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State/Territory Name: OH

State Plan Amendment (SPA) #: 13-019

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

November 25, 2014

John McCarthy, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: TN 13-019

Dear Mr. McCarthy:

Enclosed for your records is an approved copy of the following State Plan Amendment:

Transmittal #13-019 -Medicaid Professional Fee Schedule Update, September 1, 2013
-Effective September 1, 2013

Please contact Christine Davidson, of my staff, at (312) 886-3642 or christine.davidson@cms.hhs.gov if you have any questions.

Sincerely,

/s/
Verlon Johnson
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Ogbe Aideyman, ODM
Andy Jones, ODM
Sarah Curtin, ODM
Becky Jackson, ODM
Greg Niehoff, ODM

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	1. TRANSMITTAL NUMBER: **13-019 (REVISED)**
	2. STATE: OHIO
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
	4. PROPOSED EFFECTIVE DATE: September 1, 2013

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR PART 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2013 $ 263 thousands
b. FFY 2014 $3,154 thousands

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, Item 2-a, Page 1 of 8
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Attachment 4.19-B, Item 5-a, Page 1 of 7
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9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

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10. SUBJECT OF AMENDMENT:
Medicaid Professional Fee Schedules update September 1, 2013

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: **John B. McCarthy**

14. TITLE: **STATE MEDICAID DIRECTOR**

15. DATE SUBMITTED: **9/30/2013**

16. RETURN TO:
Becky Jackson
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/30/13

18. DATE APPROVED: 11/25/14

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 9/1/13

20. SIGNATURE OF REGIONAL OFFICIAL: /s/

21. TYPED NAME: Verlon Johnson

22. TITLE: Associate Regional Administrator

23. REMARKS:

FORM CMS-179 (07-92)

Instructions on Back

2. a. Outpatient Hospital Services

Outpatient hospital services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.20.

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.

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 the Ohio Medicaid claims system.

Payment for all other Outpatient hospital services 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 Outpatient hospital services fee schedule.

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

The agency's Outpatient hospital services fee schedule was set as of January 1, 2013, and is effective for services provided on or after that date.

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

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 billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's Other laboratory and x-ray services fee schedule.

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

The agency's laboratory and x-ray services fee schedule was set as of September 1, 2013 and is effective for services provided on or after that date.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

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

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

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

The agency's tobacco cessation counseling services fee schedule was set as of January 1, 2012, and is effective for services provided on or after that date.

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

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

5. a. Physicians' services.

Physicians' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.50.

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

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

The agency's physicians' services fee schedule was set as of September 1, 2013 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.

Non-covered services are identified on the state developed Medicaid fee schedule medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates by "NC" as the current price.

The following payment scenarios also exist:

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

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.

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 physician evaluation and management office services, when provided in a hospital setting (i.e., inpatient, outpatient or emergency department) and by physicians who do not qualify for section 1202 enhanced payments, is the lesser of the provider's billed charge or 80 percent of the Medicaid maximum.

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

Optometrists' Services

Optometrists' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 42 CFR 441.30.

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

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

The agency's physicians' (including optometrists') services fee schedule set as of January 1, 2013 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.

Optometrists' services are subject to a co-payment as referenced 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.

a. Podiatrists' services.

Podiatrists' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.60.

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 Department's Podiatrists' services fee schedule.

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

The agency's podiatrists' services fee schedule was set on January 1, 2013, and is effective for services provided on or after that date.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

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

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

a. Podiatrists' services, continued.

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.

The maximum reimbursement for podiatrists' evaluation and management office services, 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:

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 types of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

b. Optometrists' Services

Optometrists' services (other than those provided under 42 CFR 435.531 and 436.531) are not now but were previously provided under the plan. Services of the type an optometrist is legally authorized to perform are specifically included in the term "physicians' services" under this plan and are reimbursed whether furnished by a physician or an optometrist.

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.

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

The agency's chiropractors' services 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.

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

The agency's mechanotherapists' services 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.

Psychologists' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.60.

Payment for Psychologists' services is the lesser of the billed charge or eighty-five percent of the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Psychologists' services fee schedule.

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

The agency's psychologists' services fee schedule was set as of January 1, 2013, 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.

d. Other practitioners' services

(4) Pharmacists' services.

Providers will be reimbursed a fee schedule amount for administering seasonal and pandemic influenza vaccines.

Except as otherwise noted in the state plan, the state developed fee schedule rates for seasonal and pandemic influenza vaccine administration are the same for both governmental and private providers.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/ProviderTypes/TheOhioMedicaidDrugProgram.aspx.

The agency's pharmacists' services fee schedule rate was set October 1, 2009, and is effective for services provided on or after that date.

When a provider administers a seasonal or pandemic influenza vaccine in a pharmacy, the administration fee is the lesser of the provider's charge or the Medicaid maximum fee schedule amount of ten dollars. This fee schedule amount is effective for services provided on or after October 1, 2009, and applicable to services rendered by governmental and private providers.

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

d. Other practitioners' services

5. Physician assistants' services

Physician assistants' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.60.

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

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

The agency's physician assistants' fee schedule was set as of September 1, 2013 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 applicable to physicians also apply to physician assistants:

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 Department will reimburse for services provided by a physician assistant the lesser of the billed charge or eighty-five per cent of the Medicaid maximum, utilizing a modifier that indicates the provider and services are subject to an adjusted rate, unless the service is the type usually provided by medical personnel below the physician assistant and/or advanced practice nurse level of education (e.g., collection of specimens, immunizations). The Department will reimburse for services provided by a physician assistant either the lesser of the billed charge or one hundred per cent of the Medicaid maximum.

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.

A. Certified Registered Nurse Anesthetists' (CRNAs') services:

The payment methodology for anesthesia services consists of multiplying the sum of the procedure base units (from the latest Relative Value Guide by the American Society of Anesthesiologists) and the time units (per each 15 minutes) by the conversion factor [$ = (B + T) X CF].

B. Clinical Nurse Specialists' (CNSs') services:

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.

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

The agency's clinical nurse specialists' fee schedule was set as of September 1, 2013 and is effective for services provided on or after that date.

The following payment scenarios also exist:

The maximum reimbursement for CNSs' 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.

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:

Office or other outpatient services, evaluation and management of new and established patients

Office or other outpatient consultations for new and established patients

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

C. Certified Nurse Practitioners' (CNP) services, other than certified pediatric or family nurse practitioners' services

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.

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

The agency's certified nurse practitioners' fee schedule was set as of September 1, 2013 and is effective for services provided on or after that date.

The following payment scenarios also exist:

The maximum reimbursement for CNPs' 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.

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:

Office or other outpatient services, evaluation and management of new and established patients

Office or other outpatient consultations for new and established patients.

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

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 for an intermittent or part-time nursing visit is the lesser of the billed charge or an amount based on the Medicaid maximum for the service listed on the Department's fee schedule. "Base rate" means the amount paid for up to the first four units of service delivered. "Unit rate" means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service delivered. Reimbursement for a visit is calculated as follows:

The Medicaid maximum rate for intermittent or part-time nursing services visit not rendered in a group setting is equal to the sum of:

(1) The base rate; and

(2) The unit rate multiplied by the number of covered units following the first four units included in the base rate.

The Medicaid maximum rate for intermittent or part-time nursing services visit rendered in a group setting is equal to seventy-five percent of the sum of:

(1) The base rate; and

(2) The unit rate multiplied by the number of covered units following the first four units included in the base rate.

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

The agency's home health intermittent or part-time nursing services fee schedule was set as of October 1, 2011, 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

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

Home health aide services provided by a home health agency under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.70

Payment for a home health aide visit is the lesser of the billed charge or an amount based on the Medicaid maximum for the service listed on the Department's fee schedule. "Base rate" means the amount paid for up to the first four units of service delivered. "Unit rate" means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service delivered. Reimbursement for a visit is calculated as follows:

The Medicaid maximum rate for home health aide services visit not rendered in a group setting is equal to the sum of:

(1) The base rate; and

(2) The unit rate multiplied by the number of covered units following the first four units included in the base rate.

The Medicaid maximum rate for home health aide services rendered in a group setting is equal to seventy-five percent of the sum of:

(1) The base rate; and

(2) The unit rate multiplied by the number of covered units following the first four units included in the base rate.

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

The agency's home health aide services fee schedule was set as of October 1, 2011, 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 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 Durable Medical Equipment fee schedule. Where no Medicaid maximum is specified, payment is the average wholesale price (AWP) minus 23 per cent.

Payment for blood glucose monitors, test strips, lancets, lancing devices, needles including pen needles, calibration solution/chips, and syringes with a needle less than or equal to 1 milliliter will be based on wholesale acquisition cost (WAC) plus seven percent. In the event that WAC cannot be determined, reimbursement will be AWP minus 14.4 percent. The Medicaid maximum is the amount listed on the Department's Pharmacy fee schedule.

For all other items, 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 Durable Medical Equipment fee schedule. Where no Medicaid maximum is specified, payment is 72 per cent of the list price or, if no list price is available, 147 per cent of the invoice price.

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

The agency's Medical supplies, equipment, and appliances fee schedule was set as of September 1, 2013 and is effective for services provided on or after that date. The agency's diabetic testing and injection supplies fee schedule (under the Pharmacy fee schedule) was set as of July 1, 2013, 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-language pathology and audiology services provided by a home health agency or 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.

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

      The agency's home health physical therapy, occupational therapy, speech-language pathology, and audiology services 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 fee for the service listed on the Department's fee schedule, calculated as follows.

"Base rate" means the amount paid for up to the first four units of service delivered. "Unit rate" means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service delivered.

The Medicaid maximum rate for a private duty nursing visit not rendered in a group setting is equal to the sum of:

1. The base rate; and
2. The unit rate multiplied by the number of units over four.

The Medicaid maximum rate for a private duty nursing visit rendered in a group setting is equal to seventy-five percent of the sum of:

1. The base rate; and
2. The unit rate multiplied by the number of units over four.

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

The agency's private duty nursing fee schedule was set as of October 1, 2011, 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 Department's fee schedule identifies two rates for private duty nursing services, one for agency providers and another for non-agency/independent nurses.

9. Clinic services.

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

AHCCs' services under this section are covered by Ohio Medicaid in accordance with 42 CFR § 440.90.

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

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

The agency's Clinic services fee schedule was set as of September 1, 2013 and is effective for services provided on or after that date.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

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

9. Clinic services, continued.

c. Ambulatory surgery centers (ASCs).

Payment for ASCs' services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the Department's ASCs' services 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.

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

The agency's ASC services fee schedule was set as of September 1, 2013 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.

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. The Medicaid maximum is the amount listed on the Department's Dental services fee schedule.

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

The agency's dental services fee schedule was set as of January 1, 2013 and is effective for services provided on or after that date.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

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

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.

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

The agency's physical therapy 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.

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

The agency's occupational therapy 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.

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

The agency's speech, hearing, and language disorders services 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.

a. Prescribed drugs

Payment for prescribed drugs meets all reporting requirements and provisions of section 1927 of the Social Security Act.

Payment for prescribed drugs will be made based on the various categories as specified below.

Payment for selected over-the-counter drugs provided by nursing facilities (NFs) for their recipient-residents is included in the nursing facility services. Nursing facilities receive a per diem amount that includes payment for selected over-the-counter drugs and are responsible for ensuring that their recipient-residents obtain those drugs. Payment for selected over-the-counter drugs provided to residents of NFs is included in the facility per diem and is not eligible for reimbursement on a fee-for-service basis. Reimbursement methodology for nursing facilities is described in Attachment 4.19-D.

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

a. Prescribed drugs (continued)

Determination of allowable pharmaceutical product cost: Drugs dispensed for take-home use ("pharmacy benefit").

No supplemental allowance will be authorized for broken-lot charges, prescription delivery charges or state and local sales tax.

Billings must be submitted on the basis of the pharmacy's reasonable and customary charge, that is, a charge which does not exceed the average prescription price paid by the general public for similar services, including billing charges, family prescription profiles, delivery charges, and other pharmaceutical services.

Payment for covered drugs is the lesser of the submitted charge or the calculated allowable minus any applicable co-payment. The calculated allowable consists of product cost and a dispensing fee.

(1) Maximum Allowable Cost (MAC) pharmaceuticals
   (A) Maximum allowable costs have been determined by the federal Department of Health and Human Services for selected drugs. The Department shall not make reimbursement for these products, in the aggregate, at a rate higher than the federal upper limit (FUL) prices.
   (B) The Department may establish a MAC for additional selected drugs where either bio-equivalency of the drugs has been established or bio-inequivalency of the drugs has not been established. Reimbursement for state MAC drugs shall be based on the sixty-fifth percentile of the estimated acquisition cost of all readily available generically equivalent drugs.

(2) Estimated Acquisition Cost (EAC) pharmaceuticals
   (A) All products, other than those designated as MAC drugs, will be considered EAC drugs. Reimbursement will be based on the estimate of wholesale acquisition cost (WAC) determined by periodic review of pricing information from Ohio drug wholesalers, pharmaceutical manufacturers and a pharmacy pricing update service. The maximum reimbursement for these drugs will be WAC plus seven per cent.
   (B) In the event that WAC cannot be determined, the Department will define "EAC" as average wholesale price (AWP) minus 14.4 per cent.

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

a. Prescribed drugs (continued)

(3) Dispensing fee

The dispensing fee for non compounded drugs shall be one dollar and eighty cents.

The State has a separate dispensing fee for compounded prescriptions. Claims submitted for infusion compounds will receive a dispensing fee of ten dollars per day, with a maximum dispensing fee of seventy dollars per claim. Total parenteral nutrition claims will receive a dispensing fee of fifteen dollars per day, with a maximum dispensing fee of one hundred fifty dollars per claim. Compounded drugs that are not infusion compounds or total parenteral nutrition claims will receive a single six dollar dispensing fee per prescription.

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

a. Prescribed drugs (continued)

Determination of allowable pharmaceutical product cost: Drugs administered in the professional provider setting.

All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx. The agency's vaccines, toxoids, and other provider-administered pharmaceuticals fee schedule was set as of September 1, 2013, 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 reimbursement amount for a covered non-VFC vaccine, toxoid, or other provider-administered pharmaceutical is the lesser of the submitted charge or the maximum allowable fee. The maximum allowable fee is the first applicable item from the following ordered list:

(a) An amount specified in or determined in accordance with the Ohio Administrative Code (e.g., the fee for a "by report" procedure);
(b) The Medicare Part B payment limit shown in the current Part B drug pricing files posted on the Medicare web site;
(c) One hundred seven per cent of the wholesale acquisition cost (WAC); or
(d) Eighty-five and six-tenths per cent of the average wholesale price (AWP).

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.

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

The agency's dentures 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.

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

The agency's prosthetic devices 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.

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

The agency's eyeglasses 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.

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

d. Rehabilitative services

1. Rehabilitative services provided by community mental health facilities.

Each community mental health agency shall maintain a schedule of usual and customary charges for all community mental health services it provides. The agency shall use its usual and customary charge schedule when billing Medicaid for rendered services. Reimbursement for community mental health services shall be the lesser of the charged amount or the Medicaid maximum amount.

Calculation of the Medicaid maximum amount for community mental health services:

A. For all community mental health services except community psychiatric supportive treatment (CPST), the Medicaid maximum amount is equal to the unit rate for the service according to the department's service fee schedule multiplied by the number of units rendered.

B. For CPST services not rendered in a group setting, the Medicaid maximum amount is calculated as follows:
   1. If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
   2. If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:
      a. The unit rate according to the department's service fee schedule multiplied by six; and
      b. Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

C. For CPST services rendered in a group setting, the Medicaid maximum amount is calculated as follows:
   1. If the total number of service units rendered by a provider per date of service is less than or equal to six, the Medicaid maximum amount is equal to the unit rate according to the department's service fee schedule multiplied by the number of units rendered.
   2. If the total number of services units rendered by a provider per date of service is greater than six, the Medicaid maximum amount is equal to the sum of:
      a. The unit rate according to the department's service fee schedule multiplied by six; and

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

d. Rehabilitative services

1. Rehabilitative services provided by community mental health facilities, continued

b. Fifty percent of the unit rate according to the department's service fee schedule multiplied by the difference between the total number of units rendered minus six.

As a condition of participation, all Medicaid providers of community mental health services must have a current "Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations". Providers agree to comply with state statutes, Ohio Administrative Code rules, and Federal statutes and rules. This includes compliance with Ohio Administrative Code rule related to the annual submission of a cost report and related information to the Ohio Department of Mental Health and Addiction Services (OhioMHAS). OhioMHAS will provide this information to the Ohio Department of Medicaid on an annual basis and in accordance with the requirements of the interagency agreement between the two departments. Future fee schedule updates will be based upon this information.

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 fee schedule rates are effective for services provided on or after October 4, 2010.

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

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Subparts C and D.

The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

With respect to individuals who are receiving rehabilitation services as residents of facilities the State shall not claim FFP for room and board and for non Medicaid services as a component of the rate for services authorized by this section of the state plan (Attachment 4.19-B, Item 13-d-1 page 2 of 2.) The rates in the department's service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly supporting the provision of the non-institutional services will be included in the rates.

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

2. Rehabilitative services provided by alcohol and other drug treatment programs

Each community alcohol and other drug treatment program shall maintain a schedule of usual and customary charges for all community alcohol and other drug treatment services it provides. The program shall use its usual and customary charge schedule when billing community Medicaid for rendered services. Payments for covered services will be based on the lesser of the charged amount or the Medicaid maximum amount for the rendered service according to the department's service fee schedule.

As a condition of participation, all Medicaid providers of alcohol and other drug treatment services must have a current "Ohio Health Plans Provider Enrollment Application/Time Limited Agreement for Organizations". Providers agree to comply with state statutes, Ohio Administrative Code rules, and Federal statutes and rules. This includes compliance with Ohio Administrative Code rule related to the annual submission of a cost report and related information to the Ohio Department of Mental Health and Addiction Services (OhioMHAS). OhioMHAS will provide this information to the Ohio Department of Medicaid on an annual basis and in accordance with the requirements of the interagency agreement between the two departments. Future fee schedule updates will be based upon this information.

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 fee schedule rates are effective for services provided on or after October 4, 2010. All rates are published on the agency's website at medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The unit of service definitions can be found by accessing the agency's website at: medicaid.ohio.gov/PROVIDERS/FeeScheduleandRates.aspx.

The State shall not claim FFP for any non-institutional service provided to individuals who are residents of facilities that meet the Federal definition of an institution for mental diseases or a psychiatric residential treatment facility as described in Federal regulations at 42 CFR 440.140 and 440.160 and 42 CFR 441 Subparts C and D.

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

2. Rehabilitative services provided by alcohol and other drug treatment programs, continued

The State shall not claim FFP for any services rendered by providers who do not meet the applicable Federal and/or State definition of a qualified Medicaid provider.

With respect to individuals who are receiving rehabilitation services as residents of facilities, the State shall not claim FFP for room and board and for non-Medicaid services as a component of the rate for services authorized by this section of the plan (Attachment 4.19-B, Item 13-d-2, page 2 of 2). The rates in the department's service fee schedule as authorized by this plan amendment shall be set using methods that ensure the rates do not include costs not directly related to the provision of Medicaid services such as costs associated with the cafeteria. Only those facility (direct or indirect) costs that can be identified as directly supporting the provision of the non-institutional services will be included in the rates.

17. Nurse-midwife services.

Nurse-midwife services under this section are covered by Ohio Medicaid in accordance with 42 CFR §§ 440.165 and 441.21.

Payment for Nurse-midwife 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 Nurse-midwife services fee schedule.

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

The agency's nurse-midwife services fee schedule was set as of September 1, 2013 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 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.

18. Hospice Care.

The department will perform a desk audit on each Hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

23. Certified pediatric and family nurse practitioners' services.

Certified pediatric and family nurse practitioners' services under this section are covered by Ohio Medicaid in accordance with 42 CFR §§ 440. 166 and 441.22.

Payment for Certified pediatric and family nurse practitioners' 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 Certified pediatric and family nurse practitioners' services fee schedule.

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

The agency's certified pediatric and family nurse practitioners' services fee schedule was set as of September 1, 2013 and is effective for services provided on or after that date.

By-report services are unlisted procedures that require manual review by the appropriate single state agency staff. The reimbursement rate for these services is determined using one of a variety of different payment methodologies. Examples of the possible methodologies are a percentage of charges, gap filling, and pricing using a similar service, product, or procedure that has an established reimbursement rate. The specific methodology utilized depends on the service, product, or procedure performed.

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

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.

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.

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

The agency's transportation 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.

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 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 fee schedule.

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

The agency's fee schedule was set as of January 1, 2012, 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, a 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. A FBC will not be reimbursed separately for the professional component of such services.