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 Chapter 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; and

(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 one, each pair, box of fifty, etc.

(D) Column indicating coverage status:

"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. "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. "H*" indicates that the item is not reimbursable for a consumer residing in a nursing home (NH).

~~(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. "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. "H*" indicates that the item is not reimbursable for a consumer residing in a nursing home.~~

~~(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 "Y" 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. This quantity has been established as a guideline without a prior authorization and not to reflect a definitive amount. In all cases, the dispensing of medical supplies and equipment is based on medical necessity which can be documented in the consumer's medical record and prescribed by an eligible prescriber. If there is no maximum quantity indicated, the quantity authorized will be based on medical necessity as determined by the department.

For auditing purposes, any units with one per day dispensing parameters that have not exceeded thirty one units per month in total will not be found to be dispensed above and beyond program parameters and thus would not require a prior authorization to be obtained by the provider.

(G) "RNT/P" indicator.

The rental/purchase ~~Rental/purchase~~ indicator~~.~~, "RO" means the item is always rented, "PP" means item is always purchased and "R/P" means item is designated as ~~rent to purchase~~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 the ~~recipient's~~consumer'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)~~(including rebates) 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. 3/2008), or attached documentation, the amount of the discount.~~ This policy is implemented in accordance with federal regulations at 42 C.F.R. 1001.952 ~~(April 17, 2002)~~.

(J) ~~The durable~~Durable medical equipment ~~prescriber~~ prescribers and ~~provider~~ providers must be fiscally, administratively, and contractually in compliance with applicable federal "Stark II" ~~regulation, 42 C.F.R 411.354~~ regulations (42 C.F.R 411.354) and federal "Anti-Kickback Safe Harbor" ~~regulation~~regulations, as they apply to referrals ~~sent~~ to entities with which they or members of their immediate family have a financial relationship. ~~for designated health services or medical supplies and they apply to the medicaid program and medicaid consumers.~~

(K) Any requests for items that exceed the specified maximum allowable indicator referenced in paragraph (F) of this rule and do not otherwise require prior authorization (PA) must be submitted for review by the department before reimbursement for such items will be considered.

(L) The following documentation must be submitted with all PA requests:

(1) A fully completed form JFS 01913 "Certificate of Medical Necessity/Prescription General Medical Supplies: Overage" (CMN) (appendix B to this rule) that is signed and dated no more than thirty days before the first date of service.

(2) Any other documentation as required or requested by the department for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(M) Medical supplier services must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care which addresses the need for medical supplier services. This prescription must contain the original signature of the ordering prescriber that attests to the medical necessity of these services.

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CERTIFIED ELECTRONICALLY

Certification

03/19/2012

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