5101:3-10-05 **Reimbursement for covered services.**

(A) For each claim for reimbursement, providers must keep in their files a legible written or typed prescription, including a diagnosis, signed and dated not more than sixty days prior to the first date of service by the recipient's attending physician. For incontinence garments and related supplies, a legible written or typed physician prescription, signed and dated not more than thirty days prior to the first date of service must be maintained on file by the provider; prescriptions for incontinence garments and related supplies must include all information required in accordance with rule 5101:3-10-21 of the Administrative Code. For medical supplies only, other than incontinence garments and related supplies, an oral prescription with all of the required information recorded in writing by the provider will suffice. For ongoing services or supplies, a new prescription must be obtained at least every twelve months. Medical supply providers are required to keep all records and prescriptions in accordance with rules ~~5101:3-1-172~~ 5101:3-1-17.2 and ~~5101:3-1-173~~ 5101:3-1-17.3 of the Administrative Code.

(B) The reimbursement allowed by the department for medical equipment that is rented or purchased includes at a minimum, the following:

(1) The manufacturer's and dealer's warranty; and

(2) Any adjustments and/or modifications required within ninety days of the dispensing date (for purchases) or during the total rental period (for rentals), except those occasioned by major changes in the patient's condition; and

(3) Instruction to the recipient in the safe use of the equipment; and

(4) Cost of delivery to the recipient's residence and, when appropriate, to the room in which the equipment will be used.

(5) For further details on specific items, see rules 5101:3-10-08 and beyond in Chapter 5101:3-10 of the Administrative Code.

(C) Unless prior authorization has been obtained for used equipment, all equipment that is purchased must be new at the time of purchase or have been new at the time of rental for the same recipient. Used equipment, if clearly designated on the prior authorization request form as used, in good working order, and covered by the same warranty as new equipment, may be provided if approved by the department. Reimbursement for used equipment will be the lower of eighty per cent of the medicaid maximum or the billed charge. The modifier code UE must be used when billing for the purchase of used durable medical equipment.

(D) Replacement items or parts will only be reimbursed for patient-owned medical equipment. See rule 5101:3-10-08 of the Administrative Code for details regarding reimbursement for repair of durable medical equipment.

(E) Automatic refills of medical supply orders are not eligible for reimbursement. Providers of medical supplies shall ascertain the quantity of supplies needed and shall not dispense supplies in excess of the amount actually needed by the recipient for the prescribed period. No supplies shall be billed before they have been provided to the recipient.

(F) Payment for durable medical equipment, medical supplies (~~excluding~~ including enteral ~~and parenteral~~ nutrition products), orthoses, and prostheses is limited to the lower of the usual and customary charge of the supplier, the department's medicaid maximum as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code, or, where no maximum is set forth in appendix DD, seventy-five per cent of the average recommended list price. ~~The pricing methodology for enteral and parenteral nutrition products is set forth in Chapter 5101:3-9 of the Administrative Code.~~ Costs of delivery and service calls related to DME and medical supply items must be considered an integral part of the supplier's cost of doing business. A separate charge for these services will not be recognized.

(G) Duplicate equipment, supplies, or services, or conflicting equipment prescribed for a recipient, are not reimbursable.

(1) "Conflicting equipment" is defined as equipment which is contraindicated due to the possession by the recipient of equipment, regardless of payment source, which serves the same or a similar purpose. Examples would be a wheelchair followed by a power-operated vehicle (or vice versa), or more than one wheelchair, or more than one monaural hearing aid.

(2) Suppliers are responsible for ascertaining in the preliminary discussion with the recipient and/or attending physician, whether there is conflicting equipment. All suppliers are expected to know whether currently requested equipment is contraindicated by equipment supplied by a different supplier.

(3) If a recipient's condition changes and warrants new or different equipment, the existing equipment must be noted and appropriate medical documentation must be furnished when prior authorization is requested for the new equipment.

(H) The department will not reimburse for materials or services covered under the manufacturer's or dealer's warranty. Providers must keep a copy of the warranty

and the date of purchase in their files. A copy of the warranty must be provided on the request of the department.

(I) Purchase or rental of durable medical equipment.

A current physician's prescription must accompany each request for prior authorization of purchase or rental of durable medical equipment. The department reserves the right to determine whether an item will be rented or purchased. Rental of equipment is valid only as long as medical necessity exists and is documented.

(1) Rental only.

Certain durable medical equipment requiring frequent and substantial servicing to ensure the health and safety of recipients will be designated as "rental only." This includes, but is not limited to, mechanical ventilators, oxygen concentrators, and air fluidized beds. Rental only equipment is designated RO in the "Medicaid Supply List", appendix A of rule 5101:3-10-03 of the Administrative Code. The rental payment is specified in appendix DD of rule 5101:3-1-60 of the Administrative Code. No modifier code is used in billing "rental only" items.

(2) Capped rental.

(a) For those items of equipment designated "capped rental", rental payments will be made at ten per cent per month of the maximum amount allowable for a maximum of twelve months. At the end of the twelfth month, rental payments will cease. The provider must continue to provide the equipment and to service the equipment as long as medical necessity exists. At the end of each six-month period following the initial twelve-month rental period, the provider may bill a single service charge to the department, not to exceed the monthly rental fee for that item. The provider retains ownership of the equipment. Capped rental equipment is not purchased and is therefore not eligible for replacement.

(b) The modifier code CR should be used in billing capped rental items for the initial twelve months. When billing for maintenance begins, use the modifier code MS, six-month maintenance and servicing fee for reasonable and necessary parts and labor which are not covered under any manufacturer or supplier warranty.

(c) If medical necessity ends or the recipient's eligibility is interrupted or ends during the six-month service period, the service charge shall be prorated

at a rate of one-sixth per month.

(3) Routinely purchased items, lump sum purchase.

Most items on the "Medicaid Supply List" are categorized as "routinely purchased items" and would ordinarily be purchased and become the property of the recipient.

(4) Short term rental and rent to purchase.

(a) In some instances the department may determine that short term rental would be more appropriate or cost-effective than purchase of an item. In these instances, rental of equipment will be approved. Approved rental under one prior authorization number shall not exceed six months. Payment for short term rental of equipment will be made at ten per cent per month of the maximum amount allowable for a specific item. Use the modifier code RR when billing short-term rental.

(b) If a prior authorization request is received for a second rental period, the department will make a determination on whether to purchase, and will note the decision on the prior authorization form. When a decision is made to purchase the equipment, all prior rental payments will apply toward the purchase price. After ten monthly payments the equipment will be considered purchased and becomes the property of the recipient.

(c) The combined total reimbursement for rental and subsequent (within ninety days of the end of the rental service) purchase of a DME item, cannot exceed the medicaid maximum fee.

(J) For items authorized for rental on a monthly basis, payment will be made through the month in which the recipient becomes ineligible, the item is no longer medically necessary or the maximum amount allowable is reached. For items authorized for rental on a daily basis, only those days when the recipient is eligible and the item is medically necessary are billable to the department.

(K) All medicare-covered services provided to residents of long-term care facilities who are medicare and medicaid eligible must be billed by the supplier directly to medicare. When paid by medicare, medicaid payment will be made by the department as a crossover payment directly to the medical supplier.

(L) Reimbursement for back-up equipment for a medically necessary mechanical ventilator may be allowed only when the following documentation is provided:

(1) Estimated response time to the recipient's address is provided in writing, signed by the supervisor of the emergency team(s) responsible for serving the recipient's address; and

(2) The emergency medical team estimated response time is more than thirty minutes; and

(3) A statement signed by the recipient's attending physician declares that thirty minutes without a mechanical ventilator would create a life-threatening situation for the recipient.

(4) When ventilators are provided to medicaid eligible residents of a long-term care facility, reimbursement shall not be provided for more than one back-up ventilator per eight primary ventilators.

(M) With the exception of nonmolded helmets (L0110) and splints (L4300 to L4399), all covered orthotic and prosthetic devices listed in appendix A of rule 5101:3-10-20 of the Administrative Code, provided to eligible recipients who are residents of nursing facilities, may be billed direct to medicaid. Nonmolded helmets and splints must be billed to the facility and are reimbursed through the per diem payment in accordance with Chapter 5101:3-3 of the Administrative Code.

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Certification

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