5101:3-10-06 **Prior authorization.**

Unless otherwise specified, ~~Reimbursement~~reimbursement for some medical supplier services is available only upon prior authorization from the Ohio department of job and family services. (See ~~rule~~Chapter ~~5101:3-1-31~~5101:3-1 of the Administrative Code for details about ~~the~~ prior authorization ~~program~~.)

(A) Requests for prior authorization for medical supplier services must include:

(1) A legible, fully completed prior authorization form (JFS 03142, rev. 2/2003), including pertinent information such as quantity requested, manufacturer, style or model number, size and warranty period; and for purchase requests, whether the equipment is new or used. ~~and a~~Purchase requests also must include a current manufacturer's price list when the item in question does not have a Medicaid maximum rate listed in appendix DD to rule 5101:3-1-60 of the Administrative Code~~;~~.

(2) A description, including approximate age and ownership, of any similar equipment or service currently in possession of the recipient and the reason for the new request~~;~~.

(3) A prescription issued in accordance with ~~rule~~Chapter ~~5101:3-10-05~~5101:3-10 of the Administrative Code. The prescription must contain a diagnosis consistent with the medical necessity of the requested item and indicate the quantity requested. ~~; and~~

~~(4) Documentation to establish medical necessity of the requested item or service.~~

(4) As specified in Chapter 5101:3-10 of the Administrative Code, prior authorization requests for certain medical supplier services require the submission of a fully completed certificate of medical necessity (CMN) that has been signed and dated by an eligible prescriber no more than thirty days before the first date of service. Prior authorization requests for medical supplier services submitted without a fully completed and signed certificate of medical necessity as specified in Chapter 5101:3-10 of the Administrative Code will be denied due to lack of required documentation.

(5) 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.

(B) Reevaluation and prior authorization requests must be made at appropriate intervals of not more than twelve months, unless otherwise specified in Chapter 5101:3-10 of the Administrative Code.

(C) ~~Do~~Providers should not submit the billing claim form with the prior authorization request.

(D) For items ~~which~~that require multiple fittings and special construction, the first service date may be used as the dispensing date for prior authorization. However, the invoice/claim form shall not be submitted for payment until the ~~recipient~~consumer has received the item/service. Providers are required to maintain proof of delivery documentation for durable medical equipment (DME) items dispensed to consumers in their files. Accepted criteria for proof of delivery documentation are detailed in rule 5101:3-10-05 of the Administrative Code.

(E) The item or service actually supplied to a recipient must be the item/service ~~and~~in the quantity specifically approved by the department on the "Prior Authorization" (PA) form. Unless otherwise specified, no item/service substitutions are allowed without explicit authorization by the department.

(F) Providers using a healthcare common procedure coding system (HCPCS) miscellaneous code on a prior authorization request for a bundled service must itemize all bundled components for which they are requesting reimbursement using the miscellaneous code in question.

~~(F)~~(G) When a provider is requesting authorization of a service greater than the department established maximum allowable units for that service, a complete history ~~which~~that includes the date and amount of all services provided and billed previously must be ~~indicated~~included. A detailed explanation must be provided of the medical necessity for the additional services. Requests for authorization of additional services will not be considered without this information.

(H) Prior authorization requests for replacement medical equipment will be considered based on medical necessity. However, cases suggesting malicious damage, neglect, culpable irresponsibility, or wrongful disposition of the medical equipment in question will be investigated and prior authorization may be denied where the department determines it is unreasonable to make further program payment under the circumstances presented to the department in support of the equipment replacement request. Providers will provide any information regarding requests for the replacement of medical equipment that the department deems necessary in order to evaluate the replacement request.

Effective:

R.C. 119.032 review dates: 01/02/2007

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.021
Prior Effective Dates:	4/7/77, 12/21/77, 12/30/77, 1/1/80, 3/1/84, 10/1/87, 5/1/90, 2/17/91, 9/1/02