

ACTION: ORIGINAL  
FILED

DATE: 09/24/2002  
11:23 AM

**Rule Summary and Fiscal Analysis (Part A)**

**Department Of Job And Family Services**

Agency Name

**Division Of Medical Assistance**

Division

**Mary H Mynatt**

Contact

**30 East Broad St. 31st Floor Columbus OH 43266 - 614-466-4605**  
**0423**

Agency Mailing Address (Plus Zip)

Phone

Fax

**5101:3-4-12**

Rule Number

**AMENDMENT**

TYPE of rule filing

Rule Title/Tag Line

**Immunizations.**

**RULE SUMMARY**

1. Is the rule being filed consistent with the requirements of the RC 119.032 review? **Yes**

2. Are you proposing this rule as a result of recent legislation? **No**

3. Statute prescribing the procedure in accordance with the agency is required to adopt the rule: **119.03**

4. Statute(s) authorizing agency to adopt the rule: **5111.02**

5. Statute(s) the rule, as filed, amplifies or implements: **5111.02**

6. State the reason(s) for proposing (i.e., why are you filing,) this rule:

To amend the rule.

7. If the rule is an AMENDMENT, then summarize the changes and the content of the proposed rule; If the rule type is RESCISSION, NEW or NO CHANGE,

then summarize the content of the rule:

This rule contains policies relating to immunization services covered by Medicaid. The Department is amending this rule to discontinue certain local level codes which are not compliant with H.I.P.A.A. regulations and to use standard codes for these services. Policy on immune globulin services is also being updated.

8. If **revising** or **refiling** this rule, identify changes made from the previously filed version of this rule; if none, please state so:

*Not Applicable.*

9. 119.032 Rule Review Date: **9/24/2002**

(If you answered NO to question No. 1, provide the scheduled review date. If you answered YES to No. 1, the review date for this rule is the filing date.)

NOTE: At time of final filing, two dates are required: the current review date plus a date not to exceed 5 years from the effective date for Amended rules or a date not to exceed 5 years from the review date for No Change rules.

### **FISCAL ANALYSIS**

10. Estimate the total amount by which *this proposed rule* would **increase / decrease** either **revenues / expenditures** for the agency during the current biennium (in dollars): Explain the net impact of the proposed changes to the budget of your agency/department.

This will have no impact on Revenues or Expenditures

\$ 0.00

This proposed rule will not change the Agency's projected budget during the current biennium.

11. Identify the appropriation (by line item etc.) that authorizes each expenditure necessitated by the proposed rule:

Item: N/A

Expenditure: N/A

12. Provide a summary of the estimated cost of compliance with the rule to all directly affected persons. When appropriate, please include the source for your information/estimated costs, e.g. industry, CFR, internal/agency:

While there is no cost to comply with these changes, providers billing the local level codes must begin using standard codes for these services when billing Medicaid. Providers would already be using standard codes for other payers.

13. Does this rule have a fiscal effect on school districts, counties, townships, or municipal corporations? **No**

14. Does this rule deal with environmental protection or contain a component dealing with environmental protection as defined in R. C. 121.39? **No**