*** DRAFT – NOT FOR FILING ***

5101:3-13-01 **Fee-for-service ambulatory health care clinics (AHCCs): general provisions.**

Requirements outlined in this rule apply to all fee-for-service AHCCs identified in paragraph (B) of this rule.

(A) Definitions.

(1) "Ambulatory health care clinic (AHCC)" is a free-standing ambulatory health care facility that furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist, without regard to whether the clinic itself is administered by a physician or dentist.

(2) "Ambulatory health care facility," in accordance with the American medical association, national uniform claim committee, health care provider taxonomy, version 6.0, (January 2006), is a facility or distinct part of a facility that:

(a) Provides services on an outpatient basis in a fixed location or specifically designed mobile unit; and

(b) Does not provide overnight accommodations.

(3) "Cost-based ambulatory health care clinic" is an AHCC that is eligible for reimbursement on an encounter basis (in accordance with Chapters 5101:3-16 , 5101:3-28, or 5101:3-29 of the Administrative Code) rather than on a service code basis.

(4) "Department," for the purposes of this chapter, is the Ohio department of job and family services (ODJFS).

(5) "Fee-for-service ambulatory health care clinic" is an AHCC that is eligible for reimbursement on a service code basis (in accordance with chapter 5101:3-13 of the Administrative Code) rather than an encounter basis.

(6) "Free-standing" means having no administrative, organizational, financial or other connection with a hospital or long-term care facility. A free-standing clinic may be physically located in a hospital or long-term care facility as long as the clinic remains independent, as evidenced by cost reports and separate employer identification number (EIN).

(7) "Medical services" are, for the purposes of this Chapter, defined in accordance with rule 5101:3-1-01 of the Administrative Code.

(8) "Non-specialty clinic" is an AHCC that provides a broad range of health care services.

(9) "Specialty clinic" is an AHCC that provides a limited or focused scope of health care services (e.g., dental, vision, dialysis).

(B) Medicaid providers eligible to be reimbursed by the department for AHCC services are either non-specialty or specialty clinics.

(1) Non-specialty clinics are:

(a) Primary care clinics, in accordance with rule 5101:3-13-01.1 of the Administrative Code; and

(b) Public health department clinics, in accordance with rule 5101:3-13-01.3 of the Administrative Code.

(2) Specialty clinics are:

(a) Community mental health/alcohol and drug addiction services clinics, in accordance with rule 5101:3-13-01.2 of the Administrative Code;

(b) Outpatient rehabilitation clinics, in accordance with rule 5101:3-13-01.4 of the Administrative Code;

(c) Family planning clinics, in accordance with rule 5101:3-13-01.5 of the Administrative Code;

(d) Professional optometry school clinics, in accordance with rule 5101:3-13-01.6 of the Administrative Code;

(e) Professional dental school clinics, in accordance with rule 5101:3-13-01.7 of the Administrative Code;

(f) Speech-language/audiology clinics and diagnostic imaging clinics, in accordance with rule 5101:3-13-01.8 of the Administrative Code; and

(g) End-stage renal disease (ESRD) dialysis clinics, in accordance with rule 5101:3-13-01.9 of the Administrative Code.

(C) Any organization applying to be a fee-for-service AHCC medicaid provider on or after January 1, 2008 must:

(1) Meet the definition of an AHCC in accordance with paragraph (A)(1) of this rule;

(2) Not be eligible as a medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as

physical therapists, psychologists, or chiropractors in accordance with division (B)(5)(c)(i) of section 2317.02 of the Revised Code;

(3) Be enrolled as a medicare provider;

(4) Bill medicare as the primary insurer for services provided to patients eligible for both medicare and medicaid;

(5) Meet all specific requirements of at least one medicaid provider type listed under paragraph (B) of this rule;

(6) Submit to the department appropriate documentation of compliance with the requirements set forth in paragraphs (C)(1) to (C)(5) of this rule, in accordance with Chapter 5101:3-1 of the Administrative Code and the Ohio medicaid provider application/agreement for organizations, Job and Family Services (JFS) 0651 (rev. 5/2006).

(D) Covered services include services identified per specific AHCC provider type set forth in rules 5101:3-13-01.1 to 5101:3-13-01.9 of the Administrative Code and the executed Ohio medicaid provider application/agreement for organizations, JFS 0651 (rev. 5/2006). AHCCs may be eligible providers of:

(1) Physician services in accordance with paragraph (D)(1) of rule 5101:3-4-01 of the Administrative Code;

(2) Dental services in accordance with rule 5101:3-5-01 of the Administrative Code;

(3) Vision services in accordance with paragraph (A)(5)(a) of rule 5101:3-6-01 of the Administrative Code;

(4) Podiatry services in accordance with Chapter 5101:3-7 of the Administrative Code;

(5) Advance practice nurse services in accordance with rules 5101:3-8-20 to 5101:3-8-23 of the Administrative Code;

(6) Laboratory services in accordance with rule paragraph (A)(2) of rule 5101:3-11-02 of the Administrative Code, if certified to perform laboratory procedures under Clinical Laboratory Improvement Act (CLIA);

(7) Psychology services in accordance with paragraph (E)(1) of rule 5101:3-8-01 of the Administrative Code;

(8) EPSDT services in accordance with Chapter 5101:3-14 of the Administrative Code;

(9) Transportation services in accordance with 5101:3-15 of the Administrative Code;

(10) Disability medical assistance in accordance with Chapter 5101:3-23 of the Administrative Code; and

(11) Therapy services in accordance with Chapter 5101:3-34 of the Administrative Code.

(E) Limitations.

(1) AHCCs must follow all applicable general medicaid provisions of Chapter 5101:3-1 of the Administrative Code, including, but not limited to:

(a) The co-payment program set forth in rule 5101:3-1-09 of the Administrative Code; and

(b) Co-payments in managed care settings set forth in Chapter 5101:3-26 of the Administrative Code.

(2) AHCCs are limited to specific types of services and/or reimbursement codes as specified by provider type in rules 5101:3-13-01.1 to 5101:3-13-01.9 of the Administrative Code.

(3) Coverage limitations set forth in Chapter 5101:3-4 of the Administrative Code apply to AHCC services provided by physicians.

(4) Coverage limitations set forth in Chapter 5101:3-5 of the Administrative Code apply to AHCC services provided by dentists.

(5) Coverage limitations set forth in Chapter 5101:3-6 of the Administrative Code apply to AHCC services provided by opticians and optometrists.

(6) Coverage limitations set forth in Chapter 5101:3-7 of the Administrative Code apply to AHCC services provided by podiatrists.

(7) Coverage limitations set forth in rule 5101:3-8-23 of the Administrative Code also apply to advanced practice nurse services provided under the auspices of an AHCC.

(8) Take-home drugs must be billed through the pharmacy program as described in Chapter 5101:3-9 of the Administrative Code.

(9) Durable medical equipment (DME) for take-home use must be billed through the DME program as described in Chapter 5101:3-10 of the Administrative Code.

(10) Coverage limitations set forth in Chapter 5101:3-11 of the Administrative Code also apply to laboratory services provided by AHCCs.

(11) Coverage limitations set forth in rule 5101:3-8-05 of the Administrative Code apply to AHCCs providing psychology services.

(12) Coverage limitations set forth in Chapter 5101:3-14 of the Administrative Code apply to AHCCs providing services to individuals age birth to twenty-one years of age.

(13) Coverage limitations set forth in rules 5101:3-8-05 and 5101:3-4-29 of the Administrative Code also apply to mental health services provided under the auspices of an AHCC.

(14) Coverage limitations set forth in Chapters and 5101:3-15 of the Administrative Code apply to AHCCs providing transportation services.

(15) Coverage limitations set forth in Chapters 5101:3-17 and 5101:3-21 of the Administrative Code, regarding abortion and sterilization procedures, apply to AHCCs.

(16) Coverage limitations set forth in Chapter 5101:3-23 of the Administrative Code apply to AHCCs providing disability medical assistance medical program services.

(17) Coverage limitations set forth in Chapter 5101:3-26 of the Administrative Code apply to AHCCs with medicaid managed care program contracts. For consumers in the medicaid managed care program, claims submission requirements, including prior authorization requests for AHCC services, are specified in rules 5101:3-26-03.1 and 5101:3-26-05.1 of the Administrative Code.

(18) Coverage limitations set forth in Chapter 5101:3-34 of the Administrative Code also apply to therapy services provided under the auspices of an AHCC.

(F) The department reimburses fee-for-service AHCCs in accordance with rule 5101:3-1-60 of the Administrative Code.

Replaces: 5101:3-13-01, Part of 5101:3-13-03, Part of 5101:3-13-04, Part of 5101:3-13-05, Part of 5101:3-13-06

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