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John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Medicaid Handbook Transmittal Letters

MHTL 3347-14-01 (Update - Medicaid Requirements for Ordering, Referring, and Prescribing Providers for the Following Billing Providers: Outpatient Health Facilities and Clinics)

Medicaid Handbook Transmittal Letter (MHTL) No. 3347-14-01

Medical Assistance Letter (MAL) 594

May 16, 2014

TO: Eligible Providers of Outpatient Health Facilities and Clinics

FROM: John B. McCarthy

Director, Department of Medicaid (ODM)

SUBJECT: UPDATE - Medicaid Requirements for Ordering, Referring, and Prescribing Providers for the following billing providers: Outpatient Health Facilities and Clinics.

Summary

Rule [5160-1-17.9](#), "Ordering or referring providers," has been created in order to comply with new program integrity regulations contained in Section 6401 of the Patient Protection and Affordable Care Act (ACA). Medicaid is implementing new requirements in accordance with 42 CFR 455.410, "Enrollment and screening of providers," and 42 CFR 455.440, "National Provider Identifier (NPI)." Ohio Medicaid is thus required to enroll and screen all ordering, referring, certifying, and prescribing providers. The name and NPI of such providers are required on the claim for services rendered, procedures performed, items supplied, or drugs furnished or dispensed (services) and billed to the Department.

To implement the federal regulations described above, Rule 5160-1-17.9 specifies that Medicaid cannot pay the eligible rendering provider for any health care service requiring a referral, order, certification, or prescription from a physician or other health care professional unless the ordering, referring, certifying, or prescribing (ORP) provider is enrolled with Ohio Medicaid. Furthermore, if a claim fails to include the NPI or the legal name of the physician or health care professional who ordered, referred, certified, or prescribed the service, Medicaid reimbursement will not be allowed. Claims submitted to a managed care organization are specifically exempted from the new requirements.

ORP phase-in (or pay and post) period

The Ohio Department of Medicaid (ODM) will begin ORP implementation by posting edits for claims that require, but do not include, both the ordering, referring, certifying, or prescribing (ORP) provider's legal name and NPI and if the ORP provider is not enrolled in Medicaid. The edit will not deny the claim; rather the billing provider will receive information from ODM that states the claim does not have the required ordering, referring, certifying, or prescribing provider information. This phase-in period is expected to run from July 1, 2014 through at least December 31, 2014. Again, billing providers will not receive a denial for payment because of ORP implementation but will receive information that may require action on the part of both the billing and ORP provider.

Providers who are rendering services to Medicaid beneficiaries and bill the Department should ensure that such services are being ordered, referred, certified, or prescribed by a provider who is enrolled in Medicaid. The billing provider should double-check their applicable Medicaid program rules to determine what services requires an order, referral, certification, or prescription. The Department will soon be releasing a list of provider types and specialties to which the requirements of ORP will apply. The Department has created an abbreviated screening and application process for providers who do not wish to bill the Department but who wish to enroll as ordering, referring, certifying, or prescribing providers-only. An application fee is not required and the application can be filled out online. The Department is also working diligently to create a way in which billing providers can search the Medicaid enrollment status of the ordering, referring, certifying, or prescribing services in MITS.

As has been recommended in previous guidance by ODM, Medicaid providers who bill for services that are referred, ordered, certified, or prescribed by non-Medicaid enrolled physicians or other health care

professionals should be preparing for future enforcement by ensuring those referring, ordering, and prescribing physicians and other health care professionals have NPIs and are enrolled in the Medicaid program. **ODM plans on issuing a series of implementation guidance in the coming weeks that will, among other things, clarify who is potentially impacted by the change in policy. This letter serves as the first of such implementation guidance.**

- Providers who are enrolled as Provider Types (PT) 04, "Outpatient Health Facilities," and that specialize in physical therapy, speech therapy, lab, or x-ray and submit bills to the Department for services rendered will always be required to submit the name and NPI of the ordering provider and the provider will be required to be enrolled with the Ohio Medicaid program. Please consult the applicable Medicaid coverage rules to ensure the provider is authorized to order the covered service.
- Providers who are enrolled as PT 50, "Clinic," and that specialize in rehabilitation (including physical therapy), hearing and speech, diagnostic imaging, pharmacy, durable medical equipment, or orthotics and prosthetics and submit bills to the Department for services rendered will always be required to submit the name and NPI of the ordering provider and the provider will be required to be enrolled with the Ohio Medicaid program. Please consult the applicable Medicaid coverage rules to ensure the provider is authorized to order the covered service.
- Providers who are enrolled as PT 51, "Mental Health Clinic," and that operate as pharmacy and submit bills to the Department for drugs will always be required to submit the name and NPI of the prescribing provider and the provider will be required to be enrolled with the Ohio Medicaid program. Please consult the applicable Medicaid coverage rules to ensure the provider is authorized to prescribe the covered drug.
- **ODM has decided not to implement ORP requirements for automatic crossovers.** Crossovers submitted directly to ODM by the provider may be subject to ORP requirements.

For further information, all providers are welcome to view ODM's responses to ORP Frequently Asked Questions (FAQ) at <http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment/ORP.aspx> Providers may also call the ODM provider hotline at 1-800-686-1516.

More guidance on the implementation of Rule 5160-1-17.9 will be introduced in the coming weeks.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid may be accessed through the ODJFS main page or directly at <http://www.medicaid.ohio.gov>.

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- (4) Select the desired item from the 'Table of Contents' pull-down menu.

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

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5101:3-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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 Medicaid 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.

To receive automatic electronic notification when new Medicaid transmittal letters are published, sign up for the ODJFS e-mail subscription service at <http://www.odjfs.state.oh.us/subscribe/>.

Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Medicaid

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

MHTL 3347-09-03 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3347-09-03

January 8, 2010

TO: All Eligible Ambulatory Health Care Clinics
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

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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";
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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

MHTL 3347-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3347-09-02

July 10, 2009

TO: All Eligible Fee-for-Service Ambulatory Health Care Clinic 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.

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Bureau of Provider Services
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Columbus, OH 43216-1461
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MHTL 3347-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3347-09-02

Date

TO: All Eligible Fee-for-Service Ambulatory Health Care Clinic Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

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

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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](#).

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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

MHTL 3347-09-01

Medicaid Handbook Transmittal Letter (MHTL) 3347-09-01

February 19, 2009

TO: All Eligible Fee-for-Service Ambulatory Health Care Clinic 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

MHTL 3347-08-01

Medicaid Handbook Transmittal Letter (MHTL) 3347-08-01

July 17, 2008

To: Ambulatory Health Care ESRD Dialysis Clinics
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Fee Increases for Dialysis Clinics

Effective July 1, 2008

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce changes to the Ohio Administrative Code (OAC) rule 5101:3-1-60 governing Medicaid reimbursement.

Medicaid Reimbursement - Rule [5101:3-1-60](#)

The Department is pleased to announce that the Medicaid maximums for dialysis revenue center codes will be increased as part of the Governor's biennium budget. A 3% increase is being implemented for claims with dates of service on and after July 1, 2008. The fee changes can be found in Appendix DD to rule 5101:3-1-60 of the Ohio Administrative Code.

These Medicaid maximum changes are applicable to claims for consumers remaining in traditional Medicaid (fee-for-service) who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule 5101:3-1-60 will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution:

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/>.

The full text of this rule amendment can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals>.

Providers may view documents online by:

- (1) Selecting "Ohio Health Plans";
- (2) Selecting "Fee for Service Clinics"; and,
- (3) Selecting this MHTL number from the "Table of Contents" pull-down menu.

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MHTL 3347-07-01

Medicaid Handbook Transmittal Letter (MHTL) 3347-07-01

January 9, 2008

TO: Fee-for-Service Ambulatory Health Care Clinics
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Fee-For-Service Ambulatory Health Care Clinic (AHCC) Rules

The purpose of this Medicaid Handbook Transmittal Letter (MHTL) is to announce updates to the rules governing Fee-For-Service Ambulatory Health Care Clinics and to provide reminders regarding existing policy.

Chapter 5101:3-13 of the Ohio Administrative Code (OAC) has been re-organized as part of the five year rule review process. This re-organization coordinates the review cycle for all rules within the Chapter and will simplify future reviews. Rules 5101:3-13-01, 5101:3-13-03, 5101:3-13-04, 5101:3-13-05, 5101:3-13-06, and 5101:3-13-07 of the OAC are rescinded and replaced with new rules 5101:3-13-01, 5101:3-13-01.1, 5101:3-13-01.3, 5101:3-13-01.4, 5101:3-13-01.5, 5101:3-13-01.6, 5101:3-13-01.7, 5101:3-13-01.8, and 5101:3-13-01.9. The behavioral health clinic rule (5101:3-13-01.2) has temporarily been placed in a to-be-refiled (TBR) status in order to allow for additional refinement with stakeholder involvement.

The full text of each of these rule changes can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Clinic - Fee For Service Handbook. The Department encourages providers to visit the website and review the full text of the new Fee-For-Service Ambulatory Health Care Clinic rules.

Key points of interest in the new rules are:

- Rule 5101:3-13-01 contains definitions and requirements that are applicable to all fee-for-service Ambulatory Health Care Clinics;
- New rules 5101:3-13-01.1, 5101:3-13-01.3, 5101:3-13-01.4, 5101:3-13-01.5, 5101:3-13-01.6, 5101:3-13-01.7, 5101:3-13-01.8, and 5101:3-13-01.9 of the Administrative Code address the specific conditions for participation in the Medicaid program that are unique for each type of AHCC (primary care; public health department; outpatient rehabilitation clinics; family planning; professional optometry school; professional dental school; speech-language/audiology and diagnostic imaging; and dialysis clinics).

Rule 5101:3-10-10 of the OAC, entitled "**Dialysis equipment**," is amended to update the reference to rescinded rule 5101:3-13-07 of the Administrative Code with a reference to new rule 5101:3-13-01.9 of the Administrative Code. This is the only change to rule 5101:3-10-10 of the Administrative Code.

Rule 5101:3-13-01 of the OAC, entitled "**Eligible ambulatory health care clinic provider**," is rescinded. New **rule 5101:3-13-01** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): general provisions**" outlines the general provisions that apply to all Fee-For-Service Ambulatory Health Care Clinics. Key points of this new rule include:

- Expanded list of definitions used for fee-for-service ambulatory health care clinics;
- Clarification of required qualifications for enrollment as a fee-for-service ambulatory health care clinic, including that professional associations of physicians, dentists, optometrists, opticians, podiatrists, physical and or occupational therapists, psychologists, or chiropractors are not eligible to be an ambulatory health care clinic;
- Clarification of coverage and limitations of coverage for fee-for-service ambulatory health care clinics; and

- Reference to Chapter 5101:3-34 of the Administrative Code that addresses physical therapy, occupational therapy, speech-language pathology/audiology services.

Rule 5101:3-13-03, entitled "**Covered primary care clinic services (nonspecialty or multiservice clinics)**," is rescinded. New **rule 5101:3-13-01.1** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): primary care clinics**," outlines the provisions that are applicable to primary care clinics and **rule 5101:3-13-01.3** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): public health department clinics**" outlines the provisions that are applicable to public health department clinics.

Key points of new **rule 5101:3-13-01.1**, "**Fee-for-service ambulatory health care clinics (AHCCs): primary care clinics**," include:

- Expanded list of definitions used for primary care clinics;
- Clarification of required qualifications for Medicaid enrollment as a primary care clinic;
- Clarification of coverage and limitations of coverage for primary care clinics; and
- Inclusion of language stating that referral protocols must be in place for services not provided.

Key points of new **rule 5101:3-13-01.3**, "**Fee-for-service ambulatory health care clinics (AHCCs): public health department clinics**," include:

- Expanded list of definitions used for public health department clinics;
- Clarification of required qualifications for Medicaid enrollment as a public health department clinic; and
- Clarification of coverage and limitations of coverage for public health department clinics.

Rule 5101:3-13-04, entitled "**Covered specialty clinic services**," is rescinded. New rules 5101:3-13-01.4, 5101:3-13-01.5, 5101:3-13-01.6, 5101:3-13-01.7, 5101:3-13-01.8, and 5101:3-13-01.9 of the Administrative Code address specific requirements that are unique to the following specialty types of ambulatory health care clinics: outpatient rehabilitation clinics; family planning; professional optometry school; professional dental school; speech-language/audiology and diagnostic imaging; and dialysis clinics.

Key points of new **rule 5101:3-13-01.4** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): outpatient rehabilitation clinics**" include:

- Expanded list of definitions used for outpatient rehabilitation clinics;
- Clarification of required qualifications for Medicaid enrollment as an outpatient rehabilitation clinic;
- Clarification of coverage and limitations of coverage for outpatient rehabilitation clinics; and
- Reference to Chapter 5101:3-34 of the Administrative Code that addresses physical therapy, occupational therapy, speech-language pathology/audiology services.

Key points of new **rule 5101:3-13-01.5** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): family planning clinics**" include:

- Expanded list of definitions used for family planning clinics;
- Clarification of required qualifications for Medicaid enrollment as a family planning clinic;
- Clarification of coverage and limitations of coverage for family planning clinics; and
- Clarification of the role of Medicaid managed care plans in the provision of family planning services:
 - Medicaid managed care plan members are permitted to self-refer to any qualified family planning provider (QFPP); and
 - Medicaid managed care plans are responsible for payment of claims for family planning services delivered by non-contracting QFPPs at the lesser of one hundred percent of the Ohio Medicaid program fee-for-service reimbursement rate or billed charges in effect for the date of service.

Key points of new **rule 5101:3-13-01.6** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): professional optometry school clinic**" include:

- Expanded list of definitions used for professional optometry school clinics;
- Clarification of required qualifications for Medicaid enrollment as a professional optometry school clinic; and
- Coverage and limitations of coverage for professional optometry school clinics.

Key points of new **rule 5101:3-13-01.7** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): professional dental school clinic**," include:

- Expanded list of definitions used for professional dental school clinics;
- Clarification of required qualifications for Medicaid enrollment as a professional dental school clinic; and
- Clarification of coverage and limitations of coverage for professional dental school clinics.

Key points of new **rule 5101:3-13-01.8** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): speech-language/audiology and diagnostic imaging clinics**," include:

- Use of "speech-language/audiology and diagnostic imaging clinic" instead of "Diagnostic Clinics";
- Expanded list of definitions used for speech-language/audiology and diagnostic imaging clinics;
- Clarification of required qualifications for Medicaid enrollment as a speech-language/audiology or diagnostic imaging clinic;
- Clarification of coverage and limitations of coverage for speech-language/audiology and diagnostic imaging clinics;
- Addition of references specific to clinics that provide speech/language/audiology services; and
- Addition of references specific to clinics that provide diagnostic imaging services.

Key points of **new rule 5101:3-13-01.9** of the OAC, entitled "**Fee-for-service ambulatory health care clinics (AHCCs): end-stage renal disease (ESRD) dialysis clinics**" include:

- Expanded list of definitions used for ESRD dialysis clinics;
- Clarification of required qualifications for Medicaid enrollment as an ESRD dialysis clinic;
- Clarification of coverage and limitations of coverage for ESRD dialysis clinics;
- Clarification that Medicaid providers, including fee-for-service ambulatory health care ESRD dialysis clinics, must determine whether Medicare or other third party insurers are responsible for the coverage of a Medicaid patient's dialysis treatment for the date of treatment. Medicaid is the payer of last resort for ESRD services;
- Clarification of the dialysis clinic claims, billing and reimbursement processes;
- ESRD dialysis clinic claims for "clinic facility dialysis services" are payable only if submitted in accordance with national uniform billing committee (NUBC) requirements, using revenue center code(s) and appropriate procedure code(s) as described in Appendix A to this rule;
- Clarification of requirements regarding composite rates:
 - The department reimburses ambulatory health care ESRD dialysis clinics for dialysis treatment, dialysis support, and dialysis treatment with self-care training using composite rates;
 - The composite rates include specific laboratory tests, diagnostic services, and drugs (including injections and immunizations) in specific quantities and frequencies;
 - Items included in the composite rates may not be billed separately by the ESRD dialysis clinic or by any laboratory for the same date of dialysis treatment;

- Laboratory services may be performed in the clinic or by an outside laboratory if the clinic or laboratory is clinical laboratory improvement act (CLIA) certified;
- Laboratory tests are included in the composite rate regardless of where the tests are performed; and
- Composite rates do not include a physician's professional supervision; and
- ESRD dialysis clinic composite rates are listed in rule 5101:3-1-60 of the Administrative Code;
- Laboratory tests, diagnostic services, and drugs provided in excess of the frequency described in the composite rates are subject to review and potential recovery; and
- The department reimburses physician providers for physician professional services associated with the medical management of ESRD patients in accordance with rule 5101:3-4-14 of the Administrative Code.

Web Page and Paper Distribution:

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Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider"
- (2) Selecting "Clinic - Fee For Service"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

JFS 03400 ODJFS Service Provider Update Request Form

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments (rules 5101:3-10-10, 5101:3-13-01, 5101:3-13-01.1, 5101:3-13-01.3, 5101:3-13-01.4, 5101:3-13-01.5, 5101:3-13-01.6, 5101:3-13-01.7, 5101:3-13-01.8, or 5101:3-13-01.9) by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

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 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01), is maintained in the General Information e-book.

[Click here to view MHTL 3334-09-02, Discontinuing the Disability Medical Assistance \(DMA\) Program and the Rescission of Ohio Administrative Code \(OAC\) Rule 5101:3-23-01](#)

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 583 (Medicaid Pharmacy Coverage for Dual Eligibles Effective January 1, 2013)

Medical Assistance Letter (MAL) [583](#) is maintained in the Pharmacy Services e-book.

MAL 582 (Pharmacy Program Changes Effective October 1, 2012)

Medical Assistance Letter (MAL) [582](#) is maintained in the Pharmacy Services e-book.

MAL 561 (Announcement of Changes to Coverage of Prescription Drugs and Certain Medical Supplies)

Medical Assistance Letter No [561](#) is maintained in the Pharmacy Services e-book.

MAL 550 (Changes to the Fee-For-Service Pharmacy Program Effective October 1, 2008)

Medical Assistance Letter No [550](#) is maintained in the Pharmacy Services e-book.

MAL 546 (March 20, 2008 - Pharmacy Recordkeeping: Requirement for Tamper-Resistant Prescription Forms)

Medical Assistance Letter No [546](#) is maintained in the Pharmacy Services e-book.

MAL 531 (Information Providers Must Know About the NPI in Order to Get Paid)

Medical Assistance Letter (MAL) 531

June 7, 2007

To: Dialysis Clinics
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform dialysis clinic providers who are enrolled in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for a dialysis clinic is a unique, ten-digit, entity type 2 identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008, dialysis clinic providers that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their NPI number and their current Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

Dialysis clinics **MUST** enumerate through NPPES, disclose their NPI to ODJFS and bill ODJFS using both their NPI and Medicaid legacy identifiers. This MAL provides direction to dialysis clinic providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Dialysis clinic provider claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.* Dialysis clinic provider claims submitted to ODJFS on or after January 1, 2008 will be denied if the dialysis clinic provider's NPI number is not in the required field(s) on the claim. Dialysis clinic provider claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* See special instructions for paper and tape claims (below in this MAL).

I. How do I get an NPI?

Dialysis clinic providers can receive an NPI number by submitting an NPI application to NPPES. To obtain an NPI, dialysis clinic providers should contact NPPES directly **at <http://nppes.cms.hhs.gov> or by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY))**. Dialysis clinic providers can apply for an NPI electronically or by paper.

When you apply for your NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,
- taxonomy number, and
- employer identification number (EIN).

It is also important that you make it clear that you are applying for an NPI for a Non-individual, Ambulatory Health Care Facility, clinic provider. A listing of taxonomy codes for clinic providers can be found at <http://www.wpc-edi.com/codes/taxonomy>.

II. How must my NPI relate to my Medicaid legacy number?

If your dialysis clinic received this MAL, you submitted a claim or claims as a dialysis clinic provider at least once during the last twelve months. When dialysis clinic providers enroll to do business with ODJFS, they are issued a dialysis clinic provider Medicaid legacy number. When dialysis clinic providers subsequently submit claims for payment, ODJFS expects the billing provider, the pay to provider and the rendering provider to be the same (the dialysis clinic provider).

Services rendered by other practitioners employed by or under contract with the dialysis clinic provider should be billed under the dialysis clinic provider's NPI and the dialysis clinic provider's Medicaid legacy number (when both numbers are required). This directive applies as soon as you receive your NPI number and remains in effect after January 1, 2008.

Dialysis clinic providers must submit only the non-individual NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as an individual dialysis clinic provider. Only one NPI number can be associated with your individual Ohio Medicaid legacy number. A dialysis clinic provider's NPI should never be submitted to ODJFS with a Medicaid legacy number that belongs to any other provider.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for dialysis clinic providers. Instructions for submitting the NPI are also contained in the ODJFS EDI 837 Institutional Companion Guide, which is available at: <http://ifs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing NPI on EDI 837 Institutional Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The dialysis clinic's NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The dialysis clinic's NPI must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the dialysis clinic's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The EDI standard does not require the rendering provider loop(s) to be completed if the rendering provider is the same as the pay to provider. For dialysis clinics billing Medicaid, the pay to provider and the rendering provider are always the same provider. Do not send NPI information in the NM108 and NM109 nor the Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (neither loop 2310B nor 2420B).

Billing on Paper Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

At this time, ODJFS only accepts the Centers for Medicare and Medicaid Services (CMS) 1450, also referred to as the UB-92. ODJFS will continue to only accept the UB-92 until a date for the adoption of the UB-04 is established and announced by ODJFS.

Dialysis clinic providers using the UB-92 (required until announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the UB-92 will cause the claim to reject or may cause the claim to pay inappropriately.

When the new paper UB-04 is adopted by ODJFS, NPI numbers will be required on the new claim form and the processing and submission rules that apply to EDI claims will also apply to the new paper UB-04 form.

IV. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires dialysis clinic providers to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that provider in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

V. Am I required to share my NPI number with ODJFS?

Yes, the dialysis clinic provider must disclose to ODJFS the NPI number that has been assigned to the provider. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://ifs.ohio.gov/OHP/providers/npi.stm>.

VI. Am I required to share my NPI with other entities?

Yes, as stated in Section V, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the dialysis clinic provider in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

VII. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

VIII. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

IX. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the dialysis clinic providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The provider Services Section
P.O. Box 1461
Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://jfs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 530

Medical Assistance Letter (MAL) 530

June 7, 2007

To: Comprehensive Clinics, Dental Clinics, Diagnostic Clinics, Family Planning Clinics, Mental Health/ADAS Clinics, Optometry Clinics, Public Health Department Clinics, Rehabilitation Clinics
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform Ambulatory Health Care Clinic providers who are enrolled in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for the clinics is a unique, ten-digit identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008, clinic providers that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their NPI number and their current Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

Clinics **MUST** enumerate through NPPES, disclose their NPI to ODJFS and bill ODJFS using both their NPI and Medicaid legacy identifiers. This MAL provides direction to clinic providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Clinic provider claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.*

Clinic provider claims submitted to ODJFS on or after January 1, 2008 will be denied if the clinic provider's NPI number is not in the required field(s) on the claim. Clinic provider claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* See special instructions for paper and tape claims (below in this MAL).

I. How do I get an NPI?

Clinic providers can receive an NPI number by submitting an NPI application to NPPES. To obtain an NPI, clinic providers should contact NPPES directly at <http://nppes.cms.hhs.gov> or by phone at **1-800-465-3203 (or 1-800-692-2326 (TTY))**. Clinic providers can apply for an NPI electronically or by paper.

When you apply for your NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,
- taxonomy number, and

- employer identification number (EIN).

It is also important that you make it clear that you are applying for an NPI for a non-individual, Ambulatory Health Care Facility clinic provider. A listing of taxonomy codes for clinic providers can be found at <http://www.wpc-edi.com/codes/taxonomy>.

II. How must my NPI relate to my Medicaid legacy number?

If your clinic received this MAL, you submitted a claim or claims as a clinic provider at least once during the last twelve months. When clinic providers enroll to do business with ODJFS, they are issued a clinic provider Medicaid legacy number. When clinic providers subsequently submit claims for payment, ODJFS expects the billing provider, the pay to provider and the rendering provider to be the same (the clinic provider).

Services rendered by other practitioners employed by or under contract with the clinic provider should be billed under the clinic provider's NPI and the clinic provider's Medicaid legacy number (when both numbers are required). This directive applies as soon as you receive your NPI number and remains in effect after January 1, 2008.

Clinic providers must submit only the non-individual NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as an individual clinic provider. Only one NPI number can be associated with your individual Ohio Medicaid legacy number. A clinic provider's NPI should never be submitted to ODJFS with a Medicaid legacy number that belongs to any other provider.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for clinic providers. Instructions for submitting the NPI are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at: <http://ifs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The clinic's NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The clinic provider's NPI must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the clinic provider's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The EDI standard does not require the rendering provider loop(s) to be completed if the rendering provider is the same as the pay to provider. For clinics billing Medicaid, the pay to provider and the rendering provider are always the same provider. Do not send NPI information in the NM108 and NM109 nor the Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (neither loop 2310B nor 2420B).

Note: Dental school clinics use the 837D (dental) and all other clinics use the 837P (professional).

Billing on Paper Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the **new** CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the **old** CMS 1500).

Clinic providers using the old CMS 1500 (required until announced) must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old CMS 1500 will cause the claim to reject or may cause the claim to pay inappropriately.

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

Note: Dental school clinics should continue to use the American dental Association (ADA) 2000 paper form. ODJFS will continue to only accept the **old** ADA 2000 until a date for the adoption of the **new** ADA 2006/7 is established and announced by ODJFS.

IV. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires clinic providers to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that provider in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

V. Am I required to share my NPI number with ODJFS?

Yes, the clinic provider must disclose to ODJFS the NPI number that has been assigned to the provider. If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://jfs.ohio.gov/OHP/providers/npi.stm>.

VI. Am I required to share my NPI with other entities?

Yes, as stated in Section V above, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the clinic provider in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

VII. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

VIII. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

IX. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

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

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The provider Services Section
P.O. Box 1461
Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://jfs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 529

Medical Assistance Letter No 529 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Advanced Practice Nurse Services e-book.

[Click here to view MAL 529, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 528

Medical Assistance Letter No 528 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Advanced Practice Nurse Services e-book.

[Click here to view MAL 528, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

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 Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 479

Medical Assistance Letter (MAL) No. 479

January 28, 2005

TO: Fee-for-service clinics
FROM: Barbara E. Riley, Director
SUBJECT: Five-year rule review: Fee-for-service clinic reimbursement rule

The purpose of this Medicaid Assistance Letter (MAL) is to announce updates resulting from 5-year rule review of the reimbursement rule which governs fee-for-service clinic services. This rule amendment will be effective March 1, 2005.

The full text of each of this rule amendment can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the fee-for-service clinic book.

I. Rule amendments Rule 5101:3-13-06

The amendments to rule 5101:3-13-06 of the Administrative Code did not result in policy changes. The amendments consist mainly of grammatical or organizational changes which may improve the reader's understanding of the rule content.

One organizational change in the rule was to create sub-paragraphs to clarify existing reimbursement policy pertaining to public or non-profit clinics versus existing policy pertaining to proprietary clinics.

A clarifying paragraph was also added to reinforce that the Department pays the lesser of the provider's billed charge or the Medicaid maximum for the code. The Medicaid maximum for all codes is listed in the appendix to rule 5101:3-1-60 of the Administrative Code. If the amount billed to the Department exceeds the Department's maximum, the amount paid will be automatically reduced to the maximum amount permitted. This is not a policy change.

The paragraphs in the rule referring to the "global fee" for obstetrical services were removed since this form of clinic reimbursement was discontinued January 1, 2002 since this clinic type is not HIPAA-compliant.

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

MAL 476

Medical Assistance Letter (MAL) No. 476

December 21, 2004

TO: Community Mental Health Agencies Certified by the Ohio Department of Mental Health to Provide Medication Somatic Services

FROM: Thomas J. Hayes, Director

SUBJECT: Risperdal Consta

Risperdal Consta is a physician administered injection given every 2 weeks. The Department began covering this injection for services provided on and after April 1, 2004. Risperdal Consta is available for those clients who have one of the following diagnoses: schizophrenia, schizoaffective disorder, delusional disorder and psychosis NOS.

The current procedure code for Risperdal S0163 for 12.5 mg has been discontinued by the Centers for Medicare and Medicaid effective for dates of service on and after January 1, 2005. The new code is J2794 and is for 0.5 mg. The Medicaid maximum for J2794 for 0.5 mg is \$4.64. Multiple units may be billed in the unit's field based upon the appropriate dosage being administered. Bill the number of units necessary to cover the dosage given. For example, if 25 mg were administered the units billed would be 50 and the maximum payment would be \$ 232.

As stated in MAL 464 dated April 7, 2004, community mental health agencies that are certified by ODMH to provide medication/somatic services may directly bill ODJFS for the drug as part of the medical benefit. This requires community mental health agencies to have an **ODJFS issued** Medicaid provider number- **provider type 51**. This Medicaid provider number is a distinct and separate number from the number you have to bill crossover claims. The process for obtaining this Medicaid number was described in MAL 464.

As stated in MAL 464, the Medicaid provider number assigned provider type 51 should be used for billing ODJFS directly for this drug (i.e., for most agencies it will be the number received through this process).

All claims for community mental health services provided in conjunction with this drug should continue to be billed to the local ADAMH/CMH Board through MACSIS.

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

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 464

Medical Assistance Letter (MAL) No. 464

April 7, 2004

TO: Community Mental Health Agencies Certified by the Ohio
Department of Mental Health to Provide Medication Somatic Services

FROM: Thomas J. Hayes, Director

SUBJECT: Risperdal Consta

We are pleased to be able to share that through collaborative efforts between the Ohio Department of Job and Family Services (ODJFS) and the Ohio Department of Mental Health (ODMH), Risperdal Consta will be available as a Medicaid-covered medication for services provided on and after April 1, 2004.

Risperdal Consta is a physician administered injection given every 2 weeks. Risperdal Consta will be made available for those clients who have one of the following diagnoses: schizophrenia, schizoaffective disorder, delusional disorder and psychosis NOS. Please see the attached list for a complete list of DSM4CD and ICD9CD codes that fall in each of these categories.

Due to the dispensing requirements of Risperdal Consta, the Ohio Department of Job and Family Services (ODJFS) has decided to include this drug under the medical benefit rather than the outpatient pharmacy benefit. This drug requires refrigeration and stock rotation by date and is supplied in a single use kit, including needle and diluent. In addition, Risperdal Consta is not a self-administered drug, therefore ODJFS and ODMH agree that it would be appropriate to cover the drug as part of the medical benefit. The physician or advanced practice nurse (with prescribing privileges) must write the order and the injection will be administered in the clinic.

This is essentially the first psychotropic medication to be made available in this way (as part of the medical benefit as opposed to the outpatient pharmacy benefit).

Community mental health agencies that are certified by ODMH to provide medication/somatic services may directly bill ODJFS for the drug as part of the medical benefit. This requires community mental health agencies to have an **ODJFS issued** Medicaid provider number. This Medicaid provider number is a distinct and separate number from the number you have to bill crossover claims. The process for obtaining this Medicaid number and the limitations on the use of current Medicaid provider numbers is described in the next section of this medical assistance letter.

Medicaid Number Application Process

Providers who already have a Medicaid provider number as an ODJFS mental health/alcohol and other drug (MH/AOD) clinic (Provider Type (PT) 51) must use that ODJFS-issued provider number to bill ODJFS directly for Risperdal Consta.

Providers who do not have an ODJFS-issued Medicaid provider number (assigned a provider type mental health clinic- provider type 51) must obtain this Medicaid provider number to bill for Risperdal Consta.

Note: Providers may not use the Medicaid number recently assigned for Medicare *community mental health services crossovers* (assigned as provider type 84) to bill ODJFS for Risperdal Consta. If this is the only Medicaid provider number you have you must apply for another type (51) of Medicaid provider number to bill Risperdal Consta.

To obtain the Medicaid provider number (PT 51) necessary to bill ODJFS for Risperdal Consta the agency must complete and submit an ODJFS provider application. Please contact Tammy Bealer in the ODMH Office of Medicaid to request an application packet. Requests may be made by phone (614) 387-2799 or by email bealert@mh.state.oh.us Please include your agency name, contact name, complete mailing address and telephone number in your request for application.

Once a provider has submitted a complete application packet to the ODMH Office of Medicaid, the application information will be verified and forwarded to ODJFS for approval. ODJFS will contact providers in writing of

their approval including the assignment of their Medicaid number. Providers whose applications are denied will also be notified by ODJFS in writing.

Assuming that conditions of eligibility are met, the effective date of the provider agreement can be no earlier than April 1, 2004, the effective date that Risperdal Consta is eligible for reimbursement. Claims must be received by the department within three hundred sixty-five days of the actual date the service was provided, unless the provisions in paragraphs OAC 5101:3-1-19.3 (E)(1) and (E)(2) apply.

Reimbursement Policy and Pricing for Medicaid Consumers Who Are Not Dually Eligible for Medicare

The Medicaid provider number assigned provider type 51 will be used for billing ODJFS directly for this drug (i.e., for most agencies it will be the number received through this process).

All claims for community mental health services provided in conjunction with this drug should continue to be billed to the local ADAMH/CMH Board through MACSIS.

The procedure code for Risperdal Consta 12.5mg is S0163. The Medicaid maximum payment for each unit billed for this code is \$111.04. Multiple units may be billed based upon the appropriate dosage being administered. Bill the number of units necessary to cover the dosage given. For example, if 25 mg were administered the units billed would be 2 and the maximum payment would be \$222.08, if 37.5 mg were administered the units billed would be 3 and the maximum payment would be \$333.12.

Purchasing Options

The Ohio Department of Mental Health advises that there are two primary ways community mental health clinics may obtain Risperdal Consta.

The first option requires the community mental health agency to purchase the drug, in case lots, from a wholesaler. The agency must establish an account with a vendor to purchase the drug. The agency must then document the provision of the drug in the patient's record and bill Medicaid using the identified HCPCS code (S0163) to receive reimbursement.

The second option requires the community mental health agency to contract with a specialty pharmacy. The agency may request a specific number of injections from the specialty pharmacy. The specialty pharmacy will ship the requested injections to the community mental health agency for administration. The agency must then document the provision of the drug in the patient's record and bill Medicaid using the identified HCPCS code (S0163) to receive reimbursement.

Patients cannot take a prescription to their local pharmacy to be filled.

Patient Assistance Program

Information regarding referrals to the patient assistance program for Risperdal Consta may be obtained through the *CONSTANT*Access toll free number (877) 747-7524 Monday - Friday.

*CONSTANT*Access also has reimbursement specialists available to assist providers and patients with a variety of billing and coverage questions.

Attachment

[Click here to view the complete list of DSM4CD and ICD9CD codes for clients who have one of the following diagnoses: schizophrenia, schizoaffective disorder, delusional disorder and psychosis NOS.](#)

MAL 461

Medical Assistance Letter (MAL) NO. 461

January 6, 2004

TO: All Providers of End-Stage Renal Disease (ESRD) services provided in the Independent Free-Standing Clinic Setting
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Update for 2003 HCPCS Changes

BILLING UPDATE EFFECTIVE JANUARY 1, 2004

This Medical Assistance Letter (MAL) is intended for independent free-standing dialysis clinics providing end-stage renal disease services. Information about professional dialysis services provided by physicians can be found in Medicaid Handbook Transmittal Letter (MHTL) 3336-04-01 outlining all physician service updates effective January 1, 2004.

The purpose of this MAL is to announce the proposed implementation of the 2004 HCPCS (including CPT and alpha-numeric) codes and the policies relating to the code changes.

Beginning on and after January 1, 2004, the range of codes used to bill for epoetin (Q9920-Q9940) will be discontinued. To be reimbursed for epoetin injections, ESRD clinics must bill the new Q-code (Q4055, injection, epoetin alfa, 1000 units) with the appropriate revenue center code.

End-stage renal disease clinics must continue to bill codes 90918-90921 for reimbursement of professional services provided by a physician. The new HCPCS G-codes (G0308-G0327) will not be covered professional services provided by a physician in an ESRD clinic.

Questions pertaining to this MAL should be addressed to:

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 1-614-728-3288

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 452

Medical Assistance Letter (Mal) No. 452

September 9, 2003

TO: All Providers of End-Stage Renal Disease (ESRD) services provided in the Independent Free-Standing Clinic Setting
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas J. Hayes, Director

SUBJECT: Changes to the Ohio Administrative Code (OAC) rule 5101:3-13-07 for all Independent Free-Standing Clinics providing ESRD services

BILLING CHANGE EFFECTIVE OCTOBER 1, 2003

The purpose of this Medical Assistance Letter (MAL) is to clarify proposed changes for end-stage renal disease (ESRD) free-standing clinics effective October 1, 2003. Changes include switching from paper claim type ODJFS 6780 to the UB-92 claim, implementation of the 837I (institutional) electronic transaction, new billing codes (mainly the use of certain revenue center codes and/or procedure codes) and more detailed language of covered services and limitations (e.g., what is and isn't included in the dialysis composite rate).

Effective for services provided on and after October 1, 2003, the local level Z-codes will not be compliant per the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Accordingly, the Department is taking this opportunity to switch claim types and procedure codes to be more in line with Medicare and industry standards.

Please Note: This does not mean we will do business exactly like Medicare. Some requirements will remain different that are necessary for Medicaid.

It will be important that each independent clinic obtain a copy of OAC rule 5101:3-13-07 and a copy of the new billing instructions. Paper copies will not be automatically sent out to providers per the ODJFS Paper Transmittal Reduction initiative. Both the rule and billing instructions will be available online at <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid>. Paper copies may be acquired from ODJFS by filling out the attached ODJFS 03400 paper request form and sending it to the appropriate address or fax number given on the form.

Please note that HIPAA implemented a policy that four-digit revenue codes are required when billing on all UB-92 paper or 837i electronic claims. The billing instructions tell providers they must bill using the correct four-digit revenue center code (there will be a leading zero to the revenue center code).

Also, another important issue is that all services must be billed on the date of service they were provided. Unlike Medicare where monthly billing occurs, Medicaid requires that, for example, each time EPO is given to the patient, the dialysis clinic must bill for the EPO services provided to a patient on a given day. Do not bill all EPO injections as one line item for the whole month. You must itemize each service on the date it was provided. This billing procedure must be followed for all independent free-standing ESRD clinics services, including dialysis treatments, injections of any kind, laboratory and diagnostic services.

Please refer to the rule and billing instructions for further information for independent free-standing ESRD dialysis clinics.

Questions pertaining to this MAL should be addressed to:

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 1-614-728-3288

MAL 450

Medical Assistance Letter No 450 (June 26, 2003 - Prenatal Care Reimbursement - Billing Changes Effective July 1, 2003), is maintained in the Physician Services Handbook.

[Click here to view MAL 450, Prenatal Care Reimbursement - Billing Changes Effective July 1, 2003 in the Physician Services Handbook.](#)

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 443

Medical Assistance Letter (MAL) No. 443

February 11, 2003

TO: Rehabilitation and Comprehensive Clinics
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Code Changes for H.I.P.A.A.

BILLING CHANGE EFFECTIVE JULY 1, 2003

The Health Insurance Portability and Accountability Act (H.I.P.A.A.) requires that all payers use standard code sets for all services. Therefore the Department will be discontinuing the local level X and Z codes for transportation to the clinics currently used by a few clinics since the codes are not H.I.P.A.A.-compliant. Effective for services provided on and after **July 1, 2003**, the codes X9099 and Z7228 are no longer payable by the Department.

Should you have concerns about this change, there will be a public hearing on the proposed Medicaid reimbursement rule 5101:3-1-60 on February 11, 2003.

Questions pertaining to this MAL should be addressed to:

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 1-614-728-3288

MAL 433

Medical Assistance Letter (MAL) No. 433

August 19, 2002

TO: All Providers Billing Speech Therapy Z Codes
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Thomas Hayes, Director

SUBJECT: Billing Change for Speech Therapy

BILLING CHANGE EFFECTIVE JANUARY 1, 2003

The Health Insurance Portability and Accountability Act (H.I.P.A.A.) requires that all payers use the same codes for all services. Therefore the Department will be discontinuing the local level Z codes currently used by many clinics that provide speech therapy services since they are not H.I.P.A.A.-compliant. Effective for services provided on and after January 1, 2003, the Z codes Z2585, Z2586, Z2591, Z2593, and Z2595 are no longer payable by the Department. All providers who currently use these Z codes should advise their billers that these codes are not payable after December 31, 2002.

Providers who offer speech therapy services may begin using the existing speech therapy CPT codes (92506, 92507, 92508) at any time.

Please note that the CPT codes for speech therapy are not time-based codes. Providers should bill one unit for each speech therapy code provided regardless of time spent with the patient.

Questions pertaining to this MAL should be addressed to:

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 1-614-728-3288

MAL 393

Medical Assistance Letter (MAL) No. 393

May 10, 2001

TO: All Clinic Providers of Global Fee Obstetrical Services
Directors, County Departments of Job and Family Services
Directors, District Offices

FROM: Jo Ann Davidson, Director

SUBJECT: New Reimbursement Policy For Global Fee Clinics

GLOBAL CLINIC REIMBURSEMENT

BILLING CHANGE EFFECTIVE JANUARY 1, 2002

The global billing method will continue to be an option for public health clinics until January 1, 2002. At that time, all global clinics will be converted to their former provider type as a public clinic and will be required to bill for obstetrical services using standard obstetrical codes as defined in the obstetrical rule 5101: 3-4-08 of the Administrative Code. For your convenience, attached is a copy of the obstetrical section of the physician handbook which lists the obstetrical codes and their descriptions. These codes must be used beginning January 1, 2002.

Any clinic provider wishing to voluntarily switch from the global method to standard obstetrical billing before January 1, 2002 may elect this option by requesting this change in writing to the Department's Provider Enrollment section of Provider Network Management.

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

Rules Related to Clinic - Fee For Service

MHTL 3347-07-01

Effective Date: January 1, 2008

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

(A) Definitions.

- (1) "Ambulatory health care clinic (AHCC)" is a free-standing ambulatory healthcare facility that furnishes outpatient (non-institutional) health care by or under the direction of a physician or dentist, without regard to whether the clinic itself is administered by a physician or dentist.**
- (2) "Ambulatory health care facility" is a facility or distinct part of a facility that:**
 - (a) Provides services on an outpatient basis in a fixed location or specifically designed mobile unit; and**
 - (b) Does not provide overnight accommodations.**
- (3) "Cost-based ambulatory health care clinic" is an AHCC that is eligible for reimbursement on an encounter basis (in accordance with Chapters 5101:3-16, 5101:3-28, or 5101:3-29 of the Administrative Code) rather than on a service code basis.**
- (4) "Department," for the purposes of this chapter, is the Ohio department of job and family services (ODJFS).**
- (5) "Fee-for-service ambulatory health care clinic" is an AHCC that is eligible for reimbursement on a service code basis (in accordance with chapter 5101:3-13 of the Administrative Code) rather than an encounter basis.**
- (6) "Free-standing" means having no administrative, organizational, financial or other connection with a hospital or long-term care facility. A free-standing clinic may be physically located in a hospital or long-term care facility as long as the clinic remains independent, as evidenced by cost reports and separate employer identification number (EIN).**
- (7) "Medical services" are, for the purposes of this Chapter, defined in accordance with rule 5101:3-1-01 of the Administrative Code.**
- (8) "Non-specialty clinic" is an AHCC that provides a broad range of health care services.**
- (9) "Specialty clinic" is an AHCC that provides a limited or focused scope of healthcare services (e.g., dental, vision, dialysis).**

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

- (1) Non-specialty clinics are:**
 - (a) Primary care clinics, in accordance with rule 5101:3-13-01.1 of the Administrative Code; and**
 - (b) Public health department clinics, in accordance with rule 5101:3-13-01.3 of the Administrative Code.**
- (2) Specialty clinics are:**
 - (a) Community mental health services clinics, in accordance with rule 5101:3-13-01.2 of the Administrative Code;**
 - (b) Outpatient rehabilitation clinics, in accordance with rule 5101:3-13-01.4 of the Administrative Code;**

- (c) Family planning clinics, in accordance with rule 5101:3-13-01.5 of the Administrative Code;
- (d) Professional optometry school clinics, in accordance with rule 5101:3-13-01.6 of the Administrative Code;
- (e) Professional dental school clinics, in accordance with rule 5101:3-13-01.7 of the Administrative Code;
- (f) Speech-language/audiology clinics and diagnostic imaging clinics, in accordance with rule 5101:3-13-01.8 of the Administrative Code; and
- (g) End-stage renal disease (ESRD) dialysis clinics, in accordance with rule 5101:3-13-01.9 of the Administrative Code.

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

- (1) Meet the definition of an AHCC in accordance with paragraph (A)(1) of this rule;
- (2) Not be eligible as a medicaid provider as a professional association of physicians, dentists, optometrists, opticians, podiatrists, or limited practitioners such as physical therapists, psychologists, or chiropractors in accordance with division (B)(5)(c)(i) of section 2317.02 of the Revised Code;
- (3) Be enrolled as a medicare provider;
- (4) Bill medicare as the primary insurer for services provided to patients eligible for both medicare and medicaid;
- (5) Meet all specific requirements of at least one medicaid provider type listed under paragraph (B) of this rule;
- (6) Submit to the department appropriate documentation of compliance with the requirements set forth in paragraphs (C)(1) to (C)(5) of this rule, in accordance with Chapter 5101:3-1 of the Administrative Code and the Ohio medicaid provider application/agreement for organizations, Job and Family Services (JFS) 0651 (rev. 5/2006).

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

- (1) Physician services in accordance with paragraph (D)(1) of rule 5101:3-4-01 of the Administrative Code;
- (2) Dental services in accordance with rule 5101:3-5-01 of the Administrative Code;
- (3) Vision services in accordance with paragraph (A)(5)(a) of rule 5101:3-6-01 of the Administrative Code;
- (4) Podiatry services in accordance with Chapter 5101:3-7 of the Administrative Code;
- (5) Advance practice nurse services in accordance with rules 5101:3-8-20 to 5101:3-8-23 of the Administrative Code;
- (6) Laboratory services in accordance with rule paragraph (A)(2) of rule 5101:3-11-02 of the Administrative Code, if certified to perform laboratory procedures under Clinical Laboratory Improvement Act (CLIA);
- (7) Psychology services in accordance with paragraph (E)(1) of rule 5101:3-8-01 of the Administrative Code;
- (8) EPSDT services in accordance with Chapter 5101:3-14 of the Administrative Code;
- (9) Transportation services in accordance with 5101:3-15 of the Administrative Code;

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

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

(E) Limitations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective: 01/01/2008

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/8/79, 1/14/83, 4/2/83, 6/3/83, 10/1/87, 4/1/88, 9/1/89, 7/1/93, 7/12/93 (Emer.), 10/1/93; 5/17/01, 3/1/05

5160-13-01.1 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Primary Care Clinics

Formerly 5101:3-13-01.1 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Primary Care Clinics

[MHTL 3347-07-01](#)

Effective Date: January 1, 2008

Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

- (1) "Primary care clinic" is an AHCC that provides primary care services in one location. This type of clinic may be administered by a number of different types of agencies/organizations, including community action agencies, or independent and un-affiliated local agencies/foundations.
- (2) "Primary care" is health care rendered by licensed health care providers delivering services within their scope of practice, who are specifically trained for and skilled in comprehensive first contact and continuing care for persons with any sign, symptom, or health concern not limited by problem origin, organ system, or diagnosis. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses, appropriate medication management in a variety of health care settings and in coordination/collaboration with other health care professionals and systems (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).
- (3) "Primary care physician" is a generalist physician who provides definitive care to the undifferentiated patient at the point of first contact and takes continuing responsibility for providing the patient's care. Such a physician must be specifically trained to provide primary care services. Primary care physicians devote the majority of their practice to providing primary care services to a defined population of patients. The style of primary care practice is such that the personal primary care physician serves as the entry point for substantially all of the patient's medical and health care needs - not limited by problem origin, organ system, or diagnosis. Primary care physicians are advocates for the patient in coordinating the use of the entire health care system to benefit the patient.
- (4) "Primary health care" is a method of health care delivery in which teams of providers are accountable for providing comprehensive services to their patients.

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care primary care clinic provider on and after January 1, 2008 must:

- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code;
- (2) Meet the definition of a primary care clinic, in accordance with paragraph (A) of this rule; and
- (3) Be certified or accredited by:
 - (a) The joint commission;
 - (b) The accreditation association for ambulatory health care (AAAHC);
 - (c) The healthcare facilities accreditation program of the American osteopathic association;
 - (d) The community health accreditation program (CHAP); or
- (4) Receive state or federal grant funds for the provision of health services.

(C) A primary care clinic may provide all or some of the covered services identified in and provided in accordance with paragraph (D) of rule 5101:3-13-01 of the Administrative Code.

- (1) If a primary care clinic does not provide a service, it must have a formal working arrangement with other medical providers for the services needed by the individual beyond the capability of the clinic.

(2) Primary care clinic services must be provided in accordance with the limitations identified in paragraph (E) of rule 5101:3-13-01 of the Administrative Code.

(D) Federally qualified health centers (FQHCs), rural health clinics (RHCs), and outpatient health facilities (OHFs) may submit claims as a primary care clinic only when billing for services that are not covered under the prospective payment system (PPS) base rate, in accordance with Chapters 5101:3-28, 5101:3-16, and 5101:3-29 of the Administrative Code. These services include:

(1) Inpatient hospital surgery;

(2) Inpatient hospital visits or consultations;

(3) Services provided to dual-eligibles when medicare cross-over claims for services are not paid through the automatic medicare crossover process in accordance with rule 5101:3-1-05 of the Administrative Code; and

(4) Services submitted as disability medical assistance claims.

Replaces: Part of 5101:3-13-01, Part of 5101:3-13-03

Effective: 01/01/2008

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/8/79, 4/1/88

5160-33-01.3 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Public Health Department Clinics

Formerly 5101:3-13-01.3 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Public Health Department Clinics

MHTL 3347-07-01

Effective Date: January 1, 2008

Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

- (1) "Local health department" means a health department operated by the board of health of a city or general health district or the authority having the duties of a board of health under Chapter 3709. of the Revised Code.**
- (2) "Public health department," for the purposes of this chapter, has the same meaning as "local health department."**

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care public health department clinic provider on and after January 1, 2008 must:

- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code;**
- (2) Have legal status as a county, city, or combined health district; and**
- (3) Meet the standards for boards of health and local health departments in accordance with Chapter 3709 and Section 3701.342 of the Revised Code.**

Replaces: Part of 5101:3-13-01, Part of 5101:3-13-03, Part of

5101:3-13-04

Effective: 01/01/2008

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/8/79, 1/14/83, 4/2/83, 4/1/88

5160-33-01.4 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Outpatient Rehabilitation Clinics

Formerly 5101:3-13-01.4 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Outpatient Rehabilitation Clinics

MHTL 3347-07-01

Effective Date: January 1, 2008

Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

- (1) "Outpatient rehabilitation clinic" is defined in accordance with 42 C.F.R. 485.703 (10/01/2006). An outpatient rehabilitation clinic provides "basic rehabilitation services," including any or all of the following services: physical therapy, occupational therapy, speech-language pathology services, audiology services.**
- (2) "Comprehensive outpatient rehabilitation facility (CORF)" is defined in accordance with 42 C.F.R. 485.51 (10/01/2006). A CORF provides more rehabilitation services than physical therapy, occupational therapy, speech-language pathology (SLP) services, audiology services. A CORF might also provide services such as cardio/pulmonary rehab**

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care outpatient rehabilitation clinic provider on and after January 1, 2008 must:

- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code; and**
- (2) Be certified by medicare:**
 - (a) As either an outpatient rehabilitation clinic; or**
 - (b) A CORF.**
- (3) Provide services in accordance with division level 5101:3 of the Administrative Code, including, but not limited to physical therapy, occupational therapy, and speech language pathology (SLP)/audiology services in accordance with Chapter 5101:3-34 of the Administrative Code.**

(C) Coverage limitations set forth in Chapter 5101:3-33 of the Administrative Code also apply to therapy services provided under the auspices of an AHCC.

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

Effective: 01/01/2008

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/8/79, 1/14/83, 4/2/83, 4/1/88

5160-33-01.5 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Family Planning Clinics

~~*Formerly*~~ 5101:3-13-01.5 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Family Planning Clinics

[MHTL 3347-09-02](#)

Effective Date: July 1, 2009

Most Current Prior Effective Date: [January 1, 2008](#)

Requirements outlined in rule [5101:3-13-01](#) of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

- (1) "Family planning," ~~in accordance with rule 5101:3-4-07 of the Administrative Code, is the means, in accordance with rule 5101:3-21-02 of the Administrative Code, of enabling individuals of childbearing age, including minors who can be considered to be sexually active, to determine freely the number and spacing of their children~~ preventing or delaying pregnancy.
- (2) "Family planning clinics" are ambulatory health care clinics (AHCCs) whose primary function is to provide family planning services.
- (3) "Family planning services" ~~are defined~~ means, in accordance with rule 5101:3-21-02 of the Administrative Code, pregnancy prevention/contraceptive management services.
- (4) "Qualified family planning provider (QFPP)" ~~means any public or nonprofit health care provider that complies with federal guidelines/standards and receives funding for family planning services either under Title X of the Public Health Services Act or from the Ohio department of health~~ is defined in accordance with rule 5101:3-26-01 of the Administrative Code.

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care family planning clinic provider on and after January 1, 2008 must:

- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code; and
- (2) Meet one or more of the following qualifications:
 - (a) Affiliation with the planned parenthood federation of America (PPFA);
 - (b) Receive a grant award for the provision of family planning services under Title X of the Public Health Services Act; or
 - (c) Receive a grant award through the Ohio department of health for family planning services under the child and family health services program; and/or
 - (d) Receive a grant award through the Ohio department of health's women's health services, in accordance with rule 3701-68-01 of the Administrative Code.

(C) Covered services are family planning services, including medical, consultative, and educational services as specified in accordance with rule ~~5101:3-4-07~~ 5101:3-21-02 of the Administrative Code.

(D) Coverage limitations set forth in Chapter 5101:3-26 of the Administrative Code apply to AHCCs. ~~Medicaid managed care plan members are permitted to self-refer to any qualified family planning provider (QFPP). In accordance with Chapter 5101:3-26 of the Administrative Code, medicaid managed care plans are responsible for payment of claims for family planning services delivered by non-contracting QFPPs at the lesser of one hundred per cent of the Ohio medicaid program fee-for-service reimbursement rate or billed charges in effect for the date of service.~~

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

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/8/79, 1/14/83, 4/2/83, 10/1/87, 4/1/88, 9/1/89, 1/1/08

5160-33-01.6 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Professional Optometry School Clinics

***Formerly* 5101:3-13-01.6 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Professional Optometry School Clinics**

MHTL 3347-07-01

Effective Date: January 1, 2008

Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

- (A) Any organization applying to be a medicaid fee-for-service ambulatory health care professional optometry school clinic provider on and after January 1, 2008 must:
- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code; and
 - (2) Be a professional optometry school clinic accredited by the accreditation council on optometry education (ACOE) of the American optometric association.
- (B) Covered services are optometry services specified in accordance with Chapter 5101:3-6 of the Administrative Code.
- (C) In accordance with paragraph (A)(5)(a) of rule 5101:3-6-01 of the Administrative Code, AHCCs are eligible providers of vision services. Coverage limitations set forth in Chapter 5101:3-6 of the Administrative Code apply to AHCC services provided by opticians and optometrists.

Replaces: Part of 5101:3-13-01, Part of 5101:3-13-04

Effective: 01/01/2008

R.C. 119.032 review dates: 01/01/2013

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 12/30/77, 1/14/83, 4/2/83

5160-33-01.7 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Professional Dental School Clinics

***Formerly* 5101:3-13-01.7 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Professional Dental School Clinics**

MHTL 3347-07-01

Effective Date: January 1, 2008

Requirements outlined in this rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

- (A) Any organization applying to be a medicaid fee-for-service ambulatory health care professional dental school clinic provider on and after January 1, 2008 must:
- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code; and
 - (2) Function as a training facility for a professional dental school clinic accredited by the commission on dental accreditation (CODA) of the American dental association (ADA).
- (B) Covered services are covered dental services in accordance with Chapter 5101:3-5 of the Administrative Code.
- (C) Limits.
- (1) In accordance with rule 5101:3-5-01 of the Administrative Code, AHCCs are eligible providers of dental services. Coverage limitations set forth in Chapter 5101:3-5 of the Administrative Code apply to AHCC services provided by dentists.
 - (2) Individual dentists working within an ambulatory health care professional dental school clinic are not required to have provider numbers. The clinic must retain proof of legal authorization for each dentist without medicaid provider number to provide services.

Replaces: Part of 5101:3-13-01, Part of 5101:3-13-04

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5160-33-01.8 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Speech-Language/Audiology Clinics and Diagnostic Imaging Clinics

***Formerly* 5101:3-13-01.8 Fee-for-Service Ambulatory Health Care Clinics (AHCCs): Speech-Language/Audiology Clinics and Diagnostic Imaging Clinics**

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Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

- (1) "Diagnostic imaging," in accordance with rule 3701-83-51 of the Administrative Code, means the production of images used for medical diagnosis using magnetic resonance imaging (MRI), positron emission tomography (PET), computed tomography (CT), nuclear medicine. Diagnostic imaging does not mean the production of images used for medical diagnosis using diagnostic x-ray, mammography, or ultrasound.**
- (2) "Freestanding diagnostic imaging center," in accordance with rule 3701-83-51 of the Administrative Code, means a facility, or part of a facility, at which diagnostic imaging services are provided. A freestanding diagnostic imaging center does not include hospitals registered under section 3701.07 of the Revised Code**
- (3) "Mobile diagnostic imaging center," in accordance with paragraph (J) of rule 3701-83-51 of the Administrative Code, means any arrangement in which diagnostic imaging services are transported to various sites. A mobile diagnostic imaging center does not include movement within a hospital or movement to a site where the equipment will be located permanently and does not include the provision of diagnostic imaging by an entity that is reviewed as part of a hospital accreditation program.**
- (4) "Speech and hearing clinic" is an AHCC that provides speech, language, and audiology services designed to improve and restore the functioning of an individual.**

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care speech-language/audiology clinic or diagnostic imaging clinic on and after January 1, 2008 must:

- (1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code;**
- (2) Specialize in either speech-language/audiology services or diagnostic imaging services;**
- (3) Not meet the requirements of any other AHCC type identified in Chapter 5101:3-13 of the Administrative Code;**
- (4) Provide services in accordance with division 5101:3 of the Administrative Code; and**
- (5) If providing diagnostic imaging services, be:**
 - (a) A freestanding diagnostic imaging center; or**
 - (b) A mobile diagnostic imaging center; and**
 - (c) Licensed, registered, and credentialed in accordance with applicable, federal, state, and local laws.**
- (6) If providing speech and hearing services, deliver such services:**
 - (a) In accordance with rule 5101:3-4-17 of the Administrative Code; and**
 - (b) By professionals holding a certificate of clinical competence in speech-language pathology (CCC-SLP) and/or a certificate of clinical competence in audiology (CCC-A), issued by the American speech-language hearing association (ASHA).**

Replaces: Part of 5101:3-13-01, Part of 5101:3-13-04

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Appendix A - Revenue Center Codes (RCCs)

[Click here to view Appendix A - Revenue Center Codes \(RCCs\)](#)

Requirements outlined in rule 5101:3-13-01 of the Administrative Code apply to all fee-for-service AHCCs.

(A) Definitions.

- (1) "Ambulatory health care ESRF dialysis clinic" is a renal dialysis facility that meets the requirements outlined in paragraph (C) of this rule and provides chronic maintenance dialysis for end-stage renal disease (ESRD).**
- (2) "Chronic maintenance dialysis," in accordance with rule 3701-83-23 of the Administrative Code, means the regular provision of dialysis for an end stage renal disease patient with any level of patient involvement.**
- (3) "Composite payment rate" is a prospective system for the comprehensive payment of all modes of outpatient (in-facility and method I home) maintenance dialysis services. The composite payment rate covers most items and services related to the treatment of a patient's ESRD. The composite rate covers the complete dialysis treatment, specific laboratory tests, diagnostic services, laboratory services, and drugs (including injections and immunizations) in specific quantities and frequencies, as described in appendix A to this rule. The composite rate does not cover physician professional services, separately billable laboratory services, or separately billable drugs. Dialysis composite rates are listed in rule 5101:3-1-60 of the Administrative Code.**
- (4) "Continuous ambulatory peritoneal dialysis" (CAPD) is a type of peritoneal dialysis in which the patient's peritoneal membrane is used as a dializer. CAPD is usually performed three to five times a day in four to six hour cycles.**
- (5) "Continuous cycling peritoneal dialysis" (CCPD) is a type of peritoneal dialysis in which the patient's peritoneal membrane is used as a dializer. CAPD is usually accomplished three times a night in approximately three hours cycles, using an automatic peritoneal dialysis cyler.**
- (6) "Dialysis" is a process by which waste products are removed from the body by diffusion from one fluid compartment to another across a semi-permeable membrane. The two types of dialysis procedures currently in common use are hemodialysis and peritoneal dialysis.**
- (7) "Dual-eligible," for the purposes of this rule, means a patient who is eligible for both medicare and medicaid coverage of ESRD services.**
- (8) "End-stage renal disease" (ESRD) occurs from the destruction of normal kidney tissues over a long period of time. The loss of kidney function in ESRD is usually irreversible and permanent.**
- (9) "End-stage renal disease patient," in accordance with rule 3701-83-23 of the Administrative Code, means an individual who is at a stage of renal impairment that appears irreversible and permanent and who requires a regular course of dialysis or renal transplantation to ameliorate uremic symptoms and maintain life.**
- (10) "ESRD services" are diagnostic, therapeutic, rehabilitative, or palliative services, including:**
 - (a) Services furnished at an ambulatory health care ESRD dialysis clinic by or under the general or direct supervision of a physician.**

- (b) Services furnished outside an ambulatory health care ESRD dialysis clinic by clinic personnel under the general or direct supervision of a physician to a patient who does not reside in a permanent dwelling or does not have a fixed home or mailing address.
- (c) Services specified by revenue center codes delineated in appendix A to this rule.
- (11) "Free-standing" is defined in accordance with rule 5101:3-13-01 of the Administrative Code.
- (12) "Freestanding dialysis center" or "dialysis center," in accordance with rule 3701-83-23 of the Administrative Code, means a facility that provides chronic maintenance dialysis to ESRD patients on an outpatient basis, including the provision of dialysis services in the patient's place of residence. A freestanding dialysis center does not include a hospital or other entity that performs dialysis services that are reviewed and accredited or certified as part of the hospital's accreditation or certification as required by section 3727.02 of the Revised Code.
- (13) "Home dialysis" is dialysis performed by an appropriately trained patient and patient caregiver at home. Home dialysis, in accordance with rule 3701-83-23 of the Administrative Code, means dialysis performed by an appropriately trained patient, with or without minimal assistance, at the patient's place of residence.
- (14) "Home dialysis training" is a program that trains ESRD patients to perform home dialysis with little or no professional assistance, and trains other individuals to assist patients in performing home dialysis.
- (15) "Hospital-based ESRD facilities" are an integral and subordinate part of a hospital, as evidenced by the cost report, in accordance with Chapter 5101:3-2 of the Administrative Code.
- (16) "Hemodialysis" is a renal dialysis procedure in which blood passes through an artificial kidney machine and the waste products diffuse across a manmade membrane into a bath solution known as dialysate after which the cleansed blood is returned to the patient's body. Hemodialysis is usually accomplished in three to four hours sessions, three times a week.
- (17) "In-facility dialysis" is dialysis furnished on an outpatient basis at an approved renal dialysis facility.
- (18) "Intermittent peritoneal dialysis" (IPD) is a type of peritoneal dialysis in which waste products pass from the patient's body through the peritoneal membrane into the peritoneal cavity where the dialysate is introduced and removed periodically by machine. IPD is usually conducted for approximately thirty hours per week in three or fewer sessions of ten or more hours.
- (19) "Method I" is medicare terminology used to describe the provision of home dialysis services whereby a renal dialysis facility assumes responsibility for providing all home dialysis equipment, supplies and support services.
- (20) "Peritoneal dialysis" is a renal dialysis procedure in which waste products pass from a patient's body through the peritoneal membrane into the peritoneal (abdominal) cavity where the dialysate is introduced and removed periodically. The three types of peritoneal dialysis are continuous ambulatory peritoneal dialysis (CAPD), continuous cycling peritoneal dialysis (CCPD), and intermittent peritoneal dialysis (IPD).
- (21) "Physician professional services," in accordance with rule 5101:3-4-14 of the Administrative Code, are age-specific services performed in an outpatient setting that are related to a patient's ESRD.
- (22) "Renal dialysis center" is a hospital unit approved by medicare to furnish the full spectrum of services required for the care of ESRD dialysis patients.
- (23) "Renal dialysis facility" is a unit approved by medicare to furnish dialysis services directly to ESRD patients.
- (24) "Self-dialysis" is dialysis performed by an appropriately trained ESRD patient with little or no professional assistance.

(25) "Self-dialysis training" is a program that trains ESRD patients to perform self-dialysis with little or no professional assistance, and trains other individuals to assist patients in performing self-dialysis.

(26) "Staff-assisted dialysis" is dialysis performed by the staff of a renal dialysis center or facility.

(B) Any organization applying to be a medicaid fee-for-service ambulatory health care dialysis clinic provider on and after January 1, 2008 must:

(1) Meet the criteria for fee-for-service AHCC providers in accordance with paragraph (C) of rule 5101:3-13-01 of the Administrative Code; and

(2) Be certified by medicare as a dialysis facility;

(3) Be licensed by the director of the Ohio department of health in accordance with Chapter 3701-83 of the Administrative Code and demonstrate to the director of health that it meets the requirements of section 3702.30 of the Revised Code and either meets the requirements of Chapter 3701-83 of the Administrative Code or has submitted an acceptable accreditation inspection report, in accordance with rule 3701-83-05 of the Administrative Code; and in accordance with rule 3701-83-02 of the Administrative Code, complies with rules 3701-83-23 to 3701-83-24 of the Administrative Code. Non-Ohio providers must be licensed by their respective state's authority if applicable.

(4) Provide services in accordance with division level 5101:3 of the Administrative Code.

(C) Dialysis clinic claims, billing, payment/reimbursement.

(1) Fee-for-service ambulatory health care dialysis clinic providers that have executed the standard medicaid provider agreement and meet all eligibility requirements specified in paragraph (C) of this rule may bill the department for ESRD dialysis services.

(2) All medicaid providers, including fee-for-service ambulatory health care dialysis clinics, must determine whether medicare or other third party insurers are responsible for the coverage of a medicaid patient's dialysis treatment for the date of treatment. Medicaid is the payer of last resort for ESRD services.

(a) Medicaid coverage of ESRD services for patients, including dual-eligibles, begins with the initial onset of dialysis treatment.

(i) If CMS determines that the patient is medicare eligible at the onset of the disease, medicaid coverage as the primary payer begins with the initial onset of dialysis and continues until medicare coverage begins (usually three months).

(ii) If CMS determines that the patient is not medicare eligible at the onset of the disease, medicaid coverage continues as long as the dialysis treatments are medically necessary and the patient is eligible for medicaid.

(b) The medicaid provider must pursue medicare eligibility for the patient through CMS within the first three months of a medicaid eligible patient's initial dialysis treatment.

(i) The provider must retain proof in the medical record that the patient has applied for medicare coverage and is ineligible.

(ii) The department may conduct a retrospective review to verify that the provider assisted the patient to apply for medicare coverage.

(iii) Fee-for-service ambulatory health care dialysis clinic providers shall bill medicare cross-over claims in accordance with rule 5101:3-1-05 of the Administrative Code.

(3) Dialysis clinic claims for "clinic facility dialysis services" are payable only if submitted in accordance with national uniform billing committee (NUBC) requirements, using revenue center code(s) and appropriate procedure code(s) as described in appendix A to this rule.

- (4) Dialysis clinics must document in the patient's medical record the medical necessity, defined in accordance with rule 5101:3-1-01 of the Administrative Code, of each service provided and billed to the department. to verify that the services were rendered as billed on the claim.
- (5) The department reimburses ambulatory health care dialysis clinics for dialysis treatment, dialysis support, and dialysis treatment with self-care training using composite rates, as described in appendix A to this rule. The composite rates include specific laboratory tests, diagnostic services, and drugs (including injections and immunizations) in specific quantities and frequencies, as described in appendix A to this rule. Items included in the composite rates may not be billed separately by the dialysis clinic or by any laboratory for the same date of dialysis treatment. Laboratory services may be performed in the clinic or by an outside laboratory if the clinic or laboratory is clinical laboratory improvement act (CLIA) certified. Laboratory tests are included in the composite rate regardless of where the tests are performed. Composite rates do not include a physician's professional supervision. Physician professional supervision may only be billed by physicians, in accordance with rule 5101:3-4-14 of the Administrative Code. Dialysis clinic composite rates are listed in rule 5101:3-1-60 of the Administrative Code.
- (a) Composite rates for medicaid coverage of dialysis treatment.
- (i) Dialysis treatment is available to patients in both clinic and home settings.
- (ii) Limits.
- (a) The department will reimburse dialysis clinics for in-facility and method I home dialysis at a maximum frequency of one treatment per recipient per day. These rates are to be used only by clinics providing care to patients who have elected medicare's method I payment system.
- (b) Treatment sessions for hemodialysis and IPD are limited to three treatments per week. This limitation may be exceeded only if additional treatments are determined to be medically necessary, defined in accordance with rule 5101:3-1-01 of the Administrative Code, by the physician who is primarily responsible for dialysis services and the medical necessity for the services is documented in the medical record.
- (c) Treatment sessions for CCPD and CAPD are limited to a daily composite rate. Treatments for CCPD and CAPD must be determined to be medically necessary by the physician who is primarily responsible for the dialysis services. The medical necessity for the services must be documented in the patient's medical record.
- (b) Composite rates for medicaid coverage of dialysis support services.
- (i) The patient may elect to make his/her own arrangements for securing necessary supplies and equipment in either the home or the clinic setting.
- (ii) Only dialysis clinics using medicare's method II payment system may bill the department using the composite rate for support services.
- (iii) The composite rate for support services does not include durable medical equipment (DME) or laboratory services. Payment for supplies will be made to the DME supplier at rates listed under rule 5101:3-10-03 of the Administrative Code entitled "medicaid supply list."
- (iv) The department will reimburse a dialysis clinic for support services composite rates at a maximum frequency of once per month.
- (c) Composite rates for medicaid coverage of dialysis treatment with self-care training.
- (i) The composite rate for dialysis treatment with self-care training reflects training costs per session.
- (ii) Limits.

- (a) Hemodialysis treatment services with self-care training is limited to fifteen sessions or three months of training, whichever comes first.
 - (b) IPD treatment services with self-care training is performed in ten to twelve hour sessions and is limited to four weeks of training.
 - (c) CAPD treatment services with self-care training is performed five days a week and is limited to a maximum of fifteen training sessions.
 - (d) CCPD treatment services with self-care training is performed five to six days a week and is limited to a maximum of fifteen training sessions.
- (6) The department reimburses dialysis clinics for medically necessary laboratory tests (as described in Chapter 5101:3-11 of the Administrative Code), diagnostic services, and prescribed drugs (including therapeutic injections as described in rule 5101:3-4-13 of the Administrative Code) and immunizations (as described in rule 5101:3-4-12 of the Administrative Code) not included in the composite rates or that exceed the frequency described in the composite rates as described in appendix A to this rule, if:
 - (a) The medical record documents the medical necessity for the laboratory test, diagnostic service, and/or drug; and
 - (b) The laboratory test, diagnostic service, and/or drug is a covered medicaid service.
- (7) Laboratory tests, diagnostic services, and drugs provided in excess of the frequency described in the composite rates are subject to review and potential recovery.
- (8) The department reimburses physician professional services associated with the medical management of ESRD patients in accordance with rule 5101:3-4-14 of the Administrative Code.
- (9) The department reimburses durable medical equipment providers for supplies associated equipment and all related medical supplies necessary for the home dialysis patient who elects to receive such services under Method II, in accordance with rule 5101:3-10-10 of the Administrative Code.
- (10) The department reimburses for medical transportation to and/or from dialysis treatment in accordance with Chapter 5101:15 of the Administrative Code.
- (11) The following services are non-covered:
 - (a) All blood products;
 - (b) All services exceeding the limitations defined in Chapters 5101:3-1, 5101:3-4, 5101:3-05, 5101:3-06, 5101:3-8, 5101:3-9, 5101:3-13, 5101:3-14, 5101:3-15, and 5101:3-24 of the Administrative Code;
 - (c) Services determined by the department as not medically necessary or that are duplicative of a service provided concurrently by another medicaid provider;
 - (d) Any service not provided in accordance with the criteria and protocols set forth by the Ohio law for advanced practice nurses, registered nurses, and physician assistants;
 - (e) All services itemized as non-covered in rule 5101:3-4-28 of the Administrative Code.

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Notice

A Clinic - Fee For Service provider handbook is not currently available. However, when Ohio Administrative Code (OAC) rules or Medical Assistance Letters (MAL) are issued, regarding Clinic - Fee For Service, they will be posted here.