5101:3-1-60 **Medicaid reimbursement.**

(A) The medicaid payment for a covered service constitutes payment-in-full and may not be construed as a partial payment when the reimbursement amount is less than the provider's charge. The provider may not bill the recipient for any difference between the medicaid payment and the provider's charge or request the recipient to share in the cost through a copayment or other similar charge, other than medicaid co-payments as defined in rule 5101:3-9-09 of the Administrative Code.

(B) Medicaid reimbursement is not available for noncovered services or for covered services which are denied by the department as a result of either a prepayment review, utilization review, or prior authorization process (see Chapter 5101:3-2 of the Administrative Code for a description of how these provisions are applied to inpatient and outpatient hospital services).

(C) Reimbursement is made only for those covered medicaid services actually needed and received by eligible medicaid recipients. The amount of payment is determined in accordance with federal and state laws and regulations. In establishing medicaid maximums, the department must assure that the maximum reimbursement is consistent with efficiency, economy, and quality of care.

(D) The state's appropriation determines the total amount of funds that may be expended for health services under medicaid. The maximums used by the department may be less than the maximums permitted under federal law, but may not be more. Providers are expected to bill the department their usual and customary charge (i.e., the amount they charge the general public). If the amount billed to the department exceeds the department's maximum, the amount paid will automatically be reduced to the maximum permitted.

(E) The department reimburses ambulance/ambulette/wheelchair vehicle providers, ambulatory health care centers, ambulatory surgery centers, chiropractors, dentists, home health agencies, laboratory and x-ray facilities, medical suppliers, optometrists, physical therapists, physicians, podiatrists, private duty nurses, psychologists, and other limited practitioners at the lesser of their billed charge or the medicaid maximum. Providers must bill their usual and customary charge (the amount charged to the general public).

(F) The department reimburses pharmacies for drugs at the lesser of the billed charge or the maximum allowed for the cost of the drug plus a dispensing fee for those drugs listed in appendix A of rule 5101:3-9-12 of the Administrative Code. Providers must bill their usual and customary charge (the amount charged to the general public).

(G) Rural health clinics and federally qualified health centers are reimbursed using a

prospective payment system in accordance with federal legislation. Additional provisions regarding reimbursement for rural health clinic services may be found in Chapter 5101:3-16 of the Administrative Code. Additional provisions regarding reimbursement for services provided by federally qualified health centers using prospective payment rates specified in federal regulation may be found in Chapter 5101:3-28 of the Administrative Code.

(H) Outpatient health facilities are reimbursed on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Additional provisions regarding reimbursement for these services may be found in Chapter 5101:3-29 of the Administrative Code.

(I) Reimbursement for long-term care facilities is described in Chapter 5101:3-3 of the Administrative Code and for inpatient and outpatient hospitals in Chapter 5101:3-2 of the Administrative Code.

(J) The medicaid maximums are determined as follows:

(1) For practitioner services, clinical laboratory services, x-ray services, ambulatory health care center services, and ambulance and ambulette/wheelchair vehicle services, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD of this rule unless otherwise stated in Chapters 5101:3-4, 5101:3-5, 5101:3-7, 5101:3-8, 5101:3-11, 5101:3-12, 5101:3-13, 5101:3-15, and 5101:3-17 of the Administrative Code. For free-standing ambulatory end-stage renal disease clinics, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD of this rule. Rule 5101:3-13-07 of the Administrative Code describes the situations where the medicaid maximum is reimbursed at the revenue center code level and when the medicaid maximum is paid at the code level.

(2) For the total procedure for anatomical laboratory services, for services provided on and after July 1, 2003, payment will be based on the medicaid maximum for the service as shown in appendix DD of this rule. For services provided prior to July 1, 2003, the medicaid maximum is five hundred per cent of the amounts shown in the previous price column in appendix DD of this rule.

(3) For medical supplier services, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD of this rule. Additional provisions regarding reimbursement for these services may be found in Chapter 5101:3-10 of the Administrative Code.

(4) For facility services provided by an ambulatory surgery center (ASC), the medicaid maximum is the surgical group rate. The surgical group rates are as

follows.

(a) For an ASC-covered procedure classified in surgical group one for dates of service February 17, 1991 and thereafter, the rate shall be two hundred forty-seven dollars.

(b) For an ASC-covered procedure classified in surgical group two for dates of service February 17, 1991 and thereafter, the rate shall be three hundred thirty-two dollars.

(c) For an ASC-covered procedure classified in surgical group three for dates of service February 17, 1991 and thereafter, the rate shall be three hundred eighty-one dollars.

(d) For an ASC-covered procedure classified in surgical group four for dates of service February 17, 1991 and thereafter, the rate shall be four hundred sixty-nine dollars.

(e) Five hundred thirty-five dollars for an ASC-covered procedure classified in surgical group five.

(f) Seven hundred five dollars for an ASC-covered procedure classified in surgical group six.

(g) Seven hundred forty-three dollars for an ASC-covered procedure classified in surgical group seven.

(h) Eight hundred fourteen dollars for an ASC-covered procedure classified in surgical group eight.

(i) One thousand and thirty-three dollars for an ASC-covered procedure classified in surgical group nine.

Covered ASC procedures are classified into nine surgical procedures number one, two, three, four, five, six, seven, eight, or nine. The surgical group for each covered procedure is contained in appendix DD of this rule in the columns "ASC current group", "Current ASC effective date", and "Current ASC end date".

(5) Reimbursement for professional anesthesia services as described in rules 5101:3-4-21, 5101:3-4-21.1 and 5101:3-4-21.2 of the Administrative Code shall be as follows:

(a) For services provided on and after May 1, 2001, the reimbursement methodology using anesthesia code billing described in the rules listed in paragraph (J)(5) of this rule.

(b) For services provided January 1, 2000 until May 1, 2001, the maximum reimbursement for anesthesia services less than or equal to sixty minutes will be eighty-four dollars and thirty-two cents plus eighty cents per minute; and for anesthesia services greater than sixty minutes maximum reimbursement will be one hundred forty nine dollars and twenty cents plus eighty cents per minute over sixty minutes.

(c) For services provided on January 1, 1997 through December 31, 1999: the maximum reimbursement for anesthesia services less than or equal to sixty minutes will be fifty-eight dollars and fifteen cents plus fifty-five cents per minute; and for anesthesia services greater than sixty minutes maximum reimbursement will be one hundred two dollars and eighty-eight cents plus fifty-five cents per minute over sixty minutes.

(d) For services provided prior to January 1, 1997: the maximum reimbursement for anesthesia services less than or equal to sixty minutes will be fifty-eight dollars and fifteen cents plus fifty cents per minute; and for anesthesia services greater than sixty minutes, the maximum reimbursement will be one hundred two dollars and eighty-eight cents plus fifty cents per minute over sixty minutes.

(K) For core home care services, the medicaid maximums shall be as described in rule 5101:3-1-07 of the Administrative Code.

(L) In establishing the medicaid maximums as described in paragraph (J) of this rule, the department will assure that the maximum determined does not exceed the authorized level for the same services under the medicare program.

(M) Except for those provisions specified in paragraph (M)(4) of this rule, effective January first of each calendar year, the department adds and deletes procedure codes and revises procedure codes in accordance with the annual update of the health care financing administration's common procedure coding system (HCPCS).

(1) The department will implement the updated HCPCS coding system on January first.

(2) The HCPCS coding system effective for the calendar year prior to January first (the prior year HCPCS coding system) will continue to be effective for

medicaid providers during a transition period from January first to March thirty-first.

(3) Providers may choose to bill either the updated HCPCS coding system or the prior year HCPCS coding system for dates of service during the transition period from January first to March thirty-first.

(a) During the transition period, all services must be billed using the updated HCPCS system or the prior year HCPCS system. Providers may not use both systems during the transition period.

(b) If a provider chooses to bill the prior year HCPCS system during the transition period, rules that were effective December thirtieth of the prior calendar year will apply to any services provided during the transition period.

(4) To assure a smooth transition to the standard code sets and transactions required under the Health Insurance Portability and Accountability Act (HIPAA), the department will not be doing the annual 2003 update of procedure code revisions or health care financing administration's common procedure coding system (HCPCS) by January 1, 2003. Instead, the codes will be implemented over a nine month period from January 1, 2003 to October 1, 2003.

(N) For dates of service on and after January 1, 2000, the medicaid maximum fee for a medicaid-covered physical medicine and rehabilitation service procedure is the maximum allowable payment for each unit of service as defined by the current procedural terminology (CPT). For dates of service prior to January 1, 2000, payment for physical medicine and rehabilitation service codes defined in time increments (e.g. one unit equals fifteen minutes) is not made on the basis of time; providers may bill for, and payment is limited to, one unit of service for the entire procedure regardless of the time spent.

(O) The column entitled "lab & prof/tech indic." denotes that the procedure is composed of both technical and professional components for a certain time period. A key for the alphabetic codes shown in this column are shown below. For example, the indicator "C" means that the medicaid maximum for the professional component would be forty per cent of the medicaid maximum for the total procedure and the medicaid maximum for the technical component would be sixty per cent of the medicaid maximum for the total procedure.

Key for prof/tech split:

C Forty - sixty

D	Eighty - twenty
E	Professional component - 400
F	Ten - ninety
G	Twenty - eighty
H	Twenty-five - seventy-five
I	Thirty - seventy
J	Thirty-five - sixty-five
K	Fifty - fifty
L	Sixty - forty
M	Seventy - thirty
O	One hundred - zero
P	Seventy-five - twenty-five
Q	Ninety - ten

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