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State Territory Name: OHIO

State Plan Amendment (SPA) #: 23-0005

This file contains the following documents in the order

listed:1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

April 10, 2023

Maureen Corcoran, Director
Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Ohio 43215

RE: Ohio State Plan Amendment 23-0005

Dear Ms. Corcoran:

We have reviewed the proposed Ohio State Plan Amendment (SPA) to Attachment 4.19-B, OH-23-0005, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on March 15, 2023. This plan updates the rates for Non-Institutional Payment Schedules.

Based upon the information provided by the State, we have approved the amendment with an effective date of January 1, 2023. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any questions or need further assistance, please contact Debi Benson at 1-312-886-0360 or Deborah.Benson@cms.hhs.gov.

Sincerely,

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 2 3 — 0 0 5

2. STATE: OH

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

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

4. PROPOSED EFFECTIVE DATE: January 1, 2023

5. FEDERAL STATUTE/REGULATION CITATION
Sections 1905(a)(3),(6),(7),(9),(11),(12),(17),(23),(28) of the Act; 42 CFR 440.30, .100, .110, .120, .165, .166

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2023 $ 0
b. FFY 2024 $ 0

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

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*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

9. SUBJECT OF AMENDMENT
Payment for Services: Non-Institutional Payment Schedule Updates for 2023

10. GOVERNOR'S REVIEW *(Check One)*
( ) GOVERNOR'S OFFICE REPORTED NO COMMENT
( ) COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
( ) NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
(●) OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

11. SIGNATURE OF STATE AGENCY OFFICIAL

12. TYPED NAME: **MAUREEN M. CORCORAN**

13. TITLE: **STATE MEDICAID DIRECTOR**

14. DATE SUBMITTED: March 15, 2023

15. RETURN TO
Tiffany Williams
Ohio Department of Medicaid
P.O. BOX 182709
Columbus, Ohio 43218

FOR CMS USE ONLY

16. DATE RECEIVED: **March 15, 2023**

17. DATE APPROVED: April 10, 2023

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL: **January 1, 2023**

19. SIGNATURE OF APPROVING OFFICIAL

20. TYPED NAME OF APPROVING OFFICIAL: **Todd McMillion**

21. TITLE OF APPROVING OFFICIAL: **Director, Division of Reimbursement Review**

22. REMARKS

CMS-179 Blocks 7 and 8 Addendum
TN OH-23-005

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3. Other laboratory and x-ray services.

Other laboratory and x-ray services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.30.

Payment for other laboratory and x-ray services is the lesser of the submitted charge or an established amount based on the Medicaid maximum for the service. For each clinical diagnostic laboratory test, the established amount is not to exceed the corresponding Medicare allowed amount.

The Medicaid maximum for other laboratory services is the amount listed on the Department's laboratory services fee schedule. For a newly-covered laboratory service, the initial maximum payment amount is set at 75% of the applicable Medicare allowed amount listed in the Clinical Laboratory Fee Schedule or the Medicare Physician Fee Schedule. If the Medicare amount for a covered laboratory service becomes less than the current Medicaid maximum payment amount, then the Medicaid maximum payment amount for that service is reestablished at 75% of the current applicable Medicare allowed amount.

The Medicaid maximum for x-ray services is the amount listed on the Department's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule. For a newly-covered x-ray service represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. A payment reduction provision applies when more than one advanced imaging procedure is performed by the same provider or provider group for an individual patient in the same session. Payment is made for the primary procedure at 100%, payment for each additional technical component is made at 50%, and payment for each additional professional component is made at 95%. This payment reduction provision took effect on January 1, 2017.

Each code representing a newly covered laboratory or x-ray service is located on the agency's CPT and HCPCS Level II Procedure Code Changes schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the laboratory services or MSRIAP fee schedule.

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

The agency's laboratory services fee schedule was set as of April 1, 2019, and is effective for services provided on or after that date.

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate single state agency staff. The payment amount for these services is determined through the application of one of a variety of different payment methods, such as adopting the maximum payment amount for a similar service, taking the unweighted average of the maximum payment amounts for a group of related services, or using percentage of charges. The specific method used depends on the service.

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

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

a. Podiatrists' services.

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

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new podiatry code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date. The site differential payment was set as of January 1, 2014, and is effective for services provided on or after that date.

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

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

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

c. Chiropractors' services.

Payment for covered services described in Attachment 3.1-A, Item 6-c is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency’s Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) payment schedule.

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

The agency's MSRIAP payment schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

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

d. Other practitioners' services.

(1) Mechanotherapists' services.

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

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

The agency's mechanotherapists' services fee schedule was set as of January 1, 2023, 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) Pharmacist services.

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

      For licensed pharmacists enrolled with the Department, payment for administration of a covered immunization, injection of medication, or provider-administered pharmaceutical, is the lesser of the billed charge or the Medicaid maximum specified in the agency’s provider-administered injectable pharmaceutical fee schedule. Payment for managing medication therapy is the lesser of the billed charge or 85% of the Medicaid maximum specified in the agency’s Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule. These amounts are effective for services provided on or after January 1, 2023.

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

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

   d. Other practitioners' services (continued)

      (7) Dietitians' services

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

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

      The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

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

   d. Other practitioners' services

      (8) Anesthesiologist Assistants' services.

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

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

The base unit value is assigned by the American Society of Anesthesiologists in its "Relative Value Guide"; the time unit value is the number of fifteen-minute increments, rounded to the nearest tenth. The conversion factor and multiplier are effective for dates of service on or after January 1, 2022, and are listed on the agency's Anesthesia fee schedule, which is published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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

Each new anesthesia code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

The agency adopts new anesthesia codes in accordance with the anesthesia base unit values assigned by the American Society of Anesthesiologists in its "Relative Value Guide". The anesthesia base unit value files are located at https://www.cms.gov/files/zip/2022-anesthesia-base-units-cpt-code.zip.

Additional codes for certain services provided by Anesthesiologist Assistants (i.e., trigger-point injections) are located on the State's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

   d. Other practitioners' services

      (9) Acupuncturists' services

Payment for acupuncturists' services is the lesser of the submitted charge or the Medicaid maximum payment amount listed on Ohio Medicaid's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) payment schedule. The payment amounts were set as of January 1, 2023, and are effective for acupuncturists' services provided on or after that date.

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

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

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

d. Other practitioners' services

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

Payment for licensed RN services for home visiting and lactation consulting services is made to the practitioner's employer or designated provider entity and is the lesser of the provider's submitted charge or the Medicaid maximum payment amount listed on Ohio Medicaid's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) payment schedule. The payment amounts were set as of January 1, 2023, and are effective for services provided on or after that date.

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

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

7. Home health services, continued.

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

      Payment for medical supplies, equipment, and appliances is the lesser of the submitted charge or an amount based on the Medicaid maximum for the item or service.

      The Medicaid maxima for blood glucose monitors, test strips, lancets, lancing devices, needles including pen needles, calibration solution/chips, and needle-bearing syringes with a capacity up to three milliliters are 107% of the wholesale acquisition cost (WAC); if the WAC cannot be determined, the Medicaid maximum is 85.6% of the average wholesale price (AWP). The State's Diabetic Testing and Injection Supplies payment schedule (part of the Pharmacy payment schedule) was set as of April 1, 2017.

      The Medicaid maxima for oxygen are listed on the State's Oxygen payment schedule, which was set as of July 16, 2018.

      The Medicaid maxima for wheelchairs, parts, accessories, and related services are listed on the State's Wheelchair payment schedule, which was set as of January 1, 2017.

      The Medicaid maxima for enteral nutrition products are listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule. Where no Medicaid maximum is specified, payment is 77% of the AWP.

      The Medicaid maxima for other medical supplies, equipment, and appliances are listed on the State's main DMEPOS payment schedule. Where no Medicaid maximum for a medical supply item is specified, payment is 72% of the list price; if no list price is available, it is 147% of the invoice price.

      The State's main DMEPOS payment schedule was set as of July 1, 2021.

      For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new DMEPOS code will be located on the State's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the DMEPOS fee schedule.

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

9. Clinic services, continued.

c. Ambulatory surgery centers (ASCs).

Payment for ASCs' services is the Medicaid maximum for the service. The Medicaid maximum is an amount based on the Enhanced Ambulatory Patient Group (EAPG) and any discounting, consolidation or packaging factors assigned by 3M's EAPG software. These factors are defined in Attachment 4.19-B, Item 2-a, section E. Payment for laboratory and radiology services is the lesser of billed charges or the payment calculated under EAPG. Payment for all laboratory services will be no more than the Medicare fee schedule amount.

For each date of service every CPT/HCPCs code on a claim is assigned an EAPG. An EAPG groups together services that are similar in nature, have similar costs and utilizes similar material. For each EAPG there is a relative weight, which reflects the cost of the services in that EAPG. The payment for the detail is the product of the EAPG relative weight and the ASC base rate. All ASC are assigned the same base rate. Payment for EAPG 00233 is increased by 145% and EAPG 00485 is increased by 233%.

The following services are paid outside of EAPG and are paid as specified below:

- Payment for pharmaceuticals is the lesser of the billed charge or the amount in the provider administered pharmaceutical fee schedule.
- Payment for durable medical equipment (DME) is the lesser of the billed charge or the amount in the DME fee schedule.
- Payment for claims assigned to a dental service EAPG type will be $953.60.
- Pharmaceutical, DME and dental are paid outside of the EAPG but are subject to discounting, consolidation and packaging factors as determined by the EAPG software.

ASCs may only bill for the technical component of laboratory, radiology, and diagnostic and therapeutic services.

The relative weights that apply to ASC services are the same ones developed for outpatient hospital services, which are described in Attachment 4.19-B, Item 2-a, section I. The ASC base rate is 90% of the outpatient base rate which is described in Attachment 4.19-B, Item 2-a, section G. The ASC base rates and relative weights were set as of January 2, 2020 and are effective for services provided on or after that date. The ASC base rate, relative weights, pharmaceutical fee schedule and DME fee schedule are published on the agency's website at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

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

10. Dental services.

Dental services under this section are covered by Ohio Medicaid in accordance with 42 CFR 440.100.

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

Effective for dates of service on and after January 1, 2016, the maximum reimbursement for dental services rendered by a provider whose office address is in a rural Ohio county is the lesser of the billed charges or 105 percent of the Medicaid maximum for the particular service.

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

The agency's dental services fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

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

Selected dental services are subject to a co-payment as specified in Attachment 4.18-A of the State plan.

11. Physical therapy and related services.

a. Physical therapy.

Physical therapy (PT) services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for PT services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new PT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

Payment for PT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG-exempt.

Payment for PT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for PT services provided to residents of nursing facilities is included in the nursing facility per diem rate.

11. Physical therapy and related services, continued.

b. Occupational therapy.

Occupational therapy (OT) services are covered as hospital, home health agency, physician, limited practitioner, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (6), (7), and (9) for reimbursement provisions.

Payment for OT services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new OT code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

Payment for OT services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

Payment for OT services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

Payment for OT services provided to residents of nursing facilities is included in the nursing facility per diem rate.

11. Physical therapy and related services, continued.

    c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

    Speech-language pathology and audiology (SLPA) services are covered as hospital, home health agency, physician, nursing facility, clinic, or Medicaid School Program (MSP) services. See items (1), (2), (5), (7), and (9) for reimbursement provisions.

    Payment for SLPA services provided by outpatient hospitals, physicians, limited practitioners, and clinics is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

    A payment reduction provision applies when more than one therapy procedure or unit of service within the same therapy discipline or same therapy plan of care is performed by the same provider or provider group for an individual patient on the same date of service. Payment is made for the primary procedure at 100%; payment for each additional unit or procedure is 80%. This payment reduction provision took effect on January 1, 2014.

    For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new SLPA code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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

    The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

    Payment for SLPA services provided by inpatient hospitals is subject to Diagnostic Related Group (DRG) prospective payment, or cost if DRG exempt.

    Payment for SLPA services provided to residents of intermediate care facilities for individuals with intellectual disabilities (ICF-IID) is included in the facility per diem.

    Payment for SLPA services provided to residents of nursing facilities is included in the nursing facility per diem rate.

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

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 https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates.

Dentures are included on the agency's dental services fee schedule.

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 submitted charge or an amount based on the Medicaid maximum. The Medicaid maximum for a prosthetic device is listed on the State's main Durable Medical Equipment, Prostheses, Orthoses, and Supplies (DMEPOS) payment schedule.

    For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new prosthetic device code can be found on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the DMEPOS fee schedule.

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

    The agency's DMEPOS fee schedule was set as of January 1, 2019 and is effective for services provided on or after that date.

    By-report items and services require manual review by appropriate staff members or contractors. Payment for these items and services is determined on a case-by-case basis. The specific method used depends on the item or service (for example, comparison with a similar service that has an established maximum payment rate or application of a percentage of charges). This schema was effective on July 16, 2018.

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

17. Nurse-midwife services.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse-midwife (CNM) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

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

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new nurse-midwife code will be located on the agency’s CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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

The agency's MSRIAP fee schedule was set as of January 1, 2023,and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends on the service; examples include comparison with a similar service that has an established maximum payment rate and application of a percentage of charges.

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

23. Certified pediatric and family nurse practitioners' services.

Unless otherwise specified, the maximum payment amount for a service furnished by a certified nurse practitioner (CNP) in a non-hospital setting is the lesser of the submitted charge or the Medicaid maximum listed on the agency's Medicine, Surgery, Radiology and Imaging, and Additional Procedures (MSRIAP) fee schedule; for a service furnished in a hospital setting, the maximum payment amount is 85% of the Medicaid maximum listed on the agency's MSRIAP fee schedule.

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

The maximum payment amount for a procedure performed bilaterally on the same patient by the same provider is the lesser of the submitted charge or 150% of the Medicaid maximum allowed for the same procedure performed unilaterally.

The maximum payment amount for designated surgical procedures performed on the same patient by the same provider is the lesser of (1) the submitted charges or (2) for the primary procedure (the procedure having the highest Medicaid maximum payment), 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the secondary procedure, 50%; and for each additional procedure, 25%.

The maximum payment amount for maternity delivery is the lesser of (1) the submitted charge or (2) for a single delivery or the first delivery of a multiple birth, 100% of the Medicaid maximum from the agency's MSRIAP fee schedule; for the second delivery of a multiple birth, 50%; for the third delivery of a multiple birth, 25%; and for each additional delivery of a multiple birth, zero.

For a newly-covered procedure, service, or supply represented by a new HCPCS procedure code, the initial maximum payment amount is set at 80% of the Medicare allowed amount. Each new CNPs' services code will be located on the agency's CPT and HCPCS Level II Procedure Code Changes payment schedule at https://medicaid.ohio.gov/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates until it is moved to the MSRIAP fee schedule.

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

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

By-report services require manual review by the appropriate agency staff. Payment for these services is determined on a case-by-case basis. The specific method used depends

28. Licensed or otherwise state-approved freestanding birth centers (FBC) and licensed or otherwise state-recognized covered professionals providing services in the freestanding birth center.

Payment for FBC facility services is the lesser of the billed charge or an amount based on the Medicaid maximum for the service. The Medicaid maximum is the amount listed on the agency's Medicine, Surgery, Radiology and Imaging, and additional procedures (MSRIAP) fee schedule.

Payment for FBC services is based on a reimbursement rate for each HCPCS code. Maximum reimbursement for facility services is the lesser of the provider's billed charges or one hundred percent of the rate listed on the MSRIAP fee schedule.

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

The agency's MSRIAP fee schedule was set as of January 1, 2023, and is effective for services provided on or after that date.

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

In addition to reimbursement for facility services, an FBC may also be reimbursed for laboratory procedures, radiological procedures, and diagnostic and therapeutic procedures provided in connection with a covered FBC procedure. To be reimbursed for these procedures, FBC providers must bill using appropriate HCPCS codes. An FBC will not be reimbursed separately for the professional component of such services.