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 collect and/or bill the consumer for any difference between the medicaid payment and the provider's charge or request the consumer to share in the cost through a deductible, coinsurance, co-payment or other similar charge, other than medicaid co-payments as defined in rule 5101:3-1-09 of the Administrative Code.

Nothing in division 5101:3 of the Administrative Code shall preclude providers from charging/collecting, or waiving the collection of, medicare co-payments for medicare part D services to medicaid consumers. Medicaid consumer liability provisions set forth in paragraph (D) of rule 5101:3-1-13.1 of the Administrative Code do not apply to medicare part D services.

(1) For dental, vision, non-emergency emergency department services and prescription services that are subject to a co-payment in accordance with rule 5101:3-1-09 of the Administrative Code, the following principles shall apply:

(a) The medicaid maximum for dental services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-5-01 of the Administrative Code.

(b) The medicaid maximum for vision services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-6-01 of the Administrative Code.

(c) The medicaid maximum for pharmacy services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-9-09 of the Administrative Code.

(d) The medicaid maximum for non-emergency emergency department services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-2-21.1 of the Administrative Code.

(2) In accordance with rule 5101:3-1-08 of the Administrative Code, providers are expected to take reasonable measures to determine any third-party resource available to the consumer and to file a claim with that third party when required to do so under rule 5101:3-1-08 of the Administrative Code. The Ohio department of job and family services shall reimburse the lesser of the provider's billed charge for the service or the medicaid maximum, minus the third-party payment and minus any applicable medicaid copayment amount. If the result is zero or less, medicaid will make no further payment. Providers must bill their usual and customary charge (the amount charged to the general public).

(B) Medicaid reimbursement is not available for non-covered services or for covered services that 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 that are medically necessary and received by eligible medicaid consumers. 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) Except as otherwise provided, 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 to 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, vision, dental and ambulance and ambulette/wheelchair vehicle services, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD to this rule unless otherwise stated in Chapters 5101:3-4, 5101:3-5, 5101:3-6, 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 to this rule. Chapter 5101:3-13 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, payment will be based on the medicaid maximum for the service as shown in appendix DD to this rule.

(3) For medical supplier services, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD to 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 July 1, 2008 through December 31, 2009, the rate shall be two hundred fifty-four dollars and forty-one cents. For dates of service January 1, 2010 and thereafter, the rate shall be two hundred forty-six dollars and seventy-eight cents.

(b) For an ASC-covered procedure classified in surgical group two for dates of service July 1, 2008 through December 31, 2009, the rate shall be three hundred forty-one dollars and ninety-six cents. For dates of service January 1, 2010 and thereafter, the rate shall be three hundred thirty-one dollars and seventy cents.

(c) For an ASC-covered procedure classified in surgical group three for dates of service July 1, 2008 through December 31, 2009, the rate shall be three hundred ninety-two dollars and forty-three cents. For dates of service January 1, 2010 and thereafter, the rate shall be three hundred eighty dollars and sixty-six cents.

(d) For an ASC-covered procedure classified in surgical group four for dates of service July 1, 2008 through December 31, 2009, the rate shall be four hundred eighty-three dollars and seven cents. For dates of service January 1, 2010 and thereafter, the rate shall be four hundred sixty-eight dollars and fifty-eight cents.

(e) For an ASC-covered procedure classified in surgical group five for dates of service July 1, 2008 through December 31, 2009, the rate shall be five hundred fifty-one dollars and five cents. For dates of service January 1, 2010 and thereafter, the rate shall be five hundred thirty-four dollars and fifty-two cents.

(f) For an ASC-covered procedure classified in surgical group six for dates of service July 1, 2008 through December 31, 2009, the rate shall be seven hundred twenty-six dollars and fifteen cents. For dates of service January 1, 2010 and thereafter, the rate shall be seven hundred four dollars and thirty-seven cents.

(g) For an ASC-covered procedure classified in surgical group seven for dates of service July 1, 2008 through December 31, 2009, the rate shall be

seven hundred sixty-five dollars and twenty-nine cents. For dates of service January 1, 2010 and thereafter, the rate shall be seven hundred forty-two dollars and thirty-three cents.

(h) For an ASC-covered procedure classified in surgical group eight for dates of service July 1, 2008 through December 31, 2009, the rate shall be eight hundred thirty-eight dollars and forty-two cents. For dates of service January 1, 2010 and thereafter, the rate shall be eight hundred thirteen dollars and twenty-seven cents.

(i) For an ASC-covered procedure classified in surgical group nine for dates of service July 1, 2008 through December 31, 2009, the rate shall be one thousand sixty-three dollars and ninety-nine cents. For dates of service January 1, 2010 and thereafter, the rate shall be one thousand thirty-two dollars and seven cents.

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

(5) The reimbursement methodology for professional anesthesia services is in accordance with rules 5101:3-4-21, 5101:3-4-21.1 and 5101:3-4-21.2 of the Administrative Code.

(K) For home health and private duty nursing services, the medicaid maximums shall be as described in rules 5101:3-12-05 and 5101:3-12-06 of the Administrative Code respectively.

(L) Except as otherwise permitted by federal statute or regulation and at the department's discretion, the department will assure that the medicaid maximums described in paragraph (J) of this rule, do not exceed the authorized level for the same services under the medicare program.

(M) Effective January first of each calendar year, the department adds, deletes, and revises procedure codes in accordance with the annual update of the healthcare common procedure coding system (HCPCS). The department will implement the updated HCPCS coding system on January first.

(N) The column in appendix DD to this rule entitled "prof/tech split" 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 is shown below at

the end of this paragraph. 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
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

(O) The use of professional (26) and/or technical (TC) modifiers and general rules outlining place of service restrictions are identified with a PCTC indicator in a PCTC indicator column in appendix DD to this rule. Numeric values and the lower case alpha characters that may accompany a PCTC indicator are defined in rule 5101:3-4-11 of the Administrative Code.

Effective: 12/31/2012

CERTIFIED ELECTRONICALLY

Certification

12/31/2012

Date

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