Ohio | Department of Job and Family Services

Ted Strickland, Governor
Douglas E. Lumpkin, Director

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-09-XX

TO: All Eligible Physicians
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 $22,874,174.

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 incontinent garment HCPCS codes has been reduced by 13 percent, resulting in an annual savings of approximately $3,362,752. 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 and occupational 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 610 CPT codes and results in annual savings of approximately $5,459,678**.** These 610 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-six (73 percent) of the 610 codes were surgical codes, 93 (15 percent) were radiology codes, and 66 (11 percent) were medicine codes, of which 37 (56 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:

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.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: http://www.odjfs.state.oh.us/subscribe/.

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

5101:3-1-60 **Medicaid reimbursement.**

(A) The medicaid payment for a covered service constitutes payment-in-full and may not be construed as a partial payment when the reimbursement amount is less than the provider's charge. The provider may not collect and/or bill the consumer for any difference between the medicaid payment and the provider's charge or request the consumer to share in the cost through a deductible, coinsurance, co-payment or other similar charge, other than medicaid co-payments as defined in rule 5101:3-1-09 of the Administrative Code.

Nothing in division 5101:3 of the Administrative Code shall preclude providers from charging/collecting, or waiving the collection of, medicare co-payments for medicare part D services to medicaid consumers. Medicaid consumer liability provisions set forth in paragraph (D) of rule 5101:3-1-13.1 of the Administrative Code do not apply to medicare part D services.

(1) For dental, vision, non-emergency emergency department services and prescription services that are subject to a co-payment in accordance with rule 5101:3-1-09 of the Administrative Code, the following principles shall apply:

(a) The medicaid maximum for dental services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-5-01 of the Administrative Code.

(b) The medicaid maximum for vision services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-6-01 of the Administrative Code.

(c) The medicaid maximum for pharmacy services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-9-09 of the Administrative Code.

(d) The medicaid maximum for non-emergency emergency department services will be the total medicaid maximum payment reduced by the total medicaid co-payment amount and the provider may collect and/or bill the consumer the total medicaid co-payment amount determined in accordance with rule 5101:3-2-21.1 of the Administrative Code.

(2) In accordance with rule 5101:3-1-08 of the Administrative Code, providers are expected to take reasonable measures to determine any third-party resource available to the consumer and to file a claim with that third party when required to do so under rule 5101:3-1-08 of the Administrative Code. The Ohio department of job and family services shall reimburse the lesser of the provider's billed charge for the service or the medicaid maximum, minus the third-party payment and minus any applicable medicaid copayment amount. If the result is zero or less, medicaid will make no further payment. Providers must bill their usual and customary charge (the amount charged to the general public).

(B) Medicaid reimbursement is not available for non-covered services or for covered services that are denied by the department as a result of either a prepayment review, utilization review, or prior authorization process (see Chapter 5101:3-2 of the Administrative Code for a description of how these provisions are applied to inpatient and outpatient hospital services).

(C) Reimbursement is made only for those covered medicaid services that are medically necessary and received by eligible medicaid consumers. The amount of payment is determined in accordance with federal and state laws and regulations. In establishing medicaid maximums, the department must assure that the maximum reimbursement is consistent with efficiency, economy, and quality of care.

(D) The state's appropriation determines the total amount of funds that may be expended for health services under medicaid. The maximums used by the department may be less than the maximums permitted under federal law, but may not be more. Providers are expected to bill the department their usual and customary charge (i.e., the amount they charge the general public). If the amount billed to the department exceeds the department's maximum, the amount paid will automatically be reduced to the maximum permitted.

(E) Except as otherwise provided, the department reimburses ambulance/ambulette/wheelchair vehicle providers, ambulatory health care centers, ambulatory surgery centers, chiropractors, dentists, home health agencies, laboratory and x-ray facilities, medical suppliers, optometrists, physical therapists, physicians, podiatrists, private duty nurses, psychologists, and other limited practitioners at the lesser of their billed charge or the medicaid maximum. Providers must bill their usual and customary charge (the amount charged to the general public).

(F) The department reimburses pharmacies for drugs at the lesser of the billed charge or the maximum allowed for the cost of the drug plus a dispensing fee for those drugs listed in appendix A to rule 5101:3-9-12 of the Administrative Code. Providers must bill their usual and customary charge (the amount charged to the general public).

(G) Rural health clinics and federally qualified health centers are reimbursed using a prospective payment system in accordance with federal legislation. Additional provisions regarding reimbursement for rural health clinic services may be found in

Chapter 5101:3-16 of the Administrative Code. Additional provisions regarding reimbursement for services provided by federally qualified health centers using prospective payment rates specified in federal regulation may be found in Chapter 5101:3-28 of the Administrative Code.

(H) Outpatient health facilities are reimbursed on a prospective reasonable cost-related basis from cost reports filed by each participating clinic. Additional provisions regarding reimbursement for these services may be found in Chapter 5101:3-29 of the Administrative Code.

(I) Reimbursement for long-term care facilities is described in Chapter 5101:3-3 of the Administrative Code and for inpatient and outpatient hospitals in Chapter 5101:3-2 of the Administrative Code.

(J) The medicaid maximums are determined as follows:

(1) For practitioner services, clinical laboratory services, x-ray services, ambulatory health care center services, vision, dental and ambulance and ambulette/wheelchair vehicle services, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD to this rule unless otherwise stated in Chapters 5101:3-4, 5101:3-5, 5101:3-6, 5101:3-7, 5101:3-8, 5101:3-11, 5101:3-12, 5101:3-13, 5101:3-15, and 5101:3-17 of the Administrative Code. For free-standing ambulatory end-stage renal disease clinics, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD to this rule. Chapter 5101:3-13 of the Administrative Code describes the situations where the medicaid maximum is reimbursed at the revenue center code level and when the medicaid maximum is paid at the code level.

(2) For the total procedure for anatomical laboratory services, for services provided on and after July 1, 2003, payment will be based on the medicaid maximum for the service as shown in appendix DD to this rule.

(3) For medical supplier services, the medicaid maximums are one hundred per cent of the amounts shown in appendix DD to this rule. Additional provisions regarding reimbursement for these services may be found in Chapter 5101:3-10 of the Administrative Code.

(4) For facility services provided by an ambulatory surgery center (ASC), the medicaid maximum is the surgical group rate. The surgical group rates are as follows.

(a) For an ASC-covered procedure classified in surgical group one for dates of service ~~July 1,2008~~ January 1, 2010 and thereafter, the rate shall be ~~two hundred fifty-four dollars and forty-one cents~~ two hundred forty-six dollars and seventy-eight cents.

(b) For an ASC-covered procedure classified in surgical group two for dates of service ~~July 1, 2008~~ January 1, 2010 and thereafter, the rate shall be ~~three hundred forty-one dollars and ninety-six cents~~ three hundred thirty-one dollars and seventy cents.

(c) For an ASC-covered procedure classified in surgical group three for dates of service ~~July 1, 2008~~ January 1, 2010 and thereafter, the rate shall be ~~three hundred ninety-two dollars and forty-three cents~~ three hundred eighty dollars and sixty-six cents.

(d) For an ASC-covered procedure classified in surgical group four for dates of service ~~July 1, 2008~~ January 1, 2010 and thereafter, the rate shall be ~~four hundred eighty-three dollars and seven cents~~ four hundred sixty-eight dollars and fifty-eight cents.

(e) ~~Five hundred fifty-one dollars and five cents~~ Five hundred thirty-four dollars and fifty-two cents for an ASC-covered procedure classified in surgical group five.

(f) ~~Seven hundred twenty-six dollars and fifteen cents~~ Seven hundred four dollars and thirty-seven cents for an ASC-covered procedure classified in surgical group six.

(g) ~~Seven hundred sixty-five dollars and twenty-nine cents~~ Seven hundred forty-two dollars and thirty-three cents for an ASC-covered procedure classified in surgical group seven.

(h) ~~Eight hundred thirty-eight dollars and forty-two cents~~ Eight hundred thirteen dollars and twenty-seven cents for an ASC-covered procedure classified in surgical group eight.

(i) ~~One thousand sixty-three dollars and ninety-nine cents~~ One thousand thirty-two dollars and seven cents for an ASC-covered procedure classified in surgical group nine.

Covered ASC procedures are classified into nine surgical procedures numbered one, two, three, four, five, six, seven, eight, or nine. The surgical group for each covered procedure is contained in appendix DD to this rule in the columns "ASC current group," "Current ASC effective date," and "Current ASC end date".

(5) For services provided on and after ~~May 1, 2001~~ January 1, 2010, reimbursement methodology for professional anesthesia services is in accordance with rules 5101:3-4-21, 5101:3-4-21.1 and 5101:3-4-21.2 of the Administrative Code.

(K) For home health and private duty nursing services, the medicaid maximums shall be as described in rules 5101:3-12-05 and 5101:3-12-06 of the Administrative Code respectively.

(L) Except as otherwise permitted by federal statute or regulation and at the department's discretion, the department will assure that the medicaid maximums described in paragraph (J) of this rule, do not exceed the authorized level for the same services under the medicare program.

(M) Effective January first of each calendar year, the department adds, deletes, and revises procedure codes in accordance with the annual update of the healthcare common procedure coding system (HCPCS) defined in rule 5101:3-1-19.3 of the Administrative Code. The department will implement the updated HCPCS coding system on January first.

(N) The column entitled "lab & prof/tech indic." denotes that the procedure is composed of both technical and professional components for a certain time period. A key for the alphabetic codes shown in this column is shown below at the end of this paragraph. For example, the indicator "C" means that the medicaid maximum for the professional component would be forty per cent of the medicaid maximum for the total procedure and the medicaid maximum for the technical component would be sixty per cent of the medicaid maximum for the total procedure.

Key for prof/tech split:

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C	Forty - sixty
D	Eighty - twenty
E	Professional component - four hundred
F	Ten - ninety
G	Twenty - eighty
H	Twenty-five - seventy-five
I	Thirty - seventy
J	Thirty-five - sixty-five
K	Fifty - fifty
L	Sixty - forty
M	Seventy - thirty
O	One hundred - zero
P	Seventy-five - twenty-five
Q	Ninety - ten

5101:3-4-21.2 **Anesthesia conversion factors.**

(A) For modifiers "AA", "AD", or "QZ", the conversion factor is ~~fifteen dollars and twenty-eight~~ fourteen dollars and eighty-two cents for dates of service on and after ~~May 1, 2001~~January 1, 2010.

(B) For modifiers "QK", QX", or "QY", the conversion~~ factors are as follows:~~factor is fifteen dollars and seventy-seven cents for dates of service on and after January 1, 2010.

~~(1) Sixteen dollars and ninety-eight cents for dates of service between May 1, 2001, until September 1, 2002; and~~

~~(2) Sixteen dollars and twenty-six cents for dates of service beginning September 1, 2002.~~

(C) Services billed with the "QK", "QX", or "QY" modifiers described in paragraph (D)(1) of rule 5101:3-4-21 of the Administrative Code will be reimbursed at fifty per cent of the conversion factor stated in paragraph (B) of this rule.

5101:3-5-02 **Dental program: covered diagnostic services and limitations.**

The following dental examination codes may be billed for any place of service in accordance with the coverage and limitations set forth in Chapter 5101:3-5 of the Administrative Code.

(A) Clinical oral examination.

(1) Comprehensive oral evaluation.

(a) The comprehensive oral evaluation is typically used by a general dentist and/or a specialist when evaluating a consumer comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues. It may require interpretation of information acquired through additional diagnostic procedures. Additional diagnostic procedures should be reported separately.

A comprehensive oral evaluation would include the evaluation and recording of the consumer's dental and medical history and a general health assessment. It may typically include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships, periodontal conditions (including periodontal charting), hard and soft tissue anomalies, oral cancer screening, etc.

(b) The comprehensive oral evaluation shall be limited to one per provider-consumer relationship.

(c) The comprehensive oral evaluation shall not occur in combination with the periodic oral evaluation.

(2) Periodic oral evaluation.

(a) This includes an evaluation performed on a consumer of record to determine any changes in the consumer's dental and medical health status since a previous comprehensive or periodic evaluation. This includes periodontal screening and may require interpretation of information acquired through additional diagnostic procedures. Report additional diagnostic procedures separately.

(b) Effective for dates of service on or after January 1, 2006, the periodic oral evaluation shall not occur more frequently than once every one hundred eighty days for consumers twenty-years of age and younger. Those exams occurring more frequently shall not be reimbursed by the department.

(c) Effective for dates of service from January 1, 2006 through June 30, 2008, the periodic oral evaluation shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older. Effective for dates of service ~~on or after~~ from July 1, 2008 through December 31, 2009, the periodic oral examination shall not occur more frequently than once every one hundred eighty days irrespective of the consumer's age. Those exams occurring more frequently shall not be reimbursed by the department.

(d) Effective for dates of service on or after January 1, 2010, the periodic oral evaluation shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older.

~~(d)~~(e) The periodic oral evaluation shall not occur in combination with the comprehensive oral evaluation and not before one hundred eighty days after the comprehensive oral evaluation.

(3) Limited oral evaluation - problem focused.

(a) An evaluation limited to a specific oral health problem or complaint. This may require interpretation of information acquired though additional diagnostic procedures.

(b) The limited oral evaluation - problem focused shall include any necessary palliative treatment.

(c) Evaluations solely for the purpose of adjusting dentures are noncovered except as specified in rule 5101:3-28-04 of the Administrative Code.

(d) The limited oral evaluation - problem focused may not be billed in conjunction with other dental procedures, with the exception of x-rays on the same date of service.

(B) Radiographs/diagnositc imaging (including interpretation). All radiographs, when presented to the department for review, shall be of diagnostic quality, properly mounted, properly exposed, clearly focused, clearly readable and free from defect for the area of the mouth on which the radiograph was performed.

(1) Intraoral, complete series (including bitewings).

(a) A complete series of radiographs shall consist of a minimum of twelve or more films. This shall include all periapical, bitewing, and occlusal film necessary for the diagnosis.

(b) A complete series of radiographs is allowed only once every five years. If a complete set of radiographs is required more frequently, prior authorization must be obtained.

(c) Periapical films shall show complete visibility of the periodontal ligament, crown and root structure in its entirety.

(2) Intraoral periapical, first film.

(3) Each additional intraoral periapical film.

(4) Intraoral occlusal film.

(5) Extraoral - first film. The extraoral film shall be allowed as an adjunct to complex treatment.

(6) Bitewing - single film.

(7) Bitewing - two films.

(8) Bitewing - three films.

(9) Bitewing - complete series, minimum of four films.

(a) The complete bitewing series is only reimbursable in the presence of erupted permanent second molars. Bitewing radiographs, in combination with other radiographs or when made alone, are allowed at six-month intervals providing they do not exceed the limitations set forth in paragraph (B) of this rule.

(b) Bitewing radiographs are permitted as frequently as at six month intervals, however, they are recommended at intervals of six to twenty four months, consistent with consumer risk for oral disease.

(c) Bitewing films shall show complete visibility of clinical crowns with no overlapping and cannot be substituted for periapical films in instances where endodontic treatment is necessary.

(10) Panoramic film.

(a) The panoramic film is an extraoral radiograph on which the maxilla and mandible are depicted on a single film.

(b) All bitewing and periapical film needed to render the necessary radiographic diagnosis is included in the fee for panoramic radiographs.

(c) Panoramic radiographs shall be permitted for consumers six years of age and older. If the dentist feels that it is medically necessary for a consumer under six years old to receive a panoramic radiograph, prior authorization must be obtained.

(d) Panoramic radiographs shall not be repeated more frequently than once every five years. If such radiographs are required more frequently, prior authorization must be obtained.

(e) Panoramic radiographs shall not occur in combination with a complete series of radiographs. A minimum of five years must elapse between the provision of panoramic radiographs and a complete series of radiographs, unless prior authorization is obtained.

(f) Panoramic films shall show complete visibility of tooth crowns, roots, bony and soft tissues in both arches with little or no overlapping of tooth crowns.

(11) Cephalometric film with tracing. Prior authorization shall be required for cephalometric films and tracings.

(12) Diagnostic photographs in conjunction with orthodontic treatment. Prior authorization shall be required for diagnostic photographs.

(13) Temporomandibular joint films. Prior authorization shall be required for temporomandibular joint films including submission of consumer history and treatment plan. Temporomandibular joint films to include four to six films are covered only if required by the department. Effective for dates of service from January 1, 2006 through June 30, 2008, temporomandibular joint films were covered only for consumers twenty-years of age and younger.

*** DRAFT – NOT FOR FILING ***

5101:3-5-04 **Dental program: covered preventive services and limitations.**

The following preventive services are covered under the dental care program subject to the specified limitations.

(A) Prophylaxis.

(1) Dental prophylaxis, adult.

(a) This shall include the necessary scaling and/or polishing procedures of the teeth to remove coronal plaque, calculus and stains of transitional or permanent dentition for consumers ages fourteen and older.

(b) Effective for dates of service on or after January 1, 2006, the dental prophylaxis shall not occur more frequently than once every one hundred eighty days for consumers twenty-years of age and younger. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.

(c) Effective for dates of service from January 1, 2006 through June 30, 2008, the dental prophylaxis shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older. Effective for dates of service ~~on or after~~ from July 1, 2008 through December 31, 2009, the dental prophylaxis shall not occur more frequently than once every one hundred eighty days irrespective of the consumer's age. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.

(d) Effective for dates of service on or after January 1, 2010, the dental prophylaxis shall not occur more frequently than once every three hundred sixty-five days for consumers twenty-one years of age and older.

(2) Dental prophylaxis, child.

(a) This shall include the necessary scaling and/or polishing procedures to remove coronal plaque, calculus and and stains of primary or transitional dentition for consumers only through age thirteen.

(b) The dental prophylaxis shall not occur more frequently than once every one hundred eighty days. Those prophylaxes occurring more frequently than once every one hundred eighty days shall not be reimbursed by the department.

(B) Topical application of fluoride - child.

(1) Topical fluoride treatments (includes sodium, stannous and acid phosphate fluoride foam, gel, varnish and in-office rinse) shall be allowed for consumers under the age of twenty-one.

(2) Treatment that incorporates fluoride with the polishing compound shall be considered part of the prophylaxis procedure and not a separate topical fluoride treatment.

(3) Topical application of fluoride to the prepared portion of a tooth prior to restoration, the use of self or home fluoride application procedures, and application of sodium fluoride as a desensitizing agent are not covered treatments.

(4) The topical application of fluoride is limited to one application per one hundred eighty days.

(C) Sealant - per tooth. Pit and fissure sealants shall be permitted on previously unrestored occlusal areas of permanent molars subject to the following limitations:

(1) Sealants shall be allowed on permanent first molars for consumers under age eighteen.

(2) Sealants shall be allowed on permanent second molars for consumers under age eighteen.

(D) Space maintenance (passive appliances).

(1) Effective for dates of service from January 1, 2006 through June 30, 2008, space maintenance (passive appliances) were not covered services for consumers twenty-one years of age and older.

(2) Space maintainer - fixed - unilateral.

(3) Space maintainer - fixed - bilateral.

(4) Space maintainer - removable - unilateral.

(5) Space maintainer - removable bilateral.

(6) The preservation of arch length should be the main consideration in the evaluation of a consumer for a space maintainer. Space maintainers are permitted after the loss of a young permanent tooth or the premature loss of a primary tooth when an indeterminant time exists before the eruption of the permanent tooth.

5101:3-10-05 **Reimbursement for covered services.**

(A) Unless otherwise specified, for each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the consumer's prescriber. For incontinence garments and related supplies, a legible written or typed prescriber's prescription, signed and dated not more than thirty days prior to the first date of service must be maintained on file by the provider; prescriptions for incontinence garments and related supplies must include all information required in accordance with rule 5101:3-10-21 of the Administrative Code. . Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-17.2 and 5101:3-1-17.3 of the Administrative Code.

(1) Providers are required to maintain proof of delivery documentation for durable medical equipment (DME) items or equipment dispensed to consumers in their files. Accepted criteria for proof of delivery documentation are as follows:

(a) Providers, their employees, or anyone else having a financial interest in the delivery of DME items are prohibited from signing and accepting an item on behalf of a consumer; and

(b) Any person accepting a delivery of DME items on behalf of a consumer will note on the delivery slip obtained by the provider his or her relationship to the consumer in question. The signature of the person accepting a delivery of DME items should be legible. If the signature of the person accepting the delivery is not legible, the provider/ shipping service will note the name of the person accepting the delivery on the delivery slip; or

(c) If the provider utilizes a shipping service or mail order, an example of proof of delivery would include the service's tracking slip, and the supplier's own invoice. If possible, the supplier's records will also include the delivery service's package identification number for the package sent to the consumer. The shipping service's tracking slip will reference each individual package, the delivery address, the corresponding package identification number given by the shipping service, and the date delivered. If a provider utilizes a shipping service or mail order, the provider shall use the shipping date as the date of service on the claim. Providers may also utilize a return postage-paid delivery invoice from the consumer or consumer's designee as a form of proof of delivery. The descriptive information concerning the DME item (i.e., the consumer's name, the quantity, detailed description, brand name, and serial number) as well as the required signatures from either the consumer or the consumer's designee will be included on this invoice as well; and

(d) For those consumers who are residents of a long term care facility (LTCF), providers will obtain legible copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the consumer (e.g., nurse's notes).

(2) Except as provided in this paragraph, prescriptions for durable medical equipment (DME) and medical supplies must originate as a result of a face to face examination between the prescriber and the consumer. A separate examination for each subsequent DME item prescribed is not necessary if:

(a) The prescriber has reviewed the medical record generated from a face to face examination that was conducted within the previous twelve months by the prescriber, and the DME item or items are related to the diagnoses that were established in that face to face examination; or

(b) The prescription is written based on the judgment of a prescriber who has reviewed the consumer's medical records from a face to face examination conducted within the previous twelve months by a different prescriber, and the item or items are related to the diagnoses that were established in that face to face examination.

All DME and medical supply prescriptions for a long term supply of disposable items (i.e., diabetic test strips, incontinence garments or wound supplies), can be renewed no sooner than ninety days prior to the expiration of the current prescription. DME or medical supply prescriptions are only valid for a maximum of one year.

(3) The DME and medical supply prescriber must be fiscally, administratively, and contractually in compliance with applicable federal "Stark II" regulation, 42 C.F.R 411.354 and federal "Anti-Kickback Safe Harbor" regulation, as it applies to referrals sent to entities with which they or members of their immediate family have a financial relationship for designated health services and as it applies to the medicaid program and medicaid consumers.

(B) The reimbursement allowed by the department for medical equipment that is rented or purchased includes at a minimum, the following:

(1) The manufacturer's and dealer's warranty; and

(2) Any costs associated with assembling medical equipment or parts used for the assembly of medical equipment; and

~~(2)~~(3) Any adjustments and/or modifications required within ninety days of the dispensing date (for purchases) or during the total rental period (for rentals), except those occasioned by major changes in the consumer's condition; and

~~(3)~~(4) Instruction to the consumer in the safe use of the equipment; and

~~(4)~~(5) Cost of delivery to the consumer's residence and, when appropriate, to the room in which the equipment will be used.

~~(5)~~(6) For further details on specific items, see Chapter 5101:3-10 of the Administrative Code.

(C) Unless prior authorization has been obtained for used equipment, all equipment that is purchased must be new at the time of purchase or have been new at the time of rental for the same consumer. Used equipment, if clearly designated on the prior authorization request form as used, in good working order, and covered by the same warranty as new equipment, may be provided if approved by the department. Reimbursement for used equipment will be the lower of eighty per cent of the medicaid maximum or the billed charge. The modifier code UE must be used when billing for the purchase of used durable medical equipment.

(D) Replacement items or parts will only be reimbursed for consumer-owned medical equipment. See rule 5101:3-10-08 of the Administrative Code for details regarding reimbursement for repair of durable medical equipment.

(E) Automatic refills of medical supply orders are not eligible for reimbursement. Providers of medical supplies shall ascertain the quantity of supplies needed monthly by a consumer and shall not dispense supplies in excess of one month's supply per month for the duration of the prescribed period. No supplies shall be billed before they have been provided to the consumer.

(F) Unless otherwise stated, payment for durable medical equipment (including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories), medical supplies, orthoses, and prostheses is reimbursed utilizing the following criteria:

(1) When the item or items in question appear in appendix DD to rule 5101:3-1-60 of the Administrative Code, the provider shall bill the department the provider's usual and customary charge and will receive the lesser of the usual and customary charge or the Medicaid maximum rate that appears on appendix DD to rule 5101:3-1-60 of the Administrative Code; or

(2) When the item or items in question do not appear in appendix DD to rule 5101:3-1-60 of the Administrative Code, but a list price is presented to the department for reimbursement, the provider shall bill the department the provider's usual and customary charge and will receive the lesser of the usual and customary charge or ~~seventy-five~~seventy-two per cent of the list price; or

(3) When the item or items in question do not appear in appendix DD to rule 5101:3-1-60 of the Administrative Code, and there is no list price that is presented to the department for reimbursement, the provider shall bill the department the

provider's usual and customary charge and will receive the lesser of the usual and customary charge or one hundred ~~fifty~~forty-seven per cent of the provider's invoice price less any discounts or rebates applicable at the time of billing but exclusive of any discounts or rebates the provider may receive subsequent to the time of billing; or

(4) When paragraph (F)(2) of this rule is otherwise applicable but the department has available the providers invoice price, the department will pay the lesser of the amounts determined under paragraphs (F)(2) and (F)(3) of this rule.

(5) The "list price" is defined as the most current price of an item or items that is recommended by the product's manufacturer for retail sale. This price cannot be established nor obscured or deleted by the provider on any documentation supplied to the department for consideration of reimbursement. A provider may set list price for custom products where the provider is both the manufacturer and the provider so long as the list price is equal to or less than comparable manufacturer produced products. This price and documentation submitted to support this price is subject to approval by the department.

(6) The "invoice price" is defined as the price of an item or items delivered by the provider to the consumer that gives details of price, quantity and type of supplies dispensed to the consumer and reflects the provider's net costs in accordance with paragraph (I) of rule 5101:3-10-03 of the Administrative Code. This information cannot be obscured or deleted on any documentation supplied to the department for consideration of reimbursement. This price and documentation submitted to support this prices is subject to approval by the department.

(7) Costs of delivery and service calls related to DME and medical supply items must be considered an integral part of the supplier's cost of doing business. A charge for these services will not be recognized when billed separately as a component of any reimbursement rate for services rendered.

(8) It is expected that the consumer will be supplied with the most cost effective durable medical equipment that will meet the consumer's clinical needs as identified and ordered by the prescriber.

Cost effective durable medical equipment is defined by the Ohio department of job and family services (ODJFS) to mean that the provider has taken into account all of the consumer's clinical and ambulatory needs in order to identify durable medical equipment that will meet the consumer's clinical and lifestyle requirements utilizing specific equipment and/or medical supplies that are available at the lowest cost to ODJFS.

(G) Duplicate equipment, supplies, or services, or conflicting equipment prescribed for a recipient, are not reimbursable.

(1) "Conflicting equipment" is defined as equipment which is contraindicated due to the possession by the consumer of equipment, regardless of payment source, which serves the same or a similar purpose. Examples would be a wheelchair followed by a power-operated vehicle (or vice versa), or more than one wheelchair.

(2) Suppliers are responsible for ascertaining in the preliminary discussion with the consumer and/or attending prescriber, whether there is conflicting equipment. All suppliers are expected to know whether currently requested equipment is contraindicated by equipment supplied by a different supplier.

(3) If a consumer's condition changes and warrants new or different equipment, the existing equipment must be noted and appropriate medical documentation must be furnished when prior authorization is requested for the new equipment.

(H) The department will not reimburse for materials or services covered under the manufacturer's or dealer's warranty. Providers must keep a copy of the equipment specific warranty and the date of purchase in their files. A copy of the equipment specific warranty must be provided on the request of the department and must be submitted with any prior authorization request for repairs.

Any repair or servicing done on consumer durable medical equipment that is consumer owned must be documented and kept in the providers file and be accessible to the Ohio medicaid program upon request.

(I) Purchase or rental of durable medical equipment.

A current prescriber's prescription must accompany each request for prior authorization of purchase or rental of durable medical equipment. The department reserves the right to determine whether an item will be rented or purchased. Rental of equipment is valid only as long as medical necessity exists and is documented.

(1) Rental only.

Certain durable medical equipment requiring servicing to ensure the health and safety of recipients will be designated as "rental only." Rental only equipment is designated RO in the "Medicaid Supply List", appendix A to rule 5101:3-10-03 of the Administrative Code. The rental payment is specified in appendix DD of rule 5101:3-1-60 of the Administrative Code. Unless otherwise specified, no modifier code is used in billing "rental only" items.

(2) Routinely purchased items, lump sum purchase.

Most items on the "Medicaid Supply List" are categorized as "routinely purchased items" and would ordinarily be purchased and become the property of the consumer.

(3) Short term rental and rent to purchase.

(a) In some instances the department may determine that short term rental would be more appropriate or cost-effective than purchase of an item. In these instances, rental of equipment will be approved. Approved rental under one prior authorization number shall not exceed six months, unless specified elsewhere in Chapter 5101:3-10 of the Administrative Code. Payment for short term rental of equipment will be made at ten per cent per month of the maximum amount allowable for a specific item. Use the modifier code RR when billing short-term rental.

(b) If a prior authorization request is received for a second rental period, the department will make a determination on whether to purchase the item or items in question, and will note the decision to purchase on the prior authorization form. When a decision is made to purchase the equipment, all prior rental payments will apply toward the purchase price of the item or items in question, and the provider will receive one final payment for the remainder of the items maximum allowable amount as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. The equipment will then be considered purchased and becomes the property of the consumer. The provider will notify the consumer when an item has been purchased on his or her behalf by ODJFS.

(c) The combined total reimbursement for rental and subsequent (within ninety days of the end of the rental service) purchase of a DME item, cannot exceed the medicaid maximum fee.

(d) ~~All~~Unless otherwise specified, durable medical equipment listed in rule 5101:3-10-03 of the Administrative Code that is designated R/P must have a prior authorization before reimbursement is authorized.

(J) For items authorized for rental on a monthly basis, payment will be made through the month in which the consumer becomes ineligible, the item is no longer medically necessary or the maximum amount allowable is reached. For items authorized for rental on a daily basis, only those days when the consumer is eligible and the item is medically necessary are billable to the department.

(K) All medicare-covered services provided to residents of long-term care facilities who are medicare and medicaid eligible must be billed by the supplier directly to medicare. When paid by medicare, medicaid payment will be made by the department as a crossover payment directly to the medical supplier.

(L) Reimbursement for back-up equipment for a medically necessary mechanical ventilator may be allowed only when the documentation required in rule 5101:3-10-22 of the Administrative Code is provided.

(M) With the exception of nonmolded helmets and splints , all covered orthotic and prosthetic devices listed in appendix A to rule 5101:3-10-20 of the Administrative Code, provided to eligible consumers who are residents of nursing facilities, may be billed direct to ODJFS. Nonmolded helmets and splints must be billed to the facility and are reimbursed through the per diem payment in accordance with Chapter 5101:3-3 of the Administrative Code.

5101:3-10-26 **Enteral nutritional products.**

(A) Definition

"Enteral nutrition" is defined as oral or tube-delivered caloric sustenance products for those medicaid consumers demonstrating a disability or life-threatening disease with significant nutritional problems that cannot be managed by ordinary or blenderized foods.

(B) Coverage determination

(1) For an enteral nutritional product to be considered for coverage, one of the following criteria must be met:

(a) The consumer is unable to swallow food due to a damaged or diseased (non-functioning) oral pathway and must be tube-fed, as determined and documented by a licensed prescriber.

(b) The consumer has the ability to swallow, but is unable to meet caloric and nutritional requirements from ordinary foods, including pureed or blenderized foods, to maintain life-sustaining functions, as determined and documented by a licensed prescriber.

(2) Consumers with infants and children age five or younger whose children require enteral nutrition products, breast-feeding consumers with an infant one year of age or younger, or post-partum mothers with a child six months of age or younger, must apply to their county women, infant and children (WIC) program for an eligibility evaluation before coverage by the Ohio department of job and family services (ODJFS) will be considered.

(C) Non-covered products

(1) Enteral nutrition products that are designed to provide meal replacements, or snack alternatives to be eaten within the context of a consumer's individualized meal plan, are not covered. These products include, but are not limited to:

(a) Shakes;

(b) Meal bars;

(c) Snack bars;

(d) Supplement thickeners;

(e) Cereals;

(f) Puddings;

(g) Vitamins/ minerals; and

(h) Blenderized or pureed foods prepared in a personal residence or long term care facility (LTCF).

(2) Enteral nutrition products that are designed as meal replacements, or to be eaten within the context of a consumer's prescribed reduced calorie diet for consumers with diabetes, obesity issues, pre- or post-gastric bypass, or bariatric surgery, are not covered.

(3) Enteral nutrition products that are administered in an outpatient provider setting (i.e., a dialysis outpatient clinic or a facility receiving per diem payments from the department) are not separately reimbursable.

(4) Adult and pediatric electrolyte replacement is covered under the pharmacy benefit program as described in Chapter 5101:3-9 of the Administrative Code.

(5) Any facility receiving per diem reimbursement from the Ohio medicaid program for a consumer's care cannot submit claims to ODJFS for separate reimbursement for enteral nutritional products.

(D) Prior authorization

(1) The following documentation must be submitted for prior authorization (PA) before reimbursement for enteral nutrition products will be considered:

(a) A fully completed form JFS 01907 (rev. 3/2008), "Certificate of Medical Necessity for Enteral Nutrition Services/ Prescription" (CMN) (appendix to this rule) that is signed and dated no more than thirty days prior to the first date of service.

(2) Prior authorization requests for medicaid consumers who cannot maintain weight must include a current weight history. Providers requesting for a consumer a daily caloric intake of greater than two thousand calories must have "section 9" of form JFS 01907 completed prior to requesting a prior authorization.

(3) Initial prior authorization requests for enteral nutrition products may be approved for a maximum of twelve months. Subsequent PAs for the same consumer for the same disease state may be approved for a maximum of one year.

(4) Consumers having a change in their treatment plan that requires the use of an enteral product that is different than a previously authorized enteral product will

require a new certificate of medical necessity before a new enteral product will be authorized.

(E) Dispensing

(1) Enteral nutrition products shall be dispensed in no greater quantity than one month's supply.

(2) Providers may dispense enteral nutrition products' generic equivalents (e.g., vendor branded or private label equivalent) if available, as long as the substituted product is correctly formulated to meet the needs of the consumer and the consumer's prescriber is notified in advance of dispensing.

(3) Medicaid providers may not provide a re-supply of enteral nutrition products sooner than one week before a consumer's next scheduled supply dispense date.

(4) No dispensing, mailing, or delivery fees are separately reimbursable by the Ohio medicaid program.

(5) The consumer will be supplied with the ordered enteral product that is in the most cost effective formulation that the consumer can tolerate.

(F) Reimbursement

(1) Unless otherwise specified, enteral nutrition products are reimbursed by the Ohio medicaid program consistent with paragraph (F) of rule 5101:3-10-05 of the Administrative Code.

(2) For enteral nutrition products that do not have a predesignated medicaid maximum allowable on the Ohio medicaid fee schedule as listed in appendix DD of rule 5101:3-1-60 of the Administrative Code, the Ohio medicaid program will reimburse the supplier's average wholesale price (AWP) minus twenty-three per cent.

(3) No more than one month's supply of enteral nutrition products is allowed for one month's prospective billing.

(4) For enteral nutrition that is administered orally, the modifier BO must be utilized in conjunction with the appropriate "Healthcare Common Procedure Coding System" (HCPCS) code as defined in rule 5101:3-1-19.3 of the Administrative Code. This modifier will be authorized for use by the PA department during the initial PA review and documented on the provider's PA letter.

5101:3-12-05 **Reimbursement: home health services.**

(A) Home health services are delivered and billed in accordance with this chapter by medicare certified home health agencies (MCRHHA). Home health service rates are identified in appendix A to this rule.

(B) The amount of reimbursement for a visit shall be the lesser of the provider's billed charge or the medicaid maximum rate. The medicaid maximum rate is determined by using a combination of the base rate and unit rate found in appendix A to this rule using the number of units of service (one unit equals fifteen minutes) that were provided during a visit in accordance with this chapter as follows:

(1) Each visit must be less than or equal to four hours (sixteen units).

(2) For a visit that is less than one hour (four units) the medicaid maximum is the amount of the base rate.

(3) For a visit that is over one hour (four units) the medicaid maximum is the amount of the base rate plus the unit rate amount for each unit over one hour (four units), but not to exceed four hours (sixteen units).

(C) The amount of reimbursement for a visit shall be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (B) of this rule when billing with the modifier HQ "group setting" for group visits.

(D) The modifiers set forth in appendix B must be used to provide additional information in accordance with this chapter.

(E) Reimbursement must be provided in accordance with paragraphs (A) to (D) of rule 5101:3-1-60 of the Administrative Code.

(F) A MCRHHA will not be reimbursed for home health services provided to a consumer that duplicates same or similar services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplemental recipient or medicaid consumer resides, such as an adult foster home, adult family home, adult group home, residential care facility, community alternative home, or other facility is paid to provide personal care or nursing services, then home health services are not reimbursable by medicaid.

(G) A MCRHHA will be reimbursed for home health services provided to a consumer if the provider has written documentation from a facility/home (i.e., an adult foster home, adult family home, adult group home, residential care facility, community alternative home, or other facility) stating that the facility/home is not responsible for providing the same or similar home health services to the consumer.

(H) Home health services provided to the consumer enrolled in the assisted living HCBS waiver in accordance with rule 5101:3-1-06 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

Appendix A
Home Health Service

Rates effective for dates of service on and after July 1, 2008 to December 31, 2009.

Code	Description	Base Rate	Unit Rate
G0154	Home Health Nursing, each 15 minutes	$56.65	$5.87
G0156	Home Health Nursing Aide, each 15 minutes	$24.72	$3.09
G0151	Physical Therapy, each 15 minutes	$72.10	$4.64
G0152	Occupational Therapy, each 15 minutes	$72.10	$4.64
G0153	Speech-Language Pathology, each 15 minutes	$72.10	$4.64

1 unit = 15 minutes

Rates effective for dates of service on and after January 1, 2010.

Code	Description	Base Rate	Unit Rate
G0154	Home Health Nursing, each 15 minutes	$54.95	$5.69
G0156	Home Health Nursing Aide, each 15 minutes	$23.98	$3.00
G0151	Physical Therapy, each 15 minutes	$69.94	$4.50
G0152	Occupational Therapy, each 15 minutes	$69.94	$4.50
G0153	Speech-Language Pathology, each 15 minutes	$69.94	$4.50

1 unit = 15 minutes

5101:3-12-06 **Reimbursement: private duty nursing services.**

(A) Private duty nursing (PDN) services are delivered and billed as PDN visits in accordance with rules 5101:3-12-02, 5101:3-12-2.3 and 5101:3-12-04 of the Administrative Code. The services are provided by medicare certified home health agencies, "otherwise accredited agencies," or "non-agency nurses." PDN service rates are identified in appendix A to this rule.

(B) The amount of reimbursement for a visit shall be the lesser of the provider's billed charge or the medicaid maximum rate. The medicaid maximum rate is determined by using a combination of the base rate and unit rate found in appendix A to this rule using the number of units of service (one unit equals fifteen minutes) that were provided during a visit in accordance with this chapter. A medicaid maximum rate for a private duty nursing visit is the amount of the base rate plus the unit rate amount for each unit over four units.

(C) The amount of reimbursement for a visit shall be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (B) of this rule when billing with the modifier HQ "group setting" for group visits.

(D) The modifiers set forth in appendix B to this rule must be used to provide additional information in accordance with this chapter.

(E) Reimbursement must be provided in accordance with paragraphs (A) to (D) of rule 5101:3-1-60 of the Administrative Code.

(F) Providers of PDN will not be reimbursed for PDN services provided to a consumer that duplicate services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplemental recipient or medicaid consumer resides, such as an adult foster home, adult family home, adult group home, ICF/MR, residential care facility, community alternative home, or other facility is paid to provide nursing services, then PDN services are not reimbursable by medicaid.

(G) Providers of PDN will be reimbursed for PDN services provided to a consumer if the provider has written documentation from a facility/home (i.e., an adult foster home, adult family home, adult group home, residential care facility, community alternative home, or other facility) stating that the facility/home is not responsible for providing the same or similar PDN services to the consumer.

(H) PDN services provided to the consumer enrolled in the assisted living HCBS waiver in accordance with rule 5101:3-1-60 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

Appendix B
Modifier Descriptions

Information Modifiers

Modifier	Description	Requirement
U1	Infusion therapy	Must be used when code T1000 is used for the purpose of home infusion therapy in accordance with rule 5101:3-12-02 of the Administrative Code.
U2	Second visit	Must be used to identify the second visit for the same type of service made by a provider on a date of service per consumer in accordance with rule 5101:3-12-03 of the Administrative Code.
U3	Third visit or more	Must be used to identify the third or more visit for the same type of service made by a provider on a date of service per consumer in accordance with rule 5101:3-12-03 of the Administrative Code.
U4	12 hours to 16 hours per visit	Must be used when a visit is more than twelve hours but does not exceed sixteen hours in accordance with rule 5101:3-12-02 of the Administrative Code.
U5	Healthchek	Must be used to identify consumer receiving increased services due to Healthchek in accordance to rule 5101:3-12-02 of the Administrative Code.
U6	PDN authorization	Must be used to identify consumer receiving increased services in accordance to rule 5101:3-12-02 of the Administrative Code.