5101:3-3-19 **Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services.**

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable. For state-operated ICFs-MR reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code. All references to "ICFs-MR" set forth in paragraphs (A) to (K) of this rule do not include state-operated ICFs-MR.

(A) Dental services.

All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Chapter 5101:3-5 of the Administrative Code. Personal hygiene services provided by facility staff or contracted personnel are reimbursed through the facility cost report mechanism.

(B) Laboratory and x-ray services.

Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility's cost report. All laboratory and x-ray procedures covered under the medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Chapter 5101:3-11 of the Administrative Code.

(C) Medical supplier services.

Certain medical supplier services are reimbursable through the facility's cost report mechanism and others directly to the medical supply provider as follows:

(1) Items ~~which~~that must be reimbursed through the facility's cost report include:

(a) Costs incurred for "needed medical and program supplies" defined as those items ~~which~~that have a very limited life expectancy, such as, atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.

(b) Costs incurred for "needed medical equipment" (and repair of such equipment), defined as items ~~which~~that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate

for the use in the facility. Such medical equipment items include hospital beds, wheelchairs, and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.

(c) Costs of equipment associated with oxygen administration, such as, carts, regulators/humidifiers, cannulas, masks, and demurrage.

(2) Services ~~which~~that are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code, include:

(a) Certain durable medical equipment items, specifically, ventilators, and custom-made wheelchairs that have parts which are actually molded to fit the recipient.

(b) "Prostheses," defined as devices ~~which~~that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as, artificial arms or legs, electro-larynxes, and breast prostheses.

(c) "Orthoses," defined as devices ~~which~~that assist in correcting or strengthening a distorted part, such as, arm braces, hearing aids and batteries, abdominal binders, and corsets.

(d) Contents of oxygen cylinders or tanks, including liquid oxygen, except that emergency stand-by oxygen is reimbursed through the facility cost report mechanism.

(e) Oxygen producing machines (concentrators) for specific use by an individual recipient.

(D) Pharmaceuticals.

(1) Over-the-counter drugs not listed in ~~the "Ohio Medicaid Drug Formulary,"~~appendix A of rule 5101:3-9-12 of the Administrative Code, ~~drugs~~ for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.

(2) All other pharmaceuticals ~~which~~that either are listed in ~~the "Ohio Medicaid Drug Formulary~~appendix A of rule 5101:3-9-12 of the Administrative Code, or for which prior authorization was requested and approved, are reimbursable directly to the pharmacy provider for residents of NFs and ICFs-MR. Services reimbursable directly to the pharmacy provider are

subject to the following conditions:

(a) Drug amounts must be dispensed not to exceed maximum prescriptions quantities established by the Ohio department of job and family services (ODJFS).

(b) Refill dates must be maintained with the original prescription record. Refills are limited to eleven times or one year, whichever comes first, for nonscheduled drugs; five times or six months, whichever comes first, for schedule III, IV, and V drugs; and none for schedule II drugs.

(c) For chronic maintenance medications, the pharmacy provider may only bill for one dispensing fee per medication per month.

(d) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.

(e) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF or an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by pharmacy.

(E) Physical therapy, occupational therapy, speech therapy, ~~and~~ audiology services, psychologist services, and respiratory therapy services.

(1) For NFs, the costs incurred for ~~covered therapy services~~physical therapy, occupational therapy, speech therapy and audiology services provided by licensed ~~practitioners~~therapists or therapy assistants are reimbursed directly to the NF as specified in rules 5101:3-3-47 to 5101:3-3-47.3 of the Administrative Code. The costs incurred for these services provided by nursing staff of the NF are reimbursable through the facility cost report mechanism as specified in rule 5101:3-3-46 of the Administrative Code.

(2) For ICFs-MR, the costs incurred for ~~these services~~physical therapy, occupational therapy, speech therapy, audiology services, psychology services and respiratory therapy services provided by licensed therapists or therapy assistants or provided by licensed psychologists or psychology assistants and that are covered for ICF-MR residents either by medicare or medicaid, are reimbursable through the facility cost report mechanism ~~in accordance with rule 5101:3-3-80 of the Administrative Code~~. Reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered

to facility residents by contracted staff or facility staff and the overhead costs to support the provision of such services are reimbursable through the rate determined in accordance with rule 5101:3-3-78 of the Administrative Code.

(3) Psychologist services are covered for both NFs and ICFs-MR pursuant to paragraph (G) of this rule. Respiratory therapy services for NFs and ICFs-MR are covered pursuant to paragraph (H) of this rule.

(F) Physician services.

(1) A physician may be directly reimbursed for the following services provided by a physician to a resident of a NF or ICF-MR:

(a) All covered diagnostic and treatment services in accordance with Chapter 5101:3-4 of the Administrative Code.

(b) All medically necessary physician visits in accordance with rule 5101:3-4-06 of the Administrative Code.

(c) All required physician visits as described ~~below~~in paragraphs (F)(1)(c)(i) to (F)(1)(c)(iv) of this rule when the services are billed in accordance with rule 5101:3-4-06 of the Administrative Code.

(i) Physician visits must be provided to a resident of a NF or ICF-MR and must conform to the following schedule:

(a) For nursing facilities, the resident must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every ninety days, thereafter.

(b) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.

(ii) For reimbursement of the required physician visits, the physician must:

(a) Review the resident's total program of care including medications and treatments, at each visit required by paragraph (F)(1)(c)(i) of this rule;

(b) Write, sign, and date progress notes at each visit;

(c) Sign all orders; and

(d) Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.

(iii) At the option of the physician, required visits after the initial visit may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and alternate between physician and visits by physician assistant or nurse practitioner.

(iv) Physician delegation of tasks.

(a) A physician may delegate tasks to a physician assistant or nurse practitioner who ~~are~~is in compliance with the following criteria:

(i) "Nurse practitioner" means a registered professional nurse who is currently licensed to practice in the state, who meets the state's requirements governing the qualifications of nurse practitioners, and who meets one of the following conditions:

(A) Is currently certified as a primary care nurse practitioner by the "American ~~Nurses'~~Nurses Association" or by the ~~"National Board of Pediatric Nurse Practitioners and Associates"~~"Pediatric Nursing Certification Board"; or

(B) Has satisfactorily completed a formal one academic year educational program that:

(1) Prepares registered nurses to perform an expanded role in the delivery of primary care;

(2) Includes at least four months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

(3) Awards a degree, diploma, or certificate to persons who successfully complete the program; or

(ii) "Physician assistant" means a person who meets the applicable state requirements governing the qualifications for assistants to primary care physicians, and who meets at least one of the following conditions:

(A) Is currently certified by the "National Commission on Certification of Physician Assistants" to assist primary care physicians; or

(B) Has satisfactorily completed a program for preparing physician's assistants that:

(1) Was at least one academic year in length;

(2) Consisted of supervised clinical practice and at least four months (in the aggregate) of classroom instruction directed toward preparing students to deliver health care; and

(3) Was accredited by the "American Medical Association's ~~Committee on Allied Health Education and Accreditation~~Commission on Accreditation of Allied Health Education Programs"; or

(iii) Is acting within the scope of practice as defined by state law; and

(iv) Is under supervision and employment of the billing physician.

(b) A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.

(2) Services directly reimbursable to the physician must:

(a) Be based on medical necessity, as defined in rule 5101:3-1-01 of the Administrative Code, and requested by the NF or ICF-MR resident with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and

(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Every entry must be signed and dated by the physician.

(3) Services provided in the capacity of overall medical direction are reimbursable only to a NF or ICF-MR and may not be directly reimbursed to a physician.

(G) Psychologist services.

Except as otherwise provided in this paragraph, costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for ~~such~~psychologist services ~~can~~shall be made to a provider other than the NF, ICF-MR, or a community mental health center (CMHC) certified by the Ohio department of mental health (ODMH). Services provided by an employee of the CMHC must be billed directly to medicaid by the CMHC.

(H) Respiratory therapy services.

Costs incurred for physician- ordered administration of aerosol therapy ~~which~~that is rendered by a licensed respiratory care professional are reimbursable through the facility cost report mechanism. No reimbursement for ~~such~~respiratory therapy services ~~can~~shall be made to a provider other than the NF or ICF-MR.

(I) Transportation services.

Costs incurred by the facility for transporting residents by means other than covered ambulance or ambulette services are reimbursable through the facility cost report mechanism. Payment is made directly to authorized providers for covered ambulance and ambulette services as set forth in Chapter 5101:3-15 of the Administrative Code.

(J) Vision care services.

All covered vision care services, including examinations, dispensing, and the fitting of eyeglasses, are reimbursed directly to authorized vision care providers in

accordance with Chapter 5101:3-6 of the Administrative Code.

(K) Podiatry services.

Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Chapter 5101:3-7 of the Administrative Code. Payment by ~~ODHS~~ODJFS is limited to one visit per month for residents in a NF or ICF-MR setting.

Effective:

R.C. 119.032 review dates: 11/17/2005

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.20, 5111.263
Prior Effective Dates:	7/1/80, 3/1/84, 9/1/89, 10/1/90 (Emer), 12/31/90, 9/30/93, 7/4/02