



Ohio Department of Human Services

30 East Broad Street, Columbus, Ohio 43266-0423

Medicaid Reimbursement for Selected OB Services

<u>Code</u>	<u>Description</u>	<u>Medicaid Maximum</u>
59420	Prenatal visit	\$ 20.71
59430	Postpartum visit	\$ 22.78
59410	Vaginal delivery	\$400.00
59500	Cesarean section, low cervical	\$500.00

At-Risk Pregnancy Services

X5400	Prenatal Risk Assessment	\$ 10.35
X5430	Initial Care Coordination	\$ 12.42
X5431	Continuous Care Coordination	\$ 8.28
X5432	Enhanced Care Coordination	\$ 8.28
X5410	Initial Counseling and Education	\$ 15.53
X5411	Periodic Counseling and Education	\$ 10.35
X5420	Initial Nutritional Counseling	\$ 15.53
X5421	Periodic Nutritional Counseling	\$ 10.35
X5422	Nutritional Intervention	\$ 20.71
X5500	Home Visit Travel	\$ 5.18

NOTE: Information concerning the coverage of obstetrical services can be found on pages II-11 through II-20 of the Ohio Medicaid Provider Handbook, Physician Services (Chapter 3336).

TNS # 9036
SUPERSEDES
TNS # NEW

APPROVAL DATE 8-28-90
EFFECTIVE DATE 4/1/90

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AT-RISK PREGNANCY SERVICES
COMPARISON OF REIMBURSEMENT AMOUNTS AS OF APRIL, 1990

<u>WITHOUT AT-RISK SERVICES</u>		<u>WITH AT-RISK SERVICES</u>	
PRENATAL OFFICE VISIT (59420)	\$20.71	\$ 20.71	PRENATAL OFFICE VISIT (59420)
PRENATAL RISK ASSESSMENT (X5400)	10.35	\$ 10.35	PRENATAL RISK ASSESSMENT (X5400)
		\$ 15.53	INITIAL COUNSELING & EDUCATION (X5410)
		\$ 15.53	INITIAL NUTRITIONAL COUNSELING (X5420)
		\$ 12.42	INITIAL CARE COORDINATION (X5430)
		\$ <u>74.54</u>	SUBTOTAL
ADDITIONAL PRENATAL VISIT (59420)	\$20.71	\$ 20.71	ADDITIONAL PRENATAL VISIT (59420)
		\$ 10.35	PERIODIC COUNSELING & EDUCATION (X5411)
		\$ 10.35	PERIODIC NUTRITIONAL COUNSELING (X5421)
		\$ 8.28	CONTINUOUS CARE COORDINATION (X5431)
		\$ <u>49.69</u>	SUBTOTAL
2 VISITS IN 2 MONTHS	\$ 51.77	\$124.23	2 VISITS IN 2 MONTHS
5 VISITS IN 5 MONTHS	\$113.90	\$273.33	5 VISITS IN 5 MONTHS
9 VISITS IN 9 MONTHS	\$196.74	\$472.06	9 VISITS IN 9 MONTHS
VAGINAL DELIVERY	<u>\$400.00</u>	<u>\$400.00</u>	VAGINAL DELIVERY
		\$872.06	TOTAL FOR 9 VISITS AND DELIVERY
TOTAL	\$596.74	\$275.32	ADDITIONAL REIMBURSEMENT

NOTE: This is just an example. Individual patients may receive more prenatal visits or at-risk services than are listed here.

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SUPERSEDES
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OFFICIAL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OHIO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: OHIO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

OFFICIAL

QMBs: Part A MR Deductibles MR Coinsurance
Part B MR Deductibles MR Coinsurance

Othe Medicaid Recipients Part A MR Deductibles MR Coinsurance
Part B MR Deductibles MR Coinsurance

Dual Eligible (QMB Plus) Part A MR Deductibles MR Coinsurance
Part B MR Deductibles MR Coinsurance

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Supplement 1 to ATTACHMENT 4.19-B
Page 3
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: OHIO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

OFFICIAL

TN No. 91-21 Approval Date 1-16-92 Effective Date 10-1-91
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Methods and Standards for Establishing Payment Rates

1. Inpatient Hospital Services

Providers are paid the reasonable cost of services provided to Medicaid beneficiaries. Hospital billings must reflect the hospital's customary and reasonable charge for the services rendered. Interim payments approximating the allowable costs established by the provider's prior cost filings are made in the most expeditious manner which is administratively feasible.

An interim adjustment based on allowable costs are made after the end of the reporting period on a first-in first-out basis. All cost reports and settlements are considered interim until notified by the Ohio Department of Public Welfare, Bureau of Fiscal Review.

The principles and standards contained in the "Provider Reimbursement Manual" HIM 15, are to be used by providers in accumulating cost data for the Annual Reporting Forms ODPW 2930 .

Out-of-State Hospitals

Out-of-state providers of inpatient services to eligible Ohio Title XIX recipients will not be required to file Form ODPW 2930 annual "Hospital Statement of Reimbursable Cost" as is required for all Ohio hospitals unless their gross billings for services furnished within the reporting period equal or exceed \$25,000.00. Out-of-state hospitals with gross billings less than \$25,000.00 during the reporting period will be reimbursed at a percentage rate approximating allowable costs based on the average of all Ohio-based hospital percentage rates.

2. Outpatient Hospital Services

Same as the method described for inpatient hospital services.

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3. Other Laboratory and X-Ray Services

Payment for laboratory and x-ray service is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

4a. Skilled Nursing Facility Services for Individuals 21 years of Age or Older

See Attachment 4.19-D.

4b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Payment is made according to the provider type rendering service as described elsewhere in this schedule.

4c. Family Planning

Payment is made according to the provider type rendering service as described elsewhere in this schedule.

5. Physician Services

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

6. Other Types of Remedial Carea. Podiatrist Services

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

b. Optometrist Service

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

c. Chiropractic Services

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

d. Mechanotherapist Services

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

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e. Psychologist

The payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

7. Home Health Care Servicesa. Intermittent or part-time nursing service furnished by a home health agency.

Usual and customary reasonable charges are paid for services up to a limit of \$20.00 per visit. In no instance may this reimbursement exceed the amount paid by Medicare.

b. Intermittent or part-time nursing service of a professional RN or LPN when no home health agency is available.

Payment is based on the customary and reasonable charges which are made in the community for the nursing services rendered up to a maximum of \$40.00 for an eight hour shift.

c. Medical supplies, equipment, and appliances for the patient's use in his own home.

Payment is based on lesser of the billed charge or the Medicaid maximum for the particular item purchased according to the department's formulary code reference file. Decisions concerning purchase or rental of durable medical equipment is made by the authorization unit of the Bureau of Medical Operations.

d. Services of a Home Health Aid giving personal care according to a plan of treatment.

Usual and customary reasonable charges are paid for services up to a limit of \$20.00 per visit. In no instance may this reimbursement exceed the amount paid by Medicare.

8. Private Duty Nursing Services

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according to the department's procedure code reference file.

9. Clinic ServicesA. Ambulatory Health Care Centers

Payment is based on the lesser of the billed charge or the Medicaid maximum for the particular service performed according the department's procedure code reference file.

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COMMUNITY MENTAL HEALTH SERVICES PROVIDED BY COMMUNITY MENTAL HEALTH FACILITIES

GENERAL PROVISIONS: Payment for covered services in a community mental health facility is calculated on a prospective reasonable cost related basis for each state fiscal year. Prospective costs recognized for covered services provided during a particular state fiscal year are the costs which are reported in the community mental health facility's approved annual budget plan submitted to the Ohio Department of Mental Health and in accordance with the Ohio Department of Mental Health's prescribed methodology. The unit rate for each covered service is calculated on the community mental health facility's projected cost of allowable items, and thus may vary from clinic to clinic. Prospective rates refer to predetermined cost-related rates calculated for each community mental health facility from that facility's approved budget plan. The rates thus established are subject to subsequent reconciliation and cost settlement based upon the facility's reported actual costs at the end of each state fiscal year for any overpayment made for that reporting period. There will be no adjustments made to compensate for underpayments during that reporting period.

COST REPORTS: As a condition of participation in the Title XIX program, all community mental health facilities must submit cost reports at least annually for the period beginning July 1st and ending June 30th of each state fiscal year. Any community mental health facility failing to file a cost report within 90 days after the close of a state fiscal year shall have their provider status terminated. When an incomplete or inadequate cost report is submitted within the prescribed time period, the provider will be notified that information is lacking. Lacking information is due within 45 days after notification of inadequacy.

ALLOWABLE AND REASONABLE COSTS: Costs which are reasonable and allowable to patient care are those contained in the following reference material in the following priorities: "Health Insurance Manual 15 Provider Reimbursement Manual"; "Health Insurance Manual 5 Principles of Reimbursement for Provider Costs"; and "General Accepted Accounting Principles", except:

- (a) cost related to client treatment and services that are not covered in community mental health program as described in Attachment 3.1-A, item 13 (d) are not allowable.
- (b) the straight-line method of computing depreciation is required for cost filing purposes and must be used for all depreciable assets.

NEW FACILITIES: The unit charges for new facilities will be computed as follows. Upon entry into the Title XIX program, new providers will use unit rates developed from their approved annual budget plans for the fiscal year of entry. These rates will become the prospective rates for the remainder of the fiscal year of entry into the Title XIX program. New facilities will be required to submit cost reports at the end of the fiscal year of entry. For purposes of reimbursement provisions contained in this paragraph, a "new facility" is defined as any one of the following:

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- (i) a new facility never certified or accredited or participating in Medicaid prior to community mental health facility application;
- (ii) a facility not participating in the Medicaid program for one year prior to community mental health facility application.

CONVERSION TO COMMUNITY MENTAL HEALTH FACILITY PROGRAM PARTICIPATION UPON THE EFFECTIVE DATE FOR IMPLEMENTATION: For community mental health facilities which were providers under the Medicaid Ambulatory Health Care Facility program prior to the effective implementation date of this new program, the unit charges will be based upon the current billing rates the facilities are using in billing other third party sources which reimburse on a cost-related basis. These rates will remain in place until the end of the fiscal year and will be reconciled upon submission of the annual cost report.

AUDITS: The prospective rates for community mental health facility services upon being established are not subject to subsequent adjustments except in instances of rate adjustments specified under the section entitled "General Provisions" and except as specified in this section. The differences between the budget-based prospective unit rates and the unit rates reported by a facility in a cost report established by a desk audit or on-site audit are subject to recovery in full means of a retroactive rate adjustment of the current fiscal year's prospective unit rates.

- (i) Audits will be conducted by the Ohio Department of Mental Health or its designee for services rendered by the community mental health facilities participating in Title XIX (Medicaid). The examination of costs will be made in accordance with generally acceptable audit standards necessary to fulfill the scope of the audit. To facilitate this examination, providers are required to make available all records necessary to fully disclose the extent of services provided to program recipients. The principle objective of the audit is to enable the Ohio Department of Mental Health or its designee to determine that payments which have been made are in accordance with federal, state, and agency requirements. Based upon the audit, adjustments will be made as required. Records necessary to fully disclose the extent of services provided and cost associated with these services must be maintained for a period of three years or until audit is completed and every exception is resolved. The records must be available to the Ohio Department of Mental Health, the Ohio Department of Public Welfare, and the Health Care Finance Administration for audit purposes. No payment for outstanding unit rates can be made if a request for audit is refused.
- (ii) There are two types of audits. The first is a desk audit of cost reports filed each year to ensure that no mathematical error occurs, that the cost calculations are consistent with the rate setting methodology as established by the agency, and to identify categories of reported costs. A desk audit will be conducted annually. The second type of audit is a field audit. These are performed on-site or where the necessary disclosure information is maintained to assure the provider has complied with both cost principles and program regulations. The field audit will be performed every three years. Summary reports for all on-site audits shall be maintained for public review for a period of one year.

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