

Outpatient Health Facility Services Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

The Electronic Publishing Unit makes every attempt to publish accurate and current information, however, we disclaim any liability or responsibility for any typographical errors, out of date information and/or other inaccuracies that may appear in this document.

To receive eMail notifications of policy updates, go to the **ODM Email List Sign-up site** (<http://www.medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>) and subscribe to the type of communications in which you are interested. eMail notifications are sent as updates are posted to the eManuals site.

eManual Contents		
<i>Please send comments to ePubs_updates@jfs.ohio.gov</i>		
<u>Miscellaneous Medicaid Handbook Transmittal Letters</u>	<u>Managed Care Medical Assistance Letters (MALs)</u>	<u>OAC Rules Related to Outpatient Health Facilities</u>

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

[Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates](#)

MHTL 3336-10-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-01 (Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule), is maintained in the Physician Services e-book.

[Click here to view MHTL 3336-10-01, Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule](#)

Medical Assistance Letters

MAL 567 (Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule)

Medical Assistance Letter (MAL) 567

January 22, 2010

TO: All Eligible Outpatient Health Facilities
FROM: Douglas E. Lumpkin, Director
SUBJECT: Addition of H1N1 Pandemic Influenza Vaccine to Immunizations Rule

This letter provides information regarding changes to Ohio Administrative Code (OAC) rule [5101:3-4-12](#) Immunizations.

Rule [5101:3-4-12](#) specifies immunizations that are covered for the Medicaid population. The rule is being proposed for amendment to include the Current Procedural Technology (CPT) code 90663 (Influenza virus vaccine, pandemic formulation) to the list of designated free vaccines so that providers may bill for immunizations against the pandemic influenza virus, H1N1. The Department will reimburse \$10 for the administration of each dose of this vaccine needed for both children and adults. The rule also specifies how Medicaid providers can obtain the pandemic influenza vaccine free of charge from the Ohio Department of Health. It is also being modified for five-year rule review, to update date references and to clarify existing policy.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms and handbooks. The URL is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MAL 561

Medical Assistance Letter No 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 561, Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies](#)

MAL 554

Medical Assistance Letter (MAL) 554

July 10, 2009

TO: All Eligible Advance Practice Nurse Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Pregnancy Prevention/Contraceptive Management Services (Family Planning)

This letter provides information regarding the rescission, amendment, and issuance of Ohio Administrative Code (OAC) rules related to pregnancy prevention and contraceptive management services ("family planning services").

Important elements of these rules include:

1. Family planning means preventing or delaying pregnancy.
2. Family planning services means pregnancy prevention/contraceptive management services.
3. Family planning services are not subject to a co-payment, regardless of gender.
4. Infertility services are not Medicaid covered.
5. Hysterectomies and voluntary sterilizations are Medicaid covered services.
6. Providers must include valid Medicaid-covered CPT and/or HCPCS procedure codes and a valid contraceptive management diagnosis code (V25.0 through V25.9) on claims for pregnancy prevention/contraception services.

OAC rule [5101:3-1-09](#) is titled "Medicaid co-payment program [except for Medicaid consumers enrolled in the Medicaid managed health care program]." This rule establishes co-payment requirements for Medicaid consumers. Paragraph (C)(5) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that these services are not subject to a co-payment, regardless of gender. This rule is also amended to update a rule reference and correct grammatical errors.

OAC rule [5101:3-4-02](#) is titled "Scope of coverage." This rule establishes the requirements of physician supervision of services provided by nonphysicians. Paragraph (D)(2)(d) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update rule references, improve sentence structure, delete an out of date reference to registered nurses, and include a reference to occupational therapists.

OAC rule [5101:3-4-07](#) is titled "Family planning services." This rule is rescinded and replaced with rules [5101:3-21-02](#), [5101:3-21-02.1](#), and [5101:3-21-02.2](#).

OAC rule [5101:3-4-13](#) is titled "Therapeutic injections (including trigger point injections) and prescribed drugs." This rule sets forth requirements related to Medicaid coverage of therapeutic injection services. Paragraph (A)(3)(a)(iii) of this rule is amended to clarify that infertility treatment services are not Medicaid covered.

OAC rule [5101:3-4-28](#) is titled "Noncovered services." This rule describes services that are not covered by Medicaid. Paragraphs (E) and (F) are removed to clarify that hysterectomies and voluntary sterilizations are Medicaid covered services. Paragraphs (G) and (H) are amended to clarify that infertility treatment services are not Medicaid covered. This rule is also amended to remove redundant language and to update a rule reference.

OAC rule [5101:3-4-34](#) is titled "Preventive medicine services." This rule defines preventive medicine as services that prevent disease, maintain good health, and proactively avoid disease, disability and death. This rule specifies which preventive medicine services are covered under the Ohio Medicaid program. Paragraph (B)(4) of this rule is amended to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update rule references and correct formatting errors.

OAC rule [5101:3-13-01.5](#) is titled "Fee-for-service ambulatory health care clinics (AHCCs): family planning clinics." This rule outlines requirements that apply to all fee-for-service family planning AHCCs. This rule is amended to clarify definitions in paragraph (A) and to clarify that family planning services means pregnancy prevention/contraceptive management services. This rule is also amended to update a rule reference.

OAC rule [5101:3-21-01](#) is titled "Sterilization." This rule sets forth requirements regarding Medicaid coverage of permanent sterilization and hysterectomy procedures. This rule is rescinded and replaced with new rule [5101:3-21-02.2](#), "Medicaid covered reproductive health services: permanent contraception/sterilization services."

OAC rule [5101:3-21-01](#) is titled "Medicaid covered reproductive health services: preconception care services." This new rule describes Medicaid coverage of services that are provided for the primary purpose of achieving optimal outcome of future pregnancies.

OAC rule [5101:3-21-02](#) is titled "Medicaid covered reproductive health services: pregnancy prevention/contraception services overview." This new rule replaces, in part, rescinded rule [5101:3-4-07](#) and describes Medicaid coverage of services that are provided for the primary purpose of pregnancy prevention/contraceptive management.

OAC rule [5101:3-21-02.1](#) is titled "Medicaid covered reproductive health services: temporary pregnancy prevention/contraception services." This new rule replaces, in part, rescinded rule [5101:3-4-07](#) and describes Medicaid coverage of services provided for the primary purpose of temporary pregnancy prevention/contraceptive management.

OAC rule [5101:3-21-02.2](#) is titled "Medicaid covered reproductive health services: permanent contraception/sterilization services." This new rule replaces, in part, rescinded rule [5101:3-21-01](#) and in part, rescinded rule [5101:3-4-07](#). This new rule describes Medicaid coverage of services that are provided for the purpose of permanent pregnancy prevention/contraceptive management (sterilization).

OAC rule [5101:3-21-03](#) is titled "Medicaid covered reproductive health services: infertility services." This new rule describes Medicaid coverage of infertility services.

OAC rule [5101:3-29-01](#) is titled "Eligible providers." This rule describes Medicaid requirements pertaining to provider enrollment as an "outpatient health facility" (OHF). Paragraph (E) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and that such services are considered preventive in nature. This rule is also amended to update a rule reference, correct spelling and grammatical errors, and incorporate terminology consistent with Chapter [5101:3-4](#) of the Administrative Code.

OAC rule [5101:3-29-04](#) is titled "Billable services." This rule specifies Medicaid requirements pertaining to services provided by outpatient health facilities. Paragraph (B) is amended to clarify that family planning services means pregnancy prevention/contraceptive management services and to clarify that such services are considered preventive in nature. This rule is also amended to restructure paragraph (B)(1)(c) and correct spelling and grammatical errors.

These rules do not include detailed information regarding Medicaid coverage of pharmacy, durable medical equipment, and laboratory services as they relate to pregnancy prevention/contraceptive management services. Please refer to Chapters [5101:3-9](#), [5101:3-10](#), and [5101:3-11](#) of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to these topics.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided in hospitals. Please refer to Chapter [5101:3-2](#) of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to facility providers.

These rules do not include detailed information regarding Medicaid coverage of pregnancy prevention/contraceptive management services provided under managed care. Please refer to Chapter [5101:3-26](#) of the Ohio Administrative Code for details regarding Ohio Medicaid rules related to Medicaid managed care.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;

- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "[5101:3-1-60](#) Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MAL 553

Medical Assistance Letter (MAL) 553

February 19, 2009

TO: All Eligible Outpatient Health Facility (OHF) Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Physician Assistants

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rule 5101:3-4-02, "Scope of coverage" and the rescission and adoption of new OAC rule 5101:3-4-03, "Physician assistants."

OAC rule [5101:3-4-02](#) is titled "Scope of coverage." This amended rule outlines the requirements regarding physician supervision of non-physicians when non-physicians provide Medicaid reimbursable services. This rule is amended to incorporate changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This amended rule updates the reference to the required level of physician supervision of physician assistants so that such reference is consistent with proposed rule 5101:3-4-03, "Physician assistants," of the Administrative Code. Specifically, this rule removes paragraph (C)(2)(c), which indicated that physician assistants must be "under the general supervision of the physician" in order for Medicaid to reimburse eligible providers for provision of physician assistant services. This amended rule includes a new reference, paragraph (D), to rule 5101:3-4-03 and Chapter 4730-1 of the Administrative Code, "Physician assistants." This referenced rule addresses the required level of physician supervision of physician assistants in order for Medicaid to reimburse eligible providers for provision of physician assistant services.

OAC rule [5101:3-4-03](#) is titled "Physician Assistants." This new rule incorporates changes to the practice of physician assistants contained in Ohio Revised Code 4730.01 -- 4730.22, adopted under Sub. SB 154 of the 126th General Assembly. This new rule explains the conditions under which Ohio Medicaid will reimburse Medicaid providers for physician assistant services.

This new rule:

- Provides new and updated definitions as well as definitions by reference;
- Provides updated references to the Section 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code that govern the practice of Physician Assistants in Ohio;
- Removes requirements that a patient new to a physician's practice must be seen and personally evaluated by the employing physician before any treatment plan is initiated by the physician assistant;
- Removes requirements that an established patient with a new condition must be seen and personally evaluated by the supervising physician or prior to initiation of any treatment plan for that condition;
- Removes requirements that medical records for patients new to a physician's practice and medical records for established patients with a new condition must document that the supervising physician was physically present, saw and evaluated the patient and discussed patient management with the physician assistant;
- Clarifies that Medicaid providers will not be reimbursed for visits provided on the same date of service by both a physician assistant and his/her supervising physician, employing physician, employing physician group practice, or employing clinic; and
- Clarifies that direct reimbursement is not available for services provided by a hospital employed physician assistant. The reimbursement for the services provided by the physician assistant is bundled into the facility payment made to the hospital.

This rule does not include information regarding Medicaid coverage of Pharmacy, Durable Medical Equipment, and Laboratory Services. Please refer to Chapters 5101:3-9, 5101:3-10, and 5101:3-11 of the Ohio Administrative Code for Ohio Medicaid requirements related to these topics.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers"; and
- (3) Selecting "[5101:3-1-60](#) Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
800-686-1516

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[**Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.**](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 513

Medical Assistance Letter (MAL) 513

September 22, 2006

To: Outpatient Health Facilities (OHFs)
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Barbara E. Riley, Director

Re: Information about the National Provider Identifier (NPI)

In accordance with federal regulations (45 CFR § 160.103 45 CFR § 162.404), health care providers that conduct business in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) will be required to obtain a unique, ten-digit National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). The deadline for providers to begin using their NPI to bill and receive payments electronically from Medicare and Medicaid is May 23, 2007. This MAL provides direction to Outpatient Health Facilities (OHFs) on how to enumerate through NPPES to ensure successful Medicaid billing and reimbursement in Ohio using the NPI. OHFs need to enumerate through NPPES prior to the May 23, 2007 deadline. To obtain a National Provider Identifier, OHFs should contact NPPES directly at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (1-800-692-2326 (TTY)). Providers can apply for an NPI electronically or by paper.

I. Background: NPI Enumeration to Support Medicaid Reimbursement

Provider Type 04 - Prospective Payment OHF Claims

Currently, OHFs bill and receive payment based on a prospective payment established by the Department. The advent of the NPI enumeration process will not change this payment method, and new OHFs will continue to be assigned a seven-digit Medicaid provider number upon enrollment. In the future, ODJFS will refer to the Medicaid provider number as the legacy number. To maintain this method of reimbursement, each OHF must have and use a NPI number.

Provider Type 50 - Fee-for-Service Clinic Claims

Currently, OHFs use a second Medicaid provider number to bill for non-PPS covered services. They bill as a type 50 fee-for-service clinic when they bill for the following:

- 1.) Disability Medical Assistance claims;
- 2.) Medicare crossover claims not paid through the automatic crossover process; and,
- 3.) Inpatient hospital surgery, visits, or consultation claims.

It will be necessary for each OHF to separately apply for and receive a second NPI number to continue to bill and be reimbursed for non-PPS services.

II. NPI Details

As described above, OHFs that have two Medicaid provider numbers will need to acquire two NPI numbers. One NPI number will be used to submit type 04 OHF PPS claims; the other NPI number will be used to submit type 50 fee-for-service clinic claims.

OHFs can receive two different NPI numbers by submitting **two different applications** to NPPES using a different taxonomy code in each application. The taxonomy codes to use are:

261QC1500X for OHF (type 04) claims; and,

261QP2300X for fee-for-service (type 50) claims. (This taxonomy refers to a primary care clinic.)

OHFs should use these codes when completing Section D of the NPI applications when asked for the "provider taxonomy code."

The requirement for an NPI number applies both to existing OHF sites and to any OHF enrolling for the first time. The Department has updated the Medicaid provider application to capture the ten-digit NPI number from new OHFs enrolling for the first time. The NPI number should be submitted on page two of the provider application.

The NPI number can be used as soon as it is received. When billing ODJFS electronically, **OHFs should use the NPI number in conjunction with the Medicaid provider number.** (Instructions follow below.) The NPI number must be used to adjudicate EDI claims on and after May 23, 2007, the NPI deadline date.

Billing NPI on EDI Claims

The NPI number should be entered in the primary identifier field on ASCII X12 837 health care transactions. (Note: OHFs are required to bill Ohio Medicaid on the 837 Professional (P) transaction.)

When submitting EDI claims with the NPI, OHFs should use the qualifier XX in the primary identification qualifier location NM108 and the NPI in the primary identification location NM109. OHFs should continue to submit their Medicaid provider number with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid provider number in the secondary identification location REF02 until May 23, 2007 as directed in the NPI Final rule. OHFs will submit their provider identifiers in the 2010AA loop of the 837 P transaction. OHFs are not required to send the rendering provider loop in the 837. If a rendering provider loop 2310B is submitted in the 837, errors in reimbursement will occur.

Billing on Paper Claims or by Tape

OHFs should continue to use their Medicaid provider number when submitting claims in formats that use only the Medicaid provider number, e.g., the current CMS 1500 paper claim.

III. Changes in Crossover Claims Processing

Medicaid is working on being able to receive Medicare crossover claims automatically from the fiscal intermediary used by OHFs. When this happens, crossover claims will be processed using the type 04 OHF provider number. To avoid the possibility of duplicate claims payment, OHFs should check to determine whether payment has already been made under the type 04 OHF provider number before submitting crossover claims using the type 50 fee-for-service clinic number. The claim may have already crossed over to ODJFS and been paid.

ODJFS appreciates the attention of the OHFs to this matter, and as a result of their cooperation, anticipates a successful transition to NPI.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516**

MAL 480

Medical Assistance Letter (MAL) No. 480

February 25, 2005

TO: Outpatient Health Facilities (OHFs)
FROM: Barbara E. Riley, Director
SUBJECT: Five-year rule review: OHF rules

The purpose of this Medicaid Assistance Letter (MAL) is to announce updates resulting from five-year rule review of the OHF rules. These rule amendments will be effective May 1, 2005.

The full text of each of these rule amendments can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Outpatient Health Facility book.

I. Rule amendments:

Rule 5101:3-29-01

Rule 5101:3-29-03

Rule 5101:3-29-04

Rule 5101:3-29-05

The amendments to the rules listed above did not result in policy changes. The amendments consist mainly of grammatical or technical changes which may improve the reader's understanding of the rule content. There were also some technical corrections to:

1) references to other paragraphs within each rule; 2) references to existing Ohio Administrative Code rules; or 3) corrections to references to Ohio Revised Code.

In paragraph (C) of rule 5101:3-29-04 entitled Billable services, there was a clarification that medical supplies used during a visit, e.g. dressings, adhesives, are considered part of the medical encounter and should not be billed for separately. Those supplies which are given to the patient to be used later at home, e.g. colostomy supplies are to be billed separately as a medical supply. The rules for medical supplies and durable medical equipment may be found in Chapter 5101:3-10 of the Administrative Code.

In the OHF reimbursement rule, 5101:3-29-05 of the Ohio Administrative Code, paragraph (E) provides the correct form number (JFS 03421) used by OHF for cost reporting purposes.

II. Paper copies of this update

If a provider does not have access to the internet and wishes to request a paper copy of this update, please complete the attached [JFS 03400](#) form and either mail or fax the form to the address on the form.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
In-state toll free telephone number 1-800-686-1516**

Attachment

[Click here to view the JFS 03400, Health Plan Provider Update Request Form for MAL 480.](#)

MAL 473

Medical Assistance Letter No 473 (September 2, 2004 - Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 473, Pharmacy Program Initiatives: Clinical Utilization Edits and Preferred Drug List Implementation in the Pharmacy Services e-book.](#)

MAL 460

Medical Assistance Letter No 460 (December 18, 2003 - Consumer co-payments for prescription medication requiring prior authorization), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 460, Consumer co-payments for prescription medication requiring prior authorization in the Pharmacy Services e-book.](#)

MAL 456

Medical Assistance Letter No 456 (September 15, 2003 - Preferred Drug List (PDL) Information), is maintained in the Pharmacy Services e-book.

[Click here to view MAL 456, Preferred Drug List \(PDL\) Information in the Pharmacy Services e-book.](#)

MAL 447

Medical Assistance Letter No 447 (March 6, 2003 - Preferred Drug List (PDL) Information), is maintained in the Physician Services Handbook.

[Click here to view MAL 447, Preferred Drug List \(PDL\) Information in the Physician Services Handbook.](#)

MAL 441

Medical Assistance Letter (MAL) No. 441

March 4, 2003

TO: Outpatient Health Facilities (OHFs)
Directors, County Department of Job and Family Services

FROM: Thomas Hayes, Director

SUBJECT: Billing Changes Due to the Health Insurance Portability and Accountability Act (H.I.P.A.A.)

BILLING CHANGES EFFECTIVE OCTOBER 1, 2003

This is an advance notice of billing changes necessary because of provisions in the Health Insurance Portability and Accountability Act (H.I.P.A.A.). First, H.I.P.A.A. requires all payers to use standard code sets. The standard code sets include the AMA CPT coding system and the Health Care Procedural Coding System (HCPCS).

Second, if electronic claims are billed, H.I.P.A.A. requires that all payers accept standard electronic transactions. One of these transactions is the claim transaction called the 837 transaction. There are claim transactions for professional providers called the 837 P (professional) transaction and a related but separate transaction for institutional providers called the 837 I (institutional) transaction. Both of these issues (standard code sets and claim transactions) cause Ohio Medicaid to revise its billing procedures for Outpatient Health Facilities (OHFs) as well as for other providers.

This MAL addresses the changes for OHFs. We want to give OHFs plenty of time to review your billing system to accommodate these changes.

- Billing changes:

For services provided on or after October 1, 2003, follow the billing instructions applicable for services provided on and after that date. The OHF may choose to submit a paper claim or an electronic transaction:

- (1) If the OHF chooses to submit a paper claim, the OHF must submit a CMS 1500 claim form. The JFS 6780 claim form is being discontinued.
- (2) If the OHF chooses to submit an electronic transaction, the OHF must submit an 837 professional transaction.

- Coding Changes:

For services provided on or after October 1, 2003, submit the following data elements unique for OHF billings:

- (1) Enter the code T1015. The W codes are not H.I.P.A.A. compliant and can no longer be used.
- (2) Modify the code to specify the type of encounter provided, e.g. T1015U1 or T1015U2 (no spaces, no dashes):

- (a) For a medical encounter, use the modifier U1;
- (b) For a dental encounter, use the modifier U2.
- (c) For a mental health encounter, use the modifier U3;
- (d) For a physical therapy encounter, use the modifier U4;
- (e) For a speech therapy encounter, use the modifier U5;
- (f) For a vision services encounter, use the modifier U7;
- (g) For lab services encounter, use modifier UA;
- (h) For X-ray services encounter, use modifier UB
- (i) For a transportation encounter, use the modifier U9.

- (3) Enter all the procedure codes that describe the services provided during the encounter.

- Code crosswalk:

Code Crosswalk		
Current local level code:		New code and modifier after HIPAA:
W0001	Medical	T1015U1
W0002	Dental	T1015U2
W0003	Mental health	T1015U3
W0004	Vision	T1015U7
W0005	Speech therapy	T1015U5
W0006	Physical therapy	T1015U4
W0007	Lab	T1015UA
W0008	X-ray	T1015UB
W0009	Transportation	T1015U9

Questions pertaining to this MAL should be addressed to:

**The Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In state toll free telephone number 1-800-686-6108
Out-of-state telephone number 614-728-3288**

MAL 398

Medical Assistance Letter (MAL) No. 398

October 17, 2001

TO: All Outpatient Health Facility Providers
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Tom Hayes, Director

SUBJECT: Outpatient Health Facility (OHF) Rule Revisions

OUTPATIENT HEALTH FACILITY SERVICES

Effective November 1, 2001

The purpose of this MAL is to announce revisions to the Outpatient Health Facility (OHF) rules as a result of review of the OHF rules in conjunction with Ohio Revised Code Section 119. which requires each agency to review its rules once every five years. The revised OHF rules are attached. While these rules are still in proposed status, they are scheduled to be effective November 1, 2001.

Policy Changes:

Provider Eligibility:

- A provider not currently enrolled with the Department as an OHF which meets the qualifications to be an Federally Qualified Health Center (FQHC) or a rural health clinic (RHC) is not eligible to become an Outpatient Health Facility. They must enroll as an FQHC or RHC.
- A provider may not continue to have an active OHF provider number if they meet the provisions as an eligible Medicaid provider under another component of the Medicaid program including enrollment as a federally qualified health center (FQHC) or a rural health clinic (RHC). The provider must bill for services under their FQHC or OHF provider number.
- Medicaid providers may only be enrolled as one type of alternative payment clinic. An "alternative payment clinic" is defined as an OHF, FQHC, or Rural Health Clinic.
- One of the eligibility provisions for an OHF is that the eligible OHF must receive at least seventy-five of its operating funds from public sources. The Department wishes to clarify that a "public source" means federal, state, city, or county funds.
- To be an eligible OHF, a provider must provide on-site diagnostic radiological services as specified in the Ohio Revised Code. The rule has been amended to clarify that the eligible OHF must provide, at a minimum the following radiological services on-site:
 - Chest X-rays; and
 - X-rays necessary to diagnose and treat a broken foot, leg, ankle, arm, wrist, or hand.
- To be an eligible OHF, a provider must provide on-site diagnostic laboratory services as specified in the Ohio Revised Code. The minimal laboratory services are listed in rule 5101: 3-29-01 (attached). The Department has added "drawing blood for a lead poisoning screening" as a required laboratory test which must be provided on-site.

Covered Services and Limitations:

- Physical medicine services are those services described in the physical medicine section of the physician handbook (PHY1123).
- Laboratory services are those services described in the laboratory section of the physician handbook (PHY1121). All laboratory services must be provided by a CLIA certified laboratory as described in the physician handbook.
- The description of "Other services" is clarified to specify that services such as drugs or medical supplies which are incident to and in conjunction with a patient's visit to the OHF are considered to be

bundled into an encounter billing. For example, when a patient is given an injection as part of a medical visit, the injection is not billable as a separate encounter but is considered part of the medical encounter.

- The Department wishes to clarify that in the area of visions services, that corrective eyewear (eyeglasses) are covered only when provided by the Department's contracted vision laboratories.
- Service limitations:
 - The maximum number of office visits has been extended to 24 per year. Visits excluded from the 24 visit limit are listed in the "Visit" section of the physician handbook.
 - Physical medical service limits are described in section PHY.1123 of the physician handbook.
 - Speech and hearing services are limited to four per month or the number of services specified in the ambulatory clinic 5101:3-13 (Chapter 13) of the Administrative Code.

Billable Services:

- The Department wishes to clarify that services must be billed on an encounter basis. An encounter is defined as a face-to-face contact between the patient and a health professional for a covered service. The following are encounter types for an OHF:
 - Medical - W0001
 - Dental - W0002
 - Mental Health - W0003
 - Vision - W0004
 - Speech Therapy - W0005
 - Physical Therapy - W0006
 - Laboratory - W0007
 - X-ray - W0008
 - Transportation - W0009

A detailed CPT/HCPCS listing describing all services provided during any encounter must be reflected on subsequent lines of the claim for any encounter after the encounter code is billed.

- An encounter for the purpose of providing services such as drawing blood or collecting urine specimens or providing a medical supply during a patient visit is not considered a separate encounter but should be bundled into the billing for the appropriate encounter type. For example, billing for an injection should be bundled into the billing for a medical visit. Drugs given as part of a medical visit are considered part of a medical encounter.
- Take-home drugs are considered a pharmacy service and should be covered and billing according to the instructions provided in Chapter 9 of the Revised Code for pharmacy services.
- A laboratory encounter is an encounter between a medical professional and a patient to provide one or more laboratory procedures include a specimen collection. Covered laboratory tests are described in section PHY1121 of the physician handbook.
- A radiology encounter is an encounter between a medical professional and a patient to provide one or more radiology procedures.. Covered radiological tests are described in section PHY1122 of the physician handbook
- A transportation encounter should be billed on a unit basis. Each trip from the service site shall be counted as a unit of transportation. In order to meet the definition of a billable transportation unit of service, the transportation must be provided on the same date that another billable encounter or unit of service occurs.

- If a contractor provides services at locations other than the approved OHF site on behalf of the OHF, the contractor must bill for these services directly to the Department using their Medicaid provider number. In this instance, the OHF should not include the costs of the contractor's services in their cost report. However certain laboratory and x-ray services must be provided on-site at the OHF. These lab and x-ray services which must be provided at the OHF site are listed in rule 5101: 3-29-01 of the Administrative Code.
- The following services must be billed by an OHF under a separate fee-for-service provider number since the costs for these services are not included in the OHF costs:
 - Claims for Medicare crossover services;
 - Claims for services provided to Disability Assistance patients.

Reimbursement

- The general reimbursement requirements remain unchanged.
- The Department wishes to clarify that a new OHF qualifying under rule 5101: 3-29-01 of the Administrative Code (attached) will be given rates computed based on the average rate for all participating OHFs for the first year. The first-year rates will not be adjusted for any overpayments or underpayments at the end of the first year.
- All OHFs must submit cost reports on form JFS 03421 according to the instructions provided with this form and in rule 5101: 3-28-10 of the Administrative Code. Call the reimbursement section of the Bureau of Health Plan Policy (614-466-6420) if you need the new cost report.
- The ceiling on administrative and general costs for each clinical site shall not exceed 15% of the site's total allowable costs.
- The test of reasonableness for indirect costs will be computed based on the data submitted for indirect costs on the JFS 03421 form. The test of reasonableness for professional services, specifically for medical services shall not exceed the lower of either the reported allowable costs divided by reported encounters or 2.4 encounters per hour for physicians, physician assistants, advanced practice nurses, and registered nurses. The efficiency standards (tests of reasonableness for professional services) may be periodically updated at the Department's discretion based on the efficiency standards established by the local Medicare fiscal intermediary for Federally-qualified Health Centers.
- Quarterly utilization reports and quarterly utilization adjustments will no longer be required or provided.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, OH 43266-0161

In-state toll free telephone number 1-800-686-6108

Out-of-state telephone number 1-614-728-3288

Outpatient Health Facility (OHF) rules

5101:3-29-01, Eligible providers

5101:3-29-03, Coverage and limitation policies for outpatient health facility services

5101:3-29-04, Billable services

5101:3-29-05, Reimbursement

OAC Rules Related to Outpatient Health Facilities

5160-29-01 Eligible Providers

Formerly 5101:3-29-01 Eligible Providers

MAL 554

Effective Date: July 1, 2009

Most Current Prior Effective Date: May 1, 2005

In order to be determined eligible as an "outpatient health facility" (OHF) under the medicaid program, a facility must be determined by ODJFS to be in compliance with the conditions and provisions set forth in this rule.

- (A) An "eligible outpatient health facility" means a facility, other than an outpatient hospital facility, which:
- (1) Provides comprehensive primary health services, as defined in paragraph (E) of this rule, by or under the direction of a physician at least five days per week on a forty-hour-per-week basis to outpatients; and
 - (2) Is operated by one of the following:
 - (a) The board of health of a city or general health district; or
 - (b) Another public agency; or
 - (c) A nonprofit private agency or organization under the direction and control of a governing board that has no health-related responsibilities other than the direction and control of one or more such outpatient health facilities.
 - (3) Receives at least seventy-five per cent of its operating funds from public sources. "Public sources" means the following:
 - (a) Federal funds;
 - (b) State funds;
 - (c) City funds; and
 - (d) County funds.
 - (4) Is not eligible to be enrolled as an federally qualified health center (FQHC) or rural health clinic (RHC) as specified in rules [5101:3-28-01](#) and [5101:3-16-01](#) of the Administrative Code.
- (B) If an OHF has a current, valid provider number as either an FQHC or a RHC, the provider must bill for services under the FQHC or RHC provider number in accordance with the policies set forth in Chapter 5101:3-28 or 5101:3-16 of the Administrative Code. Medicaid providers may only be enrolled as one type of alternative payment clinic for a single enrollment period. An "alternative payment clinic" shall be defined as an OHF, FQHC, or rural health clinic.
- (C) In addition to meeting the standards set forth for ambulatory health care centers under rule 5101:3-13-01 of the Administrative Code, an eligible outpatient health facility must also meet the requirements of division (C) of section 5111.04 of the Revised Code as follows:
- (1) Has health and medical care policies developed with the advice of and subject to review by an advisory committee of professional personnel, including one or more physicians, one or more dentists if dental care is provided, and one or more registered ~~professional~~ nurses.
 - (2) Has a medical director, a dental director if dental care is provided, ~~and~~ a nursing director ~~responsible for the execution of such policies and has~~ physicians, dentists, nursing, and ancillary staff appropriate to the scope of services provided.
 - (3) Requires that the care of every patient be under the supervision of a physician, provides for medical care in case of emergency, has in effect a written agreement with one or more hospitals and one or more other outpatient facilities, and has an established system for the referral of patients to other resources and a utilization review plan and program.

- (4) Maintains clinical records on all patients.
- (5) Provides nursing services and other therapeutic services in compliance with applicable laws and rules and under the supervision of a registered nurse, and has a registered nurse on duty at all times when the facility is in operation.
- (6) Follows approved methods and procedures for the prescribing, dispensing, and administration of drugs and biologicals.
- (7) Maintains the accounting and record-keeping system required under federal laws and regulations for the determination of reasonable and allowable costs. Requirements for accounting and record-keeping systems adequate to be reimbursed on a prospective cost-related basis are described in rule [5101:3-29-05](#) of the Administrative Code.

(D) Each site approved as an OHF will have an individual provider agreement and will have a unique provider number assigned by the Ohio department of job and family services with the exception of those outpatient health facilities which meet the provisions of paragraphs (D)(1) to (D)(3) of this rule. A "site" is defined as a service delivery location which independently meets all requirements set forth in this rule except for services provided to hospitalized or temporarily home-bound patients. Services provided at locations other than the approved site are not recognized as OHF services. If a legal entity operates more than one qualified site as defined in this paragraph, a single provider number may be assigned, at the legal entity's option, if all of the following requirements are met:

- (1) Each participating site operated by the legal entity independently meets requirements for service provision as defined in paragraph (E) of this rule.
- (2) The legal entity operating the sites assures that the requirements set forth in paragraphs (A) to (C)(7) of this rule are met for each participating site.
- (3) The legal entity has a single, central, uniform accounting and record-keeping system applying to all participating sites.

(E) "Comprehensive primary health services" are those covered ~~preventative~~preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services provided by or under the direction of a physician at least five days per week on a forty-hour-per-week basis that include all of the following:

- (1) On-site provision of:
 - (a) Services of physicians, ~~physician's~~physician assistants, and ~~nurse practitioners~~advanced practice nurses. ~~For purposes of this provision, nurse practitioners must meet the qualifications established in section 4723.43 of the Revised Code;~~
 - (b) Covered ~~preventative~~preventive health services, such as children's eye and ear examinations, perinatal services, ~~and well-child services covered under the early and periodic screening, diagnosis and treatment program,~~ and pregnancy prevention/contraceptive management in accordance with rule [5101:3-21-02](#) of the Administrative Code;
 - (c) Covered obstetrical care services, including a ~~completed "Prenatal Risk Assessment"~~prenatal risk assessment for every ~~women~~woman receiving prenatal services, and ~~at-risk pregnancy services as described in Chapter 5101:3-4 of the Administrative Code for those women~~every woman diagnosed at risk of ~~preterm~~premature birth or poor pregnancy outcome, ~~and medically indicated at-risk pregnancy services as described in Chapter 5101:3-4 of the Administrative Code;~~
 - ~~(d) Family planning services;~~
 - ~~(e)~~(d) Diagnostic laboratory services including, at a minimum:
 - (i) Chemical examinations of urine by ~~stick~~strip or tablet methods or both (including urine ketones);
 - (ii) Microscopic examinations of urine sediment ~~;~~

- (iii) Hemoglobin or hematocrit;
- (iv) Blood sugar;
- (v) Gram stain;
- (vi) Examination of stool specimens for occult blood;
- (vii) Pregnancy tests;
- (viii) Primary culturing for transmittal to a certified laboratory;
- (ix) Test for pinworm; and
- (x) Drawing blood for a lead poisoning screening.

~~(f)~~(e) Diagnostic radiological services including at a minimum:

- (i) Chest X-ray; and
- (ii) X-rays necessary to diagnose treatment of a broken foot, ankle, leg, arm, or hand.

(2) On-site provision of or arrangement for:

- (a) Transportation services; ~~and~~ and
- (b) Emergency medical services.

Effective: 07/01/2009

R.C. 119.032 review dates: 04/14/2009 and 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.04

Prior Effective Dates: 11/10/83, 4/18/88, 11/1/01, 5/1/05

MAL 480**Effective Date: May 1, 2005****Most Current Prior Effective Date: November 1, 2001.**

(A) General provisions

Paragraph ~~(A)~~ (E) of rule 5101:3-29-01 of the Administrative Code identifies the minimal range of services an outpatient health facility must provide either directly or under arrangement in order to participate in the outpatient health facility program. In addition to these basic services, an outpatient health facility may provide other supplemental ambulatory services within the scope of the medicaid program except for institutional care. The following paragraphs identify the coverage and limitation policies applicable to items and services provided by an outpatient health facility as a basic or supplemental service.

- (1) Medical ~~service~~ ~~Services~~ services covered under this category include those services necessary for the diagnosis and/or treatment of an illness or injury rendered by an eligible provider of services within the scope of his practice and within the scope of the medicaid program. Preventative medicine as such is not a recognized service item under Ohio's medicaid program except for a specialized program known as early and periodic screening, diagnosis and treatment (EPSDT) also known as healthchek, for individuals under twenty-one years of age (~~reference identified in~~ Chapter 5101:3-14 of the Administrative Code), and at-risk pregnancy services for women who have been determined to be at risk of preterm birth or poor pregnancy outcome on JFS 03535 "Prenatal Risk Assessment" form (~~reference rules identified in~~ 5101:3-4-10 and 5101:3-4-11 of the Administrative Code). The following provisions are applicable to medical services provided by various practitioner groupings:
 - (a) "Physician services" are those covered services (~~reference identified in~~ Chapter 5101:3-4 of the Administrative Code) provided by a licensed doctor of medicine or osteopathy and those covered services (~~reference identified in~~ Chapter 5101:3-7 of the Administrative Code) furnished by a licensed doctor of podiatric medicine.
 - (b) "Physician's assistant and nurse practitioner services" are those covered services provided by a physician's assistant who holds a certificate of registration in accordance with Chapter 4730. of the Revised Code or nurse practitioner as defined in ~~division (B) of~~ section ~~4723.41~~ 4723.43 of the Revised Code. Professional services of both physician's assistants and nurse practitioners are covered if:
 - (i) Furnished in accordance with rules 5101:3-8-21 to ~~5101:3-8-26~~ 5101:3-8-27 of the Administrative Code addressing nurse practitioner and advanced practice nurses services.
 - (ii) Furnished in accordance with rule 5101:3-4-03 of the Administrative Code which describes physician assistant services.
 - (iii) Furnished in accordance with the limitations placed on registered nurse or physician's assistant under applicable state law.
 - (c) "Registered nurse and licensed practical nurse services" are those covered services provided by a registered nurse or a licensed practical nurse as defined in ~~section 4723.09~~ Chapter 4723. of the Revised Code ~~or a licensed practical nurse as defined in Chapter 4723. of the Revised Code~~. Professional services of both registered nurses and licensed practical nurses are covered if:
 - (i) Furnished under the personal supervision of a physician and otherwise provided as incidental to a physician's service as defined in paragraph (A)(1)(a) of this rule; or

(ii) Furnished independently of a physician but under the general direction of a physician within the scope of state law governing registered nurses and licensed practical nurses. Services covered under this provision are limited to those that would otherwise be covered if furnished by an M.D. or D.O. (reference Chapter 5101:3-4 of the Administrative Code) or if furnished by a D.P.M. (reference Chapter 5101:3-7 of the Administrative Code).

- (2) "Dental services" are those covered services (~~reference~~ identified in Chapter 5101:3-4 of the Administrative Code) provided by a licensed dentist or a person under the personal supervision of a dentist. Prior authorization ~~must~~ shall be obtained for any service subject to prior authorization.
- (3) "Mental health services" are those covered services identified in rule ~~5101:3-8-02~~ 5101:3-8-05 of the Administrative Code which are provided by a clinical psychologist and those covered mental health services identified in rule 5101:3-4-29 of the Administrative Code provided by a clinical social worker, (~~reference~~ identified in rule 5101:3-16-01 of the Administrative Code.) A licensed social worker may provide mental health services within the scope and limitations of rule 5101:3-4-29 of the Administrative Code. Prior authorization must be obtained for any service subject to prior authorization.
- (4) "Vision care services" are those covered items and services (~~reference~~ identified in Chapter 5101:3-6 of the Administrative Code) provided by a licensed optometrist or optician. Prior authorization ~~must~~ shall be obtained for any service subject to prior authorization.
- (5) "Speech and hearing services" are those covered services (~~reference rule 5101:3-13-04~~ identified in Chapter 5101:3-13 of the Administrative Code) provided by a licensed audiologist or speech pathologist.
- (6) "Physical medicine services" are those covered services (~~reference~~ identified in rule 5101:3-4-26 of the Administrative Code) provided by a physician, podiatrist, licensed physical therapist, or mechanotherapist. Services provided by nonlicensed personnel under the personal supervision of a licensed physical therapist or mechanotherapist are not covered.
- (7) "Laboratory services" are those covered services (~~reference~~ identified in Chapter 5101:3-11 of the Administrative Code) provided by the OHF. All laboratory services must be provided by a Clinical Laboratory Improvement Act ~~CLIA~~ (CLIA) certified laboratory as specified in Chapter 5101:3-11 of the Administrative Code.
- (8) "Radiology services" are those covered services (~~reference Chapter 5101:3-11~~ identified in rule 5101:3-4-25 of the Administrative Code) provided by the OHF.
- (9) "Transportation services" are those services needed to transport the patient to and from the OHF or to and from other medicaid providers with whom the OHF has referral arrangements. Such transportation services do not include ambulance or ambulette services as defined in Chapter 5101:3-15 of the Administrative Code.
- (10) "Other services" are those covered services furnished as incident to and in conjunction with services identified in paragraphs (A)(1) to (A)(9) of this rule. Other services are considered part of the services provided as part of each encounter type such as medical, vision, or dental services. "Other services" would include drugs or supplies used during a visit to the OHF. Durable medical equipment and orthotics and prosthetics as identified in Chapter 5101:3-10 of the Administrative Code and medical supplies that are given to a patient to use at home are to be billed and reimbursed as specified in paragraph (C) of rule 5101:3-29-04 of the Administrative Code.
- (11) Abortion services ~~-Reference rule~~ are described in 5101:3-17-01 of the Administrative Code.
- (12) Sterilization services ~~-Reference rule~~ are described in 5101:3-21-01 of the Administrative Code.

(B) Service limitations

- (1) Medical -- The maximum number of office visits is twenty-four per year. Visits excluded from the twenty-four visit limitation are those listed in rule [5101:3-4-06](#) of the Administrative Code.
- (2) Mental health -- The maximum number of therapeutic services ~~is four per month~~ specified in rule [5101:3-8-05](#) of the Administrative Code. Diagnostic testing is limited to ~~eight hours per year~~ the number specified in rule 5101:3-8-05 of the Administrative Code. ~~without prior authorization. Special psychological testing exceeding eight hours must be prior authorized.~~
- (3) Speech and hearing -- The maximum number of therapeutic services is ~~four per month~~ or the number specified for ambulatory clinics in Chapter [5101:3-13](#) of the Administrative Code.
- (4) Vision care services -- For each twelve-month period, only one vision examination is covered for patients age twenty or younger and age sixty and older. For each twenty-four-month period, only one vision examination is covered for patients age twenty-one or older, but younger than age sixty. Corrective eyewear (e.g. eyeglasses) are covered only when provided by the department's contracted vision laboratories.
- (5) Physical medicine -- Services are limited to those specified in rule ~~5101:3-4-26~~ [5101:3-8-02](#) of the Administrative Code.
- (6) Dental services -- Due to the complexity of dental services, limitations cannot be listed. Reference Chapter 5101:3-5 of the Administrative Code for limitations to dental services.

Effective: 05/01/2005

R.C. 119.032 review dates: 11/17/2004 and 05/01/2010

Certification: CERTIFIED ELECTRONICALLY

Date: 02/18/2005

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.04

Prior Effective Dates: 11/10/83, 4/18/88, 11/01/01

MAL 554

Effective Date: July 1, 2009

Most Current Prior Effective Date: May 1, 2005

- (A) Billable encounters, general provisions -- For purposes of the outpatient health facility program, an "encounter" is defined as a face-to-face contact between a patient and a health professional whose services are covered under the medicaid program. For a health service to be defined as an encounter, it must meet the definitions set forth in this paragraph and must be recorded in the patient's health record. Services must be billed on an encounter basis. The types of encounters are defined in paragraph (B) of this rule. When an encounter is billed, also provide a detailed code listing on subsequent lines of the claim which describes all services provided to the patient during that encounter.
- (1) Multiple encounters with the same health professional that take place on the same day constitute a single billable encounter except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis and treatment.
 - (2) Multiple encounters with different health professionals that take place on the same day for the same illness or injury constitute a single billable encounter.
 - (3) To meet the encounter criterion, the professional must be acting independently and not assisting another professional. For example, a nurse assisting a physician during a physical examination by taking vital signs, taking a history, or drawing a blood sample is not credited with a separate encounter. A nurse who, utilizing standing orders or protocol, sees a patient to monitor physiological signs, provide medication renewal, etc., without the patient routinely seeing the physician at the same time, is credited with an encounter. The definitions of independent nursing encounters can be found in paragraph (B)(1)(c) of this rule.
 - (4) An encounter for the purpose of providing services such as drawing blood, collecting urine specimens, or providing a medical supply to the patient during the visit are not considered a medical encounter but are bundled into the appropriate encounter type. For example collecting a urine specimen would be bundled into a laboratory encounter.
 - (5) Billable encounters are limited to:
 - (a) Those which take place at the site approved for participation in the outpatient health facility program; or
 - (b) Those medical service encounters which take place in the hospital or the patient's home for the purpose of providing services to outpatient health facility (OHF) patients who are hospitalized or temporarily confined to their home.
 - (6) Encounters with individuals involved with another patient (e.g., conferences or consultations with a family member) are not billable unless such individual is independently eligible for medicaid and receives services for diagnosis and/or treatment of an illness or injury. An encounter, for example, with a family member to discuss the diagnosis and/or treatment of a child who is not present cannot be billed. A conference with family members which occurs in the course of diagnosis and/or treatment of the eligible child would be covered as a service incidental to the treatment rendered; i.e., one billable service provided to both the child and family members.
 - (7) The encounter criterion is not met nor is coverage available under medicaid for cost involved in the following circumstances:
 - (a) When a provider participates in a community meeting or group session which is not designed to provide health services to program users. Examples of such activities include

orientation sessions for new patients, health presentations to community groups (high school classes, PTA, etc.), and information presentations about the program.

- (b) When the only health service provided is part of a large scale effort such as a mass immunization program, screening program, or community-wide service program (for example, a health fair).

(B) Billable encounter definitions

- (1) "Medical encounter" is an encounter between a medical provider and a patient for the purpose of diagnosis and/or treatment of an illness or injury, including surgery. ~~Preventative medicine as such is not a covered service under Ohio's medicaid program except for the early and periodic screening, diagnosis and treatment program (EPSDT, also known as HealthChek) for individuals twenty-one years of age and under (reference Chapter 5101:3-14 of the Administrative Code) and at-risk pregnancy services for women diagnosed at risk of poor pregnancy outcome or preterm birth on the "Prenatal Risk Assessment" form (JFS 03535) identified in rules 5101:3-4-10 and 5101:3-4-11 of the Administrative Code~~ Preventive medicine services are covered in accordance with rule 5101:3-4-34 of the Administrative Code. Included in this category are physician encounters, mid-level practitioner encounters, and independent nursing encounters. ~~All covered family planning services (those related to contraception or sterilization)~~ Pregnancy prevention/contraceptive management services, defined in accordance with rule 5101:3-21-02 of the Administrative Code, are included under the definition of medical encounter.
 - (a) "Physician encounter" is an encounter between a physician or podiatrist and a patient. For purposes of this program, encounters between an ophthalmologist or a psychiatrist and a patient are included in this category as medical encounters.
 - (b) "Mid-level practitioner encounter" is an encounter between a ~~physician's~~ physician assistant or ~~nurse practitioner~~ advanced practice nurse and a patient in which the mid-level practitioner is the independent provider of a medical service.
 - (c) "Nursing encounter" is an encounter between a registered nurse or licensed practical nurse and a patient in which the nurse is acting independently and provides a nursing service. The service may be provided under standing orders of a physician, under specific instructions from a previous visit, or under supervision of a physician who has no direct contact with the patient during a visit. Examples of independent nursing encounters include: ~~administration of immunizations, injections (including allergy injections), dressing changes, and suture removal services. In the provision of family planning medical services, nursing medical encounters may include:~~
 - (i) Administration of immunizations;
 - (ii) Injections (including allergy injections);
 - (iii) Dressing changes;
 - (iv) Suture removal.
 - ~~(v)~~ (v) The supply visit for hormonal contraceptives (if blood pressure, weight, and/or other vital signs are taken); and
 - ~~(vi)~~ (vi) The return visit following insertion of an intrauterine device.
- (2) "Dental encounter" is an encounter between a dentist or dental hygienist/oral therapist under the supervision of a dentist and a patient for provision of covered dental services. All dental hygienist or oral therapist services are included under this encounter definition.
- (3) "Mental health encounter" is an encounter between a licensed psychologist or a licensed independent social worker and a patient for the provision of covered psychological services. A mental health encounter may also include mental health services provided by licensed social workers in accordance with rule [5101:3-4-29](#) of the Administrative Code.

- (4) "Vision care encounter" is an encounter between an optometrist or optician and a patient for the provision of covered vision care services.
- (5) "Speech and hearing encounter" is an encounter between an audiologist or speech pathologist and a patient for the provision of covered speech and hearing services. For purposes of the OHF program, providers shall report the numbers of individual speech and hearing procedures, in addition to speech and hearing encounters. Such reporting shall enable ODJFS to apply the speech and hearing visit limitation policy defined in paragraph (B)(3) of rule [5101:3-29-03](#) of the Administrative Code.
- (6) "Physical medicine encounter" is an encounter between a physician, physical therapist, or a mechanotherapist and a patient for receipt of a covered physical medicine service. For purposes of the OHF program, providers will be reporting the numbers of individual physical medicine procedures in addition to physical medicine encounters. Such reporting will enable the ODJFS to apply the physical medicine procedure limitation policy defined in paragraph (B)(5) of rule 5101:3-29-03 of the Administrative Code.
- (7) "Laboratory encounter" is an encounter between a medical professional and a patient to provide one or more laboratory procedures including specimen collection. Covered laboratory tests are identified in Chapter [5101:3-11](#) of the Administrative Code.
- (8) "Radiology encounter" is an encounter between a medical professional and a patient to provide one or more x-ray procedures covered under medicaid as described in rule [5101:3-4-25](#) of the Administrative Code.
- (9) "Transportation encounter" shall be billed on a unit basis. Each trip from the service site shall be counted as a unit of transportation. ~~An instance of one-way transportation of a patient to or from the qualified outpatient health facility site to assure transportation for receipt of services.~~ In order to meet the definition of a billable transportation unit of service, the transportation must be provided on the same date that another billable encounter or unit of service occurs.

(C) Medical supplies and drugs

- (1) Medical supplies used as part of the visit are considered part of the medical encounter i.e., are incidental to a service provided (e.g., bandages, dressings, and adhesive) are to be included as cost items for purposes of prospective rate determination. Those items which are given to the patient to be used at home (e.g. contraceptive supplies, colostomy supplies) are to be billed and reimbursed according to provisions governing reimbursement for the medical supplier program described in Chapter [5101:3-10](#) of the Administrative Code. Types of medical supply items which are included as cost items cannot be billed separately under the medical supplier program.
- (2) Drugs which are given as part of the visit at the facility are considered part of the medical encounter. Drugs that are dispensed for take-home use are considered a pharmacy service and are to be billed and reimbursed according to provisions governing coverage of drugs as set forth in Chapter [5101:3-9](#) of the Administrative Code.

- (D) Contracted services -- It is recognized that ~~OHF~~OHFs may wish to augment staff-delivered services through contractual arrangements. Under the OHF program, services provided by contract must be provided on-site in order to be included as a cost item in determining the prospective rate. At the option of each participating OHF, services other than those required under paragraph (E)(1)(e) of rule [5101:3-29-01](#) of the Administrative Code may be provided on-site or off-site. When the services are provided at locations other than the location at the approved site, the contractor must bill these services to the ODJFS if the contractor participates in the medicaid program. Examples of other services may include physical therapy, speech therapy, dental services, or laboratory or X-ray services which are in addition to those listed in paragraph (E) of rule 5101:3-29-01 of the Administrative Code. The laboratory and X-ray services listed in paragraph (E) of rule 5101:3-29-01 of the Administrative Code must be provided on-site except as stated in paragraph (B) of rule 5101:3-11-04 of the Administrative Code.

Contracts for services required under paragraph (E) of rule 5101:3-29-01 of the Administrative Code and contracts for any additional services to be included in the prospective rate must stipulate that the OHF retains all authority and responsibility for patient care. The execution of a contract with another party does not terminate the legal responsibility of the qualified OHF to the ODJFS to assure that all program requirements are met and that all provisions of the provider agreement as set forth in rule [5101:3-1-17.2](#) of the Administrative Code are met.

Contracts pertaining to services must specify that the OHF assumes professional and administrative responsibility for the services rendered. In order for contractual arrangements to be recognized, ~~OHF~~OHFs must provide the following information to the ODJFS at the point of entry into the program and at any subsequent point when new contracts are negotiated or when existing contracts are revised:

- (1) Identification by name and, where applicable, medicaid provider number of each individual practitioner providing services under contractual arrangements. Where the contract is let with a legal entity other than the individual practitioner, both the name of the legal entity and the names of any individual practitioners involved must be furnished.
 - (2) A written statement indicating, for each legal entity or individual practitioner, whether the contracted services are:
 - (a) To be included as a cost item and reimbursed under the applicable prospective rate assigned to the outpatient health facility; or
 - (b) To be billed independently by the legal entity or individual practitioner under contract.
- (E) The following types of services must be billed by the OHF under a separate medicaid provider number since the cost-based rates for OHFs do not apply to these services:
- (1) Claims for medicare crossover payments; and
 - (2) Claims for services provided to disability assistance patients.

Effective: 07/01/2009

R.C. 119.032 review dates: 04/14/2009 and 07/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.04

Prior Effective Dates: 11/10/83, 10/1/87, 4/18/88, 11/1/01, 5/1/05

MAL 480

Effective Date: May 1, 2005

Most Current Prior Effective Date: November 1, 2001

(A) Methods and standards for establishing payment rates

Payment for authorized services in an outpatient health facility (OHF) ~~OHF~~ is calculated on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Rates are calculated on a clinic's cost of allowable items and services, and thus may vary from clinic to clinic, subject to the tests of reasonableness described in paragraphs (C) to (F) of this rule. While payments under a prospective system are not subject to audit and retroactive settlement or adjustment, the historical costs upon which prospective rates are based are audited as described in paragraph (I) of this rule. Adjustments to the paid rate will be made if costs are found to be overstated or misrepresented in a manner which resulted in an overstatement of the previously determined prospective rate.

(1) Rates will be established for each of the following types of services rendered by a participating OHF:

- (a) Medical services
- (b) Laboratory services
- (c) Radiological services
- (d) Dental services
- (e) Speech therapy and audiology services
- (f) Mental health services
- (g) Physical therapy services
- (h) Transportation services
- (i) Vision care services

(2) Cost of items which were not requirements during the period covered by the base line cost report but which became requirements or were imposed by federal court orders during the prospective rate year are met on a retroactive basis based on cost reports filed at the conclusion of the prospective year. Only those expenses associated with the new requirements, which require the addition of new personnel or equipment, are subject to the one-time retroactive settlement. Thereafter, such costs become recognized according to the methodology described ~~above~~ in this rule.

(B) New facilities

Rates for new facilities will be computed as follows: rates will be granted based on the average rates of all participating OHFs. Ongoing rates will be calculated from a cost report filed after one complete calendar year of experience. Ongoing rates will be computed according to the criteria set forth in paragraphs (C) to (F) of this rule (with no inflationary allowance). For purposes of reimbursement provisions contained in this paragraph, a "new facility" is defined as a health care provider meeting all of the qualifications delineated in rule 5101:3-29-01 of the Administrative Code.

(C) General provisions - allowable and reasonable costs

"Costs which are reasonable and related to patient care" are those contained in the following reference material in the following priority: "Health Insurance Manual 15 Provider Reimbursement Manual," "Health Insurance Manual 5 Principles of Reimbursement for Provider Costs," available at

www.cms.hhs.gov/manuals/cmstoc.asp dated May 1, 2005 and "Generally Accepted Accounting Principles"; except that:

- (1) Costs related to patient care and services that are not covered under the OHF program as described in rule 5101:3-29-01 to 5101:3-29-04 of the Administrative Code are not allowable.
- (2) The straight line method of computing depreciation is a requirement for cost filing purposes, and it must be used for all depreciable assets.
- (3) For purposes of determining allowable and reasonable cost in the purchase of goods and services from a related party, the following definition of related shall be used: "related" is one who enjoys, or has enjoyed within the previous five years, any degree of another business relationship with the owner or operator of the facility, directly or indirectly, or one who is related by marriage or birth to the owner or operator of the facility. Upper limits for costs associated with related party transactions are set forth in paragraph (F) of this rule.
- (4) Tests of reasonableness include those identified in paragraphs (D) to ~~(H)~~(F) of this rule.
- (5) ~~The department~~ ODJFS reserves the right to establish other tests of reasonableness which may be necessary to assure effective and efficient program administration.

(D) Ceiling on administrative and general costs

Administrative and general costs for each clinical site cannot exceed fifteen per cent of the site's total allowable costs.

(E) Tests of reasonableness on indirect costs

For each of the services identified in paragraph (A)(1) of this rule except for paragraph (A)(1)(a) of this rule, otherwise allowable costs allocated as shown in for indirect costs listed on the JFS ~~03420~~ 03421 as revised on July 1, 2001, will be adjusted in instances when hours of operation of the service component are less than thirty per week on an annualized basis. Any adjustment would be computed based on application of the ratio of actual hours of operation of the service component to a base of thirty hours per week on an annualized basis, not to exceed one hundred per cent.

(F) Tests of reasonableness - professional services

Costs recognized for rate setting purposes will be adjusted based on minimum required efficiency standards calculated as encounters per hour. Prospective rates established for any of the following service components will not exceed the lower of either the reported otherwise allowable cost divided by reported encounters of service or the reported allowable cost divided by the product of hours worked by a professional and the encounters per hour as shows below:

- (1) Medical services -- 2.4 encounters per hour (medical services include services of physicians, physician assistants, advanced practice nurses, and registered nurses)
- (2) Dental services -- 1.85 encounters per hour
- (3) Mental health services --.8 encounters per hour
- (4) Vision care services -- 2.3 encounters per hour
- (5) Speech and hearing services -- 1.8 encounters per hour
- (6) Physical medicine services -- 2.0 encounters per hour

These efficiency standards may be periodically adjusted at the ~~department's~~ discretion of ODJFS are based on efficiency standards established by the medicare fiscal intermediary for federally qualified health centers.

(G) Inflationary factor

An OHF's unit rates are calculated from historical cost information as reported in cost reports filed by each participating clinic for a prior cost-reporting period. Allowable and reasonable costs determined in accordance with this rule will be updated by an inflation factor as described in this paragraph. For allowable costs recognized in the cost report year, an inflationary factor will be added for various

categories of cost equal to the total of the actual inflationary factor between the midpoint of the cost report year and the midpoint of the following year as established by the bureau of labor statistics and an estimated inflationary factor from the midpoint of the preceding year to the midpoint of the year for which the prospective rate is calculated based upon the preceding twelve-month average. For each calendar year for each of the following categories of costs, an inflationary factor will be computed using the monthly statistical data for the following areas from the bureau of labor statistics (unless otherwise specified):

- (1) Personnel (e.g., nurses, administration, legal, accounting, management, data services, employee fringe benefits, medical records, operation and maintenance services, housekeeping, and laundry).
- (2) Medical supplies subject to cost-related reimbursement and expenses.
- (3) Nondurable goods (e.g., office supplies and printing).
- (4) Fuel and utilities.
- (5) Transportation services.
- (6) Medical and rehabilitation professional personnel.
- (7) Insurance.
- (8) Real estate taxes.

(H) Cost report filing

As a condition for participation in the Title XIX program, all OHFs must submit cost reports on form JFS ~~03420~~ 03421 as specified in paragraphs (A) to (D) of this rule ~~and according to instructions found in rule 5101:3-28-05 of the Administrative Code.~~

- (1) Annual cost reports must be filed, except for the initial program year as provided in paragraph (B) of this rule, by April first of each year for the period beginning January first and ending December thirty-first of the preceding calendar year.
- (2) Failure to file an annual cost report by April first of each year will result in termination of the OHF's provider agreement, with such termination to be effective within thirty days unless a complete and adequate cost report is submitted by the OHF within that thirty-day period.
- (3) If an incomplete or inadequate cost report is received prior to April first, the ~~department~~ ODJFS will notify the OHF that information is lacking. A corrected cost report is to be submitted within forty-five days of notification of inadequacy. Any resubmission of an inadequate cost report within the forty-five-day period or any failure to resubmit within forty-five days indicates a lack of good-faith effort and will result in immediate termination.
- (4) The accrual method of accounting shall be used for all cost reports filed except that governmental institutions operating on a cash method may file on the cash method of accounting. The "accrual method of accounting" means that revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. The "cash method of accounting" means that revenues are recognized only when cash is received, and expenditures for expenses and asset items are not recorded until cash is disbursed for them.
- (5) OHFs are required to identify all related organizations; i.e., related to the OHF by common ownership or control. The cost claimed on the cost reports for services, facilities, and supplies furnished by the related organization shall not exceed the lower of (a) the cost to the related organization or (b) the price of comparable services, facilities, or supplies generally available.

(I) Audits

- (1) The prospective rates for services established for an OHF are not subject to subsequent adjustments except in instances of rate adjustments specified in paragraph (A) of this rule. The difference between the cost reported by a clinic in a cost report used for calculating the various

prospective rates and those costs established by a field or on-site audit are subject to recovery in full by means of a retroactive rate adjustment of the prospective rates. Audit exceptions will apply to the various rates established for the prospective year upon which the cost report is based, if the errors in the cost report increase the various unit rates which otherwise would have been paid. All overpayments found in on-site audits not repaid within thirty days after the audit is finalized shall be certified to the state auditor and/or attorney general for collection in accordance with the provisions of state law.

- (2) Audits will be conducted by the **department ODJFS** for services rendered by OHFs participating in Title XIX (medicaid). These audits are made pursuant to federal regulatory law and are empowered to the **department ODJFS** through section 5101.37 of the Revised Code. The examination of OHF costs will be made in accordance with generally accepted auditing standards necessary to fulfill the scope of the audit. To facilitate this examination, providers are required to make available all records necessary to fully disclose the extent of services provided to program recipients. The principal objective of the audit is to enable the department or its designee to determine that payments which have been made, or will be made, are in accordance with federal, state, and agency requirements. Based on the audit, adjustments will be made as required. Records necessary to fully disclose the extent of services provided and costs associated with those services must be maintained for a period of three years (or until the audit is completed and every exception is resolved). These records must be made available, upon request, to ODJFS and the U.S. department of health and human services for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.
- (3) There are basically two types of audits.
 - (a) The first is a desk audit of cost reports filed each year and subsequent calendar quarterly reports to ensure that no mathematical error occurs, that the cost calculations are consistent with the rate-setting formula as established by the department, and to identify categories of reported costs which, because of their exceptional nature, bear further contact with the OHF for clarification/amplification.
 - (b) The second is a field audit. These are performed on-site or where the necessary disclosure information is maintained to assure the OHF has complied with both cost principles and program regulations.

Cost reports shall be retained for at least three years. Summary reports for all on-site audits shall be maintained for public review in the Ohio department of job and family services for a period of one year. The depth of each on-site audit may vary depending upon the findings of computerized risk analysis profiles developed by the department taking into consideration such factors as cost category screens (cost categories above median), location, level of services provided medicaid recipients, occasions or frequency of services, and multi-shared costs. The depth of each on-site audit shall be at least sufficiently comprehensive in scope to ascertain, in all material respects, whether the costs as reported and submitted by the OHF are true, correct, and representative to the best of the facility's ability. Failure to retain or provide the required financial and statistical records renders the OHF liable for monetary damages equal to the difference between:

- (i) Established categorical unit rates paid to the provider for the prospective year in question; and
- (ii) The lowest categorical unit rates for like services paid in the state of Ohio to an OHF similar in structure.

Effective: 05/01/2005

R.C. 119.032 review dates: 11/17/2004 and 05/01/2010

Certification: CERTIFIED ELECTRONICALLY

Date: 02/18/2005

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.04

Prior Effective Dates: 11/10/83, 11/01/01

Notice

An Outpatient Health Facility Services provider handbook is not currently available. However, when Ohio Administrative Code (OAC) rules or Medical Assistance Letters (MAL) are issued, regarding Outpatient Health Facility Services, they will be posted in this e-book.