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 3, RULE 5101:3-3-541 AND RULE 5101: 3-3-545.

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

The following services are not covered by the program:

Services of a preventive nature such as routine laboratory procedures and annual physical checkups with the following exceptions: all EPSDT services, immunizations, routine pelvic examinations, pap smears and breast examinations, family planning visits and services, annual chest x-rays for nursing home residents, the required physician visits for LTCF residents, routine infant checkups and required physicals for employment or for participation in the Job Opportunities and Basic Skills (JOBS) program, when the employer (or other available funds) does not provide a physical free of charge.

Abortions, hysterectomies and sterilizations not meeting the requirements in 42 CFR 441.200 through 441.258.

Artificial insemination and related services.

Services for or related to the treatment of infertility, including procedures for reversal of voluntary sterilization.

Services for the treatment of obesity, including gastroplasty, gastric stapling, or ileo-jejunal shunt.

Plastic or cosmetic surgery when the surgery is performed for aesthetic purposes, including, but not limited to: rhinoplasty, ear piercing, mammary augmentation or reduction, tattoo removal, excision of keloids, fascioplasty, osteoplasty dermabration, skin grafts, lipectomy, and bepharoplasty.

Services related to forensic studies.

Paternity testing.

Acupuncture.

Biofeedback.

Services determined by another third-party payor or Medicare as not necessary.

Services of a research nature or services which are experimental.

Autopsy services.

Special services and reports.

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. (Continued)

THE DEPARTMENT WILL PAY FOR ALL MEDICALLY NECESSARY PHYSICIAN VISITS THAT ARE PROVIDED IN AN OUTPATIENT SETTING. WHEN THE TOTAL NUMBER OF VISITS ACCRUED BY A RECIPIENT DURING A CALENDAR YEAR EXCEEDS 24 VISITS, THE DEPARTMENT MAY REVIEW RECIPIENT'S PAID CLAIM HISTORY, THE RECIPIENT'S MEDICAL RECORDS AND/OR THE PHYSICIAN'S PAID CLAIM HISTORY TO DETERMINE IF:

- THE VISITS WERE MEDICALLY NECESSARY;
- THE RECIPIENT SHOULD BE REFERRED TO A MANAGED CARE PROGRAM; OR
- THE PROVIDER'S PRACTICE AND BILLING PATTERNS SHOULD BE MONITORED BY THE DEPARTMENT.

VISITS FOR CERTAIN ILLNESSES, CONDITIONS AND SERVICES ARE EXEMPTED FROM COUNTING TOWARDS THE 24 VISITS.

The maximum number of inpatient hospital visits covered for each recipient is 10 visits per month per provider.

5. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere. (Continued)

FEE-FOR-SERVICE PAYMENT FOR OBSTETRICAL AND PEDIATRIC RATES

IS FOUND IN ATTACHMENT 4.19-B, ITEM 5

6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists' services.

The visit and service limitations applied to physicians are applied to podiatrists (see Attachment 3.1-A, Item 5, Pages 1 and 2).

In addition, the following podiatric services are not covered by the program:

The evaluation or treatment of a flat foot condition, regardless of the underlying pathology.

The evaluation of sublaxations of the foot and nonsurgical measures to correct the condition or to alleviate symptoms.

Routine foot care for ambulatory or bed-ridden patients. Routine foot care includes the cutting or removal of corns, warts or calluses; the trimming of nails; observation and cleansing of the feet, use of skin creams to maintain skin tone; and nail care not involving surgery. (If the foot care is an integral part of active covered treatment of foot lesions, such as infections and diabetic ulcers -- such treatment is covered under the program.)

Vitamin B-12 injections when administered to strengthen tendons, ligaments, etc., of the foot to treat myositis.

X-rays for soft tissue diagnosis.

In addition, the following limitations apply:

Reimbursable visit levels are limited to minimal, brief, limited and intermediate visits.

Reimbursement consultation visit levels are limited to limited, intermediate, and extended visits.

Reimbursement for visits provided to a Long-Term Care Facility (LTCF) resident is limited to one visit per month.

Reimbursement for debridement of nails is limited to a maximum of one treatment within a 60-day period.

6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

b. Optometrists' services

Certain procedures are subject to prior authorization by the Department.

The following services are not covered by the program:

1. Services provided for basically cosmetic reasons such as:

   Contact lenses for reasons other than aphakia; Korestoconus, severe corneal distortion, or prescription in excess of 10 diopters.

   Replacement of glasses or frames due to a recipient's personal preference for a change of style, color, etc.

2. Technical services related to the provisions of non-covered services.

3. Frames. Payment will not be made for trimmed frames. The standard for the program is a moderately priced zyl frame or combination frame. To avoid difficulty, use frames that are priced in recent publications of FRAMES or FRAMES FAX. Discontinued frames will not be reimbursed at original wholesale price.

The underlying principle of the department's vision care policy is medical necessity and the provision of the comprehensive vision examination is limited by this principle. The department shall prior review the necessity of the comprehensive vision examination when provided more frequently than once every twenty-four month period for recipients age twenty-one or older but younger than age sixty or once every twelve month for recipients age twenty or younger or age sixty or older. This policy shall be enforced on a per patient per provider basis. Vision examinations other than a screening are limited to detecting ocular abnormalities which may be indicative of disease, injury or pathology.

6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6-c. Chiropractor services -- D.C.

Limited to four visits per month for patients in independent living arrangements for:

TREATMENTS

Covered Chiropractic services are limited to the following:

1. Treatment by means of manual manipulation of the spine to correct a subluxation.

6. Medical care and any other types of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by State law. (Continued)

6-d Other Practitioners' Services

Mechanotherapist Services -- D.M. or M.T.

Limited to four visits per month per provider for patients in independent living arrangements.

The following services are not covered by the program:

Lab and x-ray services since such are not in the scope of practice of a mechanotherapist.

Activities of daily living and diversional activities.

Office visit including tests or measurements for activities of daily living "check-out".

Licensed Psychologist Services

Covered services are those professional procedures listed in the State of Ohio Medicaid Handbook.

The following services are not covered:

Services of psychologists provided in long-term care facilities are covered by payment to the facility (See Attachment 4.19-D)

Services of school psychologists provided in facilities regulated by the State Board of Education.

Sensitivity training, encounter groups or workshops.

Sexual competency training.

Marathons and retreats for mental disorders.

Education testing and diagnosis.

Psychological testing is limited to a maximum of eight (8) hours per year per case. The fee for testing includes a written report of tests used, findings and diagnosis. Special psychological testing exceeding eight (8) hours per year requires prior written authorization.

Services are limited to 10 per month for hospital patients, four (4) per month for patients in independent living arrangements. Maximum total visits to all settings remain 10 per month per provider.

7. Home health services.

The Medical Assistance Program covers the home health services provided to a Medicaid individual in his place of residence. Such residence does not include a hospital, skilled or intermediate care facility.

Any service provided to a recipient of home health services must be ordered by the attending physician as a part of a written plan of care which is reviewed by the physician at least every 60 days. Prior authorization by the Ohio Department of Human Services is required for some specialty supplies, "Miscellaneous" supplies, and high cost equipment.

Home health services must be rendered on a part-time or intermittent care basis in accordance with the written plan of care. Home health services are not available on a full-time or continuous care basis.

The following home health services are covered under the Ohio Medicaid program.

a. Nursing services which are defined in the State Nurse Practice Act and rendered by a registered nurse or licensed practical nurse under the direct supervision or a registered nurse.

b. Home health aide services when rendered by qualified personnel. Home health aide services must be directly supervised by a registered nurse or physical therapist at least one a month.

c. Certain specified medical supplies and equipment in accordance with the specific needs of the patient, as determined by the attending physician and, where required, authorized by the department.

d. Therapy services as listed below and rendered by a licensed qualified therapist:

   1. Physical therapy which includes restorative therapy and/or maintenance therapy;

   2. Occupational therapy;

   3. Speech pathology/therapy and audiology services.

8. Private duty nursing services.

"PRIVATE DUTY NURSING SERVICES" ARE DEFINED AS THE PROVISION OF CONTINUOUS SKILLED NURSING CARE TO A RECIPIENT IN HIS PERMANENT RESIDENCE OR FOR OTHER NORMAL LIFE ACTIVITIES OUTSIDE THE RESIDENCE. "GROUP NURSING SERVICES" ARE DEFINED AS THE PROVISION OF CONTINUOUS SKILLED NURSING CARE TO TWO OR MORE RECIPIENTS IN THEIR PERMANENT RESIDENCE OR FOR OTHER NORMAL LIFE ACTIVITIES OUTSIDE THE RESIDENCE. FOR BOTH PRIVATE DUTY AND GROUP NURSING SERVICES, PERMANENT RESIDENCE DOES NOT INCLUDE A NURSING FACILITY, AN INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR), OR A HOSPITAL.

PRIVATE DUTY AND GROUP NURSING SERVICES REQUIRE A PHYSICIAN'S ORDER AND ARE PROVIDED IN ACCORDANCE WITH A WRITTEN NURSING PLAN OF TREATMENT.

ALL PRIVATE DUTY AND GROUP NURSING SERVICES ARE PRIOR AUTHORIZED BY THE DEPARTMENT.

ELIGIBLE PROVIDERS OF PRIVATE DUTY NURSING SERVICES INCLUDE REGISTERED NURSES AND CERTIFIED HOME HEALTH AGENCIES. ONLY MEDICARE-CERTIFIED HOME HEALTH AGENCIES MAY PROVIDE GROUP NURSING SERVICES.