TO BE RESCINDED

5160-10-05 **Reimbursement for covered services.**

(A) Unless otherwise specified, for each claim for reimbursement, providers must keep in their files a legible 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 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.

(1) Providers are required to maintain proof of delivery documentation for durable medical equipment (DME), medical supplies and orthotics and prosthetics dispensed to consumers. . 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 their relationship to the consumer. . The signature of the person accepting the delivery should be legible. If the signature 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. The tracking slip will reference each individual package, the delivery address, the corresponding package identification number, and the date delivered. 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 must be included on this invoice as well; and

(d) For residents of a long term care facility, 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) Prescriptions for DME, medical supplies, orthotics or prosthetics listed at http://jfs.ohio.gov/OHP/bhpp/FSRDisclaimer.stm must have originated 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 orthotics or prosthetics. The face-to-face encounter must be documented in the consumer's medical record.

(4) When the face-to-face encounter is conducted by a physician assistant, a clinical nurse specialist or a certified nurse practitioner, it must be documented by a physician signing the pertinent portion of the medical record.

(5) 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.

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

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

(b) The prescription is written based on the judgment of a prescriber who has reviewed the consumer's medical record from a face-to-face encounter conducted within the previous twelve months by a different prescriber, and the item or items are related to diagnoses that were established in that face-to-face encounter.

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

(B) The reimbursement for DME, medical supplies, orthotics or prosthetics includes at a minimum the following:

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

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

(5) Cost of delivery to the consumer's residence and, when appropriate, to the room in which the 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 DME, all DME must be new at the time of purchase or have been new at the time of rental. Used DME, if clearly designated on the prior authorization request form as used, in good working order, and covered by the same warranty as new, may be provided if approved by the department. Reimbursement for used 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 used DME.

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

(E) Automatic refills of DME, medical supplies or orthotic or prosthetic items are not eligible for reimbursement. Providers shall not dispense DME, medical supplies or orthotic or prosthetic items in excess of one month's supply for the duration of the prescribed period. No DME, medical supplies or orthotic or prosthetic shall be billed before they have been provided.

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

(1) When the item or items 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 in this appendix; or

(2) When the item or items do not appear in this appendix or appear but without a medicaid maximum rate and the provider has submitted a list price for payment, the provider shall bill the 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 this appendix or appear but without a medicaid maximum rate and the provider has submitted an invoice price for payment, the provider shall bill the usual and customary charge and will receive the lesser of the usual and customary charge or one hundred forty-seven per cent of the 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) of this rule occur concurrently, the department will reimburse the amount determined to be the most cost effective.

(5) The "list price" is defined as the most current price recommended by the manufacturer for retail sale. This price cannot be established nor obscured or deleted by the provider on any documentation supplied 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 products. Documentation submitted to support this price is subject to approval by the department.

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

(7) Costs of delivery and service calls related to DME, medical supplies, orthotics or prosthetics are considered an integral part of the provider's cost of doing

business. A charge for these services will not be recognized when billed separately.

(8) The consumer must be supplied with the most cost effective DME, medical supply or orthotic or prosthetic that meets their clinical needs.

Cost effective is defined to mean items which meet the consumer's clinical and lifestyle requirements at the lowest available cost.

(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; and

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

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

(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 consumer are not reimbursable.

(1) "Conflicting equipment" is defined as equipment which serves the same or a similar purpose regardless of payment source. Examples include a wheelchair followed by a power-operated vehicle or more than one wheelchair.

(2) Suppliers are responsible for ascertaining whether there is conflicting equipment. All providers are expected to know whether requested equipment is contraindicated by equipment supplied by a different provider.

(3) If change in a consumer's condition warrants a change in equipment, the existing equipment must be noted 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 warranty in

their files. A copy of the warranty must be provided upon request of the department and must be submitted with any prior authorization request for repairs.

Any repair or servicing done on equipment that is consumer owned must be documented, kept in the providers file, and provided to the department upon request.

(I) Purchase or rental of durable medical equipment.

A prescription must accompany each request for the prior authorization of 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.

(1) Rental only.

Certain DME requiring servicing to ensure the health and safety of recipients will be designated as "rental only." Rental only equipment is designated RO in 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) The rental of DME may be approved when it is determined to be more cost-effective than purchase. 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 will be made at ten per cent per month of the maximum amount allowable. Providers should use the modifier 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. Upon a decision to purchase, all prior rental payments will apply toward the purchase price and the provider will receive one final payment for the remainder of the item's maximum allowable amount as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. The

provider will notify the consumer when an item has been purchased on their behalf.

(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.

(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.

(K) Medicare-covered services provided to residents of long-term care facilities who are dually eligible for medicare and medicaid must be billed directly to medicare. Following payment by medicare, medicaid payment will be made directly to the provider.

(L) Reimbursement for a back-up ventilator may be allowed upon provision of the documentation required in rule 5101:3-10-22 of the Administrative Code.

(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 may be submitted for reimbursement when provided to eligible residents of nursing facilities.

(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 at http://jfs.ohio.gov/OHP/bhpp/FSRDisclaimer.stm. 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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