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

(A) Unless otherwise specified, 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 consumer's prescriber. For incontinence garments and related supplies, a legible ~~written or typed~~ prescriber's 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. ~~Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-17.2 and 5101:3-1-17.3 of the Administrative Code.~~

(1) Providers are required to maintain proof of delivery documentation for durable medical equipment (DME), ~~items or equipment~~medical supplies and orthotics and prosthetics dispensed to consumers. ~~in their files~~. ~~Accepted criteria for proof of delivery documentation are as follows:~~

(a) Providers, their employees, or anyone else having a financial interest in the delivery of DME, medical supplies or orthotic and prosthetic items are prohibited from signing and accepting an item on behalf of a consumer; and

(b) Any person accepting a delivery of DME, medical supplies or orthotic and prosthetic items on behalf of a consumer will note on the delivery slip ~~obtained by the provider his or her~~ his/her relationship to the consumer. ~~in question~~. The signature of the person accepting ~~a~~ the delivery ~~of DME items~~ should be legible. If the signature ~~of the person accepting the delivery~~ is not legible, the provider/ shipping service will note the name of the person accepting the delivery on the delivery slip; or

(c) If the provider utilizes a shipping service or mail order, an example of proof of delivery would include the service's tracking slip~~,~~ and the supplier's own invoice. If possible, the supplier's records will also include the delivery service's package identification number. ~~for the package sent to the consumer.~~ The ~~shipping service's~~ tracking slip will reference each individual package, the delivery address, the corresponding package identification number ~~given by the shipping service~~, and the date delivered. ~~If a provider utilizes a shipping service or mail order, the~~The provider shall use the shipping date as the date of service on the claim. Providers may also utilize a return postage-paid delivery invoice from the consumer or consumer's designee as a form of proof of delivery. The descriptive information concerning the DME, medical supplies or orthotic and prosthetic item (i.e., the consumer's name, the quantity, detailed description, brand name, and serial

number) as well as the required signatures from either the consumer or the consumer's designee ~~will~~must be included on this invoice ~~as well~~; and

(d) For ~~those consumers who are~~ residents of a long term care facility ~~(LTCF)~~, providers will obtain legible copies of the necessary documentation from the nursing facility to document proof of delivery or usage by the consumer (e.g., nurse's notes).

(2) In accordance with Sections 6407 (b) and (d) of the Patient Protection and Affordable Care Act, prescriptions for DME, medical supplies, orthotics or prosthetics listed on the Office of Medical Assistance (OMA) website must originate as a result of a face-to-face encounter between the prescriber and the consumer. This encounter must occur no more than one hundred and eighty days prior to the prescription being written and cannot occur following the date the prescription is written.

(3) During the face-to-face encounter, the prescriber must have evaluated the consumer, conducted a needs assessment or actively treated the consumer for the medical condition that supports the need for each covered item of DME, medical supply or orthotic or prosthetic. The face-to-face encounter must be documented in the consumer's medical record.

(4) A single face- to-face encounter can support the need for multiple covered items as long as it is clearly documented in the medical record that the consumer was evaluated or treated for a condition that supports the need for each covered item.

~~(2)~~(5) Except as provided in this paragraph, prescriptions for ~~durable medical equipment (~~DME~~)~~, ~~and medical supplies~~medical supplies, orthotics or prosthetics not referenced in paragraph (A)(2) above must originate as a result of a ~~face to face~~face-to-face ~~examination~~encounter between the prescriber and the consumer. A separate examination for each subsequent ~~DME~~ item prescribed is not necessary if:

(a) The prescriber has reviewed the medical record generated from a ~~face to face~~face-to-face ~~examination~~encounter ~~that was~~ conducted within the previous twelve months ~~by the prescriber,~~ and the DME, medical supply or orthotic or prosthetic item or items prescribed are related to ~~the~~ diagnoses ~~that were~~ established in that ~~face to face~~face-to-face ~~examination~~encounter; or

(b) The prescription is written based on the judgment of a prescriber who has reviewed the consumer's medical ~~records~~record from a ~~face to~~

face-to-face ~~examination~~encounter conducted within the previous twelve months by a different prescriber, and the item or items are related to ~~the~~ diagnoses that were established in that ~~face to face~~face-to-face ~~examination~~encounter.

~~All DME and medical supply prescriptions~~Prescriptions for a long-term supply of disposable items (~~i.e., diabetic test strips,~~ e.g., incontinence garments or wound supplies)~~,~~ can be renewed no sooner than ninety days prior to the expiration of the current prescription. DME, ~~or medical supply~~ orthotic or prosthetic and medical supply prescriptions are ~~only~~ valid for a maximum of one year~~.~~from the originating date of the prescription.

~~(3) The DME and medical supply prescriber must be fiscally, administratively, and contractually in compliance with applicable federal "Stark II" regulation, 42 C.F.R 411.354 and federal "Anti-Kickback Safe Harbor" regulation, as it applies to referrals sent to entities with which they or members of their immediate family have a financial relationship for designated health services and as it applies to the medicaid program and medicaid consumers.~~

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

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

(2) Any costs associated with assembling ~~medical equipment~~items or parts used for the assembly of ~~medical equipment~~items; ~~and~~

(3) 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 consumer's condition; ~~and~~

(4) Instruction to the consumer in the safe use of the ~~equipment~~item or items; and

(5) Cost of delivery to the consumer's residence and, when appropriate, to the room in which the ~~equipment~~item or items will be used.

(6) For further details on specific items, see Chapter 5101:3-10 of the Administrative Code.

(C) Unless prior authorization has been obtained for used ~~equipment~~DME, all ~~equipment~~DME ~~that is purchased~~ must be new at the time of purchase or ~~have been~~

~~new~~ at the time of rental. ~~for the same consumer.~~ Used ~~equipment~~DME, 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~~DME 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.~~DME.

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

(E) Automatic refills of ~~medical supply orders~~ DME, medical supplies or orthotic or prosthetic items are not eligible for reimbursement. Providers ~~of medical supplies shall ascertain the quantity of supplies needed monthly by a consumer and~~ shall not dispense ~~supplies~~DME, medical supplies or orthotic or prosthetic items in excess of one month's supply ~~per month~~ for the duration of the prescribed period. No ~~supplies~~DME, medical supplies or orthotic or prosthetic items shall be billed before they have been provided. ~~to the consumer.~~

(F) Unless otherwise stated, ~~payment for durable medical equipment~~DME (including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories), medical supplies~~, orthoses, and prostheses~~ orthotics or prosthetics is reimbursed utilizing the following criteria:

(1) When the item or items ~~in question~~ appear in appendix DD to rule 5101:3-1-60 of the Administrative Code, the provider shall bill the department the provider's usual and customary charge and will receive the lesser of the usual and customary charge or the ~~Medicaid~~ medicaid maximum rate that appears ~~on~~ in this appendix ~~DD to rule 5101:3-1-60 of the Administrative Code~~; or

(2) When the item or items ~~in question~~ do not appear in appendix DD ~~to rule 5101:3-1-60 of the Administrative Code~~ or appear but without a medicaid maximum rate and the provider has submitted a list price for payment, ~~but a list price is presented to the department for reimbursement,~~ the provider shall bill ~~the department~~ the ~~provider's~~ usual and customary charge and will receive the lesser of the usual and customary charge or seventy-two per cent of the list price; or

(3) When the item or items in question do not appear in appendix DD ~~to rule 5101:3-1-60 of the Administrative Code~~ or appear but without a medicaid maximum rate and the provider has submitted an invoice price for payment, ~~and there is no list price that is presented to the department for~~

~~reimbursement,~~ the provider shall bill ~~the department~~ the ~~provider's~~ usual and customary charge and will receive the lesser of the usual and customary charge or one hundred forty-seven per cent of the ~~provider's~~ invoice price less any discounts or rebates applicable at the time of billing but exclusive of any discounts or rebates the provider may receive subsequent to the time of billing; or

(4) In circumstances where paragraphs (F)(1), (F)(2) and (F)(3) occur concurrently, the department will reimburse the amount determined to be the most cost effective.

~~(4) When paragraph (F)(2) of this rule is otherwise applicable but the department has available the providers invoice price, the department will pay the lesser of the amounts determined under paragraphs (F)(2) and (F)(3) of this rule.~~

(5) The "list price" is defined as the most current price ~~of an item or items that is~~ recommended by the ~~product's~~ manufacturer for retail sale. This price cannot be established nor obscured or deleted by the provider on any documentation supplied ~~to the department~~ for consideration of reimbursement. A provider may set list price for custom products where the provider is both the manufacturer and the provider so long as the list price is equal to or less than comparable ~~manufacturer produced~~ products. ~~This price and documentation~~ Documentation submitted to support this price is subject to approval by the department.

(6) The "invoice price" is defined as the price ~~of an item or items~~ delivered ~~by the provider~~ to the consumer ~~that gives details of price, quantity and type of supplies dispensed to the consumer~~ and reflects the provider's net costs in accordance with ~~paragraph (I) of~~ rule 5101:3-10-03 of the Administrative Code. This information cannot be obscured or deleted on any documentation supplied ~~to the department~~ for consideration of reimbursement. ~~This price and documentation~~ Documentation submitted to support this price is subject to approval by the department.

(7) Costs of delivery and service calls related to DME, ~~and medical supply items~~ medical supplies, orthotics or prosthetics ~~must be~~are considered an integral part of the ~~supplier's~~provider's cost of doing business. A charge for these services will not be recognized when billed separately. ~~as a component of any reimbursement rate for services rendered.~~

(8) ~~It is expected that the~~The consumer ~~will be~~must be supplied with the most cost effective ~~durable medical equipment~~DME, medical supply or orthotic or prosthetic that ~~will meet the consumer's~~ meets their clinical needs. ~~as identified and ordered by the prescriber.~~

~~Cost effective durable medical equipment~~"Cost effective" is defined ~~by the Ohio department of job and family services (ODJFS)~~ to mean ~~that the provider has taken into account all of the consumer's clinical and ambulatory needs in order to identify durable medical equipment that will meet~~ items which meet the consumer's clinical and lifestyle requirements ~~utilizing specific equipment and/or medical supplies that are available~~ at the lowest available cost. ~~to ODJFS.~~

(9) A supplier of custom items may be reimbursed when the consumer for whom they were intended expires prior to dispensing under the following conditions:

(a) The Healthcare Common Procedure Coding System code used to describe the item indicates it is designed or intended for a specific individual;

(b) The item cannot be modified for use by another individual;

(c) The provider can document measurements of the consumer were taken for fitting prior to the end of life;

(d) The provider can document the consumer's health status at the time the item was requested did not indicate the end of life was imminent; and

(e) The provider uses the date the consumer's measurements were taken as the date of service for the item.

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

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

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

(3) If change in a consumer's condition ~~changes and~~ warrants a change in ~~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 ~~equipment specific~~ warranty ~~and the date of purchase in their files~~. A copy of the ~~equipment specific~~ warranty must be provided upon ~~on the~~ request of the department and must be submitted with any prior authorization request for repairs.

Any repair or servicing done on ~~consumer durable medical equipment~~DME that is consumer owned must be documented, ~~and~~ kept in the providers file, and ~~be accessible to the Ohio medicaid program~~provided to the department upon request.

(I) Purchase or rental of durable medical equipment.

A ~~current prescriber's~~ prescription must accompany each request for the prior authorization of ~~purchase or rental of durable medical equipment.~~DME. 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~~DME requiring servicing to ensure the health and safety of recipients will be designated as "rental only." Rental only equipment is designated RO in ~~the "Medicaid Supply List",~~ appendix A to rule 5101:3-10-03 of the Administrative Code. The rental payment amount is specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. Unless otherwise specified, no modifier code is used in billing "rental only" items.

(2) 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 consumer.

(3) 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,~~The rental of ~~equipment~~DME ~~will~~may be approved when it is determined to be more cost effective than purchase. ~~Approved~~The approved rental period under one prior authorization number shall not exceed six months, unless specified elsewhere in

Chapter 5101:3-10 of the Administrative Code. 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~~Providers must 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 the item. ~~or items in question, and will note the decision to purchase on the prior authorization form. When~~Upon a decision ~~is made~~ to purchase, ~~the equipment,~~ all prior rental payments will apply toward the purchase price ~~of the item or items in question,~~ and the provider will receive one final payment for the remainder of the ~~items~~item's maximum allowable amount as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. ~~The equipment will then be considered purchased and becomes the property of the consumer.~~ The provider will notify the consumer when an item has been purchased on ~~his or her~~ his/her behalf. ~~by ODJFS.~~

~~(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.~~

(c) The reimbursement for items purchased within ninety days of the end of a rental period, inclusive of all rental payments and the remaining purchase price, cannot exceed the medicaid maximum amount.

(d) Prior authorization is required prior to reimbursment for those DME items designated as R/P in appendix A to rule 5101:3-10-03 of the Administrative Code.

~~(d) Unless otherwise specified, durable medical equipment listed in rule 5101:3-10-03 of the Administrative Code that is designated R/P must have a prior authorization before reimbursement is authorized.~~

(J) For items authorized for monthly rental ~~on a monthly basis~~, payment will be made through the end of the month in which: the consumer 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, the items are billiable only those days when the consumer is eligible and the item is medically necessary. ~~are billable to the department.~~

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

~~payment~~ directly to the ~~medical supplier.~~provider.

(L) Reimbursement for a back-up ~~equipment for a medically necessary mechanical~~ ventilator may be allowed upon provision of ~~only when~~ the documentation required in rule 5101:3-10-22 of the Administrative Code. ~~is provided.~~

(M) With the exception of nonmolded helmets and splints, all covered orthotic and prosthetic devices listed in appendix A to rule 5101:3-10-20 of the Administrative Code~~, provided to eligible consumers who are residents of nursing facilities,~~ may be ~~billed~~submitted for reimbursement ~~direct to ODJFS.~~ when provided to eligible residents of nursing facilities. ~~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.~~

(N) RT (Right Side) and LT (Left Side) Modifiers

Use of either the RT or LT modifiers is required when billing for the codes listed on the OMA website. For items having the same billing code and dispensed bilaterally on the same date of service for the same consumer, both the RT and the LT modifier must be used.

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Certification

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