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

(A) Unless otherwise specified, for ~~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~~consumer's ~~attending physician~~prescriber. For incontinence garments and related supplies, a legible written or typed ~~physician~~ 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. ~~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 5101:3-1-17.2 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 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 items are prohibited from signing and accepting an item on behalf of a consumer; and

(b) Any person accepting a delivery of DME items on behalf of a consumer will note on the delivery slip obtained by the provider his or her relationship to the consumer in question. The signature of the person accepting a 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 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

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 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) Except as provided in this paragraph, prescriptions for durable medical equipment (DME) and medical supplies must originate as a result of a face to face examination 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 examination that was conducted within the previous twelve months by the prescriber, and the DME item or items are related to the diagnoses that were established in that face to face examination; or

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

All DME and medical supply prescriptions for a long term supply of disposable items (i.e., diabetic test strips, 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 prescriptions are only valid for a maximum of one year.

(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 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~~consumer's condition; and

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

(4) Cost of delivery to the ~~recipient's~~consumer'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~~consumer. 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~~consumer-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 monthly by a consumer and shall not dispense supplies in excess of ~~the amount actually needed by the recipient~~one month's supply per month for the duration of the prescribed period. No supplies shall be billed before they have been provided to the ~~recipient.~~ consumer.

(F) Unless otherwise stated, payment ~~Payment~~ for durable medical equipment (including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories), medical supplies ~~(including enteral nutrition products)~~, orthoses, and prostheses is reimbursed utilizing the following criteria: ~~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. 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.~~

(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 maximum rate that appears on appendix DD of 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, 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 five 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, 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 fifty 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) 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.

(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.

(7) 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 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 consumer will be supplied with the most cost effective

durable medical equipment that will meet the consumer's clinical needs as identified and ordered by the prescriber.

Cost effective durable medical equipment 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 the consumer's clinical and lifestyle requirements utilizing specific equipment and/or medical supplies that are available at the lowest cost to ODJFS.

(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~~consumer 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~~consumer and/or attending ~~physician~~prescriber, 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~~consumer'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 equipment specific warranty and the date of purchase in their files. A copy of the equipment specific warranty must be provided 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 that is consumer owned must be documented and kept in the providers file and be accessible to the Ohio medicaid program upon request.

(I) Purchase or rental of durable medical equipment.

A current ~~physician's~~prescriber'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. Unless otherwise specified, no~~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)~~(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 ~~recipient~~ consumer.

~~(4)~~(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, rental of equipment will be approved. Approved rental 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 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 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 maximum allowable amount as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. ~~After ten monthly payments the~~The equipment will then be considered purchased and becomes the property of the ~~recipient~~consumer. The provider will notify the consumer when an item has been purchased on his or 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.

(d) All 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 rental on a monthly basis, payment will be made through the month in which the ~~recipient~~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, only those days when the ~~recipient~~ consumer 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 required in rule 5101:3-10-22 of the Administrative Code 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~~consumers who are residents of nursing facilities, may be billed direct to ~~medicaid~~ODJFS. 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.

Effective:

R.C. 119.032 review dates: 07/01/2009

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02
Prior Effective Dates:	4/7/77, 12/21/77, 12/30/77, 1/1/80, 3/1/84, 10/1/88, 5/1/90, 6/20/90 (Emer), 9/5/90, 2/17/91, 9/1/98, 7/1/04