TO BE RESCINDED

5160-10-06 **Prior authorization.**

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

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

(1) . 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 Chapter 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.

Medical supplier services must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care which addresses the need for medical supplier services. This prescription must contain the original signature of the ordering prescriber that attests to the medical necessity of these services.

(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.

(6) Any requests for items that exceed the specified maximum allowable indicator referenced in rule 5101:3-10-03 of the Administrative Code and do not

otherwise require prior authorization (PA) must be submitted for review by the department before reimbursement for such items will be considered.

(7) The following documentation must be submitted with all PA requests for items referenced in paragraph (A)(6) of this rule:

(a) A fully completed form JFS 01913 "Certificate of Medical Necessity/ Prescription General Medical Supplies: Overage" (CMN) (appendix B to rule 5101:3-10-03 of the Administrative Code) that is signed and dated no more than thirty days before the first date of service.

(b) Any 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) Providers should not submit the billing claim form with the prior authorization request.

(D) For items 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 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 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.

(G) When a provider is requesting authorization of a service greater than the department established maximum allowable units for that service, a complete history that includes the date and amount of all services provided and billed previously must be 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:

Five Year Review (FYR) Dates: 4/27/2018

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Certification

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Date

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