

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act).

Provided:  No limitations  With limitations\*  
 Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

Provided:  No limitations  With limitations\*  
 Not provided.

23. Pediatric or family nurse practitioners' services.

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

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TN No. 91-20  
Supersedes NEW Approval Date 1-16-92 Effective Date 10/1/91  
AND 88-04 HCFA ID: 7986E

State/Territory: OHIO

AMOUNT, DURATION, AND SCOPE OF MEDICAL  
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Services of Christian Science nurses.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Care and services provided in Christian Science sanatoria.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Nursing facility services for patients under 21 years of age.

Provided:  No limitations  With limitations\*  
 Not provided.

e. Emergency hospital services.

Provided:  No limitations  With limitations\*  
 Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

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TN No. 90-45

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE  
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

           provided            X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

           Provided:            State Approved (Not Physician)  
Service Plan Allowed

           Services Outside the Home Also  
Allowed

           Limitations Described on  
Attachment

X Not Provided.

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

Thirty (30) day limitation per spell-of-illness. A spell-of-illness begins on the day of admission to a hospital and ends sixty (60) days after discharge. Days in excess of thirty (30) or additional hospitalizations before sixty (60) days have past since a prior hospitalization can be covered if certified by a hospital UR committee or PSRO/PRO as medically necessary. Medically necessity for admission and continued stay must be approved by the hospital utilization review committee or its designee, or by a PSRO/PRO. Most elective hospital admissions are subject to preadmission certification. For hospitals paid on a prospective basis, days not approved as medically necessary are not recognized in determining whether a case qualifies for additional outlier payments.

A prospective reimbursement methodology based on DRGs was adopted on October 1, 1984 for inpatient hospital services. All inpatient services are subject to prospective payment except for long-term care and rehabilitative hospitals excluded from Medicare's prospective payment system. Hospitals in non-Ohio states which provide care to Ohio Medicaid recipients are paid under the prospective payment system. Hospitals in contiguous states with Ohio Medicaid payments in excess of \$50,000 annually are peer-grouped with the Ohio peer group with the most similar wage indice and paid that peer group's rates. Hospitals in contiguous states with less than \$50,000 in payments annually and hospitals in non-contiguous states are paid based on the peer group 12 (rural hospital) rate.

Except for hospitals that are approved by Medicare to charge patients a single rate that covers hospital and physicians' services, Medicaid does not cover, as an inpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

Certain specific items and services are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; treatment of obesity; cosmetic surgery; acupuncture; services of an experimental nature; dental procedures which can be performed in the dentist's office or other nonhospital setting; and patient convenience items. Also, coverage of inpatient days for treatment of chemical dependency is limited to coverage of services for detoxification. Inpatient care for rehabilitative services related to chemical dependencies is noncovered.

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SUPERSEDES  
TNS # 85-41

APPROVAL DATE 10-12-90  
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2-a. Outpatient hospital services.

Outpatient services are those professional services provided to a patient at a hospital facility which is certified by the Ohio Department of Health for Medicare participation. Outpatient services include services provided to a patient admitted as an inpatient whose inpatient stay does not extend beyond midnight of the day of admission.

Except for hospitals that are approved by Medicare to charge patients a single rate that covers hospital and physicians' services, Medicaid does not cover, as an outpatient service, those physicians' services furnished to individual patients. In determining whether services are covered as a physician service or a hospital service, Medicaid uses the criteria adopted by the Medicare program as set forth in 42 CFR 405, Subparts D and E.

The number of outpatient visit includes, but is not limited to the following maximums:

- The maximum number of outpatient visits covered without prior authorization is four per month per recipient per provider. Additional visits, up to a maximum of ten visits, may be covered for physician services, EPSDT services, family planning, and emergency dental services, subject to prior authorization. A visit includes all services provided for an outpatient on any one date of service.
- The maximum number of outpatient visits, when the professional service is rendered by a practitioner whose scope of treatment is less than a physician's (i.e., chiropractor, speech therapist, audiologist, psychologist, etc.), is generally four per month.
- Physical therapist services are limited by a specific number of treatments.

Certain specific items and services are not covered. These may include: abortions, sterilizations, and hysterectomies not in conformance with federal guidelines; treatment of infertility; treatment of obesity; cosmetic surgery; acupuncture; services of an experimental nature; dental procedures which can be performed in the dentist's office or other nonhospital setting; and patient convenience items.

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2-b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

Limited to public, private, nonprofit or proprietary freestanding corporations designed to provide services on an outpatient basis. Services provided by Rural Health Clinics are subject to coverage and limitation policies effective for the various disciplines as described in this attachment. RHCs are certified by the Ohio Department of Health as meeting the conditions of certification for rural health clinics under Title XVIII Medicare and which have filed an agreement with HHS to be a provider of Rural Health Clinic services under Medicare.

RHCs are subject to the same limitations as ambulatory health care clinic program as defined in attachment 3.1-A (9), additionally, RHCs are subject to the same limitations as are other practitioners when rendering similar services in a RHC setting.

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2-c. Federally Qualified Health Center (FQHC) Services

Refer to Attachment 4.19-B, Item 2-c for a description of coverage and reimbursement.

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3. Other laboratory and x-ray services.

LABORATORY SERVICES ARE COVERED ONLY IF THE SERVICE IS MEDICALLY NECESSARY OR IS MEDICALLY INDICATED WHEN PROVIDED IN CONJUNCTION WITH A COVERED PREVENTIVE HEALTH SERVICE; THE LABORATORY WHICH PERFORMED THE PROCEDURE IS CERTIFIED TO PERFORM THE PROCEDURE UNDER CLIA 1988; AND THE SERVICE IS ORDERED BY A PROVIDER WHO LEGALLY AUTHORIZED TO ORDER DIAGNOSTIC PROCEDURES UNDER OHIO STATE LAW.

IN ADDITION, THE FOLLOWING LABORATORY SERVICES ARE NON-COVERED:

ROUTINE LABORATORY SCREENING AND DIAGNOSTIC PROCEDURES, EXCEPT THOSE PROVIDED IN ASSOCIATION WITH EPSDT EXAMS OR OTHER COVERED PREVENTIVE HEALTH SERVICES;

LABORATORY SERVICES PERFORMED IN CONJUNCTION WITH NON-COVERED PHYSICIAN SERVICES INCLUDING, BUT NOT LIMITED TO, ABORTIONS OR STERILIZATIONS THAT DO NOT MEET FEDERAL REQUIREMENTS, INFERTILITY SERVICES AND COSMETIC SURGERIES;

LABORATORY SERVICES PERFORMED FOR FORENSIC REASONS;

PATERNITY TESTING; AND

LABORATORY PROCEDURES PERFORMED IN CONJUNCTION WITH AN AUTOPSY.

Those diagnostic x-rays which are required to determine the existence of a subluxation and are performed by a chiropractor are limited to the specific x-rays and frequency limitations identified by the department.

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4-b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

IN OHIO HEALTHCHEK IS THE PROMOTIONAL NAME FOR EPSDT. THIS PROGRAM IS AVAILABLE FOR ALL MEDICAID ELIGIBLE INDIVIDUALS FROM BIRTH TO 21 YEARS.

SCREENING SERVICES, VISION SERVICES, HEARING SERVICES, DENTAL SERVICES AND ALL MEDICALLY NECESSARY FOLLOW-UP SERVICES ARE COVERED UNDER THE OHIO MEDICAID EPSDT PROGRAM IN ACCORDANCE WITH THE FEDERAL REQUIREMENTS.

THE MINIMUM PERIODICITY SCHEDULE FOR EPSDT SCREENING SERVICES, VISION SERVICES AND HEARING SERVICES IS AT THE AGES OF 1, 3, 5, 7, 11, AND 16 YEARS. THE MINIMUM PERIODICITY SCHEDULE FOR DENTAL SERVICES IS 1 EXAMINATION PER YEAR.

BENEFITS FOR RECIPIENTS PARTICIPATING IN THE EPSDT PROGRAM ARE NOT LIMITED TO THE SERVICES COVERED UNDER THE MINIMUM PERIODICITY SCHEDULE.

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STATE OF OH:

3.1-A  
 PRE-PRINT PAGE 2  
 ITEM 4, PAGE 1 OF 2  
REFERENCE SUPPLEMENT 2

4-a. Skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

REFERENCE SUPPLEMENT 2, RULE 5101:3-3-05 AND RULE 5101:3-3-15.

SUBSTITUTE PAGE

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