5160-10-03 **Medical supplies and the medicaid supply list.**

(A) This rule sets forth in its appendix (the "medicaid supply list") a table of medical/surgical supplies, durable medical equipment, and supplier services, along with coverage and payment information. ~~Columns in the table display the following information:~~

~~(1) "Current code": Alphanumeric healthcare common procedure coding system (HCPCS) codes to be used on claims submitted to the department for medical supplier services. Each code is intended to encompass all trade names of the particular product represented. A "not otherwise specified (NOS)" code should be used only when an item is not adequately represented by a specific code.~~

~~(2) "Item description": A brief description of the supply or equipment item.~~

~~(3) "Unit" indicator: The unit of measure (each one, each pair, box of fifty, etc.).~~

~~(4) "Medicaid" indicator: The medicaid coverage for an item.~~

~~(a) "Y" indicates that the item is covered by medicaid for all recipients, in accordance with rule 5160-10-02 of the Administrative Code, and the provider may submit claims directly to the department.~~

~~(b) "H" indicates that payment may be made only when the item is provided to recipients living in their personal residence.~~

~~(c) "H*" indicates that payment will not be made if the item is provided to a recipient living in a nursing facility.~~

~~(5) "Prior auth" indicator: Prior authorization requirements.~~

~~(a) "Y" indicates that prior authorization by the department is required before payment can be made, in accordance with rule 5160-10-06 of the Administrative Code.~~

~~(b) "N" indicates that no prior authorization is required for payment for units up to the maximum number allowable.~~

~~(6) "Max units" indicator: The greatest quantity of an item for which payment may be made without prior authorization for the time period specified. This quantity has been established as a guideline rather than a definitive amount. If no maximum quantity is indicated, the quantity authorized will be based on medical necessity as determined by the department. (Note: A provider may receive payment without prior authorization for up to thirty-one units per month of an item with an indicator of "one per day.")~~

~~(7) "RNT/P" indicator: Rental/purchase.~~

~~(a) "RO" indicates that the item is always rented.~~

~~(b) "PP" indicates that the item is always purchased.~~

~~(c) "R/P" indicates that the item is subject to the rent-to-purchase provision set forth in rule 5160-10-05 of the Administrative Code.~~

(B) In order to be eligible for payment for medical supplier services rendered, a provider must either meet the conditions set forth in Chapter 4752. of the Revised Code or be exempt from licensure under Chapter 4752. of the Revised Code.

(C) Medical supplier services must be prescribed by a ~~prescriber~~ practitioner actively involved in managing the recipient's medical care through a comprehensive plan of care that addresses the need for medical supplier services, and the medical necessity of the services must be documented in the recipient's medical record. By signing a prescription, the ordering prescriber attests to the medical necessity of the services.

(D) The following documentation must be submitted with all requests for prior authorization:

(1) A fully completed form ~~JFS~~ ODM 01913, "Certificate of Medical Necessity/Prescription; General Medical Supplies: Overage" (rev. ~~11/2011~~ 4/2016), that is signed and dated no more than thirty days before the first date of service; and

(2) Any other document required or requested by the department for certain specific medical supplier services, as detailed in Chapter 5160-10 of the Administrative Code.

(E) Requests that exceed the specified maximum for an item but do not otherwise require prior authorization must be submitted to the department for review before payment for the item will be considered.

(F) The submitted charge for gauze pads and for items described as "wound fillers/packing" must not exceed the manufacturer's suggested list price for the item. Providers must maintain a detailed record in the recipient's file of all such items that have been dispensed and for which claims have been submitted to medicaid.

(G) ~~Providers must apply any rebate or discount to the~~ The charge submitted on a claim~~.~~

~~A "discount" is~~ must reflect any rebate or discount (a reduction in the amount charged to a buyer for a purchase made either directly or through a wholesaler or a group purchasing organization) received by the provider.

Effective: 04/01/2016

Five Year Review (FYR) Dates: 11/24/2015 and 04/01/2021

CERTIFIED ELECTRONICALLY

Certification

03/21/2016

Date

Promulgated Under: 119.03
Statutory Authority: 5164.02
Rule Amplifies: 5164.02
Prior Effective Dates: 03/01/1984, 12/30/1984, 10/01/1988, 12/01/1989, 05/01/1990, 06/20/1990 (Emer), 09/05/1990, 02/17/1991, 05/25/1991, 12/30/1991, 04/01/1992 (Emer), 07/01/1992, 11/16/1992, 12/31/1992 (Emer), 04/01/1993, 07/08/1993, 12/10/1993, 12/30/1993 (Emer), 03/31/1994, 07/01/1994, 02/01/1995, 12/29/1995 (Emer), 03/21/1996, 12/31/1996 (Emer), 03/31/1997, 08/01/1997, 08/01/1998, 12/31/1998 (Emer), 03/31/1999, 01/04/2000 (Emer), 03/20/2000, 12/29/2000 (Emer), 03/30/2001, 12/31/2001 (Emer), 03/29/2002, 03/24/2003, 10/01/2004, 12/30/2004 (Emer), 03/28/2005, 12/30/2005 (Emer), 03/27/2006, 10/15/2006, 12/29/2006 (Emer), 03/29/2007, 07/30/2007, 12/16/2007, 12/31/2007 (Emer), 03/30/2008, 04/01/2009, 07/31/2009 (Emer), 10/29/2009, 12/31/2009 (Emer), 02/01/2010 (Emer), 03/31/2010, 12/30/2010 (Emer), 03/30/2011, 03/29/2012, 12/31/2013