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 submitted charge. A provider may not collect from a consumer nor bill a consumer for any difference between the medicaid payment and the provider's submitted charge, nor may a provider ask a consumer to share in the cost through a deductible, coinsurance, copayment, or other similar charge other than medicaid copayments as defined in rule ~~5101:3~~5160-1-09 of the Administrative Code. Nothing in ~~division 5101:3~~ agency 5160 of the Administrative Code, however, precludes a provider from requesting payment, collecting, or waiving the collection of medicare copayments from medicaid consumers for medicare part D services. Medicaid consumer liability provisions set forth in rule ~~5101:3~~5160-1-13.1 of the Administrative Code do not apply to medicare part D services.

(1) For dental, vision, and non-emergent emergency department services and prescription services that are subject to a copayment in accordance with rule ~~5101:3~~5160-1-09 of the Administrative Code, the total medicaid maximum fee is reduced by the total medicaid copayment amount. The provider may collect from the consumer or bill the consumer for the total medicaid copayment amount, which is determined in accordance with the relevant rule of the Administrative Code:

(a) For dental services, rule ~~5101:3~~5160-5-01;

(b) For vision services, rule ~~5101:3~~5160-6-01;

(c) For pharmacy services, rule ~~5101:3~~5160-9-09; and

(d) For non-emergent emergency department services, rule ~~5101:3~~5160-2-21.1.

(2) In accordance with rule ~~5101:3~~5160-1-08 of the Administrative Code, providers are expected to take reasonable measures to determine any third-party resource available to a consumer and to file a claim with that third party when required to do so under rule ~~5101:3~~5160-1-08 of the Administrative Code. For a reimbursable claim involving a third-party payer, the Ohio department of medicaid (the department) will reimburse a provider the lesser of two amounts:

(a) The provider's submitted charge; or

(b) The medicaid maximum fee less the sum of the third-party payment and

any applicable medicaid copayment (unless the difference is zero or less, in which case medicaid will make no further payment).

(B) Medicaid reimbursement is not available for non-covered services nor for covered services that are denied by the department as a result of a prepayment review, utilization review, or prior authorization process. (Chapter ~~5101:3~~5160-2 of the Administrative Code describes how these provisions are applied to inpatient and outpatient hospital services.)

(C) Reimbursement is made only for those covered 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 maximum fees, the department must ~~assure~~ ensure that reimbursement is consistent with efficiency, economy, and quality of care.

(D) The state's appropriation determines the total amount of funding that may be expended for services under medicaid. Providers are expected to report their usual and customary charge (the amount charged to the general public) on all claims. ~~If the amount reported on a claim to the department exceeds the department's established medicaid maximum fee, the reimbursement amount will be the medicaid maximum fee.~~ Except as otherwise permitted by federal statute or regulation, the medicaid maximum fees described in this rule must not exceed the established maximum medicare allowed amounts for the same services.

(E) Except as otherwise provided, the department reimburses the lesser of the submitted charge or the medicaid maximum fee for services or supplies furnished by advanced practice nurses, ambulance providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, home health agencies, independent diagnostic testing facilities, independent laboratories, mammography suppliers, medical suppliers, occupational therapists, optometrists, physical therapists, physicians, physician assistants, podiatrists, portable x-ray suppliers, private duty nurses, psychologists, wheelchair van or ambulette providers, and other providers of limited practitioner services.

(F) The department reimburses pharmacies for drugs at the lesser of the submitted charge or the maximum fee allowed in accordance with rule ~~5101:3~~5160-9-05 of the Administrative Code.

(G) Rural health clinics and federally qualified health centers are reimbursed through a prospective payment system established in accordance with federal law. Provisions governing reimbursement for rural health clinic services are set forth in Chapter ~~5101:3~~5160-16 of the Administrative Code and for federally qualified health center services in Chapter ~~5101:3~~5160-28 of the Administrative Code.

(H) Outpatient health facilities are reimbursed through a prospective system based on reasonable costs derived from submitted cost reports. Provisions governing reimbursement for outpatient health facility services are set forth in Chapter ~~5101:3~~5160-29 of the Administrative Code.

(I) Reimbursement for hospital services provided on an inpatient or outpatient basis is described in Chapter ~~5101:3~~5160-2 of the Administrative Code. Reimbursement for services provided in long-term care facilities is described in Chapter ~~5101:3~~5160-3 of the Administrative Code.

(J) The medicaid maximum fees for many professional or facility services are set forth in the text of or appendices to rules of the Administrative Code.

(1) For an ambulance service, ambulatory health care clinic service, clinical laboratory service, dental service, independent diagnostic testing facility service, mammography service, pathology (anatomical laboratory) service (total procedure), physician service, portable x-ray service, radiology service, vision service, or wheelchair van or ambulette service, the medicaid maximum fee is one hundred per cent of the amount specified in the relevant chapter of ~~division 5101:3~~ agency 5160 of the Administrative Code; if no amount is specified in that chapter, then the medicaid maximum fee is one hundred per cent of the amount listed in the appendix to this rule. Chapter ~~5101:3~~5160-13 of the Administrative Code delineates dialysis procedures that must be reported on a claim with appropriate revenue center codes.

(2) For the professional or technical component of a pathology service, the medicaid maximum fee is determined in accordance with paragraph (K) of this rule.

(3) For most medical supplier services, the medicaid maximum fee is one hundred per cent of the amount listed in the appendix to this rule; additional provisions governing reimbursement are set forth in Chapter ~~5101:3~~5160-10 of the Administrative Code.

(4) For a facility service provided by an ambulatory surgery center (ASC), the medicaid maximum fee is the surgical group rate indicated by numeric code in the 'current ASC group' column of the appendix to this rule. Nine surgical group rates have been established for dates of service January 1, 2010, and thereafter:

(a) Group 1: Two hundred forty-six dollars and seventy-eight cents;

(b) Group 2: Three hundred thirty-one dollars and seventy cents;

(c) Group 3: Three hundred eighty dollars and sixty-six cents;

(d) Group 4: Four hundred sixty-eight dollars and fifty-eight cents;

(e) Group 5: Five hundred thirty-four dollars and fifty-two cents;

(f) Group 6: Seven hundred four dollars and thirty-seven cents;

(g) Group 7: Seven hundred forty-two dollars and thirty-three cents;

(h) Group 8: Eight hundred thirteen dollars and twenty-seven cents; and

(i) Group 9: One thousand thirty-two dollars and seven cents.

(5) The reimbursement methodology for professional anesthesia services is set forth in rules ~~5101:3~~5160-4-21, ~~5101:3~~5160-4-21.1, and ~~5101:3~~5160-4-21.2 of the Administrative Code.

(6) Medicaid maximum fees for home health services are described in rule ~~5101:3~~5160-12-05 of the Administrative Code and for private duty nursing services in rule ~~5101:3~~5160-12-06.

(K) Additional factors may affect reimbursement for a procedure, service, or supply.

(1) An entry in the 'prof/tech split' column of the appendix to this rule indicates either that the procedure is composed of both a professional and a technical component for the time period shown or that professional interpretation of the procedure is separately reimbursable. The indicator E (which is not in current use) specifies the maximum fee for professional interpretation as a given percentage of the maximum fee for the procedure itself; the other indicators denote the relative proportions of the medicaid maximum fee allocated to the professional and technical components. For example, the indicator C means that the medicaid maximum fees for the professional component and for the technical component are, respectively, forty per cent and sixty per cent of the medicaid maximum fee for the total procedure. Fourteen indicators appear in the appendix to this rule:

(a) C: Forty per cent / sixty per cent;

(b) D: Eighty per cent / twenty per cent;

(c) E: Four hundred per cent (for professional interpretation) / not applicable;

(d) F: Ten per cent / ninety per cent;

(e) G: Twenty per cent / eighty per cent;

(f) H: Twenty-five per cent / seventy-five per cent;

(g) I: Thirty per cent / seventy per cent;

(h) J: Thirty-five per cent / sixty-five per cent;

(i) K: Fifty per cent / fifty per cent;

(j) L: Sixty per cent / forty per cent;

(k) M: Seventy per cent / thirty per cent;

(l) O: One hundred per cent / zero per cent;

(m) P: Seventy-five per cent / twenty-five per cent; and

(n) Q: Ninety per cent / ten per cent.

(2) In the 'PC/TC indicator' column of the appendix to this rule, a numeric entry shows the degree to which a procedure is professional or technical in nature or has a professional or technical component, which affects reimbursement; these numeric values are defined by the centers for medicare and medicaid services (CMS). A lowercase alphabetic entry indicates a medicaid reimbursement restriction based on the location in which the procedure or service is performed (a place-of-service restriction). Meanings of these numeric and alphabetic indicators are explained in rule ~~5101:3~~5160-4-11 of the Administrative Code.

(3) The department may set reimbursement limits based on the characteristics of an individual procedure, service, or supply or the relationships between procedures, services, or supplies. For example, reimbursement may be

disallowed for a procedure if it is incompatible with another procedure or another procedure makes it redundant. In configuring its claim-processing system, the department may define its own limits, adopt limits established by an authoritative source, or modify limits established by an authoritative source.

(L) "Healthcare common procedure coding system (HCPCS)" is a numeric and alphanumeric code set maintained and distributed by ~~the Centers for Medicare & Medicaid Services (CMS)~~CMS, www.cms.gov, for the uniform designation of certain medical procedures and services. The update of HCPCS at the beginning of each calendar year involves the addition, deletion, and revision of procedure codes. The department updates the appendix to this rule accordingly and implements corresponding changes in the medicaid claim-processing system, which take effect on January first.

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