Affairs. The OHF will then be notified of any adjustment and any new rates applicable. If the quarterly utilization evaluation report is not received within 60 days after suspension, termination will be recommended.

c. Ambulatory surgery centers.

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.

Covered ASC surgical services are listed under the column headings "Current ASC Group" and "Previous ASC Group" on the agency's fee schedule, identified by number one, two, three, four, five, six, seven, eight, or nine.

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. The agency's fee schedule was set as of January 1, 2010, 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.

10. Dental services.

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

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. The agency's fee schedule was set as of January 1, 2010, 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.

Effective for dates of service on and after January 1, 2006, 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 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 physical therapy 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 Department's fee schedule.

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. The agency's fee schedule was set as of January 1, 2010, 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 physical therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

Payment for physical therapy services provided to residents of intermediate care facilities for the mentally retarded (ICFs-MR) is included in the facility per diem.

For residents of nursing facilities (NFs), physical therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for physical therapy services provided to residents of NFs is included in the facility per diem.

11. Physical therapy and related services, continued.

b. Occupational therapy.

Occupational therapy 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 occupational therapy 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 Department's fee schedule.

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. The agency's fee schedule was set as of January 1, 2010, 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 occupational therapy services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for occupational therapy services provided to residents of intermediate care facilities for the mentally retarded (ICFs-MR) is included in the facility per diem.

For residents of nursing facilities (NFs), occupational therapy services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for occupational therapy services provided to residents of NFs is included in the facility per diem.

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 speech-language pathology and audiology (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 Department's fee schedule.

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. The agency's fee schedule was set as of January 1, 2010, 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 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 the mentally retarded (ICFs-MR) is included in the facility per diem.

For residents of nursing facilities (NFs), SLPA services are billed by NFs on a fee-for-service basis and reimbursed at the lesser of the billed charges or 85% of the Medicaid maximum. For dates of service on or after 8/1/09, payment for SLPA services provided to residents of NFs is included in the facility per diem.

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

b. Dentures.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the item. The Medicaid maximum is the amount listed on the Department's fee schedule.

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. The agency's fee schedule was set as of January 1, 2010, 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.

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 billed charge or an amount based on the Medicaid maximum for the service or item. The Medicaid maximum is the amount listed on the Department's fee schedule. Where no Medicaid maximum is specified, the provider must submit either the list price or the invoice price. The Medicaid agency will pay 72 per cent of the list price or 147 per cent of the invoice price.

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. The agency's fee schedule was set as of January 1, 2010, 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.

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

d. Eyeglasses.

Payment is the lesser of the billed charge or an amount based on the Medicaid maximum for the item. The Medicaid maximum is the amount listed on the Department's fee schedule.

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. The agency's fee schedule was set as of January 1, 2010, 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.

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. The agency's fee schedule was set as of January 1, 2010, 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 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 fee schedule.

The following payment scenarios also exist:

The maximum reimbursement for certified nurse-midwife services is the lesser of the provider's billed charge or the percentage listed below, multiplied by the site differential percentage rate, whichever is less:

eighty-five per cent of the medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.

17. Nurse-midwife services, continued.

The maximum reimbursement for the services listed below, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum:

99201* OFFICE/OP VISIT

99202* OFFICE/OP VISIT

99203* OFFICE/OP VISIT

99204* OFFICE/OP VISIT

99205* OFFICE/OP VISIT

99211* OFFICE/OP VISIT

99212* OFFICE/OP VISIT

99213* OFFICE/OP VISIT

99214* OFFICE/OP VISIT

99215* OFFICE/OP VISIT

99241 OUTPATIENT CONSULT

99242 OUTPATIENT CONSULT

99243 OUTPATIENT CONSULT

99244 OUTPATIENT CONSULT

99245 OUTPATIENT CONSULT

17. Nurse-midwife services, continued.

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	$49.85
new patient, expanded problem focused visit	$49.85
established patient, evaluation & management by non-physician	$19.73
established patient, evaluation & management by physician	$49.85

23. Certified pediatric and family nurse practitioners' services.

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. The agency's fee schedule was set as of January 1, 2010, 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 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 fee schedule.

The following payment scenarios also exist:

The maximum reimbursement for certified pediatric and family nurse practitioners' services is the lesser of the provider's billed charge or the percentage listed below, multiplied by the site differential percentage rate, whichever is less:

eighty-five per cent of the medicaid maximum when services are provided in the following places: an inpatient hospital, outpatient hospital, or hospital emergency department; or

one hundred per cent of the medicaid maximum when services are provided in any non-hospital place of service.

For Rural Health Clinic (RHC)-based, Federally Qualified Health Center (FQHC)-based and Outpatient Health Facility (OHF)-based practices, reimbursement for services is the medicaid maximum set forth in Section III of Attachment 4.19-B, Item 2c.

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

The maximum reimbursement for the services listed below, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department), is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum:

99201* OFFICE/OP VISIT

99202* OFFICE/OP VISIT

99203* OFFICE/OP VISIT

99204* OFFICE/OP VISIT

99205* OFFICE/OP VISIT

99211* OFFICE/OP VISIT

99212* OFFICE/OP VISIT

99213* OFFICE/OP VISIT

99214* OFFICE/OP VISIT

99215* OFFICE/OP VISIT

99241 OUTPATIENT CONSULT

99242 OUTPATIENT CONSULT

99243 OUTPATIENT CONSULT

99244 OUTPATIENT CONSULT

99245 OUTPATIENT CONSULT

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

The maximum reimbursement for the office visits listed below is as indicated when they are billed as a pregnancy-related service:

new patient, problem focused visit	$49.85
new patient, expanded problem focused visit	$49.85
established patient, evaluation & management by non-physician	$19.73
established patient, evaluation & management by physician	$49.85

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

24-a. Transportation.

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

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. The agency's fee schedule was set as of January 1, 2010, 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.

Transportation provided by nursing facilities for their recipient-residents is included as a part of nursing facility services. Nursing facilities receive a per diem amount that includes payment for all transportation services and are responsible for ensuring that their recipient-residents obtain those transportation services. Such services are paid for by the nursing facilities and are not eligible for reimbursement on a fee-for-service basis. For dates of service beginning 08/18/2009 and ending 09/30/2009, however, transportation providers may submit claims directly on a fee-for-service basis for providing transportation services to nursing facility residents.