5101:3-10-03 **"Medicaid Supply List".**

Unless otherwise specified, any provider seeking reimbursement for medical supplier services must meet the provisions contained within Chapter 4752. of the Revised Code or be exempt from licensure under section 4752. of the Revised Code in order to be eligible for reimbursement for services provided.

The "Medicaid Supply List" is a list of medical/surgical supplies, durable medical equipment, and supplier services, found in appendix A to this rule. This list includes the following information as described in paragraphs (A) to (G) of this rule:

(A) Alpha-numeric codes to be used when billing the department for medical supplier services:

(1) Code numbers are designed to accommodate all trade names of products dispensed unless otherwise specified;

(2) A supply code of "not otherwise specified" (NOS) should only be used when a covered item is not adequately described by a specific code.

(B) Item description.

A brief description of the supply or equipment item.

(C) "Unit" indicator. A "unit" column that lists billing units; e.g., each (1), each pair, box of fifty, etc.

(D) Two columns indicating coverage status:

(1) "Medicaid" indicator.

The medicaid coverage column has one of three possible indicators for each item. "Y" indicates the item is covered by medicaid for all recipients, in accordance with rule 5101:3-10-02 of the Administrative Code, and may be billed directly to the department. "N" and "NC" indicate that the item is not covered by the medicaid program and should not be billed to the department. "H" indicates that the item is covered by medicaid but may be billed directly to the department by the provider only for consumers who reside in their personal residence.

(2) "Medicare" indicator.

The medicare coverage column has one of three possible indicators for each item. "Y" indicates the item is covered by medicare for all beneficiaries and

medicare is the primary payor. "N" indicates the item is not covered by medicare and may be billed to medicaid. "H" indicates that the item is covered by medicare under part B for only those consumers who reside in their home (as consumer's home is defined by medicare). Providers must always bill medicare first when coverage is available. While medicaid payment will not be denied for certain items with the "Y" or "H" medicare indicator, (e.g., diabetic supplies, surgical dressings), payment inadvertently made by medicaid for any item payable by, but not billed to medicare, will be subject to recovery by the department.

(E) "Prior auth" indicator.

A prior authorization (PA) indicator. "Y" indicates prior authorization by the department is required for reimbursement (see rule 5101:3-10-06 of the Administrative Code). "N" indicates prior authorization is not required for reimbursement up to the maximum allowable units.

(F) "Max Units" indicator.

A maximum allowable (MAX) indicator means the maximum quantity of the item that may be reimbursed during the time period specified unless an additional quantity has been prior authorized. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by the department.

(G) "RNT/P" indicator.

Rental/purchase indicator. "RO" means item is always rented, "PP" means item is always purchased and "R/P" means item is designated as rent to purchase as described in rule 5101:3-10-05 of the Administrative Code.

(H) Charges for gauze pads and codes for "wound fillers/packing" are not to exceed the manufacturer's suggested list price for any item. Providers must maintain an itemized list in recipient's file of all items dispensed and billed to medicaid under these codes.

(I) Providers must fully and accurately report any discount received (including a rebate check) on a good or service when submitting a claim for reimbursement. A "discount" means a reduction in the amount a seller charges a provider who buys either directly or through a wholesaler or a group purchasing organization. "Fully and accurately reporting a discount" means deducting the amount of the discount from billed charges when submitting a claim for payment and if prior authorization is required, indicating on the "Prior Authorization" request form (JFS 03142, rev.

2/2003), or attached documentation, the amount of the discount. This policy is implemented in accordance with federal regulations at 42 C.F.R. 1001.952(h) (April 17, 2002).

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CERTIFIED ELECTRONICALLY

Certification

07/20/2007

Date

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