

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-level designation 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 reimbursement methodologies 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 ascertain any third-party resource available to the consumer and to file a claim with that third party. The Ohio department of job and family services shall reimburse the difference between the third party payment and the total medicaid maximum minus the total medicaid co-payment amount.
- (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 actually needed 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 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, vision, dental 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, 5101:3-6, 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 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 numbered 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) Habilitation center services reimbursed through the community alternative funding system are described in rule 5123:2-15-10 of the Administrative Code as authorized in accordance with rule 5101:3-38-10 of the Administrative Code.
- (M) 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.
- (N) 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) defined in rule 5101:3-1-19.3 of the Administrative Code. The department will implement the updated HCPCS coding system on January first.

- (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 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
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

Effective: 03/27/2006

R.C. 119.032 review dates: 11/01/2010

## CERTIFIED ELECTRONICALLY

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### Certification

03/17/2006

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Date

Promulgated Under: 119.03  
 Statutory Authority: 5111.02, 5111.0112  
 Rule Amplifies: 5111.01, 5111.02, 5111.0112, Am. Sub. HB 66 of the 126th GA, section 206.66.44  
 Prior Effective Dates: 7/10/83, 10/1/83 (Emer), 12/29/83, 10/1/84 (Emer), 12/30/84, 2/15/85 (Emer), 5/1/85, 8/1/85, 11/27/85 (Emer), 1/16/86, 5/9/86 (Emer), 7/30/86 (Emer), 10/25/86, 5/1/87, 10/1/87, 1/4/88, 6/23/88, 10/1/88, 1/13/89 (Emer), 4/13/89, 9/1/89 (Emer), 12/1/89, 5/1/90, 6/20/90 (Emer), 9/5/90, 11/23/90, 2/17/91, 5/25/91, 12/30/91, 4/1/92 (Emer), 7/1/92, 7/31/92 (Emer), 10/30/92, 12/31/92 (Emer), 4/1/93, 7/1/93, 11/15/93, 12/30/93 (Emer), 3/31/94, 5/2/94 (Emer), 7/1/94, 9/30/94 (Emer), 12/30/94 (Emer), 3/30/95, 8/1/95, 12/29/95 (Emer), 2/1/96 (Emer), 4/4/96, 12/31/96 (Emer), 3/31/97, 8/1/97, 10/2/97, 12/31/97 (Emer), 3/19/98, 7/1/98, 12/31/98 (Emer), 3/31/99, 12/31/99 (Emer), 3/20/00, 12/31/00 (Emer), 3/30/01, 12/31/01 (Emer), 3/29/02, 7/1/02, 11/14/02, 3/24/03, 7/1/03, 9/25/03, 12/8/03, 1/2/04 (Emer), 4/1/04, 10/01/04, 11/1/04 (Emer), 1/16/05, 9/1/05, 11/17/05, 12/30/05 (Emer)