5101:3-30-04 **Reimbursement and rate setting for community medicaid alcohol and other drug services.**

(A) This rule sets forth the reimbursement and rate setting for the following community medicaid alcohol and other drug treatment services:

(1) "Ambulatory detoxification services" as defined in paragraph (X) of rule 3793:2-1-08 of the Administrative Code.

(2) "Assessment services" as defined in paragraph (K) of rule 3793:2-1-08 of the Administrative Code.

(3) "Case management services" as defined in paragraph (M) of rule 3793:2-1-08 of the Administrative Code.

(4) "Crisis intervention services" as defined in paragraph (L) of rule 3793:2-1-08 of the Administrative Code.

(5) "Group counseling" as defined in paragraph (O) of rule 3793:2-1-08 of the Administrative Code.

(6) "Individual counseling" as defined in paragraph (N) of rule 3793:2-1-08 of the Administrative Code.

(7) "Intensive outpatient services" as defined in paragraph (Q) of rule 3793:2-1-08 of the Administrative Code.

(8) "Laboratory urinalysis" as defined in paragraph (R) of rule 3793:2-1-08 of the Administrative Code.

(9) "Medical/somatic services" as defined in paragraph (S) of rule 3793:2-1-08 of the Administrative Code.

(10) "Methadone administration services" as defined in paragraph (T) of rule 3793:2-1-08 of the Administrative Code.

(B) Each agency shall maintain a fee schedule of usual and customary charges for all community medicaid alcohol and other drug treatment services it provides. The agency shall bill the community medicaid program its usual and customary charge for a medicaid-covered service. The reimbursement rate to each agency shall be the lesser of the agency's usual and customary charge or the amount established per paragraph (E)(2) of this rule.

(C) The community medicaid program will not pay for community medicaid alcohol and other drug treatment services for medicaid clients when those same services are routinely provided to non-medicaid clients at no charge, except when medicaid reimbursement for such services are prescribed by federal law or in rule 5101:3-1-03 of the Administrative Code. If a reduced charge or no charge is made,

the lowest charge made becomes the medicaid rate for that service. The community medicaid alcohol and other drug treatment services are not considered to be provided to non-medicaid clients at no charge or at a reduced charge if all of the following requirements are met:

(1) The agency establishes a fee schedule of usual and customary charges (UCC) for each service available and the agency utilizes a sliding fee schedule whereby individuals without third party insurance are charged; and

(2) The agency collects third-party insurance information from all medicaid and non-medicaid clients; and

(3) The agency bills other responsible third party insurers or payers in accordance with rule 5101:3-1-08 of the Administrative Code when such insurers or payers are known.

(D) The agency may enter into arrangements with insurers and other responsible payers for reimbursement at levels that may differ from the published usual and customary fee schedule.

(E) Methods and standards for establishing prospective cost based unit rates for community medicaid alcohol and other drug treatment services.

(1) A prospective unit rate for each community medicaid alcohol and other drug treatment service will be calculated in accordance with the uniform cost report as established in rule 3793:2-1-09 of the Administrative Code and thus may vary from agency to agency.

(2) The prospective unit rate for covered community medicaid alcohol and other drug treatment services will be the lesser of an agency's unit rate calculated on the budgeted uniform cost report as established in rule 3793:2-1-09 of the Administrative Code or the individual service rate ceiling as established below.

(a) Ambulatory detoxification: one hundred ninety-three dollars and eighty-seven cents per unit. One unit of ambulatory detoxification is one day, there are no fractions of this unit.

(b) Assessment: ninety-six dollars and twenty-four cents per unit. One unit of assessment is one hour, fractions of this unit are allowed, reportable in six minute increments represented by tenths.

(c) Case management: seventy-eight dollars and seventeen cents per unit. One unit of case management is one hour, fractions of this unit are allowed, reportable in six minute increments represented by tenths.

(d) Crisis intervention: one hundred twenty-nine dollars and fifty-nine cents

per unit. One unit of crisis intervention is one hour, fractions of this unit are allowed, reportable in six minute increments represented by tenths.

(e) Group counseling: nine dollars and fifty-two cents per unit. One unit of group counseling is fifteen minutes and there are no fractions of units of this service allowed.

(f) Individual counseling: twenty-one dollars and eighty-two cents per unit. One unit of individual counseling is fifteen minutes and there are no fractions of units of this service allowed.

(g) Intensive outpatient: one hundred thirty-six dollars and ninety cents per unit. One unit of intensive outpatient is one day, there are no fractions of this unit.

(h) Laboratory urinalysis: sixty dollars per unit. One unit of laboratory urinalysis is defined as a screen, regardless of the number of panels and there are no fractions of units of this service allowed.

(i) Medical/somatic: one hundred seventy-six dollars and twenty-eight cents per unit. One unit of medical/somatic is one hour, fractions of this unit are allowed, reportable in six minute increments represented by tenths.

(j) Methadone administration: sixteen dollars and thirty-eight cents per unit. One unit of methadone administration is one dose and there are no fractions of units of this service allowed.

(3) Individual service unit rates shall be established at the beginning of each state fiscal year. The unit rate shall be established consistent with the guidelines for determining these costs contained in rule 3793:2-1-09 Administrative Code.

All agencies are required to file the budgeted version of the uniform cost report for medicaid rate setting purposes no later than June first of each calendar year with the Ohio department of alcohol and drug addiction services (ODADAS) and simultaneously send a copy to the ADAMHS/ADAS board for the service district in which the AOD program owner's primary place of business is located. The unit rates reported on the budgeted version of the uniform cost report will be used as the agency's prospective rates for the subsequent state fiscal year. Failure to file a budgeted uniform cost report will result in no change to the prospective unit rates for the stated time period. Any budgeted uniform cost report received after June first will be considered untimely. The untimely budgeted uniform cost report may be resubmitted as a request for rate adjustments in accordance with paragraph (E)(4) of this rule.

(4) Agencies may make rate adjustments to the unit rates within the state fiscal year

by submitting a revised budgeted uniform cost report to ODADAS and simultaneously send a copy to the ADAMHS/ADAS board for the service district in which the AOD program owner's primary place of business is located. Budgeted uniform cost reports for adjusted rates will not be accepted by ODADAS until on or after July first of any calendar year. Rate adjustments to the current period will not be accepted after May first of any calendar year.

(5) Adjustments to the rate(s) will become effective within ten business days of receipt by ODADAS or a later date if requested by the agency. Retroactive rate adjustments will not occur.

(6) Rates for services not previously contracted for and listed in paragraph (A) of this rule may be added by an agency at any time during the state fiscal year. The prospective unit rate(s) for additional services will be based upon a budgeted uniform cost report amended to include the additional services.

(a) If the budgeted uniform cost report reflects rate adjustment(s) for existing unit rates, paragraphs (E)(4) and (E)(5) of this rule apply.

(b) An agency must specify a rate effective date for services not previously contracted for and listed in paragraph (A) of this rule. For new services this effective date can be up to three hundred and sixty-five days prior to submission. This is not considered a retroactive rate adjustment.

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