5160-1-60 **Medicaid payment.**

(A) The medicaid payment for a covered procedure, service, or supply constitutes payment in full and may not be construed as a partial payment when the payment amount is less than the provider's submitted charge. A provider may not collect from a medicaid recipient nor bill a medicaid recipient for any difference between the medicaid payment and the provider's submitted charge, nor may a provider ask a medicaid recipient to share in the cost through a deductible, coinsurance, copayment, or other similar charge other than medicaid copayments as defined in rule 5160-1-09 of the Administrative Code. Nothing in agency 5160 of the Administrative Code, however, precludes a provider from requesting payment, collecting, or waiving the collection of medicare copayments from a medicaid recipient for medicare part D services. Medicaid recipient liability provisions set forth in rule 5160-1-13.1 of the Administrative Code do not apply to medicare part D services.

(B) Providers are expected to submit their usual and customary charge (the amount charged to the general public) on all claims. The medicaid payment amount for a covered service, procedure, or supply is the lesser of the submitted charge or the established medicaid maximum. Medicaid maximum payment amounts for many existing services, procedures, and supplies, particularly services rendered by practitioners of the healing arts, are set forth in the appendix to this rule. The initial maximum payment amount for a covered procedure, service, or supply represented by a new procedure code that takes effect at the beginning of a calendar year is established in accordance with paragraph (J) of this rule. Specific payment amounts or payment formulas set forth in other rules in agency 5160 of the Administrative Code supersede corresponding entries in the appendix to this rule.

(C) Pursuant to rule 5160-1-08 of the Administrative Code, providers are expected to take reasonable measures to determine any third-party resource available to a medicaid recipient and to file a claim with that third party when required to do so under rule 5160-1-08 of the Administrative Code. When there is a third-party payer, medicaid payment for a covered procedure, service, or supply is the lesser of two amounts:

(1) The provider's submitted charge; or

(2) The medicaid maximum payment amount less the sum of all third-party payments and any applicable medicaid copayment (unless the difference is zero or less, in which case medicaid will make no further payment).

(D) For services that are subject to a copayment pursuant to rule 5160-1-09 of the Administrative Code, the total medicaid maximum payment amount is reduced by the total medicaid copayment. The provider may collect from the medicaid recipient or bill the medicaid recipient for the total medicaid copayment, which is determined in accordance with the relevant rule of the Administrative Code.

(E) For a facility service provided by an ambulatory surgery center (ASC), the medicaid maximum payment amount is the surgical group rate indicated by numeric code in the 'current ASC group' column in the section of the appendix to this rule that pertains to ASC services. For dates of service beginning January 1, 2010, nine surgical group rates have been established:.

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

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

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

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

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

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

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

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

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

(F) Except as otherwise permitted by federal statute or regulation, the medicaid maximum payment amounts described in this rule must not exceed the established maximum medicare allowed amounts for the same procedures, services, or supplies.

(G) Medicaid payment is not allowed for non-covered procedures, services, and supplies nor for covered procedures, services, or supplies that are denied by the department as a result of a prepayment review, utilization review, or prior authorization process. (Chapter 5160-2 of the Administrative Code describes how these provisions are applied to inpatient and outpatient hospital services.)

(H) Additional information about the coverage of and payment for certain procedures is shown in the 'prof/tech split' and 'PC/TC indicator' columns of the appendix to this rule.

(1) A 'prof/tech split' entry indicates that the procedure is made up of both a

professional and a technical component for the time period shown. The indicator denotes the relative proportions of the medicaid maximum payment amount allocated to the professional and technical components. For example, the indicator C means that the medicaid maximum payment amounts for the professional component and for the technical component are, respectively, forty per cent and sixty per cent of the medicaid maximum payment amount for the total procedure. There are thirteen such indicators:

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) A numeric 'PC/TC indicator' entry shows the degree to which a procedure is professional or technical in nature or has a professional or technical component; these numeric values are defined by the centers for medicare and medicaid services (CMS), http://www.cms.gov. A lowercase alphabetic 'PC/TC indicator' entry indicates a medicaid payment restriction based on the location in which the procedure is performed (a place-of-service restriction).

Meanings of these numeric and alphabetic indicators are summarized in the appendix to this rule.

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

(J) The "Healthcare Common Procedure Coding System (HCPCS)" is a numeric and alphanumeric code set maintained and distributed by CMS for the uniform designation of certain medical procedures and related services. Level one of HCPCS consists of "Current Procedural Terminology (CPT)," a comprehensive listing of medical terms and codes published by the American medical association (AMA), http://www.ama-assn.org, for the uniform designation of diagnostic and therapeutic procedures in surgery, medicine, and the medical specialties. At the beginning of each calendar year, CMS and the AMA may add procedure codes, discontinue (delete) procedure codes, and revise the descriptions of procedure codes. For a covered procedure, service, or supply represented by a new HCPCS procedure code that takes effect at the beginning of a calendar year, the initial maximum payment amount is set at eighty per cent of the medicare allowed amount. For convenience, a list of such initial maximum payment amounts is posted no later than January first on the department's web site, http://medicaid.ohio.gov.

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Certification

12/21/2015

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