

Durable Medical Equipment Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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eManual Contents

Please send comments to ePubs_updates@jfs.ohio.gov

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Notice

A Durable Medical Equipment (DME) provider handbook is currently not available.

Below please find Ohio Administrative Code (OAC) rules regarding DME Services and links to the OAC (found in the Legal Services collection).

Medical Assistance Letters

MAL 532

Medical Assistance Letter No 532 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Ambulatory Surgery Center Services e-book.

[**Click here to view MAL 532, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.**](#)

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 506

Medical Assistance Letter (MAL) No. 506

June 27, 2006

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Proof of compliance with the licensure/certification requirements by the Ohio Respiratory Care Board for providers of certain home medical equipment (HME) known in the Medicaid program as durable medical equipment (DME), effective August 1, 2006

The purpose of this Medical Assistance Letter (MAL) is to provide notice that eligible Ohio Medicaid providers of DME services will be required to submit proof of licensure, certificate of registration, or exemption from licensure or registration by the Ohio Respiratory Care Board (ORCB) to the Department to receive reimbursement for certain medical equipment for dates of service on and after August 1, 2006.

Additionally, this MAL is to provide notice that previous Medicaid reimbursement for covered services provided in violation of Chapter 4752 of the Ohio Revised Code, and in the rules promulgated thereunder, is subject to audit recovery because Medicaid providers are required to comply with all state statutes and rules.

Chapter 4752 of the Ohio Revised Code requires licensure or certification for Ohio DME/HME providers choosing to sell or rent equipment that fall into the categories of life sustaining equipment, technologically sophisticated equipment, or other equipment as defined therein, effective September 15, 2005. Chapter 4752 also specifies exemptions from this requirement for certain DME providers.

To be eligible for reimbursement for certain medical equipment for dates of service on and after August 1, 2006, providers must have on file with the Department a copy of their license or certificate of registration, or statement establishing an exemption under section 4752.02 of the Ohio revised Code. DME providers who believe they are exempt from licensure/certification requirements must submit a notarized statement and/or other acceptable proof, documenting their reason for exemption. Failure to submit acceptable proof of compliance will result in denial of all claims for services rendered in violation of Chapter 4752.

Providers should submit documentation of compliance with Chapter 4752 to:

Provider Enrollment Unit
P.O. Box 1461
Columbus, Ohio 43216-1461

As a guideline to help clarify which DME/HME providers are subject to licensure requirements, the ORCB has recently developed the following list of examples of some of the HME/DME equipment that falls into these categories that require the provider of those services be licensed.

Life Sustaining Equipment includes: ventilators, oxygen concentrators, oxygen liquid systems, oxygen compressed gas systems, and non-invasive ventilator systems (i.e., bi-level, iron lungs, rocking beds, and diaphragmatic pacers).

Technologically Sophisticated Equipment includes: oxygen conservation devices, CPAP (continuous positive airway pressure), bi-level airway pressure devices, IPV (intrapulmonary percussive ventilation), IPPB (intrapulmonary positive pressure breathing), cough-assist mechanical in-exsufflator, apnea monitors, percussors (for chest physiotherapy), suction machines, feeding machines, infusion pumps, CPM (continuous passive motion) devices, TENS (transcutaneous electric nerve stimulators), and custom seating or positioning systems.

Other Equipment includes: auto-titrating airway devices, pulse oximeters, home photo therapy (bili lights or blankets), large volume air compressors for tracheostomy, electric wheelchairs and custom scooters, in-home

patient lifts, and individually sized, customized accessories or any items that are an integral part of equipment defined in any of these categories of equipment.

A complete list of Medicaid covered DME procedure codes that, if rented or sold, require providers to comply with this licensure is posted at: <http://ifs.ohio.gov/ohp/infodata/hipaacomcds.stm>

Providers can contact the ORCB to learn more about the licensure/registration requirement at www.respiratorycare.ohio.gov or by calling 614-644-4732.

DME Question Line and Mailbox

In February 2005, ODJFS established a DME Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization (PA) requests or claims submissions. For such questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider Network Management at 1-800-686-1516.

The department recommends that providers view forms and the entire text of the DME rules for the Durable Medical Equipment program at:

<http://emanuals.odjfs.state.oh.us/emanuals>

These forms and other department forms can also be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of this MAL including attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

Attachment

[Click here to view the Ohio Medicaid DME Procedure Codes Requiring Provider Licensure or Certificate of Registration](#)

MAL 471

Medicaid Assistance Letter (MAL 471)

November 1, 2004

TO: All Providers Billing Hearing Aids
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Hearing aid codes and policy

The purpose of this MAL is to announce changes from local level Medicaid codes to HIPAA compliant V codes for conventional hearing aids. The Department has crosswalked the local level codes to the V codes for conventional hearing aids and other covered hearing aid service, e.g. batteries, ear molds. A crosswalk from the local level codes to the V codes can be found on the Department's web site at <http://ifs.ohio.gov/ohp/infodata/hipaacomcnds.stm>.

I. Hearing Aid Rule/Policy and Medicaid Maximum

The current hearing aid rule, 5101:3-10-11 of the Administrative Code (effective 1/1/95) is still in effect. In July 2004, the Department proposed a new hearing aid rule that would have expanded coverage to include programmable and digital hearing aids. However, despite repeated rule filings, the proposed rule is not in effect. We encourage you to go to the Department's web site to review the rule in its entirety at <http://emanuals.odjfs.state.oh.us/emanuals>.

The Department will only cover conventional hearing aids as described in section II of this MAL. The Medicaid maximum remains at \$413.88 for a monaural hearing aid.

II. Billing for Services That Require Prior Authorization

With the exception of ear molds, batteries and minor repairs, all hearing aid services require prior authorization (PA). For all hearing aids and any other hearing service requiring prior authorization (PA), the following instructions have been established to assure appropriate processing of claims containing prior authorized procedure codes for dates of service through December 31, 2004.

Existing prior authorizations already issued by ODJFS containing old codes will be honored for services rendered for dates of service through December 31, 2004. Providers must bill the procedure code(s) contained on the prior authorization approval letter. If these PAs are not utilized for dates of service through December 31, 2004, a new PA request must be submitted with the new HIPAA compliant code(s).

New PA requests for a hearing aid (not already submitted to ODJFS) must reflect the appropriate V code. The Department will not process a new PA for a hearing aid billed with the old hearing aid code (A9040) for a PA received on and after November 15, 2004. The Department will honor a PA containing the old code as long as the PA is received on or before November 15, 2004.

To bill for hearing services that do not require PA, simply use the new HIPAA compliant V code for the service, e.g. V5266 for batteries, for dates of service on and after November 1, 2004. Please continue to use the local level codes to bill for repair of a hearing aid. The local level codes are Y9041 for a minor repair or Y9042 for a major repair of a hearing aid. The Department will notify providers when the HIPAA compliant codes for repairs are ready for use.

III. Requesting paper updates

If a provider does not have access to the internet and wishes to request a paper copy of these updates, please complete the attached JFS 03400 form and either mail or fax the form to the address on the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management section
P.O. Box 1461
Columbus, Ohio 43216-1461
In-state toll free telephone number 1-800-686-1516

MAL 443A

Medical Assistance Letter No. 443A

February 7, 2003

TO: All Providers of Medical Supplier Services
FROM: Tom Hayes, Director
SUBJECT: Changes to the Ohio Medicaid Medical Supplier Program

The purpose of this Medical Assistance Letter (MAL) is to set forth the most recent changes to Ohio administrative code (OAC) rule 5101:3-10-03, "Medicaid Supply List". Changes will be effective on April 1, 2003 unless otherwise specified.

Page 6 - Incontinence Garments and Related Supplies: Local level "Y" codes have been deleted and have been replaced with HIPAA compliant "A" codes. Reimbursement for these codes has also been reduced in order to be more consistent with market prices.

Page 9, Ostomy Supplies; Page 12, Family Planning Supplies; Page 21, Ventilators, CPAP, Other Respiratory Equipment; Page 23, Monitoring Equipment: New codes added. Deleted codes valid until June 30, 2003.

Page 13 - Equipment and Supplies for ESRD: Changes to codes, units and limitations for gloves.

Upon receiving this MAL, please refer to the websites listed below for detailed information. Please review these rules in their entirety for all changes, updates, additions, and deletions. All previous versions of OAC 5101:3-10-03 and OAC 5101:3-1-60 should be filed as obsolete.

These proposed rules can be viewed at:

Medical Supply List - <http://www.state.oh.us/odjfs/OLS/pubhearings/032303/3-10-03.pdf>

Reimbursement - <http://www.state.oh.us/odjfs/OLS/pubhearings/032303/3-1-60.pdf>

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations	In-state:
Provider Network Management Section	1-800-686-6108 (option 1) or
P.O. Box 1461	614-728-3288 (option 1)
Columbus, OH 43216-1461	Out of state: 614-728-3288 (option 1)

It has come to our attention that some providers are inappropriately billing for take home pharmacy services by using J-codes. Ohio Medicaid limits J-code usage only to professionals that are administering the drug to the patient in an office setting. J-codes should not be used by any other provider or in any other setting.

Effective immediately, Medicaid providers currently classified as provider type "76" (Durable Medical Supplier) that have a current pharmacy license with a pharmacist dispensing medications, to be used by the patient in their residence, in accordance with Ohio Board of Pharmacy regulations are eligible to apply for a "prescribed drug" category of service. Those who qualify will be considered an "other provider" for purposes of rules and reimbursement, as set forth in OAC 5101:3-9. The effective date of the "prescribed drug" category of service for providers approved by the department may be retroactive, in accordance with OAC 5101:3-1-17.4.

To be eligible, a DME provider must submit a written request for a "prescribed drug" category of service. This request must include and/or identify the following:

1. Ohio Medicaid provider identification number;

2. Copy of the most recent terminal drug distributor license for the provider and any attachments;
3. Copy of the responsible pharmacist's license.

The request for the "prescribed drug" category of service and all required documentation should be addressed to:

DME Provider Enrollment
PO Box 1461
Columbus, OH 43216-1461

All medications must be dispensed in accordance with Board of Pharmacy regulations. Upon approval of the "prescribed drug" category of service by the department, pharmacy claims must be processed using the NCPDP standard and submitted to First Health Services for adjudication. The department can not accept pharmacy claims or adjustments. If pharmacy claims are not submitted using the online Point-of-Sale system then paper claims, using a Universal Claim Form, must be submitted to First Health Services at the following address:

First Health Services Corp.
Ohio Paper Claims Processing Unit
PO Box C-85042
Richmond, VA 23261-5042

Pharmacy billing and claim submission instructions can be found in the provider manual on our website at [*http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm](http://www.state.oh.us/odjfs/ohp/bhpp/meddrug.stm). Questions on billing procedures should be addressed to First Health Services at 877-518-1545.

**Note: the hardcopy erroneously lists the URL as: <http://www.state.oh.us/odjfs/ohp/meddrug.stm>, however the electronic version has been updated to reflect the correct URL.*

MAL 438

Medical Assistance Letter No. 438

December 20, 2002

TO: ALL PROVIDERS OF MEDICAL SUPPLIER SERVICES
DIRECTORS, COUNTY DEPARTMENTS OF JOB AND FAMILY SERVICES
DIRECTORS, DISTRICT OFFICES

FROM: THOMAS J. HAYES, DIRECTOR

SUBJECT: CHANGES TO APNEA MONITOR RULE

Rule 5101:3-10-09 of the Ohio administrative code entitled "Apnea monitors" is being amended as part of the five year rule review. Changes were made to clarify language and remove outdated references.

This rule was effective as of December 5, 2002. This rule can be viewed at <http://www.state.oh.us/odjfs/OLS/pubhearings>

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216-1461

In-state: 1-800-686-6108 (option 1) or

614-728-3288 (option 1)

Out of state: 614-728-3288 (option 1)

MAL 435

Medical Assistance Letter No. 435

Medical Supplier Services

June 25, 2002

TO: All Providers of Medical Supplier Services

FROM: Thomas Hayes, Director

SUBJECT: Changes to the Ohio Medicaid Durable Medical Equipment and Medical Suppliers Program

The purpose of this Medical Assistance Letter (MAL) is to set forth the most recent changes to the Ohio Administrative Code (OAC) Rules identified below. These rules were reviewed, and changes made, as part of the legislatively mandated 5-year rule review process. The effective date for these changes is September 1, 2002.

OAC 5101:3-10-06, "Prior Authorization". Changes were made to clarify the requirements for requesting a prior authorized service. This includes indicating quantity requested on the prescription and supplying the same item/service in the same quantity as approved by the department.

OAC 5101:3-10-07, "Reimbursement by Title XVIII (medicare)". This rule was rescinded, as it is duplicative to rule 5101:3-1-05.

OAC 5101:3-10-08, "Repair of Medical Equipment". Changes were made to clarify prescription requirements for repairs.

OAC 5101:3-10-10, "Dialysis Equipment". Changes were made to specify that medicaid should only be billed if medicare has denied for other than lack of medical necessity. Also, suppliers can only bill for these services if the patient is not receiving dialysis under Method I.

OAC 5101:3-10-17, "Blood Glucose Monitors (glucometers)". Changes were made to update the language used to describe the acceptable diagnoses. The specific form for requesting PA on specialized monitors was also changed to the standard PA request form (JFS 03142).

A separate rule (OAC 5101:3-10-02.1) is being proposed to clarify that prescriptions for medical supplier services written by Advanced Practice Nurses (APNs) are also covered.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In State: 1-800-686-6108 (option 1) or
(614) 728-3288 (option 1)
Out of State: (614) 728-3288 (option 1)**

MAL 405

Medical Assistance Letter No. 405

Medical Supplier Services

January 16, 2002

TO: All Providers of Medical Supplier Services

FROM: Thomas Hayes, Director

SUBJECT: Changes to the Ohio Medicaid Durable Medical Equipment and Medical Suppliers Program

The purpose of this Medical Assistance Letter (MAL) is to set forth the most recent changes to Ohio Administrative Code (OAC) Rules: 5101:3-10-03, "Medical Supply List"; and 5101:3-10-20, "Covered Orthotic and Prosthetic Services and Associated Limitations".

Many new codes that became available for possible implementation will be reviewed in detail at a later date as HIPAA coding is determined. The miscellaneous codes are still available with prior authorization for items that don't have a specific code recognized by the department.

Some blood pressure monitor code descriptions have been changed federally to be "for dialysis" (see codes A4660, A4663, A4670). The State would already expect these items to be bundled into the local level dialysis codes (Y2090, Y2091, Y2092) as the note in the supply list states "all supplies and equipment for home dialysis of ESRD patients are to be billed under a single code". The above mentioned "A" codes will currently remain available for non-dialysis recipients, but they will be reviewed again this summer. If, by July 1, 2002, the feds have not changed these descriptions and no new codes have been added for these products for non-dialysis patients, then the State will make changes to implement the federal description.

Upon receiving this MAL and the accompanying OAC rules, previous versions of the OAC rules should be filed as obsolete. All new codes and description changes are effective January 1, 2002 unless otherwise specified.

OAC Rules:

A. Medicaid Supply List (Appendix A of OAC Rule 5101:3-10-03)

The Medicaid Supply List has been updated to include the following changes. Several new codes have replaced older codes. Where applicable on the Medicaid Supply List, the new code or changes to a code has been underlined, and the new code is directly below the discontinued code. Discontinued codes have been crossed out.

Please review the attached rule in its entirety, for all the following changes, updates, additions, and deletions:

Dressings/Tape/Gauze Page 2 of 27

The following code has been deleted, effective March 31, 2002:

A6020 "Collagen based wound dressing, wound cover"

The following codes have had a description modification:

A6196 "Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less"

A6197 "Alginate or other fiber gelling dressing, wound cover, pad size more than 16 but less than or equal to 48 sq. in."

A6198 "Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in."

Wound Fillers Page 5 of 27

The following code has had a description modification:

A6199 "Alginate or other fiber gelling dressing, wound filler"

The following code is now a covered medical supply under Ohio Medicaid:

A6010 "Collagen based wound filler, dry form"

Urological Supplies Page 6 of 27

The following code has been discontinued, effective March 31, 2002:

A4329 "External catheter starter set, male/female, includes catheters/urinary collection device, bag/pouch and accessories"

The following code has had a description modification:

A4358 "Urinary leg/abdominal bag, vinyl, with or without tube with strap"

Ostomy Supplies Page 8 of 27

Code A4364 has been modified to read "Adhesive liquid or equal, any type, per oz"

Miscellaneous Supplies Page 10 of 27

Code Y9105 "Breast pump, electric" has been discontinued effective March 31, 2002 and has been replaced by code E0603.

Code Y9104 "Breast pump, heavy duty electrical (rental only)" has been discontinued effective March 31, 2002 and has been replaced by code E0604.

Enteral and Parenteral Nutrition Therapy Only Page 11 of 27

The following codes have been discontinued, effective March 31, 2002:

B4084 "Gastrostomy/jejunostomy tubing (foley type only)"

B4085 "Gastrostomy tube, silicone with sliding ring"

The following code is now a covered medical supply under Ohio Medicaid:

B4086 "Gastrostomy/jejunostomy tube; any type/material"

Hospital Beds Page 15 of 27

Code E0298 "Hospital bed, heavy-duty, extra wide, with any type side rails, with mattress" has been discontinued effective March 31, 2002 and has been replaced by code K0549.

Traction Equipment and Hospital Bed Accessories Page 16 of 27

Code E1810 has been modified to read "Dynamic adjustable knee extension/flexion device; includes soft interface material"

Ventilators, CPAP, and Other Respiratory Equipment Page 17 of 27

Code K0184 has been modified to read "Nasal single piece interface, replacement for CPAP nasal application device"

Suction Pumps and Suctioning Equipment Page 19 of 27

Code E0600 has been modified to read "Suction pump, home model, portable or stationary, complete"

Monitoring Equipment Page 19 of 27

The following code has been discontinued, effective March 31, 2002:

E0609 "Blood glucose monitor with special features (voice synthesizer) complete"

The following codes are now a covered supply requiring prior authorization:

E2100 "Blood glucose monitor with integrated voice synthesizer"

E2101 "Blood glucose monitor with integrated lancing/blood sample"

Wheelchairs Page 25 of 27

The following codes have been discontinued, effective March 31, 2002:

K0008 "Custom manual wheelchair base"

K0013 "Custom motorized/power wheelchair base"

B. List of Orthotic and Prosthetic Procedures (Appendix A of OAC Rule 5101:3-10-20)

The List of Orthotic and Prosthetic Procedures has been updated to include the following changes. Several new codes have been added, effective January 1, 2002. Other codes have had a change in the description of a previously covered code. Additions to the list have been underlined and deletions have been crossed through.

Please read the attached rule in its entirety, for all the following changes, updates, additions, and deletions:

Spinal - Cervical Page 1 of 65

The following codes have had a description modification:

L0100 "Cranial orthosis helmet with or without soft interface; molded to patient model"

L0110 "Cranial orthosis helmet, with or without soft interface; non-molded"

Spinal - Lumbar - Sacral Page 3 of 65

Code L0515 has been modified to read "LSO, anterior-posterior control, with rigid or semi-rigid posterior panel; prefab"

Thoracic - Hip - Knee - Ankle Page 9 of 65

Code L1510 has been modified to read "THKAO, standing frame with or without tray and accessories"

Lower Limb - Ankle - Foot Page 12 of 65

Code L1930 has been modified to read "AFO, plastic or other material, prefab"

Code L1940 has been modified to read "AFO, molded to patient model, plastic or other material"

Additions to Straight Knee or Offset Knee Joints Page 17 of 65

Code L2415 has been modified to read "Addition to knee lock with integrated release mechanism, each joint"

Additions - General Page 20 of 65

Code L2755 has been modified to read "Addition to lower extremity orthosis, high strength, light weight material"

Specific Repair Page 33 of 65

Code L4000 has been modified to read "Replace girdle for spinal orthosis"

Lower Limb - Endoskeletal Page 36 of 65

Code L5300 has been discontinued, effective March 31, 2002. It is being replaced by code L5301. The description has been modified to read "Below knee, molded socket, SACH foot, shin, endoskeletal system"

Code L5310 has been discontinued, effective March 31, 2002. It is being replaced by code L5311. The description has been modified to read "Knee disarticulation (or through knee), molded socket, external knee joint SACH foot, shin, endoskeletal system"

Code L5320 has been discontinued, effective March 31, 2002. It is being replaced by code L5321. The description has been modified to read "Above knee, molded socket, open end, SACH foot endoskeletal system, single axis knee"

Code L5330 has been discontinued, effective March 31, 2002. It is being replaced by code L5331. The description has been modified to read "Hip disarticulation, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee SACH foot"

Code L5340 has been discontinued, effective March 31, 2002. It is being replaced by code L5341. The description has been modified to read "Hemipelvectomy, Canadian type, molded socket, endoskeletal system, hip joint, single axis knee SACH foot"

Additions - Socket Variations Page 40 of 65

The following codes have been discontinued, effective March 31, 2002:

- L5667 "Addition to lower extremity, below knee, socket insert, suction suspension, with locking mechanism"
- L5669 "Addition to lower extremity, below knee, socket insert, suction suspension, without locking mechanism"

The following codes have had a description modification:

- L5704 "Custom shaped protective cover, below knee"
- L5705 "Custom shaped protective cover, above knee"
- L5706 "Custom shaped protective cover, knee disarticulation"
- L5707 "Custom shaped protective cover, hip disarticulation"

Questions pertaining to this MAL should be addressed to:

**The Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In State: 1-800-686-6108
(614) 728-3288
Out of State:(614) 728-3288**

MAL 399

Medical Assistance Letter No. 399

Medical Supplier Services

October 18, 2001

TO: All Providers of Medical Supplier Services
FROM: THOMAS J. HAYES, DIRECTOR
SUBJECT: CHANGES TO THE OHIO MEDICAID OXYGEN RULE

The purpose of this Medical Assistance Letter (MAL) is to set forth the most recent changes to Ohio Administrative Code (OAC) Rule 5101:3-10-13, "Oxygen: Covered Services and Limitations".

Upon receiving this MAL and the accompanying OAC rule, previous versions of this rule should be filed as obsolete. The existing rule is being rescinded and is being replaced with the attached rule, effective November 1, 2001.

Please carefully review the attached rule for changes. Some of the key changes to make note of are the following:

Editorial Changes:

- The rule has been reorganized to better differentiate sections.
- Appendices have been reorganized to clarify different billing situations.

Portable Oxygen:

- Coverage criteria for portable oxygen has been clarified. (paragraph B)

Prior Authorization Requests:

- Length of time a prior authorization can be requested for has been extended to a maximum of 24 months, dependent on medical necessity. (paragraph D1)

Documentation:

- Clarified what constitutes documentation to corroborate a provider request. (paragraph D1)
- Changed date requirement of ABG or pulse oximetry reading for initial and re-certifications. (paragraph D2)
- Removed time limit for physician signature of certificate of medical necessity. (paragraph D2)
- Allowed a documentation of refill amount and delivery information in place of a meter reading when documenting amount of oxygen used. (paragraphs F1 and H1)
- Allowed a dated form documenting the pulse oximetry reading in place of a dated print out. (paragraph G4)

Coverage Requirements:

- Clarified and expanded lab criteria. (paragraph E)

Questions pertaining to this MAL should be addressed to:

**The Bureau of Plan Operations
The Provider Network Management Section
PO Box 1461
Columbus, OH 43266-0161
In State: 1-800-686-6108 or (614) 728-3288
Out of State: (614) 728-3288**

MAL 392

MEDICAL ASSISTANCE LETTER NO. 392

MEDICAL SUPPLIER SERVICES

January 22, 2001

TO: All Providers of Medical Supplier Services
FROM: JACQUELINE ROMER-SENSKY, DIRECTOR
SUBJECT: CHANGES TO THE OHIO MEDICAID DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIERS PROGRAM

The purpose of this Medical Assistance Letter (MAL) is to set forth the most recent changes to Ohio Administrative Code (OAC) Rules: 5101:3-10-03, "Medicaid Supply List"; and 5101:3-10-20, "Covered Orthotic and Prosthetic Services and Associated Limitations".

Upon receiving this MAL and the accompanying OAC rules, previous versions of the OAC rules should be filed as obsolete. All new codes and description changes are effective January 1, 2001 unless otherwise specified.

OAC Rules:

A. Medicaid Supply List (Appendix A of OAC Rule 5101:3-10-03)

The Medicaid Supply List has been updated to include the following changes. Several new codes have replaced older codes. Where applicable on the Medicaid Supply List, the new code or change to a code has been underlined, and the new code is directly below the discontinued code. Discontinued codes have been crossed out.

Please review the attached rule in its entirety, for all the following changes, updates, additions, and deletions:

Dressings/Tape/Gauze Pages 5-6 of 32

The following codes have had a description modification:

- A6222 "Gauze, impregnated, other than water, hydrogel or normal saline, pad size 16 sq inches or less, without adhesive border"
- A6223 "Gauze, impregnated, other than water, hydrogel or normal saline, pad size more than 16 but less than or equal to 48 sq. inches, without adhesive border"
- A6224 "Gauze, impregnated, other than water, hydrogel or normal saline, pad size more than 48 sq. inches, without adhesive border"

The following codes are now a covered medical supply under Ohio Medicaid.

- A6021 "Collagen dressing, pad size, 16 sq. inches or less, each"
- A6022 "Collagen dressing, pad size more than 16 sq. inches, but less than or equal to 48 sq. inches, ea"
- A6023 "Collagen dressing, pad size more than 48 sq. inches, each"
- A6231 "Gauze, impregnated, hydrogel, for direct wound contact, pad size 16 sq. inches or less, each dressing"
- A6232 "Gauze, impregnated, hydrogel, for direct wound contact, pad size greater than 16 sq. inches, but less than or equal to 48 sq. inches, each dressing"
- A6233 "Gauze, impregnated, hydrogel, for direct wound contact, pad size more than 48 sq. inches, each dressing"

Prior authorization is required for codes A6021, A6022, and A6023.

Diabetic Supplies/Blood Glucose Monitor Supplies Page 8 of 32

Code A4250, "Urine test or reagent strips or tablets", has had a price change. Effective April 1, 2001 the maximum reimbursement will be 0.26 per each.

Code A4253, "Blood glucose test, reagent strips for glucose monitor (per 50 strips)", has a change in the maximum units per month. The maximum units per month has been increased to 4 units (1 unit equals a box of 50 strips), effective April 1, 2001.

Code A4259, "Lancets, per box of 100", has a change in the maximum units per month. The maximum units per month has been increased to 2 units (1 unit equals a box of 100 lancets), effective April 1, 2001.

Distilled Water/Sterile Saline/Disinfectant Solution Page 9 of 32

Code K0182, "Water, distilled, 1000ml", has been discontinued effective March 31, 2001 and will be replaced by code A7018.

Incontinence Garments and Related Supplies Page 9 of 32

Code Y9139, "Incontinence supplies, not otherwise specified", will require Prior authorization, effective April 1, 2001.

Urological Supplies Pages 9-11 of 32

Code K0280, "Extension drainage tubing, any type or length, with connector/adaptor, for use with urinary leg band or uro", has been discontinued effective March 31, 2001 and has been replaced by code A4331.

Code K0281, "Lubricant, individual sterile packet (for sterile cath only)", has been replaced by code A4332 and is a non-covered service by Ohio Medicaid.

Code K0407, "Urinary catheter anchoring device, adhesive skin attachment", has been discontinued effective March 31, 2001 and has been replaced by code A4333.

Code K0408, "Urinary catheter anchoring device, leg strap", has been discontinued effective March 31, 2001 and has been replaced by code A4334.

Code K0409, "Sterile water, irrigation solution, 1000ml", has been discontinued effective March 31, 2001 and has been replaced by code A4319.

Code K0410, "Male external catheter, with adhesive coating", has been discontinued effective March 31, 2001 and has been replaced by code A4324.

Code K0411, "Male external catheter, with adhesive strip", has been discontinued effective March 31, 2001 and has been replaced by code A4325.

Ostomy Supplies Page 11 of 32

The description for code A4364 has been modified to read "Adhesive for facial prosthesis only, liquid, per oz".

Miscellaneous Supplies Page 14 of 32

Code 4560, "Pessary", has been discontinued effective March 31, 2001; in its place code A4561, "Pessary, rubber, any type", and code A4562, "Pessary, non-rubber, any type", have been added. Both codes A4561 and A4562 have a maximum quantity of 1 per year and a maximum reimbursement of \$10.24.

Equipment and Supplies for ESRD Page 14 of 32

Effective April 1, 2001 the following codes no longer require Prior Authorization.

Y2090 "Home hemodialysis for ESRD"
Y2091 "CAPD home dialysis"
Y2092 "CCPD home dialysis"

Infusion Pump Equipment (Non-Nutrition) and Accessories Pages 15-16 of 32

Effective April 1, 2001 the following codes no longer require Prior Authorization unless quantity limits are exceeded.

E0781 "Ambulatory infusion pump, w/ administration equipment, worn by patient"

E0791 "Parenteral infusion pump, stationary, any (non-nutritional) (including pole)"
A4305 "Disposable drug delivery system, flow rate 50ml or more per hour"
A4306 "Disposable drug delivery system, flow rate 5ml or less per hour"

Infusion Supplies Page 16 of 32

Effective April 1, 2001 the following codes no longer require Prior Authorization unless quantity limits are exceeded.

A4222 "Supplies for external drug infusion pump, per bag" Max qty of 60/month.
Y9190 "Supplies for external drug infusion pump, per cassette" Max qty of 30/month.
B4239 "IV administration set with drainage tubing (not for nutrition)"
B4240 "IV administration set with Y-attachment, drainage tubing (not for nutrition)"

Heavy Duty Walkers Page 17 of 32

Code K0458, "Heavy duty walker without wheels", has been discontinued effective March 31, 2001 and has been replaced by code E0148.

Code K0459, "Heavy duty wheeled walker, each", has been discontinued effective March 31, 2001 and has been replaced by code E0149.

Commodes Page 17 of 32

Code K0457, "Extra wide/heavy duty commode chair", has been discontinued effective March 31, 2001 and has been replaced by code E0168.

Hospital Beds Page 19 of 32

Code K0456, "Hospital bed, heavy duty, extra wide, w/ any type side rails, w/mattress", has been discontinued effective June 30, 2001 and has been replaced by code E0298.

Traction Equipment and Hospital Bed Accessories Page 20 of 32

Code E1810, "Dynamic adjustable knee extension/flexion device", has been added as a covered service. Prior Authorization is not required, there is a limit of 1 per medical event, this is a rental only item and reimburses at a maximum of \$75.00 per month.

Tracheostomy Care Pages 20-21 of 32

Code A4623, "Tracheostomy, inner cannula (replacement only)", has been modified to allow a maximum of 30 per month, effective April 1, 2001.

Code Y9188, "Trachea tube holder (E.G. Dale), other than twill tape, if medically necessary", has been modified to allow a maximum of 15 per month, effective April 1, 2001.

Ventilators, CPAP, and Other Respiratory Equipment Pages 21-22 of 32

Code K0183, "Nasal application device, used with CPAP", has had a modification to the maximum allowable reimbursement. Effective April 1, 2001 the amount will be \$66.71.

Humidifiers/Nebulizers Pages 22-23 of 32

Code E1375, "Nebulizer, portable, w/small compressor, w/limited flow," has been discontinued effective March 31, 2001.

Code E0575 has been modified to read "Nebulizer, ultrasonic, large volume (BA-400)"

B. List of Orthotic and Prosthetic Procedures (Appendix A of OAC Rule 5101:3-10-20)

The List of Orthotic and Prosthetic Procedures has been updated to include the following changes. Several new codes have been added, effective January 1, 2001. Other codes have had a change in the description of a previously covered code. Additions to the list have been underlined when a code number and capitalized when alpha; deletions have been crossed through.

Please read the attached rule, in its entirety, for all the following changes, updates, additions, and deletions:

Description Changes

The following codes have had a change in their description, from Custom Molded to Prefabricated. Please refer to the attached List of Orthotic and Prosthetic Procedures to determine the modified description in detail.

Code	Page
L1650	11
L1660	11
L1686	12
L1832	13
L1843	13
L1845	13
L1902	14
L1930	14
L2112	16
L2116	16
L2132	17
L2134	17
L2136	17

Lower Limb Hip-Knee-Ankle-Foot Page 15 of 68

Code L2038 has been modified to read "KAFO, full plastic, with knee joint, multi-axis ankle, molded to patient model, lively orthosis or equal".

Upper Limb Elbow Page 30 of 68

Code L3760, "EO with adjustable locking joints, prefabricated", has been added as a new code requiring prior authorization.

Upper Limb Wrist-Hand-Finger Pages 30-33 of 68

Code L3923, "HFO without joints, prefabricated", has been added as a new code requiring prior authorization.

Speech Aids Pages 66-67 of 68

New code K0541, "Speech generating device, digitized speech, prerecorded message less than or equal to 8 minutes", has been added. Prior authorization is required with a maximum reimbursement of \$666.00, limited to one per 5 years.

New code K0542, "Speech generating device, digitized speech, prerecorded message greater than 8 minutes", has been added. Prior authorization is required with a maximum reimbursement of \$594.00, limited to one per 5 years.

New code K0543, "Speech generating device, synthesized speech, requiring physical contact for message formulation", has been added. Prior authorization is required with a maximum reimbursement of \$7000.00, limited to one per 5 years.

New code K0544, "Speech generating device, synthesized speech, permitting multiple methods of message formulation", has been added. Prior authorization is required with a maximum reimbursement of \$7000.00, limited to one per 5 years.

New code K0545, "Speech generating software program for PC or PDA", has been added and requires prior authorization. It is limited to one per 5 years.

New code K0546, "Accessory for speech generating device, mounting system", has been added and requires prior authorization. It is limited to one per 5 years.

New code K0547, "Accessory for speech generating device, not otherwise specified", has been added and requires prior authorization.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, OH 43266-0161
In State: 1-800-686-6108 or (614) 728-3288
Out of State: (614) 728-3288

MAL 385

MEDICAL ASSISTANCE LETTER NO. 385

February 29, 2000

TO: All Providers of Medical Supplier Services
FROM: JACQUELINE ROMER-SENSKY, DIRECTOR
SUBJECT: CHANGES TO THE OHIO MEDICAID DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIERS PROGRAM

The purpose of this Medical Assistance Letter (MAL) is to set forth the most recent changes to Ohio Administrative Code (OAC) Rules: 5101:3-10-03, "Medicaid Supply List"; 5101:3-10-18, "Hospital Beds and Pressure-Reducing Support Surfaces"; and 5101:3-10-20, "Covered Orthotic and Prosthetic Services and Associated Limitations." Also included with this MAL is a new "Billing Instructions" section and a new "Desk Reference" section.

Upon receiving this MAL and the accompanying OAC rules, Billing Instructions, and Desk Reference, previous versions of the OAC rules, Billing Instructions, and Desk Reference section should be filed as obsolete.

Section I. of this MAL contains the new Desk Reference section. Section II. of this MAL contains the changes to the aforementioned OAC rules. Section III. of this MAL contains the new Billing Instructions.

I. Desk Reference:

ODHS Medicaid Telephone Directory: A listing of customer service phone numbers for different areas of the Ohio Department of Human Services.

Forms List: A listing of ODHS forms and other related forms (e.g., claim forms, prior authorization forms, claim adjustment forms).

Top 10 Commonly Asked Questions: A listing of the top ten questions commonly asked by Medicaid providers. Included are the most frequently-asked questions and answers pertaining to claims processing and recipient eligibility.

II. OAC Rules:

A. Medicaid Supply List (Appendix A of OAC Rule 5101: 3-10-03)

The Medicaid Supply List has been updated to include the following changes. Several new codes have replaced older codes. Where applicable on the Medicaid Supply List, the new code or change to a code has been underlined, and the new code is directly above the discontinued code. Discontinued codes have been crossed out.

Please review the attached rule, in its entirety, for all of the following changes, updates, additions, and deletions:

Syringes/Needles

The description for code A4215 has been modified to include needles for insulin pens. The description now reads "Needles only, sterile, any size, including pen needles." The maximum fee has been increased to \$0.25 per needle.

Diabetic Supplies/Blood Glucose Monitor Supplies

The description for code Y9107 has been modified to include insulin pens. The description now reads, "Insulin injector, manual, including insulin pens."

Code A4258, "Spring powered device for lancet," is now a covered medical supply under Ohio Medicaid. Prior authorization is not required. The maximum quantity is one per year and the maximum allowable fee is \$13.75 each.

Urological Supplies

The Medicare indicator for code K0280, "Extension drainage tubing, any type or length, with connector/adaptor, for use with urinary leg bag or uro.," has been updated to reflect that the code is not covered by Medicare.

Ostomy Supplies

Coding Revision: Codes for Ostomy Supplies have been revised from "K" to "A" series codes. The "A" codes are valid for dates of service on or after January 1, 2000.

The "K" codes are being discontinued and will not be valid for dates of service after March 31, 2000. Prior authorizations issued for "K" codes are valid and will be payable for dates of service through June 30, 2000.

Providers should begin using "A" codes as soon as possible. Please refer to pages 11 through 13 of the attached Medicaid Supply List for a list of ostomy supplies, the new "A" codes, and the corresponding discontinued "K" codes. Each discontinued "K" code is below the "A" code that has replaced it.

Descriptions for the new "A" codes are slightly more descriptive than the "K" codes they are replacing.

In addition, the description for code A5126 has been modified to include non-adhesive disks and foam pads. The description now reads, "Adhesive or non-adhesive; disk or foam pad."

Ostomy Code Pricing: Prices for the new "A" codes will be the same as the corresponding "K" codes.

Equipment and Supplies for ESRD

The "Note" which precedes the list of codes for ESRD equipment and supplies has been modified to be more descriptive. It now states: "All supplies and equipment for home dialysis of ESRD recipients are to be billed under a single code. Maximum allowed payment for equipment and supplies combined is \$1200/mo for Y2090 and Y2091, and \$1500/mo for Y2092."

Enteral and Parenteral Nutrition Therapy Only The Medicare indicator for code Y2040, "Gastrostomy button (replacement only...)," has been updated to reflect that the code is not covered by Medicare.

Infusion Pump Equipment and Accessories

The Medicare indicators for codes E0791, "Parenteral infusion pump, stationary, any," and Y2020, "Syringe infusion pump," have been updated to reflect that the codes are not covered by Medicare.

Commodes

Prior authorization is no longer required on code K0457, "Extra wide/heavy duty commode chair." The allowable fee is now \$129.56.

Decubitus Care Equipment

The Medicare indicator for code E0191, "Heel or elbow protector," has been updated to reflect that the code is not covered by Medicare.

Miscellaneous Respiratory Care Supplies

Coding Revision: Codes for Miscellaneous Respiratory Care Supplies have been revised from "K" to "A" series codes.

The "A" codes are valid for dates of service on or after January 1, 2000.

The "K" codes are being discontinued and will not be valid for dates of service after March 31, 2000.

Providers should begin using "A" codes as soon as possible. Please refer to page 21 of the attached Medicaid Supply List for a list of miscellaneous respiratory care supplies, the new "A"

codes, and the corresponding discontinued "K" codes. Each discontinued "K" code is below the "A" code that has replaced it. Descriptions for the new "A" codes are slightly more descriptive than the "K" codes they are replacing.

Ventilators, CPAP, and Other Respiratory Equipment

Code E0453, "Therapeutic ventilator (IPPV)," has been discontinued effective June 30, 2000, and has been replaced by two codes, K0533 and K0534. E0453 will be payable for dates of service through June 30, 2000.

Code E0452, "Intermittent assist device with CPAP (APAP)," has been discontinued effective June 30, 2000, and has been replaced by code K0532. E0452 will be payable for dates of service through June 30, 2000.

The "K" codes are valid for dates of service on or after January 1, 2000. Providers should begin using the new "K" codes as soon as possible. Please refer to page 22 of the attached Medicaid Supply List for descriptions and billing information for codes K0533 and K0534, as well as code K0532.

Vaporizers/Postural Draining Boards

The description for code E0605 has been modified to read, "Vaporizer, room type." The reference to "Hot or cool mist" has been removed.

Suction Pumps and Suctioning Supplies

Coding Revision: Three codes for suction pumps and suctioning supplies have been revised from "K" to "A" series codes.

The "A" codes are valid for dates of service on or after January 1, 2000.

The "K" codes are being discontinued and will not be valid for dates of service after March 31, 2000. Prior authorizations issued for "K" codes are valid and will be payable for dates of service through June 30, 2000.

Providers should begin using "A" codes as soon as possible. Please refer to page 24 of the attached Medicaid Supply List for a list of suction pumps and suctioning supplies, the new "A" codes, and the corresponding discontinued "K" codes. Each discontinued "K" code is below the "A" code that has replaced it.

Wheelchairs-Miscellaneous Accessories

The maximum allowable fee for code E1065, "Power attachment (to convert any standard chair to motorized, e.g. Solo)," has been increased to \$2382.89.

Additions and changes to the Medicaid Supply List are effective for dates of service on and after January 1, 2000. For codes not requiring prior authorization, codes that have been deleted will not be valid for dates of service after March 31, 2000. For codes requiring prior authorization, codes that have been deleted will not be valid for dates of service after June 30, 2000.

B. Hospital Beds and Pressure Reducing Support Surfaces (OAC Rule 5101:3-10-18)

The previous version of OAC Rule 5101:3-10-18, "Hospital Beds," dated March 21, 1996, has been rescinded. It has been replaced with the attached new OAC Rule 5101:3-10-18, entitled "Hospital Beds and Pressure-Reducing Support Surfaces," **which is effective January 1, 2000**. The new rule includes clarifications of coverage criteria and medical necessity documentation requirements for hospital beds. The rule also includes revised coverage criteria and medical necessity documentation requirements for pressure-reducing support surfaces used in the treatment and management of pressure sores. Documentation requirements have been streamlined and coverage criteria has been updated in the new version of the rule to be consistent with current industry standards for treatment protocols.

C. Covered Orthotic and Prosthetic Services and Associated Limitations (OAC Rule 5101:3-10-20)

The "List of Covered Orthotic and Prosthetic Procedures," (Appendix A of OAC Rule 5101:3-10-20), has been updated to include the following changes. Fees have been increased for dates of service on or after January 1, 2000. Several new codes have been added, effective January 1, 2000. Several other codes which have been covered under Ohio Medicaid prior to January 1, 2000, have been added to the list as well. The effective date of those codes is indicated at the end of the description for the code. Additions to the list have been underlined.

Please review the attached rule, in its entirety, for all of the following changes, updates, additions, and deletions:

Prior Authorization Changes

Prior authorization is no longer required for the following codes unless the maximum limit is exceeded.

Please refer to the attached List of Covered Orthotic and Prosthetic Procedures for descriptions of these codes.

Code	Page
L2190	17
L2200	17
L2210	17
L2220	18
L2240	18
L2270	18
L2405	19
L2760	22
L2770	22
L2785	22
L2795	22
L2810	22
L2820	22
L2830	22
L2840	22
L3140	24
L3150	24
L3218	25

L3223	25
L3300	26
L3310	26
L3580	28

Lower Limb-Hip

Code L1690, "Combo, bilateral, lumbo-sacral, hip, femur orthosis," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per medical event.

Lower Limb-Knee

New code, L1843, "KO, single, upright, thigh and calf, with adjustable flexion and extension joint, medial-lateral and rotation control, custom fitted," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Code L1847, "KO, double upright with adjustable joint with air support cham.," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

New code, L1885, "KO, single or double upright, thigh and calf, with functional active resistance controls," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Lower Limb-Hip-Knee-Ankle-Foot (Or Any Combination)

New code, L2035, "KAFO, full plastic, static prefabricated, pediatric size" has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Code L2039, "KAFO, full plastic, single upright, poly-axial hinge molded to patient model, has been added to the list." The effective date of coverage of this code under Ohio Medicaid is January 1, 1998. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Additions-Shoe-Ankle-Shin-Knee

The description for code L2275 has been modified to read "Addition to lower extremity, varus/valgus correction, plastic modification, padded/lined."

Additions to Straight Knee or Offset Knee Joints

Code L2430, "Addition to lower extremity, orthosis, incr. lock at knee joint," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1998. Prior authorization is required and the maximum reimbursement is 2 per orthosis.

Additions-General

Code L2755, "Addition to lower extremity orthosis, carbon graphite lamination," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1998. Prior authorization is required and the maximum reimbursement is 4 per year.

Orthopedic Footwear

New code, L3224, "Orthopedic footwear, woman's shoe, oxford, used as an integral part of a brace (orthosis)" has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per foot per year.

New code, L3225, "Orthopedic footwear, man's shoe, oxford, used as an integral part of a brace (orthosis)" has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per foot per year.

Shoe Modification

The Medicare indicator for code L3332, "Lift, elevation, inside shoe, tapered up to one-half inch," has been modified to reflect that the code is not covered under Medicare.

Upper Limb-Shoulder

Code L3675, "SO, vest type abduction restrainer, canvas or equal" has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per medical event.

Upper Limb-Wrist-Hand-Finger

Code L3956, "Add. joint to upper extremity orthosis, any material," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1998. Prior authorization is required and the maximum reimbursement is 1 per medical event.

Splints

Code L4310, "Multi podus or equal orthotic preparatory management system for lower extremities," was discontinued effective March 31, 1999. It has been replaced by code L4396.

Code L4320, "Addition to AFO, multi podus (or equal) orthotic preparatory management system for lower extremities, flexible foot positioner with soft interface for AFO, with velcro closure, custom fitted," was discontinued effective March 31, 1999. It has been replaced by code L4392.

New code, L4392, "Replace soft interface material, ankle contracture splint," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per medical event.

New code, L4396, "Ankle contracture splint," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per medical event.

Additions To Lower Extremity New code, L5617, "Addition to lower extremity, quick change self-aligning unit, above knee or below knee, each," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

Endoskeletal

New code, L5814, "Addition, endoskeletal knee-shin system, polycentric, hydraulic swing phase control mechanical stance phase lock," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

New code, L5826, "Addition, endoskeletal knee-shin system, single axis, hydraulic swing phase control, with miniature high activity frame," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

New code, L5845, "Addition, endoskeletal knee-shin system, stance flexion feature, adjustable," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

New code, L5846, "Addition, endoskeletal knee-shin system, microprocessor control feature, swing phase only," has been added to the list. The effective date of coverage of this code under

Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

New code, L5930, "Addition, endoskeletal system, high activity knee control frame," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

Code L5968, "Addition to lower limb prosthesis, multiaxial ankle with swing phase active dorsiflexion feature," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Code L5975, "All lower extremity prostheses, combo single axial ankle," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

New code, L5981, "All lower extremity prostheses, flex walk system or equal," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 4 years.

New code, L5985, "All lower extremity prostheses, dynamic prosthetic pylon," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

New code, L5987, "All lower extremity prostheses, shank foot system with vertical loading," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Code L5988, "Addition to lower limb prosthesis, vertical shock reducing pylon feature," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

Additions-Upper Limb

Code L6693, "Upper extremity addition, locking elbow, forearm counterbalance," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

General-Breast Prostheses

Code L8015, "External breast prosthesis garment with form," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 3 per year.

Code L8035, "Custom breast prosthesis, molded to patient model," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 1 per 2 years.

General-Elastic Supports

Code L8195, "Gradient compression stocking waist lng. 30-40mm," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 1999. Prior authorization is required and the maximum reimbursement is 6 per year.

Prosthetic Socks

New code, L8417, "Prosthetic sock/sheath, including a gel cushion liner, below knee or above knee," has been added to the list. The effective date of coverage of this code under Ohio Medicaid is January 1, 2000. Prior authorization is required and the maximum reimbursement is 12 per year.

The description of code L8435 no longer includes the word "wool." The description for this code now reads, "Prosthetic sock, multi-ply, upper limb, each."

III. Billing Instructions:

A new "Billing Instructions" section of the Ohio Medicaid Provider Handbook is being included with this MAL. The Billing Instructions section sent in 1999 with MAL No. 377 should be removed and filed as obsolete and replaced with the attached Billing Instructions section included with this MAL.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43266-0161

In-state 1-800-686-6108 (toll free) or (614) 728-3288

Out of State: (614) 728-3288

Medicaid Handbook Transmittal Letters

MHTL 3344-13-01 (Rule 5160-10-11 Hearing Aids (Renumbered from 5101:3-10-11))

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-13-01

November 18, 2013

TO: Durable Medical Equipment (DME) Providers of Medicaid Services
Directors, County Departments of Job and Family Services
CEOs, Managed Care Plans

FROM: John B. McCarthy, Director

SUBJECT: Rule 5160-10-11 Hearing aids (renumbered from 5101:3-10-11)

Summary

The following rule was amended and filed to be effective for dates of service on and after December 1, 2013.

Rule [5160-10-11](#) (renumbered from 5101:3-10-11) titled, "Hearing aids," sets forth the coverage and reimbursement provisions for hearing aids. This rule was filed for five-year rule review. The changes to this rule include the following:

- The establishment of a certificate of medical necessity to be used by providers when requesting prior authorization for hearing aids.
- Updated language pertaining to hearing test results for adults.
- Updated language extending the coverage of digital hearing aids to adults.
- Updated language regarding the warranty for digital hearing aids.
- Updated language requiring prior authorization for CROS and BiCros hearing aids dispensed to adults.
- Updated language regarding the return of newly dispensed hearing aids.
- Updated language extending the coverage of bilateral hearing aids to adults.

Access to Rules and Related Material

The main ODJFS web page includes links to valuable information about its services and programs; the address is <http://www.jfs.ohio.gov>. The web page of the Ohio Department of Medicaid may be accessed through the ODJFS main page or directly at <http://www.jfs.ohio.gov/ohp/>.

ODJFS maintains an "electronic manuals" web page of the department's rules, manuals, transmittal letters, forms, and handbooks. The web address for this "eManuals" web page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

From the "eManuals" page, providers may view documents online by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' collection.
- (2) Select the appropriate service provider type or handbook.
- (3) Select the desired document type.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule 5160-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

- (1) Select the 'Ohio Health Plans - Provider' folder.
- (2) Select 'General Information for Medicaid Providers'.
- (3) Select 'General Information for Medicaid Providers (Rules)'.
- (4) Select '5160-1-60 Medicaid Reimbursement' from the 'Table of Contents' pull-down menu and then scroll down to the link to Appendix DD.

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DME Question Line and Mailbox

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MHTL 3344-12-02 (OAC Rule, 5101:3-10-24, Speech generating devices (SGD))

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-12-02

April 13, 2012

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services
Managed Health Care Plans

FROM: Michael B. Colbert, Director

SUBJECT: OAC Rule, 5101:3-10-24, Speech generating devices (SGD)

Summary

To comply with the requirements of the five-year rule review process, the Department has rescinded existing OAC rule 5101:3-10-24 and adopted a new replacement OAC rule 5101:3-10-24. This action is effective May 1, 2012. The new rule provides additional provider clarification in regards to the dispensing of SGD's to Medicaid consumers as well as provide new certificates of medical necessity (CMNs) for use by providers in order to facilitate the request for prior authorization of SGD devices.

Rule [5101:3-10-24](#), entitled "Speech generating devices (SGDs)", was codified to provide the most current medical necessity criteria for SGD's dispensed to Medicaid consumers.

Changes: This rule replaces former rule 5101:3-10-24, which was rescinded. This rule provides dispensing criteria for SGD's when provided to Medicaid consumers. This rule also introduces new certificates of medical necessity (CMNs) for use by providers in order to request the prior authorization of SGD services and related equipment under the Medicaid program.

The new CMNs for SGD services are appendixes to new rule 5101:3-10-24 and are as follows:

[JFS 02924](#) Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Initial Certification

[JFS 02925](#) Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Recertification

[JFS 02926](#) Certificate of Medical Necessity/Prescription Speech Generating Device (SGD)

Access to Rules and Related Material

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- (4) Select the desired item from the 'Table of Contents' pull-down menu.

Most current Medicaid maximum reimbursement amounts are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view this information by following these steps:

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- (2) Select 'General Information for Medicaid Providers'.
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Additional Information

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans, Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone (800) 686-1516

MHTL 3344-12-01 (2012 Regular File Durable Medical Equipment {DME})

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-12-01

March 27, 2012

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services
CEOs, Managed Health Care Plans

FROM: Michael B. Colbert, Director

SUBJECT: 2012 Regular File Durable Medical Equipment (DME)

Summary

Rule 5101:3-10-20 "Covered Orthotic & Prosthetic Services and Associated Limitations" has been amended to adopt the new Healthcare Common Procedure Coding System (HCPCS) 2012 codes. This rule is effective March 29, 2012 and replaces the emergency version of this rule which was effective December 30, 2011.

Rules 3-10-03 "Medicaid Supply List" and 3-10-06 "Prior Authorization" were also amended to provide additional provider clarification in regards to the dispensing of medical equipment and supplies provided by the Medicaid program.

Rule 3-10-06 "Prior Authorization," is being submitted for five-year rule review.

Rule 5101:3-10-03, "Medicaid Supply List," describes and defines general provisions for DME providers who dispense medical equipment to Ohio Medicaid consumers and provides a comprehensive listing of items currently reimbursed by Ohio Medicaid.

Changes: Updated the rule body and appendix of this rule to provide additional information regarding coverage indicators in the appendix to this rule. Added to this rule a new Certificate of Medical Necessity (CMN) form for providers to utilize to request prior authorization of medical supplies to be dispensed at quantities which exceed the maximum allowable.

Rule 5101:3-10-06, "Prior Authorization," describes and defines general provisions pertaining to prior authorization for DME providers who dispense medical equipment to Ohio Medicaid consumers.

Changes: Updated the rule body of this rule to remove references to an obsolete form in paragraph (A) (1). Added additional provider clarification in paragraph (A) (3).

Rule 5101:3-10-20, "Covered orthotic and prosthetic services and associated limitations," describes and defines general provisions for DME providers who dispense orthotic and prosthetic equipment to Ohio Medicaid consumers and provides a comprehensive listing of items currently reimbursed by Ohio Medicaid.

Changes: Updated the appendix to remove deleted HCPCS codes.

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Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone (800) 686-1516

MHTL 3344-11-05 (OAC Rules 5101:3-10-35 and 5101:3-10-20)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-11-05

August 26, 2011

TO: Eligible Providers of Durable Medical Equipment Services
Chief Executive Officers, Managed Care Plans (MCPs)
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OAC Rules 5101:3-10-35, Cranial orthotic remolding devices and OAC Rule 5101:3-10-20, Covered orthotic and prosthetic services and associated limitations

Summary

The following rules in this transmittal letter rule set forth specific coverage criteria and reimbursement for cranial orthotic devices and cochlear implant batteries and make available the appropriate Healthcare Common Procedure Coding System (HCPCS) for this equipment and related supplies.

Rule [5101:3-10-35](#), entitled "Cranial orthotic remolding devices," sets forth the medical criteria necessary for the dispensing of a cranial orthotic remolding device.

This rule defines the coverage and non-coverage criteria for the acquisition of cranial orthotic remolding devices. In addition, this rule contains provider instructions for submission of claims for the rendering of services to consumers utilizing cranial orthotic remolding devices.

Rule [5101:3-10-20](#), entitled "Covered orthotic and prosthetic services and associated limitations," sets forth information regarding the orthotic and prosthetic equipment and supplies covered by the Medicaid program.

Changes: This rule was amended to include the addition of cochlear implant batteries and cranial orthosis billing codes and related supplies. The codes added to the appendix of this rule are S1040, L7368, L8621, L8622, L8623, and L8624. Code L3230 (Orthopedic footwear) was updated in order to provide additional provider information.

Access to Rules and Related Material

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Most current Medicaid maximum reimbursement amounts are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view this information by following these steps:

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Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
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Telephone (800) 686-1516

MHTL 3344-11-04 (MITS-Related Changes to Rules in OAC Chapter 5101:3-10)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-11-04

July 28, 2011

TO: Eligible Providers of Durable Medical Equipment Services
Chief Executive Officers, Managed Care Plans (MCPs)
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: MITS-Related Changes to Rules in OAC Chapter 5101:3-10

Summary

The rules addressed in this transmittal letter are being amended for three reasons: (1) to comply with requirements of the five-year review process, (2) to update existing rule language, and (3) to support implementation of the Medicaid Information Technology System (MITS). MITS is Ohio Medicaid's new electronic claims submission interface and is scheduled to become operational on August 2, 2011, which is the effective date of these rules.

Rule Changes

Rule 5101:3-10-01, "Eligible providers," establishes provider enrollment criteria for the Ohio Medicaid Durable Medical Equipment (DME) program.

Changes: Language has been added to clarify the specific provider types that are eligible for a valid provider agreement with Ohio Medicaid.

Rule 5101:3-10-13, "Oxygen: covered services and limitations," establishes provisions for the supply of oxygen services to Medicaid consumers by providers of DME services.

Changes: Terminology has been updated. Coverage of oxygen services furnished by current providers has been clarified.

Rule 5101:3-10-26, "Enteral nutrition," establishes provisions for the supply of enteral products to Medicaid consumers by providers of DME services.

Changes: Terminology for providers of enteral services has been updated and clarified.

Rule 5101:3-10-31, "Therapeutic footwear for consumers with diabetes," establishes provisions for the supply of therapeutic footwear to Medicaid consumers by providers of DME services.

Changes: Language describing prior authorization submission requirements has been replaced with a reference to the appropriate rule. Terminology for providers of therapeutic footwear has been updated.

Rule 5101:3-10-32, "Ostomy and urological supplies," establishes provisions for the supply of ostomy and urological supplies to Medicaid consumers by providers of DME services.

Changes: Terminology for providers of ostomy and urological services has been updated and clarified.

Access to Rules and Related Material

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- (2) Select 'General Information for Medicaid Providers'.
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Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
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MHTL 3344-11-03 (OAC Rules 5101:3-10-03, Medicaid Supply List, 5101:3-10-20, Covered Orthotic & Prosthetic Services & Associated Limitations)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-11-03

March 28, 2011

TO: Eligible Providers of Durable Medical Equipment Services
Chief Executive Officers, Managed Care Plans (MCPs)
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OAC Rules 5101:3-10-03, Medicaid Supply List, 5101:3-10-20, Covered Orthotic & Prosthetic Services & Associated Limitations

Summary

The following rules in this transmittal letter have been amended to comply with requirements of the five-year rule review process and to adopt the new Healthcare Common Procedure Coding System (HCPCS) 2010 and 2011 codes. These rules are effective March 30, 2011 and replace emergency versions of these rules which were effective December 30, 2010. These rules were also amended to provide additional provider clarification in regards to the dispensing of medical equipment and supplies.

Rule Changes

Rule [5101:3-10-03](#), entitled "Medicaid Supply List," sets forth the list of durable medical equipment and supplies covered by the Medicaid program.

Changes: This rule was amended to delete obsolete codes and add new codes in accordance with changes made by the American Medical Association (AMA) to the 2010 and 2011 Healthcare Common Procedure Coding System (HCPCS). The rule was modified to reflect the provisions reflected in OAC rules 5101:3-3-19 and 5101:3-3-19.1 regarding the medical supplier services which are reimbursable directly to the medical supply provider for consumers residing in a nursing facility or intermediate care facility for the mentally retarded. Further clarification is being provided to the change effective on January 1, 2010 which lowered the monthly allowed amount without a prior authorization of incontinence codes T4535 and T4538 for adults age 21 years or older from 300 units per month to 200 units per month. In addition, wheelchair code E2377 is being authorized for separate reimbursement upon initial issue of a wheelchair.

This rule was also amended to add clarifying paragraphs to the sections that pertain to urological, ostomy and wound supplies as well as ventilator equipment. This clarification was added to remind providers to review specific program coverage criteria contained in OAC Chapter 5101:3-10 prior to dispensing these items. Clarifying rule language was added to provide stakeholders with additional information regarding the "Max Units" indicator in appendix A.

Rule [5101:3-10-20](#), entitled "Covered orthotic and prosthetic services and associated limitations," sets forth information regarding the orthotic and prosthetic equipment and supplies covered by the Medicaid program.

Changes: This rule was amended to include the deletion of obsolete codes in accordance with changes made by the AMA to the 2010 and 2011 HCPCS coding system.

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Office of Ohio Health Plans, Bureau of Provider Services
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Telephone (800) 686-1516

MHTL 3344-11-02 (OAC Rules 5101:3-10-16.1 Wheelchair rentals, 5101:3-10-21 Incontinence garments and related supplies, 5101:3-10-25 Lactation pumps, and 5101:3-10-27 CPM devices)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-11-02

April 21, 2011

TO: Eligible Providers of Durable Medical Equipment Services
Chief Executive Officers, Managed Care Plans (MCPs)
Directors, County Departments of Job and Family Services

FROM: Michael B. Colbert, Director

SUBJECT: OAC Rules 5101:3-10-16.1 Wheelchair rentals, 5101:3-10-21 Incontinence garments and related supplies, 5101:3-10-25 Lactation pumps, and 5101:3-10-27 Continuous passive motion (CPM) devices

Summary

The following rules in this transmittal letter have been amended to comply with requirements of the five-year rule review process and to provide further clarification of existing criteria for these durable medical equipment (DME) services. The effective date of these rule changes is April 25, 2011.

Rule Changes

Rule [5101:3-10-16.1](#), entitled "Wheelchair rentals," sets forth the program coverage and limitation criteria for wheelchair rental services provided to Medicaid consumers.

Changes: This rule was amended to provide further clarification of existing criteria for this service by adding additional rule language to paragraph (C) of this rule.

Rule [5101:3-10-21](#), entitled "Incontinence garments and related supplies," sets forth the program coverage and limitation criteria for the supply of incontinence garments provided to Medicaid consumers.

Changes: This rule was amended to provide further clarification of existing criteria for the dispensing of incontinence garments and related supplies. In addition, a new certificate of medical necessity (CMN) has been codified in this rule. This CMN is used by providers in order to document and, when applicable, request the prior authorization of incontinence products under the Medicaid program.

Rule [5101:3-10-25](#), entitled "Lactation pumps," sets forth the program coverage and limitation criteria for the supply of these items to Medicaid consumers.

Changes: This rule was amended to provide further clarification regarding the coverage criteria necessary for the dispensing of lactation pumps to Medicaid consumers. In addition, a new certificate of medical necessity (CMN) has been codified in this rule. This CMN is used by providers in order to document and, when applicable, request the prior authorization of lactation devices under the Medicaid program.

Rule [5101:3-10-27](#), entitled "Continuous passive motion (CPM) devices," sets forth the program coverage and limitation criteria for CPM equipment provided to Medicaid consumers.

Changes: This rule was amended to provide further clarification of existing criteria for this service by adding additional rule language to paragraphs (C), (D) and (E) of this rule.

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MHTL 3344-11-01 (Reimbursement Changes for Durable Medical Equipment (DME) Codes)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-11-01

January 31, 2011

To: All Eligible Providers of Durable Medical Equipment Services
Medicaid Managed Care Plans
Directors, County Departments of Job and Family Services

From: Michael B. Colbert, Interim Director

Subject: Reimbursement Changes for Durable Medical Equipment (DME) Codes

Changes effective December 7, 2010

In accordance with changes to Appendix DD of amended OAC rule 5101:3-1-60, effective December 6, 2010, the following Healthcare Common Procedure Coding System (HCPCS) codes are discontinued effective for dates of service on or after December 7, 2010 and no longer available to be utilized for billing Ohio Medicaid:

- L0210 Thoracic, rib belt
- L1800 Knee Orthosis
- L1815 Knee Orthosis
- L1825 Knee Orthosis
- L1901 Ankle Orthosis
- L2770 Addition to lower extremity Orthosis
- L3700 Elbow Orthosis
- L3701 Elbow Orthosis
- L3909 Wrist Orthosis
- A6200 Composite dressing, pad 16 sq. in.
- A6201 Composite dressing, pad more than 16 sq. in.
- A6202 Composite dressing, pad more than 48 sq. in.
- A6542 Gradient compression stocking, custom
- E2223 Manual wheelchair accessory, valve

Effective for dates of service on or after December 7, 2010 the following Healthcare Common Procedure Coding System (HCPCS) codes are available to be utilized for billing Ohio Medicaid:

- A4466 Garment, belt, sleeve or other covering, elastic, any type, ea
2 yr., prior authorization not required
- E2377 Power wheelchair accessory, expandable controller
1/5yrs., prior authorization is required

The reimbursement rates for the above codes are notated in Appendix DD of OAC rule 5101:3-1-60.

Any necessary changes to the Medicaid supply list OAC rule 5101:3-10-03 and the Orthotics and Prosthetic supply list OAC rule 5101:3-10-20 as a result of these reimbursement changes will be made by the department at a future date.

DME Question Line and Mailbox:

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests to include the initiation or status of a prior authorization or information regarding previous claims submissions for durable medical equipment.

Web Page:

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To receive electronic notification when new Medicaid transmittal letters are published, subscribe at <http://www.odjfs.state.oh.us/subscribe/>.

Questions pertaining to this MHTL should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus OH 43216-1461
800-686-1516

MHTL 3344-10-01 (Changes to Coverage of Prescription Drugs and Certain DME Supplies)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-10-01

January 25, 2010

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes to Coverage of Prescription Drugs and Certain Durable Medical Equipment (DME) supplies

This letter provides information regarding changes to coverage of certain medical supplies for all Ohio Medicaid consumers, including members of Medicaid Managed Care Plans (MCPs). To support these changes, amendments are being made to Ohio Administrative Code (OAC) rule 5101:3-9-02 (Pharmacy Services: Medical Supplies and Durable Medical Equipment) and OAC [5101:3-10-17](#) (Blood Glucose Monitors [Glucometers] and Supplies) is being rescinded.

Changes To Billing of Certain Medical Supplies

OAC 5101:3-9-02, entitled " Pharmacy Services: Medical Supplies and Durable Medical Equipment" is being amended to change the way certain medical supplies are billed. Beginning with date of service February 1, 2010, only pharmacy providers will be able to bill for the supplies listed in the table below. These supplies should be billed using the NDC on the package through the pharmacy point-of-sale (POS) claim system, and can no longer be billed on a medical claim (CMS-1500 claim form or 837P EDI claim transaction). Claims that were billed to Medicare Part B or a Medicare Advantage plan as the primary payer are not affected by this change and will continue to be paid when billed on a medical claim.

The supplies affected by this change are listed in the table. The Healthcare Common Procedure Coding System (HCPCS) code is listed in the table for reference only. Beginning with date of service February 1, 2010, these supplies will be paid by the NDC number instead of the HCPCS code.

HCPCS Code	Description
A4206	Syringe with needle, sterile less than or equal to 1 cc
A4215	Needles only, sterile, any size, including pen needles
A4245	Alcohol wipes or swabs, box
A4250	Urine test or reagent strips or tablets (100 tablets or strips)
A4252	Blood ketone test or reagent strip, each
A4253	Blood glucose test or reagent strips for home blood glucose monitor, per 50
A4256	Normal, low high calibration solutions/chips (pkg)
A4258	Spring powered device for lancet
A4259	Lancets, per box of 100

E0607	Home blood glucose monitor complete
E2100	Blood glucose monitor with voice (PA required)
E2101	Blood glucose monitor with integrated lancing/blood sample (PA required)
S5560	Insulin delivery device, reusable pen; 1.5ml size
S5561	Insulin delivery device, reusable pen; 3ml size
A4614	Peak Expiratory Flow Rate Meter
A4627	Spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler

In addition to the products listed in the table condoms (male or female) may be billed through the pharmacy POS billing system. For Medicaid fee-for-service consumers, condoms may also be billed by other providers, such as clinics and DME dealers, that are registered with ODJFS to bill medical supplies. For MCP members, check with the MCP for coverage of condoms through provider types other than pharmacies. Limits and reimbursements for these supplies that are billed through the pharmacy billing system are listed in Appendix A of OAC 5101:3-9-02.

Amendments are also being made to OAC 5101:3-10-03 (Medicaid Supply List) and 5101:3-1-60 (Medicaid Reimbursement) to remove coverage of these HCPCS codes from the medical benefit under the durable medical equipment (DME) fee for service program effective February 1, 2010.

DME Question Line and Mailbox:

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests to include the initiation or status of a prior authorization or information regarding previous claims submissions for durable medical equipment.

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- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates for services other than pharmacy services and the medical supplies listed in this MHTL are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3344-09-06 (Community Provider Fee Decrease)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-09-06

January 8, 2010

TO: All Eligible Durable Medical Equipment Suppliers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

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- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3344-09-05 (Rules 5101:3-10-04, 5101:3-10-19, and 5101:3-10-34)

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-09-05

January 5, 2010

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OAC Rules 5101:3-10-04, Pneumatic Compression Devices and Accessories, 5101:3-10-19, Definitions of terms associated with orthotic and prosthetic services and 5101:3-10-34, Surgical Dressings and Related Supplies

Rule Changes

Rule changes to be effective January 7, 2010.

Rule [5101:3-10-04](#), entitled Pneumatic Compression Devices and Accessories, specifies coverage and non-coverage criteria for Medicaid supplied pneumatic compression devices. This is a new rule intended to clarify existing program coverage and limitations.

Rule [5101:3-10-19](#), entitled Definitions of terms associated with orthotic and prosthetic services, specifies definitions of clinical terms associated with the delivery of orthotic and prosthetic services for the Medicaid program. Only minor grammatical changes have been made in the body of this rule. This rule is also being filed to comply with 119.032 five-year rule review.

Rule [5101:3-10-34](#), entitled Surgical Dressings and Related Supplies, specifies coverage and non-coverage criteria for Medicaid supplied surgical dressings and associated supplies. This is a new rule intended to clarify existing program coverage and limitations.

DME Question Line and Mailbox:

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests to include the initiation or status of a prior authorization or information regarding previous claims submissions for durable medical equipment.

Webpage:

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- (2) Selecting the appropriate topic from the document list; and
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Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MHTL 3344-09-04

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-09-04

October 30, 2009

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OAC Rules 5101:3-10-13.1 Oxygen: Covered Services and Limitations in an Intermediate Care Facility for the Mentally Retarded (ICF-MR), 5101:3-10-08 Repair of Medical Equipment, 5101:3-10-03 Medicaid Supply List, and 5101:3-10-16 Wheelchairs

Rule Changes

Rule changes effective August 1, 2009.

These rules were amended as a result of Amended Substitute House Bill 1 which changed how Medicaid reimburses some services provided to nursing facility (NF) residents. These services, which include oxygen; custom wheelchairs and repair; physical, occupational and speech language pathology/audiology therapy; medical transportation (ambulance and ambulette); and some over-the-counter drugs, were previously provided by, and reimbursed to, fee-for-service providers. Amended Substitute House Bill 1 changed this arrangement by making NFs responsible for providing these services to Medicaid NF residents and by reimbursing NFs for the services through the facility cost report mechanism. Payments for these services are included in the nursing facility per diem.

Rule [5101:3-10-03](#), entitled Medicaid Supply List, sets forth a listing of medical/surgical supplies, durable medical equipment and supplier services covered by the Ohio Medicaid program. Appendix A to this rule was amended to specify that the coverage of oxygen and wheelchairs under this rule applies only to residents of Intermediate Care Facilities for the Mentally Retarded (ICFs-MR), and not to residents of NFs. This rule was also submitted for five year rule review.

Rule [5101:3-10-08](#), entitled Repair of Medical Equipment, sets for the coverage criteria for the repair of medical equipment. This rule was amended to set forth that the repair of all wheelchairs in a NF is the responsibility of the NF and reimbursable to the NF through the facility cost report mechanism. This rule was also submitted for five year rule review.

Rule [5101:3-10-13.1](#), entitled Oxygen: Covered Services and Limitations in a Long Term Facility (LTCF), sets forth the coverage and reimbursement criteria for oxygen provided to residents of long term care facilities, which includes both ICFs-MR and NFs. This rule was amended to set forth that the provision of oxygen services to residents of a NF is the responsibility of the NF and reimbursable through the facility cost report mechanism. The coverage of, and reimbursement for, oxygen services supplied to residents of an ICF-MR remain unchanged. This rule was also submitted for five year rule review.

Rule [5101:3-10-16](#), entitled Wheelchairs, sets forth the coverage and reimbursement criteria for wheelchairs. This rule was amended to set forth that the provision of wheelchairs, including all parts, options, accessories and repairs, to residents of a NF is the responsibility of the NF and reimbursable through the facility cost report mechanism. This rule was also submitted for five year rule review.

DME Question Line and Mailbox:

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Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
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Questions:

Questions pertaining to this MHTL should be directed to the following:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3344-09-03

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-09-03

August 10, 2009

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OAC Rules 5101:3-10-30, Canes, Crutches and Walkers , 5101:3-10-32, Ostomy and Urological Supplies and 5101:3-10-33, Commodes

Rule Changes

Rule changes to be effective August 17, 2009.

These rules are new additions to Medicaid for items currently dispensed under the DME program and are intended to clarify existing program coverage and limitations.

Rule [5101:3-10-30](#), entitled Canes, Crutches and Walkers, specifies coverage and non-coverage criteria for canes, crutches and walkers.

Rule [5101:3-10-32](#), entitled Ostomy and Urological Supplies, specifies coverage and non-coverage criteria for ostomy and urological supplies.

Rule [5101:3-10-33](#), entitled Commodes, specifies the coverage and non-coverage criteria for commodes.

DME Question Line and Mailbox:

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- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Office of Ohio Health Plans
Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MHTL 3344-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-09-02

June 30, 2009

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OAC Rule 5101:3-10-03, Medicaid supply list

Rule Clarification

Rule 5101:3-10-03, entitled "Medicaid supply list", contains information and program limits regarding the durable medical equipment and supplies covered by the Medicaid program. In response to stakeholder requests for policy clarification pertaining to this rule the Department would like to provide the following guidance pertaining to Appendix A to rule 5101:3-10-03.

Since November 2007, Ohio Medicaid has established or corrected automated prepayment edits in its claims processing system for durable medical equipment (DME) items, based on established program limits. These prepayment edits prevent the Medicaid claims processing system from automatically paying claims for units of DME above the maximum allowable unit limits established for each DME item on the Medicaid Supply List (Appendix A to OAC rule 5101:3-10-03). For example, if 12 units of a DME supply item with a "10 per month" unit limit are dispensed to a consumer, and the provider submits a properly completed claim to Medicaid requesting payment for 12 individual units of the supply item, the Medicaid claims processing system will pay for 10 units and deny payment for two units. The entire claim will not be denied. Claims for units of DME above the maximum allowable unit limits must be approved through the prior authorization process before payment for such units will be allowed by Medicaid.

For DME items with monthly maximum allowable unit limits (e.g., 10 per month, 300 per month, 1 every 3 months), months are measured as calendar months. For example, if 10 units of a DME supply item with a "10 per month" unit limit are dispensed to a consumer on May 30th, the provider would be able to re-dispense up to 10 units of the same supply item to the same consumer on or after June 1st. For DME items with yearly maximum allowable unit limits (e.g., 1 per year, 50 per year, 1 every 4 years), years are measured as rolling years, consisting of 12 calendar months. For example, if a DME item with a "1 per year" unit limit is dispensed to a consumer on May 15th of the current year, the provider would be able to re-dispense the same item to the same consumer on or after May 1st of the next calendar year. All maximum allowable unit limits are per consumer.

The implementation of prepayment edits for DME items is an ongoing process. All current and future DME claims are subject to these edits. It is the responsibility of each provider to know and follow program rules and to submit claims only within program limits. Any payments made in error, contrary to program coverage or based on misrepresentation, fraud or abuse are subject to recovery.

DME Question Line and Mailbox:

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests to include the initiation or status of a prior authorization or information regarding previous claims submissions for durable medical equipment.

Webpage:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>. Providers may view documents online by:

(1) Selecting the "Ohio Health Plans - Provider" folder;

- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents"

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MHTL 3344-09-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-09-01

April 3, 2009

TO: All Eligible Providers of Durable Medical Equipment Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: OAC Rules 5101:3-1-60, Medicaid reimbursement, 5101:3-10-20, Covered orthotic and prosthetic services, 5101:3-10-03, Medicaid supply list, 5101:3-10-15, Transcutaneous electrical nerve stimulators (TENS), 5101:3-10-08, Repair of medical equipment and 5101:3-10-18, Hospital beds, pressure-reducing surfaces and accessories

Rule Changes

Rule changes to be effective April 1, 2009.

Rule [5101:3-1-60](#), entitled "Medicaid reimbursement", sets forth the reimbursement policies for all professional providers. Changes included the addition of new codes, deletion of obsolete or discontinued codes, and revision of definitions and current reimbursement amounts for various medical equipment codes. Changes also included the creation of reimbursement amounts for the 2009 codes and discontinuing the reimbursement amounts for codes obsolete, discontinued or eliminated from program coverage. Some of the coding changes required amendments to existing policy on coverage.

The reimbursement amounts for specific durable medical equipment (DME) codes for which the Ohio rate would have been in excess of the comparable medicare rate as of January 1, 2009 were reduced. The average rate reduction over the DME codes is approximately 10 percent, of which five percent is attributable to aligning the medicaid rate with that of medicare and five percent is attributable to a cost-savings initiative.

Rule [5101:3-10-20](#), entitled "Covered orthotic and prosthetic services and associated limitations", sets forth information regarding the orthotic and prosthetic equipment and supplies covered by the medicaid program. Changes included the addition of new codes, deletion of obsolete codes and revision of definitional codes. Some of the coding changes required amendments to existing policy on coverage.

Rule [5101:3-10-03](#), entitled "Medicaid supply list", sets forth information regarding the durable medical equipment and supplies covered by the medicaid program. The appendix to this rule was amended to reflect changes in program coverage to include the addition of new codes and the deletion of codes that are being removed from program coverage and to require DME prescribers and providers to comply with federal anti-kickback regulations. The body of this rule was also amended in order to update and clarify coverage criteria for DME.

Rule [5101:3-10-15](#) entitled "Transcutaneous electrical nerve stimulators (TENS)", sets forth program policy pertaining to the supply of TENS units and was filed for policy amendments to reflect that prior authorization of this equipment will no longer be required for the supply of this equipment. This rule was also amended primarily to make the rule reflective of recent program changes in regards to the program coverage of TENS units. This rule has had additional coverage criteria added to it as well as revisions to the certificate of medical necessity (CMN) JFS 03402 (10/2008) Certificate of Medical Necessity/Prescription transcutaneous electrical nerve stimulators (TENS) which will be utilized by providers to document in their records the medical necessity of a TENS unit. Revisions to the rule body of this rule include but are not limited to:

- A trial period of 30 days before TENS is dispensed, up from 14 days in the current rule.
- The addition of a limitation that when a TENS unit is used for post-operative pain, reimbursement is limited to 30 days after surgery
- Requirement that, before TENS is available, other appropriate treatment modalities have been tried and failed.
- Temporomandibular joint disorder (TMJ) is eliminated as a condition for which a TENS unit is available.

- Disorders of the sacrum are eliminated as conditions for which a TENS unit is available.

Rule changes to be effective April 9, 2009.

Rule [5101:3-10-08](#), entitled "Repair of medical equipment", sets forth information regarding the necessary criteria for a provider to file a reimbursement claim to Medicaid for the repair of medical equipment. This rule was amended to revise and clarify program policy regarding the repair of durable medical equipment (DME) to include provisions for repairs resulting from malicious damage. A new certificate of medical necessity (CMN) JFS 01904 (4/2009) "Certificate of Medical Necessity/Prescription repair of durable medical equipment (DME)" was added as an appendix to this rule in order to facilitate the prior authorization for the repair of DME in lieu of a written prescription. In addition, the reimbursement rate for the repair of hearing aids was amended to reflect a program increase from the present rate of one hundred and ten per cent of the provider's invoice cost to one hundred and twenty five per cent of the provider's invoice cost.

Rule [5101:3-10-18](#), entitled "Hospital beds, pressure-reducing surfaces and accessories" specifies coverage and non-coverage criteria for hospital beds, pressure-reducing surfaces and accessories when supplied to a consumer in a private residence. This rule was updated in order to introduce new rule terminology and to codify new certificates of medical necessity (CMNs) as appendices to this rule.

[JFS 02904](#) (4/2009) Certificate of Medical Necessity/ Prescription "Decubitus Care Equipment (Pressure Reducing Support Surfaces)" was codified for providers of decubitus care equipment to utilize when seeking prior authorization.

[JFS 02910](#) (4/2009) Certificate of Medical Necessity/Prescription "Hospital Beds" was codified for providers of hospital beds to utilize when seeking prior authorization.

DME Question Line and Mailbox:

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions.

Webpage:

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- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
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Most current Medicaid maximum reimbursement rates are listed in rule 5101:3-1-60 or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Paper Distribution:

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments other than the appendix to rule 5101:3-1-60 by completing the JFS

03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, OH 43216-1461

Telephone 800-686-1516

MHTL 3344-07-05

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-07-05

January 7, 2008

TO: Eligible Providers of Durable Medical Equipment
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: E. Jones-Kelley, Director

SUBJECT: OAC Rules 5101:3-10-03, Medicaid supply list , 5101:3-10-20 Covered orthotic and prosthetic services and associated limitations, 5101:3-10-10 Dialysis equipment and 5101:3-10- 22 Volume ventilators, positive and negative pressure ventilators, continuous positive airway pressure (CPAP), alternating positive airway pressure (APAP), and intermittent positive pressure ventilation (IPPV)

Rule Changes

Rule changes to be effective December 16, 2007.

Rule 5101:3-10-03, entitled "Medicaid supply list," sets forth the durable medical equipment and supplies covered by the Medicaid program. Changes to the rule include the addition of elastic support supply codes to the appendix in response to stakeholder input that these items are not subject to licensure requirements currently administered by the Ohio Board of Orthotics, Prosthetics and Pedorthics. In addition, updated prior authorization information for both oxygen and nebulizer codes has been added to the appendix of this rule as follows:

OXYGEN SERVICES FOR CONSUMERS NOT HAVING DOCUMENTED TYPE I OR TYPE II HYPOXEMIA DO REQUIRE PA. REFER TO OAC RULE 5101:3-10-13 FOR FURTHER DETAILS.

EFFECTIVE FOR DATES OF SERVICE AFTER 12/6/07, E0570-(NEBULIZER) IS COVERED WITHOUT PRIOR AUTHORIZATION FOR CONSUMERS WHO HAVE A DOCUMENTED ICD-9 RESPIRATORY SYSTEM DIAGNOSIS (464, 466, OR 480-519).

PRIOR AUTHORIZATION IS REQUIRED FOR E0570 FOR CONSUMERS WHO DO NOT HAVE ONE OF THE DIAGNOSES SPECIFIED ABOVE.

Rule 5101:3-10-20, entitled "Covered orthotic and prosthetic services and associated limitations," sets forth the orthotic and prosthetic equipment and supplies covered by the Medicaid program. Changes to the rule include the removal of supply codes for elastic supports from the appendix of this rule. The codes for these items will now be located in the appendix of OAC rule 5101:3-10-03.

Rule changes to be effective January, 1, 2008.

Rule 5101:3-10-10, entitled "Dialysis equipment," sets forth instruction to providers pertaining to the equipment and supplies necessary for use by the home dialysis consumer. This rule was revised in order to update rule terminology and references.

Rule 5101:3-10-22, entitled "Volume ventilators, positive and negative pressure ventilators, continuous positive airway pressure (CPAP), alternating positive airway pressure (APAP), and intermittent positive pressure ventilation (IPPV)," sets forth instruction to providers pertaining to ventilation services and the supply of DME equipment and supplies currently listed on the Department's medical supply list.

This rule was amended to provide enhanced stakeholder guidance for the supply and repair of CPAP, APAP and IPPV equipment for Medicaid consumers. This rule also introduces two new certificates of medical necessity (CMNs) for use in the prior authorization of ventilator services. These forms are as follows:

JFS 01902 "Certificate of Medical Necessity/Prescription Mechanical Ventilators"

JFS 01903 "Certificate of Medical Necessity/Prescription IPPV or APAP in lieu of a Volume Ventilator"

In addition, heated humidifiers will no longer be reimbursed separately when used in conjunction with a ventilator rental as this item is now considered included in the monthly rental payment for the ventilator.

Oxygen Services

It is not necessary for a provider to complete a new CMN (JFS 01909) for any consumer currently receiving oxygen services who had an existing CMN or prior authorization on file that is less than twelve months old from the initial date of service prior to November 1, 2007.

Any newly established CMN or re-certifications of an existing CMN for oxygen services starting on or after November 1, 2007 require the oxygen provider to complete and maintain on file CMN form JFS 01909. All oxygen CMN's must be renewed once a year thereafter or whenever there is a change in the consumers treatment plan that requires a change in the consumers oxygen prescription.

Any oxygen claims for consumers in a LTCF (long term care facility) do not have to be submitted to the Medicare program prior to submission to the Ohio Department of Job and Family Services (ODJFS) for claims processing.

DME Question Line and Mailbox

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions. For such questions, providers should utilize the Interactive Voice Response (IVR) system at 1-800-686-1516.

Webpage Resources for Durable Medical Equipment Providers

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Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate topic from the document list; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

Providers may view current reimbursement rates online by:

- (1) Selecting the "Legal Services" folder;
- (2) Selecting "ODJFS Ohio Administrative Code"; and
- (3) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

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Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

ODJFS Forms

Department forms can be accessed at the following URL:

<http://www.odjfs.state.oh.us/forms/inter.asp>.

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-07-04

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-07-04

September 14, 2007

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECTS: OAC Rules 5101:3-10-13, entitled Oxygen: covered services and limitations in a private residence, and 5101:3-10-13.1 Oxygen: covered services and limitation in a LTCF (long term care facility).

New Certificate of Medical Necessity (JFS 01909).

Oxygen Coding Changes.

Prior Authorization of Covered Oxygen Services in a Private Residence.

Rule changes are effective November 1, 2007.

Rule Changes

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of the rescission and revision to the following oxygen rules and service codes:

Rule 5101:3-10-13, entitled Oxygen: covered services and limitations, which previously set forth the provisions for the supply of oxygen services to Medicaid consumers in personal residences and long term care facilities was rescinded in order to file new rules to address Medicaid's updated coverage criteria for oxygen services. This rule was replaced by new rules 5101:3-10-13 and 5101:3-10-13.1.

Rule 5101:3-10-13, entitled Oxygen: Covered services and limitations in a private residence, was adopted to address updated coverage criteria for oxygen services. This rule contains the coverage and reimbursement provisions for oxygen services when delivered in a private residence. The rule specifies coverage criteria, medical necessity and prior authorization requirements for consumers. Please note that for the majority of Medicaid consumers, prior authorization for oxygen services in a private residence will not be necessary. Prior authorization will be required only for consumers not meeting the clinical criteria for significant hypoxemia as defined in paragraph (B) of this rule. Details are provided for the use of program modifiers and payment for services rendered. This rule also details the use of designated billing codes for oxygen services rendered in a private residence and the changing of the reimbursement methodology for oxygen concentrators. Reimbursement for oxygen concentrators will no longer be based on the monthly utilization of oxygen consumed and will instead be reimbursed based on the monthly possession of an oxygen concentrator regardless of usage. The new codes pertaining to "Trans-Fill" and portable oxygen concentrator technology are also being implemented in this rule.

Rule 5101:3-10-13.1, entitled Oxygen: covered services and limitation in a LTCF (long term care facility), has been adopted to address updated coverage criteria for oxygen therapy services when delivered in a long term care facility (LTCF). Details are provided for the use of program modifiers and payment for services rendered. This rule also details the use of designated billing codes for oxygen services rendered in a LTCF and the changing of the reimbursement methodology for oxygen concentrators. Reimbursement for oxygen concentrators will no longer be based on the monthly utilization of oxygen consumed and will instead be reimbursed based on the monthly possession of an oxygen concentrator regardless of usage.

Certificate of medical necessity (JFS 01909, rev. 6/2005)

Rules 5101:3-10-13 and 5101:3-10-13.1 also introduce a new certificate of medical necessity (JFS 01909, rev. 6/2005) that must be completed in conjunction with the prior authorization request for the coverage of

oxygen services for a medicaid consumer and must be maintained on file by providers if prior authorization is not required. This form will standardize documentation of the program criteria necessary to demonstrate medical necessity and will facilitate the processing of prior authorization requests for oxygen services when prior authorization is required. The use of JFS 01909 is mandatory for dates of service on or after November 1, 2007.

Prior Authorization of Covered Oxygen Services in a Private Residence

Any existing or pending prior authorization for codes that will no longer be covered for dates of service on or after November 1, 2007 will need to be resubmitted to the Department using the appropriate covered HCPCS codes only if prior authorization is necessary under the new clinical criteria for oxygen services provided as per OAC rule 5101:3-10-13. Existing prior authorizations for oxygen services in a personal residence that no longer require prior authorization under the newly established oxygen rules should be kept in the provider's files. Existing prior authorization numbers for oxygen services in a personal residence will no longer be required for payment for dates of service on or after November 1, 2007.

Oxygen Coding Changes

The Department is providing notification of the following HCPCS coding changes for oxygen services. This notification allows sufficient time for providers to establish revised billing practices for oxygen services.

The following HCPCS codes will not be valid for reimbursement for dates of service on or after November 1, 2007:

- E1353 Oxygen regulator
- Q0036 Oxygen concentrator, including supplies
- Q0040 Portable oxygen contents
- Q0046 Portable oxygen system rental
- Y2076 Oxygen concentrator, for LTCF residents
- Y2078 Oxygen contents, gas, for LTCF residents
- Y2079 Oxygen contents, liquid, for LTCF residents
- Y2080 Portable oxygen contents, for LTCF residents
- Y2081 Oxygen, LTCF, 501-750 CU FT or 41-60 lbs
- Y2082 Oxygen, LTCF, 251-500 CU FT or 21-40 lbs
- Y2083 Oxygen, LTCF, 0-250 CU FT or 0-20 lbs

The following HCPCS codes will be valid for reimbursement for dates of service on or after November 1, 2007:

- E0431 Portable gaseous oxygen system, rental
- E0434 Portable liquid oxygen system, rental
- E1390 Oxygen concentrator, single port, LTCF only
- E1391 Oxygen concentrator, dual port, LTCF only
- E1390U1 Oxygen concentrator, single port (private residence)
- E1391U1 Oxygen concentrator, dual port (private residence)
- E1392 Portable oxygen concentrator
- K0738 Portable gaseous oxygen system, rental, transfill

Providers submitting claims for oxygen services using the inappropriate HCPCS code or modifiers for the location in which the service was provided will be denied as "invalid place of service." Providers not using the U1 modifier for oxygen concentrator services provided in a private residence will be reimbursed at the rate for these codes currently codified in Appendix DD of OAC rule 5101:3-1-60.

Providers are responsible to be familiar with the provisions of OAC rules 5101:3-10-13 and 5101:3-10-13.1 in their entirety prior to submitting any reimbursement claims for dates of service on or after November 1, 2007 to ensure program compliance with newly established criteria for the provision of oxygen services for the fee-for-service Medicaid program.

DME Question Line and Mailbox

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions. For such questions, providers should utilize the Interactive Voice Response (IVR) system at 1-800-686-1516.

Webpage Resource for Home and Durable Medical Equipment Providers

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter, and any attachments, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Durable Medical Equipment."
- (3) From the "Table of Contents" dropdown, select the transmittal letter number.

Providers will receive one hard copy of this transmittal letter and, if there are attachments, one hard copy of the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family according to the instructions at the top of the form.

ODJFS Forms

Department forms can be accessed at the following URL:

<http://www.odjfs.state.oh.us/forms/inter.asp>.

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-07-03

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-07-03

August 6, 2007

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OAC Rule 5101:3-10-03 Medicaid supply list

Rule change is effective July 30, 2007 and contains coding changes pertaining to oxygen services that will be effective for dates of service on or after November 1, 2007.

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revision to the following rule:

Rule 5101:3-10-03 entitled "Medicaid supply list" was amended primarily to reflect changes in coding due to new and revised codes for the Medicaid oxygen program. The intent of the amendment is not to change what is covered, but to replace several local-level oxygen codes with Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant Healthcare Common Procedure Coding System (HCPCS) codes and to remove the prior authorization requirements for certain covered medical supplies. In addition, the rule body of this rule is being amended to remind providers of the requirement to be compliant with the Home Medical Equipment (HME) licensure provisions of Chapter 4752 of the Revised Code administered by the Ohio Respiratory Care Board.

The following HCPCS codes were removed from the list of medical supplies requiring prior authorization for dates of service on or after July 30, 2007:

- B4220 Parenteral supply kit, premix, per day
- B4222 Parenteral supply kit, home mix, per day
- B4224 Parenteral nutrition administration kit, per day
- A4376 Ostomy pouch, drainable, with faceplate
- A4380 Ostomy pouch, urinary, with faceplate
- A4382 Ostomy pouch, urinary, heavy plastic
- A4383 Ostomy pouch, urinary, rubber

The Department is providing notification of the following HCPCS coding changes for oxygen services. This notification allows sufficient time for providers to establish revised billing practices for oxygen services.

The following HCPCS codes will not be valid for reimbursement for dates of service on or after November 1, 2007:

- E1353 Oxygen regulator
- Q0036 Oxygen concentrator, including supplies
- Q0040 Portable oxygen contents
- Q0046 Portable oxygen system rental
- Y2076 Oxygen concentrator, for LTCF residents
- Y2078 Oxygen contents, gas, for LTCF residents
- Y2079 Oxygen contents, liquid, for LTCF residents
- Y2080 Portable oxygen contents, for LTCF residents
- Y2081 Oxygen, LTCF, 501-750 CU FT or 41-60 lbs

Y2082 Oxygen, LTCF, 251-500 CU FT or 21-40 lbs

Y2083 Oxygen, LTCF, 0-250 CU FT or 0-20 lbs

Any existing or pending prior authorization requests approved for codes that will no longer be covered for dates of service on or after November 1, 2007 will need to be resubmitted to the Department using the appropriate HCPCS codes for the services provided as per OAC rules 5101:3-10-13 and 5101:3-10-13.1.

The following HCPCS codes will be valid for reimbursement for dates of service on or after November 1, 2007:

E0431 Portable gaseous oxygen system, rental

E0434 Portable liquid oxygen system, rental

E1390 Oxygen concentrator, single port, LTCF only

E1391 Oxygen concentrator, dual port, LTCF only

E1390U1 Oxygen concentrator, single port (private residence)

E1391U1 Oxygen concentrator, dual port (private residence)

E1392 Portable oxygen concentrator

K0738 Portable gaseous oxygen system, rental, transfill

DME Question Line and Mailbox

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<http://emanuals.odjfs.state.oh.us/emanuals/>

This transmittal letter, and any attachments, may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Durable Medical Equipment."
- (3) From the "Table of Contents" dropdown, select the transmittal letter number.

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ODJFS Forms

Department forms can be accessed at the following URL:

<http://www.odjfs.state.oh.us/forms/inter.asp>.

Questions pertaining to this MHTL should be directed to the following:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-07-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-07-02

April 11, 2007

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OAC Rules 5101:3-10-02 Coverage and limitations for medical supplier services, 5101:3-10-02.1 Advanced practice nurses and medical supplier services, Rule 5101:3-10-06 Prior authorization, 5101:3-10-10 Dialysis equipment, 5101:3-10-15 Transcutaneous electrical nerve stimulators (TENS), 5101:3-10-17 Blood glucose monitors (glucometers) and supplies and 5101:3-10-23 Pulse oximeters, Ohio Respiratory Care Board HME Licensure Update

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revision to the following rules:

The following rules and program changes are effective April 16, 2007.

Rule 5101:3-10-06 Prior authorization was amended in association with the five-year rule review. This rule specifies that prior authorization is required before the department will allow reimbursement for the rental or purchase of certain durable medical equipment (DME). This rule outlines the information requested on a prior authorization form, additional documentation that must accompany a prior authorization form, and the service limitations of an approved prior authorization request. This rule was amended to: allow the department to consider evidence of malicious damage to, or neglect of, DME when the department evaluates prior authorization requests for replacement DME; require providers to maintain proof of DME delivery documentation on file; add restrictions for DME substitutions; and require providers to submit a fully completed certificate of medical necessity when requesting prior authorization for DME.

Until informed otherwise, providers are reminded to continue to submit their seven digit Medicaid provider number (Medicaid legacy number) where indicated on the Prior Authorization form (JFS 03142) and any other paper form, whether or not the National Provider Identifier (NPI) number is also requested.

Rule 5101:3-10-02 Coverage and limitations for medical supplier services was amended with minimal rule body changes for the five-year rule review. Provisions allowing the advanced practice nurse (APN) to prescribe medical supplier services were added to this rule. This rule codifies the coverage and limitation criteria necessary for a provider to prescribe medical equipment and supplies through the Ohio Medicaid program.

Rule 5101:3-10-02.1 Advanced practice nurses and medical supplier services was rescinded, with its current rule language being incorporated into rule 5101:3-10-02. That rule set forth the coverage and limitation criteria necessary for an advanced practice nurse to prescribe medical equipment and supplies through the Ohio Medicaid program.

Rule 5101:3-10-10 Dialysis equipment was amended with minimal rule body changes in association with the five-year rule review. This rule codifies the current durable medical equipment (DME) policy concerning the coverage criteria for dialysis equipment for dialysis conducted in a consumer's private residence.

Rule 5101:3-10-15 Transcutaneous electrical nerve stimulators (TENS) was amended in association with the five-year rule review and to make the rule reflective of recent program changes in the program coverage of TENS units. This rule sets forth the definitions and requirements for eligibility for a TENS unit. This rule has had additional coverage criteria added to it as well as a new certificate of medical necessity "Certificate of Medical Necessity/Prescription Transcutaneous Electrical Nerve Stimulators (TENS)" JFS 03402, to be utilized by providers requesting the prior authorization of TENS services. Billing and dispensing criteria were added to this rule to aid providers in filing claims for these services.

Rule 5101:3-10-17 Blood glucose monitors (glucometers) was rescinded in association with the five-year rule review. That rule set forth the coverage criteria for blood glucose monitors. It was replaced with a new version of rule 5101:3-10-17.

Rule 5101:3-10-17 Blood glucose monitors (glucometers) and supplies was adopted to replace the currently existing rule 5101:3-10-17. This new rule sets forth the coverage criteria for blood glucose monitors and supplies dispensed to consumers of the Ohio Medicaid program. A newly developed certificate of medical necessity/prescription JFS 01910 entitled "Blood Glucose Monitor (Glucometer) and Supplies" was developed to be used for prior authorization by providers dispensing blood glucose monitors with special features, supplies and materials to enable the visually impaired to use blood glucose monitor equipment without assistance.

Rule 5101:3-10-23 Pulse oximeters was amended in association with the five-year rule review and to make the rule reflective of recent program changes to the coverage of pulse oximeters. This rule also proposes a new CMN "Certificate of Medical Necessity/Prescription Pulse Oximeter" JFS 03401 which would be utilized by providers of pulse oximeters to support prior authorization requests for this type of equipment. The addition of billing and dispensing criteria to this rule will also aid providers in filing claims for these services. The rental period for a pulse oximeter before a consideration of purchase can be made has been changed from nine months to ten months in order to align this rule language with the current reimbursement method for "rent to purchase" items.

Updated List of Home Medical Equipment Requiring ORCB Licensure

Chapter 4752 of the Ohio Revised Code requires licensure or certification through the Ohio Respiratory Care Board (ORCB) for home medical equipment (HME) providers choosing to sell or rent equipment that falls into specific categories. At its meeting on March 8, 2007, the ORCB approved an updated list of HME procedure codes that require provider licensure or certification. The new codes include power wheelchair seating systems, power wheelchair accessories, bone stimulators, and a portable gaseous oxygen system.

A complete list of Medicaid covered HME procedure codes that, if rented or sold, require providers to comply with ORCB licensure is posted at:

<http://jfs.ohio.gov/ohp/infodata/hipacomcds.stm>

DME Question Line and Mailbox

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to provide answers to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions. For such questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider Network Management at 1-800-686-1516.

The Department recommends that providers view forms and the entire text of the DME rules for the Durable Medical Equipment program at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Webpage for Home and Durable Medical Equipment Providers

The Department has established a webpage at the department's website to provide pertinent information to HME/DME providers. Information provided at this webpage includes prior authorization (PA) review turnaround time, links to Medicaid fee schedules and rates, and other helpful links and reminders.

The Department recommends that providers visit the "Information for Home and Durable Medical Equipment Providers" webpage at:

<http://jfs.test.ohio.gov/OHP/bcm/hdmeprovs.stm>

ODJFS Forms

Department forms can be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>.

If you do not have internet access, you may request a paper copy of this MHTL and its attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-07-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-07-01

January 30, 2007

TO: All Eligible Providers of Durable Medical Equipment
All Eligible Providers of Orthotic and Prosthetic Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: OAC Rules 5101:3-10-03 Medicaid supply list, 5101:3-10-12 Orthopedic shoes and foot orthoses, 5101:3-10-14 Compression garments, and 5101:3-10-20 Covered orthotic and prosthetic services and associated limitations

Rules and Program Changes are effective January 1, 2007 (except for OAC Rule 5101:3-10-14, which is effective January 15, 2007).

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revision to the following rules:

Rule 5101:3-10-03, entitled Medicaid supply list, sets forth the durable medical equipment and supplies covered by the Medicaid program. Changes to the rule include the replacement of local-level and miscellaneous codes with 2007 HIPAA-compliant codes, addition of new codes, deletion of obsolete codes, and revision of definitional changes. Some of the coding changes require amendments to existing policy on coverage.

Rule 5101:3-10-12, entitled Orthopedic shoes and foot orthoses, sets forth the conditions under which the Ohio Medicaid program will allow provider reimbursement for orthopedic shoes and foot orthoses, including allowable types of orthopedic shoes. Advanced practice nurses are considered valid prescribers (alongside physicians) of medically necessary shoe modifications or additions, subject to limitations specified in Appendix A of OAC Rule 5101:3-10-20. Orthopedic shoes are denied as non-covered if the shoe is put on over a partial foot prosthesis or other lower extremity prosthesis. For children under the age of eight, orthopedic shoes not attached to a brace are covered only for the diagnoses specified in the rule.

Rule 5101:3-10-14, entitled Compression garments, sets forth the conditions under which the Ohio Medicaid program will allow provider reimbursement for compression garments. The rule has been expanded to codify reimbursement criteria for the provision of surgical stockings and compression burn garments. Lymphedema and post-thrombotic syndrome have been added to the list of diagnoses to which coverage of compression garments is limited. Ohio Medicaid allows reimbursement for compression garments equal to or greater than 18 mm Hg. A provider is not eligible for reimbursement for custom-made or custom-fitted garments if the provider does not have a fitter on staff or under contract who is certified to fit custom garments in accordance with industry standards. Providers of custom garments must keep on file documentation subject to review by ODJFS verifying that they have a trained fitter on staff or under contract. In addition to a fully completed prior authorization form, a fully completed and signed form JFS 01905 (11/2006), "Certificate of Medical Necessity/Prescription Compression Garments (CMN)" must be submitted for prior authorization before reimbursement for compression garments will be considered. The form JFS 01905 is a new CMN form that has been added to OAC Rule 5101:3-10-14 as an appendix.

Rule 5101:3-10-20, entitled Covered orthotic and prosthetic services and associated limitations, sets forth information regarding the orthotic and prosthetic equipment and supplies covered by the Medicaid program. Changes to the rule include the addition of new codes, deletion of obsolete codes and revision of definitional codes with 2007 HIPAA-compliant codes. Some of the coding changes require amendments to existing policy on coverage.

DME Question Line and Mailbox

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions. For such questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider Network Management at 1-800-686-1516.

The Department recommends that providers view forms and the entire text of the DME rules for the Durable Medical Equipment program at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Webpage for Home and Durable Medical Equipment Providers

The Department has established a webpage at the Department's website to provide pertinent information to HME/DME providers. Information provided at this webpage includes prior authorization (PA) review turnaround time, links to Medicaid fee schedules and rates, and other helpful links and reminders.

The Department recommends that providers visit the "Information for Home and Durable Medical Equipment Providers" webpage at:

<http://jfs.test.ohio.gov/OHP/bcm/hdmeprovstm>

ODJFS Forms

Department forms can be accessed at: <http://www.odjfs.state.oh.us/forms/inter.asp>.

If you do not have internet access, you may request a paper copy of this MHTL and its attachments by completing and returning the attached form [JFS 03400](#).

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

Attachment

[Click here to view the JFS 01905, Certificate of Medical Necessity/Prescription Compression Garments](#)

MHTL 3344-06-03

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-06-03

October 17, 2006

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rules 5101:3-10-01 Eligible Providers, 5101:3-10-03 Medicaid Supply List, 5101:3-10-09 Apnea Monitors, 5101:3-10-20 Covered Orthotic and Prosthetic Services and Associated Limitations, 5101:3-10-28 Non-Invasive Bone (Osteogenesis) Stimulators, 5101:3-10-29 External Infusion Pump-Insulin and 5101:3-10-31 Therapeutic Footwear for Consumers with Diabetes.

Rules and Program Changes are effective October 15, 2006

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revisions to OAC rules 5101:3-10-01 Eligible Providers, 5101:3-10-03 Medicaid Supply List, 5101:3-10-09 Apnea Monitors, 5101:3-10-20 Covered Orthotic and Prosthetic Services and Associated Limitations and new rules 5101:3-10-28 Non-Invasive Bone (Osteogenesis) Stimulators, 5101:3-10-29 External Infusion Pump-Insulin and 5101:3-10-31 Therapeutic Footwear for Consumers with Diabetes.

OAC rule 5101:3-10-01 Eligible Providers

This rule was reviewed for five year rule review. It was amended to specify licensure requirements of eligible durable medical equipment (DME) providers for reimbursement of certain medical equipment subject to licensure under Ohio Revised Code Chapter 4752 and the rules promulgated there under through the Ohio Respiratory Care Board (ORCB).

Eligible DME providers who have a valid provider agreement as provider type (76) "medical equipment supplier" or have an approved category of service (32) "supplies and medical equipment" must submit verification to ODJFS in order for the providers to be eligible for reimbursement. The verification must show that the providers are licensed, registered, or exempt from licensure in order to rent, sell or seek reimbursement for certain equipment subject to licensure or certification in compliance with Ohio Revised Code Chapter 4752 and the rules promulgated thereunder.

OAC rule 5101:3-10-03 Medicaid Supply List

This rule was amended to reflect changes in coding instructions for DME providers. The intent of the amendments is not to change what is covered, but to change the current use of miscellaneous procedure codes to the American Medical Association (AMA) designated Healthcare Common Procedure Coding System (HCPCS) codes for the DME services being provided. In addition, the coverage of apnea monitors is being transitioned from "rental only" to "rent to purchase" which will result in the transfer of the title of the apnea monitor to the consumer at the end of the rent to purchase period.

OAC rule 5101:3-10-09 Apnea Monitors

This rule was filed for policy amendments. This rule was amended primarily to assure that the rule is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) due to the elimination of local level procedure codes for apnea monitor download services and pneumograms. In addition, the portion of this rule involving capped rental reimbursement provisions has been eliminated. Apnea monitors are now covered as a rent to purchase item only.

OAC rule 5101:3-10-20 Covered Orthotic & Prosthetic Services & Associated Limitations

The changes to the appendix of this rule reflect recent program coverage determinations of Healthcare Common Procedure Coding System (HCPCS) codes administered by the American Medical Association (AMA). This rule was also revised to reinforce the need for providers to comply with the licensure

requirements of Ohio Revised Code Chapter 4779 and the rules promulgated there under through the State Board of Orthotics, Prosthetics, and Pedorthics when dispensing orthotic and prosthetic equipment and supplies.

OAC rule 5101:3-10-28 Non-Invasive Bone (Osteogenesis) Stimulators

This rule was created in response to stakeholder request for specific coverage criteria to be codified in Ohio Administrative Code regarding the use and reimbursement for bone stimulators. This rule defines the coverage and non-coverage criteria for the acquisition of a bone stimulator and provides claim submission instructions for covered bone stimulator services. This rule also implements a new certificate of medical necessity (CMN), JFS 07134 (rev. 2/2006) "Certificate of Medical Necessity/Prescription Osteogenesis Bone Stimulators", to be used by providers of bone stimulators for prior authorization requests for this type of equipment. The use of form JFS 07134 is mandatory for dates of service on or after December 1, 2006. Any requests for bone stimulators that are received and date stamped by ODJFS prior to December 1, 2006 will be processed with the supporting documentation received.

OAC rule 5101:3-10-29 External Infusion Pump-Insulin

This rule was created in response to stakeholder request for specific coverage criteria to be codified in Ohio Administrative Code regarding the use and reimbursement for infusion pumps. This rule defines the coverage and non-coverage criteria for the acquisition of an infusion pump and provides claim submission instructions for covered infusion pump services. This rule also introduces a new certificate of medical necessity (CMN), JFS 07136 (rev. 2/2006) "Certificate of Medical Necessity/Prescription External Infusion Pump", to be used by providers of infusion pumps for prior authorization requests for this type of equipment. The use of form JFS 07136 is mandatory for dates of service on or after December 1, 2006. Any requests for external infusion pumps that are received and date stamped by ODJFS prior to December 1, 2006 will be processed with the supporting documentation received.

OAC rule 5101:3-10-31 Therapeutic Footwear for Consumers with Diabetes

This rule was created in response to stakeholder request for specific coverage criteria to be codified in Ohio Administrative Code regarding the use and reimbursement for therapeutic footwear. This rule defines the coverage and non-coverage criteria for the acquisition of therapeutic footwear and provides claim submission instructions for covered therapeutic footwear services.

MIC-KEY SETS (B9998)

Reimbursement and prior authorization (PA) submissions for mic- key sets (B9998) must be within program limits for use of a miscellaneous HCPCS procedure code. Providers should submit PA requests for the number of medically necessary mic-key kits and extension sets only. The approved PA amount will be based on the typical allowable max of up to 12 units for 12 months. A 12unit/12month authorization will be based on provider invoice for up to 8 extension sets per month and up to 4 mic-key kits per year.

The allowable for requests for less than a 12 month period will be determined based on the typical 12 month authorization. Requests for ferrell valves should be submitted on the same PA and the allowable will be based on a monthly basis. Providers should bill the authorized per unit allowable on a monthly basis.

PA requests previously returned should be resubmitted with all original PA documents including the PA letter. Providers should indicate that the request is a resubmission.

DME Question Line and Mailbox

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions. For such questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider Network Management at 1-800-686-1516.

The Department recommends that providers view forms and the entire text of the DME rules for the Durable Medical Equipment program at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Department forms can be accessed at: <http://www.odjfs.state.oh.us/forms/inter.asp>.

If you do not have internet access, you may request a paper copy of this MHTL and its attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-06-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-06-02

May 18, 2006

TO: All Eligible Providers and Prescribers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rule 5101:3-10-05 Reimbursement for covered services.

Rules and Program Changes are effective July 1, 2006

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revisions to OAC rule 5101:3-10-05 Reimbursement for covered services.

OAC rule 5101:3-10-05 Reimbursement for covered services.

This rule contains the reimbursement provisions for the Medicaid durable medical equipment (DME) program. The changes in this rule include the following:

- The addition of criteria for a recognized provider to prescribe DME for Medicaid consumers.
- Updated rule language which reflects changes in criteria for rental items as well as back up equipment for mechanical ventilators.
- Additional clarification for the billing and reimbursement of rent-to-purchase (R/P) DME items.
- The addition of criteria necessary for DME providers to document that durable medical equipment and supplies were delivered and received by the Medicaid consumer for whom it was ordered.
- Introduction of terminology which modifies reimbursement for items without a designated Medicaid maximum as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code. The modification is from the current reimbursement method of seventy five per cent of the average recommended list price to one hundred and fifty per cent of the provider invoice price when the list price is not available. "List price" and "invoice price" have been defined. A definition of "cost effective" DME is also provided.
- The option to utilize "Capped Rental" (CR) for reimbursement is being eliminated from this rule.
- All DME equipment listed in rule 5101:3-10-03 of the Administrative Code that is designated "R/P" must have a prior authorization before reimbursement is authorized. Several items previously classified as "R/P" have been re-classified as "PP" (always purchased) in order to reduce the administrative requirements necessary for providers to dispense these products to consumers. The provider will notify the consumer when an item has been purchased on his or her behalf by the Ohio Department of Job and Family Services (ODJFS).
- Requirement that the provider will keep on file a copy of any specific DME warranty for any items dispensed and will submit a copy of the specific warranty with any prior authorization request for DME repairs.
- The addition of criteria which mandate that all prescriptions for DME must originate as a result of a personal face to face examination between the prescriber and the consumer.

The intention regarding the face to face prescriber examination requirement for DME prescriptions is to clarify that the prescription for DME covered services must be a result of a physical examination and evaluation of the consumer by a prescriber within the prior twelve month period, including associated medical and diagnosis information which supports the medical need for the requested services. ODJFS believes this level of prescriber oversight enhances the quality and continuity of care provided.

- A separate examination for each subsequent DME item prescribed is not necessary if: The medical justification for the item that is ordered has been previously established by the prescriber through a face to face examination that was conducted within the previous twelve months by the prescriber; or

- The medical justification for the item is based on the judgment of a prescriber who has reviewed the consumer's medical records of a face to face examination conducted within the previous twelve months by a different prescriber.

DME Question Line and Mailbox

The Department has established a dedicated DME Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, prior authorization requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider Network Management at 1-800-686-1516.

The Department recommends that providers review form JFS 03142 and the entire text of the DME rules in the Durable Medical Equipment handbook at: <http://emanuals.odjfs.state.oh.us/emanuals>.

Click the link "Ohio Health Plan-Provider" and then the link "Durable Medical Equipment".

Department forms can be accessed at: <http://www.odjfs.state.oh.us/forms/inter.asp>.

If you do not have internet access, you may request a paper copy of this MHTL and its attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-06-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-06-01

April 10, 2006

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rule 5101:3-1-60 Medicaid reimbursement, OAC rule 5101:3-10-03 Medicaid Supply List, OAC rule 5101:3-10-16 Wheelchairs, OAC rule 5101:3-10-20 Covered Orthotic and Prosthetic Services and Associated Limitations, and OAC rule 3-10-27 Continuous passive motion (CPM) devices.

Rules and Program Changes are effective April 1, 2006

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revisions to the appendices of OAC rules 5101:3-1-60 Medicaid reimbursement, 5101:3-10-03 Medicaid Supply List, 5101:3-10-20 Covered Orthotic and Prosthetic Services and Associated Limitations, as well as, revisions to OAC rule 5101:3-10-16 Wheelchairs, and the creation of new rule 5101:3-10-27 Continuous passive motion (CPM) devices effective for dates of service on or after April 1, 2006.

OAC rule 5101:3-1-60 Medicaid reimbursement

This rule contains the reimbursement provisions and fee schedule for the Medicaid durable medical equipment (DME) program. The appendix of this rule was modified to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Existing Healthcare Common Procedure Coding System (HCPCS) codes that were deleted by the American Medical Association (AMA) for 2006 were removed from the rule while codes that are new for 2006 were added. HCPCS codes that are being deleted and are being replaced with new equivalent codes for the same product were cross walked to the appropriate new code when possible. The majority of local level DME codes were also removed from the appendix of this rule.

The body of this rule was submitted for filing with no changes. In addition, various DME codes were assigned maximum allowable pricing to eliminate the need for these items to be hand priced during the prior authorization process.

The payment for any DME item is considered to be "all inclusive" and unless otherwise specified, any installation or support components associated with the item is not eligible for separate reimbursement. Customization of any DME item must be prior authorized using the appropriate HCPCS code when applicable and is not separately reimbursable if no HCPCS code exists for this procedure.

OAC rule 5101:3-10-03 Medicaid Supply List

This rule details the durable medical equipment and supplies covered by the Medicaid program. A change to the rule body includes the redefining of the supply list designation "R/P" from previously defined purchased or rented until purchased to a definition of rent to purchase. Providers of "R/P" items can request during the initial prior authorization (PA) request that the item in question be purchased from the onset based on supporting documentation demonstrating that the consumer will need use of the "R/P" item beyond an initial ten month period.

The changes to the rule appendix are to replace local-level and miscellaneous codes with 2006 HIPAA-compliant codes when applicable. Changes include adding new codes (ex. standing frame system and pediatric gait trainers), deleting obsolete codes, and revising definitions for certain medical supplies. Specific items on the supply list have also been reclassified from a previous designation of "R/P" to "PP" which is defined as always purchased.

OAC rule 5101:3-10-16 Wheelchairs

This rule was amended to replace the local level wheelchair repair code modifier with the HIPAA compliant repair and replacement modifier "RP" to be submitted for wheelchair repairs utilizing procedures code K0108 as contained in OAC rule 5101:3-10-08 Repair of medical equipment. Additionally, several typographical errors were corrected and reference to reimbursement for residents of LTCFs through the cost report was updated to reflect current language and Revised Code reference.

OAC rule 5101:3-10-20 Covered orthotic and prosthetic services and associated limitations

This rule was amended to implement the 2006 HCPCS codes to maintain consistency with industry standards for medical coding and to comply with federal requirements under the Health Insurance Portability and Accountability Act (HIPAA). This rule sets forth information regarding covered orthotic and prosthetic equipment and supplies. The changes to the rule were intended to replace local-level and miscellaneous codes with the applicable 2006 HIPAA-compliant codes when possible. The rule was amended to add new codes, delete obsolete codes, and update definitional changes. Some of the coding changes require amendments to existing policy on coverage. This rule also introduces new procedure codes for reimbursement of repair services for orthotic and prosthetic equipment.

OAC rule 5101:3-10-27 Continuous passive motion (CPM) devices

This rule was newly established in response to stakeholder requests for specific coverage criteria regarding the use and reimbursement for continuous passive motion devices (CPM). This rule sets forth the coverage criteria for the use of a CPM device and provides instructions for submission of claims for the rendering of services to consumers utilizing the CPM device.

In order to provide consistency, this rule also authorizes a change from current reimbursement methodology for these services at one amount per each medical event to the more universal Centers for Medicare and Medicaid Services (CMS) standard of one amount per day of service up to a maximum of 21 days of service per medical event.

USE OF MISCELLANEOUS DME CODES

The use of miscellaneous DME codes such as E1399 or K0108 must have prior authorization. The only exception is when these codes are submitted with the "RP" modifier for a minor repair subject to the coverage and limitations in OAC 5101:3-10-08 Repair of medical equipment. Miscellaneous codes are intended for use only for DME items that do not have a valid Healthcare Common Procedure Coding System (HCPCS) code assigned by the American Medical Association (AMA). Miscellaneous codes are not authorized for use to seek higher reimbursement for any DME item listed in Appendix DD of OAC rule 5101:3-1-60 or to seek reimbursement for a code determined by the department to be a non-covered (NC) service. Provider requests for the use of a DME miscellaneous code must be accompanied by documentation detailing why the use of a miscellaneous is necessary in order to render services to a consumer.

DME Question Line and Mailbox

The Department has established a dedicated Durable Medical Equipment (DME) Question Line and Voice Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Voice Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call provider network management at 1-800-686-1516.

The Department recommends that providers review form JFS 03142 and the entire text of the DME rules in the Durable Medical Equipment handbook at: <http://emanuals.odjfs.state.oh.us/emanuals>.

Click the link "Ohio Health Plan Providers" (left column) and then the link "Durable Medical Equipment" (right column).

Department forms can be accessed at: <http://www.odjfs.state.oh.us/forms/inter.asp>.

If you do not have internet access, you may request a paper copy of this MHTL and rules 5101:3-10-16 and 5101:3-10-27 by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3344-05-06

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-05-06

February 15, 2006

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rule 5101:3-1-60 Medicaid Reimbursement, emergency effective December 30, 2005 and
OAC rule 5101:3-10-08 Repair of Medical Equipment, effective January 13, 2006

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of revisions to the appendix of rule 5101:3-1-60 Medicaid Reimbursement effective for dates of service on or after January 1, 2006 and rule 5101:3-10-08 Repair of Medical Equipment effective for dates of service on or after January 13, 2006.

OAC rule 5101:3-1-60 Medicaid Reimbursement, emergency effective December 30, 2005

This rule contains the reimbursement provisions and fee schedule for the Medicaid Durable Medical Equipment (DME) program. The appendix of this rule was modified to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Existing healthcare common procedure coding system (HCPCS) codes that were deleted by the American Medical Association (AMA) for 2006 were removed from the rule while codes that were new for 2006 were added. HCPCS codes that are being deleted and are being replaced with new equivalent codes for the same product were cross walked to the appropriate new code. The DME program coding changes and cross walks are available at the following site under HIPAA compliant codes:

<http://jfs.ohio.gov/ohp/infodata/hipaa.stm>

OAC rule 5101:3-10-08 Repair of Medical Equipment, effective January 13, 2006

HIPAA compliant DME program repair codes were adopted through the amendment of OAC 5101:3-10-08 Repair of Medical Equipment effective for dates of service on or after January 13, 2006.

The Repair of medical equipment rule was amended primarily to clarify claims submissions for use of non-specific HIPAA compliant repair codes requiring the use of the "RP" modifier and to change the frequency of minor hearing aid repairs without prior authorization to one every 120 days.

The DME repair program coding and billing changes are contained in the following table:

Ohio Medicaid DME Repair Program Coding and Billing Changes

Effective January 1, 2006

DME REPAIR CODES 2006 IMPLEMENTATION						
Code	Code					PRIOR
Through 12/31/05	As of 1/1/06		ITEM DESCRIPTION	UNIT		AUTH STATUS
Y4211	L4210 + L4205		Repair Ortho device <\$120	1		S*
Y4212	L4210 + L4205		Repair Ortho device > \$120	1		Y
N/A	L4205		Repair Ortho device	\$9 per		S*

			labor per 15 min	unit		
Y7511	L7510 + L7520		Repair Prosth device < \$120	1		S*
Y7512	L7510 + L7520		Repair Prosth device > \$120	1		Y
N/A	L7520		Repair Prosth device labor per 15 min	\$9 per unit		S*
Y2059	E1399 RP +E1340		DME equipment. NOS (misc) minor repair < \$100	1		S*
E1350	E1399 RP		DME equipment. NOS (misc) major repair > \$100	1		Y
E1351	E1399RP		DME equipment. NOS LTCF major repair >\$100	1		Y
E1340	E1340		Repair or nonrout service for DME, labor com per 15 min (< \$100)	\$9 per unit		S*
E1340	E1340		Repair or nonrout service for DME, labor com per 15 min (> \$100)	1		Y
Y9041	V5014**		Hearing aid minor repair <\$100	1		S* @
Y9042	V5014**		Hearing aid major repair >\$100	1		Y
Y9051	E1399 RP +E1340		Adapt com device minor repair < \$100	1		S*
Y9052	E1399RP + E1340		Adapt Com Device major repair > \$100	1		Y
Y2096	K0108RP + E1340		Wheelchair Other accessories (major repair > \$100 LTCF)	1		Y
Y2097	K0108RP+ E1340		Wheelchair Other accessories (major repair > \$100 Personal res)	1		Y
Y2098	K0108RP		Wheelchair Other accessories (minor	1		S*

	+ E1340		repair, \$100 Personal res)			
S* - Prior authorization required if more than 1 per 120 days per consumer.						
S*@ - Frequency without requiring Prior authorization changed from 365 days to 120 days effective 1/13/06.						
Y - Prior authorization required.						
**- Inclusive of material and labor charges.						

The DME repair program coding and billing changes are also available at the following site under HIPAA compliant codes:

<http://ifs.ohio.gov/ohp/infodata/hipaa.stm>

For reimbursement of repairs or replacement parts requiring materials and labor, the appropriate repair and labor codes must be submitted together on the same claim for the same date of service.

For reimbursement of repairs requiring only the time of a technician use the appropriate labor code.

For hearing aid repairs code V5014 is inclusive of repairs, labor and parts replacement and should not be submitted with a labor code.

When used for the reimbursement of repairs or replacement parts, codes K0108 and E1399 must be modified with the "RP" modifier in combination with labor code E1340 if labor charges are part of an equipment repair.

Repair Prior Authorization (PA) Transition

Due to system issues, prior authorization requests received prior to January 1, 2006 and existing prior authorization approvals for DME repairs containing old codes will be honored for dates of service prior to April 1, 2006. Providers must bill the code contained on the PA approval. Approved PAs containing old codes not used for dates of service prior to April 1, 2006 will expire and a new PA request must be submitted using new codes.

Non- Repair Prior Authorization (PA) Transition

Due to HIPAA compliance, with the exception for DME repair codes as previously stated, the Department is no longer able to provide a ninety day transition period for providers to continue to use procedure codes that have been deleted.

As a result, approved PAs containing old codes not used for dates of service prior to January 1, 2006 will expire and a new PA request must be submitted using new codes.

Approved PAs being resubmitted for a new PA number must contain new codes, amount dispensed and amount remaining including dollar amounts.

PAs reviewed after January 1, 2006 must use new codes.

Ohio Department of Job and Family Services (ODJFS) HIPPA Website

Interested providers can access the latest ODJFS HIPPA information at the following website address:

<http://ifs.ohio.gov/ohp/infodata/hipacomcds.stm>

DME Question Line and Mailbox

In February 2005, the Department established a Durable Medical Equipment (DME) Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider network management at 1-800-686-1516.

The Department recommends that providers review the entire text of the DME rules in the Durable Medical Equipment handbook at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Click the link "Ohio Health Plan Providers" (left column) and then the link "Durable Medical Equipment" (right column).

Department forms can be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of this MHTL and rule 5101:3-10-08 by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3344-05-05

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-05-05

December 29, 2005

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rule 5101:3-10-26 Enteral nutritional products

Rules and Program Changes are effective January 1, 2006

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of new rule 5101:3-10-26 Enteral nutritional products effective dates for dates of service on or after January 1, 2006 and new form JFS0197 Certificate of Medical Necessity/Prescription (Rev. 4/2005) (CMN) which accompanies this rule.

OAC Rule 5101:3-10-26 Enteral nutritional products

Rule 5101:3-10-26, entitled Enteral nutritional products, was adopted to address requests for a rule that specifies the program criteria necessary for coverage of enteral nutritional products for Medicaid consumers. This rule details a listing of enteral products that are not covered by the Medicaid program. Also provided within this rule are detailed instructions which describe prior authorization, dispensing and reimbursement criteria for enteral nutritional products.

JFS 01907 Certificate of Medical Necessity/Prescription (Rev. 4/2005)

Form JFS 01907 was adopted to address requests for one specific required form for prior authorization of Medicaid enteral products. A fully completed form JFS 01907 is considered by the Department to be a prescription so the submission of a separate prescriber prescription is no longer necessary as of January 1, 2006 as long as form JFS 01907 is utilized in conjunction with the prior authorization request.

During the transition to the new CMN, providers and prescribers of enteral products are encouraged to utilize form JFS 0197 to obtain prior authorization for enteral products for dates of service on or after January 1, 2006. Use of form JFS 0197 is required as of April 1, 2006.

DME Question Line and Mailbox

In February 2005, the Department established a Durable Medical Equipment (DME) Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider network management at 1-800-686-1516.

The Department recommends that providers review form JFS 01907 and the entire text of the DME rules in the Durable Medical Equipment handbook at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Click the link "Ohio Health Plan Providers" (left column) and then the link "Durable Medical Equipment" (right column).

Department forms can be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of this MHTL including all attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

**Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516**

Attachments

JFS 01907 - Certificate of Medical Necessity/ Prescription Enteral Nutrition Services

[Click here to view the Certificate of Medical Necessity/ Prescription Enteral Nutrition Services](#)

MHTL 3344-05-04

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-05-04

October 27, 2005

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rule 5101:3-10-16.1 Wheelchair rentals and surgical supply code A4649.

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of the creation of new rule 5101:3-10-16.1 Wheelchair rentals effective October 27, 2005, and the reactivation of code A4649 Surgical supply; miscellaneous.

OAC Rule 5101:3-10-16.1 Wheelchair rentals

Rule 5101:3-10-16.1, entitled Wheelchair rentals, was adopted in order to address provider requests for a rule that specifies current maximum reimbursement rates for rental wheelchairs for the Ohio Medicaid program. As a supplementary rule to existing rule 5101:3-10-16 entitled Wheelchairs, rule 5101:3-10-16.1 contains the current Ohio Department of Job and Family Services (ODJFS) reimbursement rates for wheelchair rentals under the Medicaid DME program when submitted for reimbursement with the use of the "RR" modifier. This rule also provides the direction necessary for providers to file claims for rental wheelchairs.

DME Code A4649 Surgical supply; miscellaneous

Program coverage for code A4649 was inadvertently discontinued effective September 1 2005. This error has been corrected with no loss of coverage during this period. Any providers receiving prior authorization or claim denials when submitting this code during this time period are instructed to resubmit the effected claim or prior authorization as soon as possible so that the proper processing of the claim or prior authorization can be initiated.

DME Question Line and Mailbox

In February 2005, the department established a DME Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider network management at 1-800-686-1516.

The department recommends that providers view the entire text of the DME rules in the Durable Medical Equipment handbook at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Click the link "Ohio Health Plan Providers" (left column) and then the link "Durable Medical Equipment" (right column).

Department forms can be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of this MHTL including all attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

MHTL 3344-05-03

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-05-03

September 22, 2005

TO: All Eligible Providers of Durable Medical Equipment, including
all Eligible Providers of Hearing Aid Services
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: OAC rules 5101:3-10-11 Hearing Aids, 5101:3-10-25 Lactation Pumps, 5101:3-1-60 Medicaid reimbursement and 5101:3-10-20 Covered orthotic and prosthetic services and associated limitations

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice that the previous OAC rule 5101:3-10-11 Hearing Aids has been rescinded and replaced by a new version of the rule effective September 1, 2005 and creation of a new OAC rule 5101:3-10-25 Lactation Pumps effective September 1, 2005. OAC rules 5101:3-1-60 Medicaid reimbursement and 5101:3-10-20 Covered orthotic and prosthetic services and associated limitations have been updated in conjunction with the expanded hearing aid coverage noted in rule 5101:3-10-11.

OAC Rule 5101:3-10-11 Hearing Aids

The Medicaid rule pertaining to Hearing Aids (OAC 5101:3-10-11) requires prior authorization for all hearing aids to be covered and reimbursed. This rule also provides coverage for digital and programmable hearing aids for consumers 20 years or younger providing the medical necessity of the requested hearing aid is established. Consumers 21 years or older are eligible for conventional hearing aids only.

Other modifications to this rule include updated standardized hearing evaluations for consumers 20 years or younger as well as the authorization for the billing of a separate dispensing fee by providers fitting a hearing aid for Medicaid consumers, effective for dates of service of September 1, 2005 and after. Hearing aid claims and submissions for equipment dispensed after September 1, 2005 will require two separate HCPCS codes for full reimbursement. One HCPCS code will reimburse for the actual hearing aid being dispensed and one HCPCS code will reimburse for the professional services of the provider dispensing the hearing aid.

Dispensing fee codes as referenced in this rule and specific hearing aid codes must be submitted together on the same prior authorization request and if approved, must be billed together with the same date of service. ODJFS will pay for only one hearing aid and only one dispensing fee per consumer in a four-year period for a conventional hearing aid or only one hearing aid and one dispensing fee in a five year period for a programmable or digital hearing aid.

Providers with existing prior authorizations for hearing aids dispensed prior to September 1, 2005 must submit the code contained on the prior authorization approval letter and will be reimbursed at the current "all inclusive" rate. Providers with existing prior authorizations for hearing aids not dispensed until after September 1, 2005 may resubmit their existing prior authorization forms utilizing the new "separate fee" method consisting of one HCPCS code for the actual hearing aid and one HCPCS code for the dispensing of the hearing aid if they so desire. Providers resubmitting previously approved prior authorizations must note on their resubmission request that the submission has been previously authorized, and that authorization of the new hearing aid codes are being sought. It is recommended that providers include their original prior authorization document with their resubmission in order to facilitate this process.

OAC Rule 5101:3-10-25 Lactation Pumps

The new Medicaid rule pertaining to the Medicaid coverage of Lactation pumps (OAC 5101:3-10-25) was initiated by ODJFS in response to provider and consumer inquiries requesting specific Medicaid coverage criteria for these DME items. This rule is effective September 1, 2005.

The particular focus of this rule is the rental of hospital grade (HG) pumps and the attachments and services included as part of the rental reimbursement rate currently paid by ODJFS for HG pumps. This rule also provides clarification regarding the purchase of both manual and electric lactation pumps for home use.

PA requests submitted must include an official [JFS 03142](#), rev. 02/2003 form completed with sufficient information to support the medical necessity of the consumer for the DME item being requested.

OAC Rule 5101:3-1-60 Medicaid reimbursement

This rule contains the reimbursement provisions for the medicaid fee for service program. This rule was modified to include the addition of current HCPCS codes as well as updating coverage and pricing methodology for various existing codes within the appendix of this rule. These modifications included but were not limited to the adjustment of various codes in response to an internal audit conducted in order to verify that no existing medicaid codes were presently reimbursing at a higher rate than medicare. The majority of new HCPCS codes which were added to this filing of 5101:3-1-60 are being established as "non covered" codes in order to establish these codes in the Medicaid reimbursement system so that these codes are available for possible use in future versions of this rule. The effective date for this filing of 5101: 3-1-60 is September 1, 2005.

In conjunction with the aforementioned change of OAC rule 5101: 3-10-11 Hearing Aids, the following codes are being activated and/or modified in order for providers to utilize them for dispense dates after September 1, 2005 in accordance with the previously mentioned instructions regarding reimbursement for Hearing aids:

V5030	Body-worn hearing aid air
V5040	Body-worn hearing aid bone
V5050	Hearing aid monaural in ear
V5060	Behind ear hearing aid
V5070	Glasses air conduction
V5080	Glasses bone conduction
V5130	In ear binaural hearing aid
V5140	Behind ear binaur hearing aid
V5150	Glasses binaural hearing aid
V5160	Dispensing fee binaural
V5170	Within ear cros hearing aid
V5180	Behind ear cros hearing aid
V5190	Glasses cros hearing aid
V5200	Cros hearing aid dispens fee
V5210	In ear bicros hearing aid
V5220	Behind ear bicros hearing aid
V5230	Glasses bicros hearing aid
V5240	Dispensing fee bicros

V5241	Dispensing fee, monaural
V5246	Hearing aid, prog, mon, ite
V5247	Hearing aid, prog, mon, bte
V5252	Hearing aid, prog, bin,ite
V5253	Hearing aid, prog, bin, bte
V5256	Hearing aid, digit, mon, ite
V5257	Hearing aid, digit, mon, bte
V5260	Hearing aid, digit, bin, ite
V5261	Hearing aid, digit,bin,bte

OAC Rule 5101: 3-10-20 Covered orthotic and prosthetic services and associated limitations

This rule contains the reimbursement provisions such as maximum units allowable and a comprehensive listing of covered devices within the appendix of this rule pertaining to the orthotic and prosthetic fee for service program. The changes in this rule are primarily the addition of HCPCS codes which would cover the addition of digital and programmable hearing aid for children as well as the removal of non covered HCPCS codes from this document. This rule will be effective September 1, 2005.

DME Question Line and Mailbox

In February 2005, the department established a DME Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider network management at 1-800-686-1516.

JFS 03142, rev. 02/2003- Prior Authorization Form

The department recommends that providers view this form and the entire text of the DME rules in the Durable Medical Equipment handbook at:

<http://emanuals.odjfs.state.oh.us/emanuals>

Click the link "Ohio Health Plan Providers" (left column) and then the link "Durable Medical Equipment" (right column).

Form **JFS 03142** and other department forms can also be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of this MHTL including all attachments by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

**Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516**

Attachment

JFS 03142 - Prior Authorization

[Click here to view the Prior Authorization](#)

MHTL 3344-02-05

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-02-05

June 7, 2005

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: WHEELCHAIR CERTIFICATES OF MEDICAL NECESSITY FORMS JFS 03411 and 03414

The purpose of this Medicaid Handbook Transmittal Letter is to provide notice of the availability of JFS forms [03411](#) and [03414](#) on the Ohio Health Plans and ODJFS websites and to inform providers that these forms will be required for the submission of prior authorization requests received on or after September 1, 2005.

The Medicaid rule pertaining to wheelchairs (OAC 5101:3-10-16) requires prior authorization for wheelchairs to be covered and reimbursed, with the exception of the rental of standard manual, hemi manual and lightweight manual (adult or pediatric) wheelchairs for a period of time not to exceed a maximum of three months. Part of the prior authorization requirement is the submission of a completed "Letter of Medical Necessity for Manual Wheelchairs Without a Custom Seating System" (JFS 03414 revised 10/2004) or "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., any wheelchair with a custom seating system)" (JFS 03411), as appropriate, for the wheelchair being requested. Currently, some providers are substituting customized versions of these forms or alternative forms for their PA submission.

PA requests submitted on or after September 1, 2005, must include an official JFS 03411 or 03414 form completed with sufficient information to support the medical necessity of the consumer for the wheelchair being requested. Providers are encouraged to use these forms before September 1, if they are not already using them.

In February 2005, the department established a DME Question Line and Mailbox to improve response to provider questions regarding program coverage and limitations. The number for this service is 614-466-1503. The DME Question Line and Mailbox is not able to answer questions regarding individual consumer eligibility, PA requests or claims submissions. For these types of questions, providers should utilize the Interactive Voice Response (IVR) system or call Provider network management at 1-800-686-1516.

The department recommends that providers view these forms and the entire text of the DME rules in the Durable Medical Equipment handbook at:

<http://emanuals.odjfs.state.oh.us/emanuals>

These forms and other department forms can also be accessed at:

<http://www.odjfs.state.oh.us/forms/inter.asp>

If you do not have internet access, you may request a paper copy of JFS forms 03411 and 03414 mentioned in this MHTL by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

Attachment

JFS 03411 - Seating/Wheeled Mobility Letter of Medical Necessity Power Wheel Chairs and/or any Custom Wheel Chair

[Click here to view the Seating/Wheeled Mobility Letter of Medical Necessity Power Wheel Chairs and/or any Custom Wheel Chair](#)

JFS 03414 - Manual Wheel Chairs without Custom Seating

[Click here to view the Manual Wheel Chairs without Custom Seating](#)

MHTL 3344-01-05

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-01-05

March 23, 2005

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Clarification and Update of Durable Medical Equipment and Orthotic and Prosthetic Rules

The purpose of this Medicaid Handbook Transmittal Letter is to provide reiteration of the durable medical equipment rule changes effective October 1, 2004 and program updates and HCPCS 2005 coding changes effective December 30, 2004.

An updated Medical Supply List OAC 5101:3-10-03 was filed on an emergency basis with an effective date of December 30, 2004. To comply with state law this rule was then submitted through the regular rule filing process with an effective date of March 28, 2005. The only changes between versions of these rules are minor in nature, based on internal and provider feedback, to correct wording and typographical errors in the description of covered procedure codes. There are no changes in coverage or procedure codes.

I. **Clarification of DME and Orthotic and Prosthetic rules effective October 1, 2004 filing.**

A. **5101:3-10-16 WHEELCHAIRS**

This section provides clarifies the department's interpretation of the wheelchair rule revisions effective October 1, 2004 pertaining to completion and submission of the wheelchair evaluation for authorization as contained in paragraphs (E) and (F) of this rule.

1. Prior Authorization evaluation by individual independent from DME provider

The wheelchair evaluation and written report must be performed by an individual who is fiscally, administratively and contractually independent from the DME provider and who receives no form of compensation from the billing DME provider.

The evaluator must furnish the DME provider with a separately completed evaluation document whether the result of the evaluation is reported on the ODJFS required Letter of Medical Necessity (JFS 03411 or JFS 03414) or a separate document. The date of the evaluation must be recorded on the document submitted for PA approval.

The purpose and intent of this rule is to assure that the evaluation is conducted independently without direct or indirect incentive or influence by the DME provider including the provision of value added support services. The practice of some DME providers to provide direct or indirect compensation, computer and software or transcription services is in violation of this rule.

2. Evaluation must be performed no longer than 90 days prior to submission of PA request

The 90 day limit is from the date the consumer is evaluated for the medical necessity of a wheelchair to the date of submission of the PA request. For a denied PA request that is resubmitted for approval, consideration will be made for the time spent in PA review and the expeditious resubmission of the PA request. Resubmitted PA requests must contain the PA number listed on the previous denial letter.

B. **5101:3-10-20 Covered Orthotic and Prosthetic Services and associated limitations and 5101:3-10-14 Compression Hose**

Gradient Compression and Surgical Stockings

Gradient compression stockings listed in OAC rule 5101:3-10-20 (L8100 - L8239) must be used only in relation to orthotic or prosthetic devices.

Requests for surgical stockings listed in OAC rule 5101:3-10-03 (A4490 - A4510) not related to orthotic or prosthetic devices must follow requirements of the Compression Hose rule, OAC 5101:3-10-14

II. **Medicaid Supply List Changes Effective December 30, 2004**

A. **Medicaid Supply List Appendix Changes pertaining to wheelchairs**

1. The following changes have been made to the "Max Units" Indicator based on provider input.

Bilateral items are now limited "per side", e.g. K0041 Large Size footplate, Limit 1/5 years per side (old limit was 2/5 years).

Seat cushion and positioning accessory limits have changed from 1/5 years to 1/2-3 years depending on the procedure code.

E1028 Wheelchair mounting hardware and K0108 Other Accessories limits are per item.
2. Selected wheelchair codes have moved between Part I and Part II of the wheelchair section of the supply list appendix.

Codes K0093 and K0097 (flat free tire inserts) are now eligible for separate reimbursement at time of initial wheelchair purchase (Part I).

Codes K0052 (swing away footrests) and E2366 and E2367 (battery chargers) are now eligible for separate reimbursement only for repair or replacement (Part II)

B. **Medicaid Supply List Appendix Changes Other Than Wheelchairs**

1. Burn Garments

Burn garments (codes A6501-A6512) have been removed from the orthotics and prosthetics rule appendix list (5101:3-10-20) and added to the medicaid supply list appendix (5101:3-10-03).
2. Tape

The covered tape codes are A4450 Tape, non-water proof, per 18 square inches; A4452 Tape, waterproof, per 18 square inches; and Y9172 Twill tape, per yard. Until further notice, providers should not submit modifiers with tape codes.
3. Repair Codes

The covered repair codes as described in the supply list are Y2059 DME repair minor, personal residence, non-wheelchair; E1350 repair, non-routine service, DME major repair, personal residence, non-wheelchair; E1351 repair, non-routine service, DME major repair, long term care facility (LTCF), non-wheelchair. The appropriate code should be submitted on minor repair claims not requiring PA. Approved PA repair requests will be returned with the appropriate code to be submitted for billing. Always bill the code that appears on the PA approval notification letter.
4. Enteral Nutrition

New enteral nutrition codes have been added. All code descriptions now contain the phrase "administered through an enteral feeding tube". The modifier BO should be used for PA requests for oral use of enteral nutrition. Providers should bill the BO modifier only if instructed to do so by the PA approval letter. Physicians must include the number of calories required per day on the certificate of medical necessity (CMN) or prescription.

B4102 and B4103 adult/pediatric electrolyte replacement are covered under the pharmacy benefit program as described in chapter 5101:3-9 of the Ohio Administrative Code, not as a DME product.

B4150 through B4162 are new covered codes.

B4151 and B4156 have been deleted.

B4104 additive for enteral formula and B4149 blenderized natural foods are not covered.

Prior Authorization Instructions

Prior authorization requests must conform with the instructions in rule 5101:3-10-06. A current manufacturer's price list must be included. This requirement includes enteral nutrition products. When a current manufacturer's price list is not available, a copy of the provider's actual invoice may be submitted. Along with the PA request, providers must submit a prescription dated before the first date of service, but not more than sixty days before the first date of service. The requirements for prescriptions are outlined in rule 5101:3-10-05.

A number of the DME procedure code changes are to codes requiring prior authorization. Providers should bill DME claims containing prior authorized codes that have been replaced using the following instructions.

1. PAs issued prior to January 1, 2005 containing old codes will be honored for dates of service through March 31, 2005. Providers must bill the procedure codes contained on the prior authorization approval letter.
2. If existing PAs are not utilized for the appropriate dates of service, a new PA request must be submitted with the new procedure codes.
3. After January 1, 2005, prior authorizations will be issued using only new codes. An exception to this is for PA requests received after January 1, 2005 for services rendered on dates of service up to and including December 31, 2004. These PA requests must contain the old codes in effect on the date of service.

Every effort was made to identify HIPAA compliant national level HCPCS codes to replace local level or obsolete codes for existing covered services. If requests for the continuation of local level codes or addition of specific HIPAA compliant codes were not identified or requested during review, they were not considered for coverage. Providers can request program consideration of specific procedure codes by submitting requests to:

Office of Ohio Health Plans
Bureau of Health Plan Policy
c/o DME Program
30 E. Broad Street, 27th Floor
Columbus, Ohio 43215-3414

The Department recommends that providers view the entire text of the DME rules in the Durable Medical Equipment handbook at:

<http://emanuals.odjfs.state.oh.us/emanuals>

If you do not have internet access, you may request a paper copy of the revised OAC5101:3-10-03 Medical Supply List rule mentioned in this MHTL by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll free telephone number 1-800-686-1516

MHTL 3344-01-04

Medicaid Handbook Transmittal Letter (MHTL) No. 3344-01-04

September 30, 2004

TO: All Eligible Providers of Durable Medical Equipment
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Update to Durable Medical Equipment Rules effective October 1, 2004

The purpose of this Medicaid Handbook Transmittal Letter is to notify providers of recent durable medical equipment rule changes that are effective October 1, 2004 and is organized by individual rule number and title.

In general, the DME rules were revised to clarify program policy, update program terminology and to make necessary revisions to comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 by implementing HIPAA compliant procedure codes. Specific program changes are covered in each individual rule section of this MHTL.

A general exception to the use of HIPAA compliant procedure codes impacting DME providers is the continued use of local level codes for the submission of equipment repair claims. Providers should continue to use the local level repair codes until further notice.

Additionally the department has decided to maintain use of a number of local level codes for services requiring Prior Authorization and for certain services which do not have a HIPAA compliant code based on constituent input. A list of these local level codes and crosswalks of local level DME codes to HIPAA compliant codes can be viewed at: <http://ifs.ohio.gov/ohp/infodata/hipacomcnds.stm>

The Department recommends that providers view the entire text of these rules in the Durable Medical Equipment handbook at:

<http://emanuals.odfjs.state.oh.us/emanuals>

Please note that the program rules and communications are no longer located at the Dynaweb address.

Special Instructions for DME Providers Submitting Claims for Prior Authorized Services

Effective for dates of service on or after October 1, 2004 there will be DME procedure code changes. Some of these procedures require prior authorization (PA). Due to the complexity of the DME procedure code crosswalk the following instructions have been established to assure appropriate processing of DME claims containing prior authorized procedure codes for dates of service through December 31, 2004.

Existing prior authorizations issued prior to October 1, 2004 containing old codes will be honored for services rendered for dates of service through December 31, 2004. Providers must bill the procedure codes contained on the prior authorization approval letter. If these PAs are not utilized for dates of service through December 31, 2004, a new PA request must be submitted with the new HIPAA compliant codes.

After October 1, 2004, prior authorizations will be issued using only new codes. An exception to this is for PA requests received after October 1, 2004 for services rendered prior to October 1, 2004. These PA requests must contain the old codes in effect on the date of service

A separate communication with specific instructions for hearing aid prior authorizations will be issued pertaining to program changes effective November 1, 2004.

Rule 5101:3-10-03 entitled **Medicaid Supply List** and its corresponding appendix contain information regarding coverage of durable medical equipment and supplies. All updates to this rule were made in the appendix. Extensive procedure code changes have been made to implement HIPAA compliant codes. With few exceptions, all Ohio specific durable medical equipment codes will now be updated to HIPAA compliant

codes. The intent of these changes was not to change what is covered, but rather to work toward the elimination of our local-level code as required by HIPAA.

Rule 5101:3-10-08 entitled **Repair of Medical Equipment** has been amended to clarify Department policy and repair coverage and limitation. This rule provides cross reference to the applicable rules regarding repairs or replacement of parts for hearing aids, orthotic and prosthetic devices and wheelchairs.

Additionally, the policy for hearing aid repairs has been amended. Major repair of hearing aids has been redefined as a repair for which the combined charges for material and labor exceed one hundred dollars and requires prior authorization. Minor repair of hearing aids has been redefined as a repair for which the combined charges for materials and labor are less than or equal to one hundred dollars and requires prior authorization for more than one minor repair per consumer in any three hundred sixty-five day period.

Rule 5101:3-10-16 entitled **Wheelchairs** has been rescinded and replaced by a new rule of the same rule number and title and contains provisions addressing the coverage of wheelchairs.

The new rule contains industry standard definitions describing wheelchairs, clarifies program coverage and limitations, prior authorization requirements and implements HIPAA compliant procedure codes.

The definition of adaptive positioning devices was clarified and the term custom seating system replaced the terms custom-molded, individually customized, contoured and adaptive seating systems.

The rule requires that a wheelchair evaluation and written report must be performed by an individual who is fiscally, administratively and contractually independent from the DME provider and who receives no form of compensation from the billing DME provider.

Rule 5101:3-10-18 entitled **Hospital Beds and Pressure-Reducing Support Surfaces** and its corresponding appendix contain provisions addressing the coverage of hospital beds and decubitus care. It has been amended to reflect current terminology and to implement HIPAA compliant codes.

Rule 5101:3-10-19 entitled **Definitions of Terms Associated with Orthotic and Prosthetic Services** was amended to update existing orthotic and prosthetic definitions and terminology.

Rule 5101:3-10-20 entitled **Covered Orthotic and Prosthetic Services and Associated Limitations** and its corresponding appendix contains language addressing coverage of orthotic and prosthetic services.

The rule was amended with new language detailing coverage for gradient compression stockings and new language detailing coverage for the repair or replacement of parts for orthotic or prosthetic devices. Language detailing the billing of visits provided in a hospital, home, nursing facility and intermediate care facilities for the mentally retarded was deleted.

The corresponding appendix to this rule was updated to reflect all covered orthotic and prosthetic codes.

Rule 5101:3-10-21 entitled **Incontinence Garments and Related Supplies** contains provisions addressing the coverage of incontinence supplies. This rule has been amended to clarify the existing rule and make grammatical corrections.

Rule 51013-10-22 entitled **Volume Ventilators, Positive and Negative Pressure Ventilators, Continuous Positive Airway Pressure (CPAP), Alternating Positive Airway Pressure (APAP), and Intermittent Positive Pressure Ventilation (IPPV)** has been amended to clarify the existing rule and prior authorization requirements. Definitions have been added for invasive and non-invasive mechanical ventilators. Program coverage has been added for E0454, pressure support ventilators with volume control.

E0450 ventilators will no longer require prior authorization.

Prior authorization timeframes have been changed. Initial prior authorizations may be approved for up to 6 months. Subsequent PAs may be approved for lifetime authorization for rental, capped rental or purchase for consumers with chronic nonreversible respiratory insufficiency and/or failure. Any change in equipment, other than changes to E0450 ventilators requires a new PA.

Heated humidifiers may be billed separately under codes S8182 or S8183 and require prior authorization.

Secondary or back-up ventilator policies have been broadened to more closely conform to guidelines from the American Association for Respiratory Care. Secondary ventilators may be prior authorized for consumers who require ventilation during regular mobility activities, such as school and outpatient therapy.

Sleep therapy (CPAP and APAP) policy was clarified by defining apnea, hypopnea and the apnea-hypopnea index and clarifying the documentation required for PA.

Sleep studies may be performed in an attended, facility based sleep study laboratory which is eligible for reimbursement from ODJFS for the study, but not in a home or mobile facility. A DME supplier may not perform the study. The two required studies may be performed consecutively as a split study and titration for oxygen or APAP may be performed during the initial study.

Rule 5101:3-10-24 entitled **Speech Generating Devices (SGDs)** formerly entitled **Assistive Communication Devices (ACDs)** contains provisions addressing the coverage of speech generating devices and has been revised to reflect current terminology and to implement HIPAA compliant codes.

To obtain a copy of the rules and future program updates: If you do not have internet access, you may request a paper copy of the rules by completing and returning the attached form JFS 03400.

Questions pertaining to this MHTL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number 1-800-686-1516

Miscellaneous Medicaid Handbook Transmittal Letters

MHTL 3334-13-06

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-13-06 (Rule 5101:3-10-05 Reimbursement for Covered Services), is maintained in the General Information e-book.

[Click here to view MHTL 3334-13-06, Rule 5101:3-10-05 Reimbursement for Covered Services](#)

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

[Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates](#)

MHTL 3334-09-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-09-02 (Discontinuing the Disability Medical Assistance (DMA) Program and the Rescission of Ohio Administrative Code (OAC) Rule 5101:3-23-01), is maintained in the General Information e-book.

[Click here to view MHTL 3334-09-02, Discontinuing the Disability Medical Assistance \(DMA\) Program and the Rescission of Ohio Administrative Code \(OAC\) Rule 5101:3-23-01](#)

Medical Supplier Services

Formerly 5101:3-10-01 Eligible Providers

MHTL 3344-11-04

Effective Date: August 2, 2011

Most Current Prior Effective Date: October 15, 2006

~~Two groups of providers~~ The following provider types are eligible for reimbursement for medical supplies, durable medical equipment (DME), orthoses, and prostheses:

- (A) Those providers who have a valid provider agreement, in accordance with eligible provider rules 5101:3-1-17 to 5101:3-1-17.4 of the Administrative Code, as provider type ~~(76)~~ "medical equipment supplier."
- (B) ~~All other~~ The following provider types who have a valid provider agreement, in accordance with eligible provider rules 5101:3-1-17 to 5101:3-1-17.4 of the Administrative Code, ~~and have an~~ may also be approved for the category of service ~~(32)~~ "supplies and medical equipment."
 - (1) Hospital;
 - (2) Physician;
 - (3) Podiatrist;
 - (4) Advanced practice nurses;
 - (5) Clinic; and
 - (6) Pharmacy.
- (C) Upon the provision of verification to ~~ODJFS~~ the Ohio department of job and family services of licensure, registration, or exemption from licensure, providers identified in paragraphs (A) and (B) of this rule are eligible to rent, sell or seek reimbursement for certain equipment considered by the Ohio respiratory care board to be subject to licensure or registration in compliance with Chapter 4752. of the Revised Code or the rules promulgated thereunder.

Effective: 08/02/2011

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/06/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 4752.01, 4752.02, 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 3/1/84, 5/1/90, 10/15/06

Effective Date: April 16, 2007

Most Current Prior Effective Date: December 10, 1993

(A) Definitions.

(1) "Medically necessary services."

Those health services **which that** are necessary for the diagnosis or treatment of disease, illness, or injury and meet accepted standards of medical practice.

(2) "Medical supplies."

Items **which that** are consumable, disposable, or have a limited life expectancy. Examples are: atomizers and nebulizers, catheters, hypodermic syringes and needles.

(3) "Durable medical equipment (DME)."

Equipment **which that** can stand repeated use, is primarily and customarily used to serve a medical purpose, is not useful to a person in the absence of illness or injury, and is appropriate for use in the home. Examples are: hospital beds, wheelchairs, and ventilators.

(4) "Orthoses."

Devices **which that** assist in correcting or strengthening a distorted body part. Examples are: arm braces, leg braces, hearing aids.

(5) "Prostheses."

Devices **which that** replace all or part of a body organ to prevent or correct physical deformity or malfunction. Examples are: artificial arms, artificial legs.

(6) "Medical equipment."

Durable medical equipment, orthoses, and prostheses.

(7) "Medical supplier services."

Any covered medical supply, durable medical equipment, orthosis, prosthesis, or related service provided by an eligible provider to an eligible recipient.

(8) "Personal residence."

Recipient's place of residence if such residence is not a hospital, nursing facility (NF) or intermediate care facility for the mentally retarded (ICF-MR).

(9) "Professional service."

Service provided by a physician, home health agency, orthotist, prosthetist, certified therapist, or other health care professional, including supplies furnished as incident to the service and **which that** are commonly either furnished as a part of the service without charge or included in the professional charge.

(B) Scope of coverage.

The medical supplier services listed as covered in appendix A **of to** rule 5101:3-10-03 and appendix A **of to** rule 5101:3-10-20 of the Administrative Code have been designated as being within the scope of the medicaid program. Any services not included on the list or designated as noncovered, are outside the scope of the program, or are components of other services. For those within the scope of the program, the department will cover the rental and/or purchase of medical supplier services after third party resources have been exhausted pursuant to rule 5101:3-1-**07_08** of the Administrative Code, and when the item requested:

- (1) Is prescribed by a physician (M.D. or D.O.) ~~or~~, a doctor of podiatric medicine (D.P.M.), an advanced practice nurse (APN) or an individual who is a certified nurse-midwife, certified nurse practitioner, clinical nurse specialist or a certified nurse anesthetist who is legally authorized under Ohio law to prescribe and/or order the covered medical supplier services;
- (2) Is determined by the department or its designee to be medically necessary;
- (3) Is provided to an eligible recipient;
- (4) Is not a component of a service that is reimbursed by:
 - (a) A DRG payment;
 - (b) Per diem rate, such as in NFs; or
 - (c) Any other payment mechanism that is designed to include coverage of the requested item;
- (5) Is not incidental to a professional service;
- (6) Is not covered under manufacturer or dealer warranty;
- (7) Unless otherwise stated, is not duplicative of any similar equipment or service currently in possession of the recipient;
- ~~(7)~~(8) Is the most cost-effective alternative ~~which~~that will meet the recipient's need as defined in paragraph (F) (8) of rule 5101:3-10-05 of the Administrative Code; and
- ~~(8)~~(9) Is for a recipient who is a resident of a NF or ICF-MR and the item is eligible for direct reimbursement as set forth in appendix A ~~of~~to rule 5101:3-10-03 and appendix A ~~of~~to rule 5101:3-10-20 of the Administrative Code, and will be used exclusively by the recipient for whom it is requested.

(C) Service limitations.

- (1) Certain devices and equipment are considered presumptively nonmedical in nature and therefore not within the scope of the medicaid fee-for-service program. Devices and equipment presumptively nonmedical include but are not limited to:
 - (a) Environmental control devices (e.g., air cleaners, air conditioners);
 - (b) Comfort and convenience devices (e.g., seat lift chairs, elevators);
 - (c) Physical fitness equipment (e.g., exercycle);
 - (d) First aid or precautionary-type equipment (e.g., preset portable oxygen units, emergency alert systems);
 - (e) Training equipment (e.g., speech teaching machines);
 - (f) Communication aids, except as covered in rule 5101:3-10-24 of the Administrative Code;
 - (g) Educational aids; and
 - (h) Hygiene equipment (e.g., bidets, bed baths).
- (2) Routine and minor first aid needs, such as band aids, antiseptics, etc., are not a benefit of the program. Likewise, personal hygiene items such as soap, or diapers for children under the age of three are not a benefit of the program.
- (3) Only standard equipment will be authorized and must be dispensed, unless specific medical information indicates a need, and prior approval has been given, for specialized equipment.
- (4) Requests for medical supplier services must originate with the ~~recipient,~~ recipient's ~~physician prescriber,~~ ~~family, or caseworker,~~ and must proceed with the recipient's full knowledge and consent.
 - (a) It is not the intent of the medicaid program that large groups of recipients in institutional or group settings be examined for defects or disabilities to determine the need for

medical supplier services, whether examinations are performed in facilities of different types or in a provider's office or store.

- (b) When requests for prior authorization of services, submitted either intermittently or en masse, indicate that group examinations have been made, such requests will be referred to the ~~bureau of surveillance and utilization review~~ office of research, assessment and accountability. ~~The bureau of surveillance and utilization review will~~ This office, at its discretion, will do an on-site review of mass requests. Those requests determined to be a part of mass screenings will be denied and returned to providers.
- (5) Devices and services generally considered by the medical profession, or designated by the federal food and drug administration, as experimental or investigational, are not covered by the program.
- (6) Equipment, devices, applications, or services are presumed to be not covered until they have been reviewed by the department for medical applications and appropriateness, safety and effectiveness, and have been designated "covered" or "noncovered." in appendix DD to rule 5101:3-1-60 of the Administrative Code.

Replaces: 5101:3-10-02.1

Effective: 04/16/2007

R.C. 119.032 review dates: 08/21/2006 and 04/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 03/30/2007

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, 10/1/88, 5/1/90, 12/10/93, 12/12/02

Formerly 5101:3-10-03 "Medicaid Supply List"

[MHTL 3334-13-13](#)

Effective Date: December 31, 2013

Most Current Prior Effective Date: [March 29, 2012](#)

5160-10-03 - [Appendix A](#), 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. 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 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 01913**, "Certificate of Medical Necessity/Prescription; General Medical Supplies: Overage" (rev. 11/2011), 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 charge submitted on a claim. A "discount" is a reduction in the amount charged to a buyer for a purchase made either directly or through a wholesaler or a group purchasing organization.

Replaces: 5160-10-03

Effective:

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

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Rule Amplifies: 5162.03, 5164.02, 5164.70, 5165.01, 5165.47

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

MHTL 3344-09-05

Effective Date: January 7, 2010

5101:3-10-04 - Appendix A: JFS 02929, Certificate of Medical Necessity/Prescription Pneumatic Compression Devices and Accessories

(A) Definitions

- (1) Lymphedema is the swelling of subcutaneous tissues due to the accumulation of excessive lymph fluid. The accumulation of lymph fluid results from impairment to the normal clearing function of the lymphatic system and/or from an excessive production of lymph. Lymphedema is divided into two broad classes according to etiology. Primary lymphedema is a relatively uncommon, chronic condition which may be due to such causes as Milroy's disease or congenital anomalies. Secondary lymphedema, which is much more common, results from the destruction of or damage to formerly functioning lymphatic channels, such as radical surgical procedures with removal of regional groups of lymph nodes (for example, after radical mastectomy), post-radiation fibrosis, and spread of malignant tumors to regional lymph nodes with lymphatic obstruction, among other causes.**
- (2) Chronic venous insufficiency (CVI) of the lower extremities is a condition caused by abnormalities of the venous wall and valves, leading to obstruction or reflux of blood flow in veins. Signs of CVI include hyperpigmentation, status dermatitis, chronic edema, and venous ulcers.**

(B) Coverage determination

- (1) Pneumatic compression devices and accessories are only covered in a private residence for the treatment of lymphedema or the treatment of chronic venous insufficiency with venous stasis ulcers.**
- (2) Pneumatic compression devices and accessories are covered in a private residence for the treatment of lymphedema if the consumer has undergone a four-week trial of conservative therapy and the prescriber determines that there has been no significant improvement or if significant symptoms remain after the trial. The trial of conservative therapy must include use of an appropriate compression bandage system or compression garment, exercise, and elevation of the limb. The compression garment may be prefabricated or custom-fabricated but must provide adequate graduated compression.**
- (3) Pneumatic compression devices and accessories are covered in a private residence for the treatment of CVI of the lower extremities only if the consumer has one or more venous stasis ulcer(s) which have failed to heal after a six month trial of conservative therapy directed by the treating prescriber. The trial of conservative therapy must include a compression bandage system or compression garment, appropriate dressings for the wound, exercise, and elevation of the limb.**
- (4) For either lymphedema or CVI with venous stasis ulcers, pneumatic compression devices are covered only when prescribed by a prescriber and when they are used with appropriate prescriber oversight, i.e., prescriber evaluation of the consumer's condition to determine medical necessity of the device, assuring suitable instruction in the operation of the machine, a treatment plan defining the pressure to be used and the frequency and duration of use, and ongoing monitoring of use and response to treatment.**
- (5) Any prescription for a pneumatic compression device and accessories must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code and who should be treating**

the consumer under a comprehensive plan of care which addresses the underlying medical need for any equipment and accessories referenced in this rule.

(C) Non-coverage determination

- (1) Pneumatic compression devices and accessories are not separately reimbursable for consumers in Long Term Care Facilities (LTCFs) as this equipment and supplies are included in the facility's per diem payment.
- (2) Accessories used for pneumatic compression of the chest or trunk will be denied as non-covered.

(D) Authorization

- (1) In addition to a fully completed prior authorization form [JFS 03142](#) (rev. 2/2003), a fully completed "Certificate of Medical Necessity/Prescription Pneumatic Compression Devices" form [JFS 02929](#) 3/2009 (appendix A to this rule) signed and dated by the treating prescriber must be obtained by the provider no more than thirty days prior to the first date of service in order to request authorization for any pneumatic compression device and/or accessories and must specify:
 - (a) The consumer's diagnosis and prognosis;
 - (b) The symptoms and objective findings, including measurements which establish the severity of the condition;
 - (c) The reason the device is required, including the treatments which have been tried and failed; and
 - (d) The clinical response to an initial treatment with the device via rental which includes the change in pre-treatment measurements, ability to tolerate the treatment session and prescribed parameters, and the ability of the consumer (or caregiver) to apply the device for continued use in the home. The initial rental period of this device cannot be less than thirty days or more than ninety days before request for purchase is made by the provider.
- (2) When a pneumatic compression device is covered, a non-segmented device or segmented device without manual control of the pressure in each chamber is generally sufficient to meet the clinical needs of the consumer.
- (3) A non-segmented compressor with a segmented appliance/sleeve is considered functionally equivalent to a compressor with a segmented appliance/sleeve.

(E) Dispensing

- (1) The following components are considered "inclusive" with any pneumatic compression device payment made by medicaid on behalf of a consumer and cannot be submitted to medicaid for separate payment:
 - (a) Any supporting wires, cables, or attachment kits;
 - (b) Education, training, monitoring, or counseling in support of the consumer's ordered treatment plan;
 - (c) Maintenance, repair, or cleaning charges incurred by the provider during a rental period; and
 - (d) Delivery, set up, or pick up charges associated with the equipment or supplies.
- (2) The provider of a pneumatic compression device must assure that the consumer (or the consumer's caregiver) is properly instructed on how to use the device and is aware of and understands any emergency procedures regarding the use of the device. The provider must maintain written documentation regarding the consumer's instruction on the use of the device in the consumer's medical record.
- (3) Upon the dispensing of a pneumatic compression device, the consumer (or the consumer's caregiver) must be supplied by the provider with a twenty-four hour, seven-day-a-week

telephone number to be utilized in case of an emergency during the rental period. This telephone number must meet all requirements of the Americans with Disabilities Act of 1990.

(F) Reimbursement

- (1) Pneumatic compression devices and accessories are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.
- (2) The department does not purchase previously utilized, refurbished or loaner pneumatic compression devices.

Effective: 01/07/2010

R.C. 119.032 review dates: 01/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 12/28/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

***Formerly* 5101:3-10-05 Reimbursement for Covered Services**

MHTL 3334-13-06

Effective Date: July 1, 2013

Most Current Prior Effective Date: January 1, 2010

- (A) Unless otherwise specified, for each claim for reimbursement, providers must keep in their files a legible ~~written or typed~~ 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 ~~written or typed~~ 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. ~~Medical supply providers are required to keep all records and prescriptions in accordance with rules 5101:3-1-17.2 and 5101:3-1-17.3 of the Administrative Code.~~
- (1) Providers are required to maintain proof of delivery documentation for durable medical equipment (DME), ~~items or equipment~~ medical supplies and orthotics and prosthetics dispensed to consumers, ~~in their files~~. 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 ~~obtained by the provider his or her~~ their relationship to the consumer, ~~in question~~. The signature of the person accepting ~~a the~~ the delivery of ~~DME items~~ should be legible. If the signature ~~of the person accepting the delivery~~ 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, ~~for the package sent to the consumer~~. The ~~shipping service's~~ tracking slip will reference each individual package, the delivery address, the corresponding package identification number ~~given by the shipping service~~, and the date delivered. ~~If a provider utilizes a shipping service or mail order, the~~ 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 ~~will~~ must be included on this invoice as well; and
- (d) For ~~those consumers who are~~ residents of a long term care facility (LTCF), 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.

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

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

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

~~(3) The DME and medical supply prescriber must be fiscally, administratively, and contractually in compliance with applicable federal "Stark II" regulation, 42 C.F.R 411.354 and federal "Anti-Kickback Safe Harbor" regulation, as it applies to referrals sent to entities with which they or members of their immediate family have a financial relationship for designated health services and as it applies to the medicaid program and medicaid consumers.~~

(B) The reimbursement ~~allowed by the department~~ for ~~medical equipment~~ DME, medical supplies, orthotics or prosthetics ~~that is rented or purchased~~ includes at a minimum; the following:

- (1) The manufacturer's and dealer's warranty; and
- (2) Any costs associated with assembling ~~medical equipment~~ items or parts used for the assembly of ~~medical equipment~~ 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 ~~equipment~~ item or items; and
- (5) Cost of delivery to the consumer's residence and, when appropriate, to the room in which the ~~equipment~~ 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 ~~equipment~~ DME, all ~~equipment~~ DME ~~that is purchased~~ must be new at the time of purchase or have been new at the time of rental. ~~for the same~~

~~consumer.~~ Used ~~equipment~~DME, if clearly designated on the prior authorization request form as used, in good working order, and covered by the same warranty as new ~~equipment~~, may be provided if approved by the department. Reimbursement for used ~~equipment~~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 ~~the purchase of~~ used ~~durable medical equipment~~DME.

- (D) Replacement items or parts will only be reimbursed for consumer-owned ~~medical equipment~~DME. See rule [5101:3-10-08](#) of the Administrative Code for details regarding reimbursement for DME repair, ~~of durable medical equipment~~.
- (E) Automatic refills of ~~medical supply orders~~ DME, medical supplies or orthotic or prosthetic items are not eligible for reimbursement. Providers ~~of medical supplies shall ascertain the quantity of supplies needed monthly by a consumer and~~ shall not dispense ~~supplies~~DME, medical supplies or orthotic or prosthetic items in excess of one month's supply ~~per month~~ for the duration of the prescribed period. No ~~supplies~~DME, medical supplies or orthotic or prosthetic shall be billed before they have been provided, ~~to the consumer~~.
- (F) Unless otherwise stated, payment for ~~durable medical equipment~~DME (including custom wheelchairs, power wheelchairs and all wheelchair parts and accessories), medical supplies, ~~orthoses, and prostheses~~ orthotics or prosthetics is reimbursed utilizing the following criteria:
- (1) When the item or items ~~in question~~ 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 medicaid maximum rate that appears ~~on in this~~ appendix ~~DD to rule 5101:3-1-60 of the Administrative Code~~; or
 - (2) When the item or items ~~in question~~ do not appear in appendix DD ~~to rule 5101:3-1-60 of the Administrative Code~~ or appear but without a medicaid maximum rate and the provider has submitted a list price for payment, ~~but a list price is presented to the department for reimbursement~~, 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 seventy-two per cent of the list price; or
 - (3) When the item or items in question do not appear in appendix DD ~~to rule 5101:3-1-60 of the Administrative Code~~ or appear but without a medicaid maximum rate and the provider has submitted an invoice price for payment, ~~and there is no list price that is presented to the department for reimbursement~~, 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 one hundred forty-seven per cent of the ~~provider's~~ 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 paragraph (F)(1), (F)(2) and (F)(3) occur concurrently, the department will reimburse the amount determined to be the most cost effective.
 - ~~(4) When paragraph (F)(2) of this rule is otherwise applicable but the department has available the providers invoice price, the department will pay the lesser of the amounts determined under paragraphs (F)(2) and (F)(3) of this rule.~~
 - (5) The "list price" is defined as the most current price ~~of an item or items that is~~ recommended by the ~~product's~~ manufacturer for retail sale. This price cannot be established nor obscured or deleted by the provider on any documentation supplied ~~to the department~~ 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 ~~manufacturer produced~~ products. ~~This price and documentation~~ Documentation submitted to support this price is subject to approval by the department.
 - (6) The "invoice price" is defined as the price ~~of an item or items~~ delivered ~~by the provider~~ to the consumer ~~that gives details of price, quantity and type of supplies dispensed to the consumer~~

and reflects the provider's net costs in accordance with ~~paragraph (I) of~~ rule [5101:3-10-03](#) of the Administrative Code. This information cannot be obscured or deleted on any documentation supplied ~~to the department~~ for consideration of reimbursement. ~~This price and documentation Documentation~~ submitted to support this price is subject to approval by the department.

(7) Costs of delivery and service calls related to DME, ~~and medical supply items~~ medical supplies, orthotics or prosthetics ~~must be~~ considered an integral part of the ~~supplier's~~ provider's cost of doing business. A charge for these services will not be recognized when billed separately, ~~as a component of any reimbursement rate for services rendered.~~

(8) ~~It is expected that the~~ The consumer ~~will be~~ must be supplied with the most cost effective ~~durable medical equipment~~ DME, medical supply or orthotic or prosthetic that ~~will meet the consumer's~~ meets their clinical needs, ~~as identified and ordered by the prescriber.~~

Cost effective ~~durable medical equipment~~ is defined ~~by the Ohio department of job and family services (ODJFS)~~ to mean ~~that the provider has taken into account all of the consumer's clinical and ambulatory needs in order to identify durable medical equipment that will meet~~ items which meet the consumer's clinical and lifestyle requirements ~~utilizing specific equipment and/or medical supplies that are available~~ at the lowest available cost, ~~to ODJFS.~~

(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 ~~recipient,~~ consumer are not reimbursable.

(1) "Conflicting equipment" is defined as equipment which ~~is contraindicated due to the possession by the consumer of equipment, regardless of payment source, which~~ serves the same or a similar purpose regardless of payment source. Examples ~~would be~~ include a wheelchair followed by a power-operated vehicle ~~(or vice versa),~~ or more than one wheelchair.

(2) Suppliers are responsible for ascertaining ~~in the preliminary discussion with the consumer and/or attending prescriber,~~ whether there is conflicting equipment. All ~~suppliers~~ providers are expected to know whether ~~currently~~ requested equipment is contraindicated by equipment supplied by a different ~~supplier.~~ provider.

(3) If change in a consumer's condition ~~changes and~~ warrants a change in ~~new or different~~ equipment, the existing equipment must be noted ~~and appropriate medical documentation must be furnished~~ 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 ~~equipment specific~~ warranty ~~and the date of purchase~~ in their files. A copy of the ~~equipment specific~~ warranty must be provided upon ~~on the~~ request of the department and must be submitted with any prior authorization request for repairs.

Any repair or servicing done on ~~consumer durable medical~~ equipment that is consumer owned must be documented, ~~and~~ kept in the providers file, ~~and be accessible to the Ohio medicaid program~~ provided to the department upon request.

(I) Purchase or rental of durable medical equipment.

A ~~current prescriber's~~ prescription must accompany each request for the prior authorization of ~~purchase or rental of durable medical equipment.~~ 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, ~~and is documented.~~

(1) Rental only.

Certain ~~durable medical equipment~~ DME requiring servicing to ensure the health and safety of recipients will be designated as "rental only." Rental only equipment is designated RO in ~~the "Medicaid Supply List"~~, 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) ~~In some instances the department may determine that short term rental would be more appropriate or cost effective than purchase of an item. In these instances,~~ The rental of equipment DME will ~~may~~ be approved when it is determined to be more cost-effective than purchase. ~~Approved~~ 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 ~~of equipment~~ will be made at ten per cent per month of the maximum amount allowable ~~for a specific item.~~ Use Providers should use the modifier ~~code~~ 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, ~~or items in question, and will note the decision to purchase on the prior authorization form.~~ Upon a decision ~~is made~~ to purchase, ~~the equipment,~~ all prior rental payments will apply toward the purchase price ~~of the item or items in question,~~ and the provider will receive one final payment for the remainder of the ~~items~~ item's maximum allowable amount as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. ~~The equipment will then be considered purchased and becomes the property of the consumer.~~ The provider will notify the consumer when an item has been purchased on ~~his or her~~ their behalf, ~~by ODJFS.~~

(c) ~~The combined total reimbursement for rental and subsequent (within ninety days of the end of the rental service) purchase of a DME item, cannot exceed the medicaid maximum fee.~~

(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 reimbursement for those DME items designated as R/P in appendix A to rule 5101:3-10-03 of the Administrative Code.

(d) ~~Unless otherwise specified, durable medical equipment listed in rule 5101:3-10-03 of the Administrative Code that is designated R/P must have a prior authorization before reimbursement is authorized.~~

(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 billable only those days when the consumer is eligible and the item is medically necessary. ~~are billable to the department.~~

(K) ~~All medicare covered~~ Medicare-covered services provided to residents of long-term care facilities who are dually eligible for medicare and medicaid ~~eligible~~ must be billed ~~by the supplier~~ directly to

medicare. ~~When paid~~ Following payment by medicare, medicaid payment will be made ~~by the department as a crossover payment~~ directly to the ~~medical supplier~~ provider.

- (L) Reimbursement for a back-up ~~equipment for a medically necessary mechanical~~ ventilator may be allowed upon provision of ~~only when~~ the documentation required in rule [5101:3-10-22](#) of the Administrative Code, ~~is provided~~.
- (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, ~~provided to eligible consumers who are residents of nursing facilities~~, may be ~~billed~~ submitted for reimbursement ~~direct to ODJFS~~. when provided to eligible residents of nursing facilities. ~~Nonmolded helmets and splints must be billed to the facility and are reimbursed through the per diem payment in accordance with Chapter 5101:3-3 of the Administrative Code~~.

(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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R.C. 119.032 review dates: 01/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 06/21/2013

Promulgated Under: 119.03

Statutory Authority: 5111.02, Sect. 309.30.75 of Am. Sub. H.B. 1 of 128th GA

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30 75 of Am. Sub. H.B. 1 of 128th GA

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Formerly 5101:3-10-21 Incontinence Garments and Related Supplies

MHTL 3344-11-02

Effective Date: April 25, 2011

Most Current Prior Effective Date: October 1, 2004

5101:3-10-21 Appendix A: JFS 02912, Certificate of Medical Necessity/Prescription Incontinence Supplies

- (A) Incontinence garments and related supplies, including disposable underpads, are covered by the medicaid program under the following conditions:
- (1) The medicaid consumer is ~~more than~~ thirty-six months of age or more; and
 - (2) The consumer is not a resident of a nursing facility or an intermediate-care facility for the mentally retarded. Coverage of incontinence garments and related supplies to these consumers is provided as part of the per diem payment to the facility already paid to the facility by the department for this consumer's monthly care; and
 - (3) The type of incontinence is:
 - (a) Secondary to disease ~~which that~~ results in irreversible loss of control of the urinary bladder and/or anal sphincter; or
 - (b) Secondary to injury of the brain or the spinal cord ~~which that~~ results in irreversible loss of control of the urinary bladder and/or anal sphincter; or
 - (c) Attributed to developmental delay or developmental disability.
 - ~~(4) Stress incontinence is considered a type of incontinence, but does not meet the definition of disease or injury as specified in paragraph (A)(3) of this rule. Consumers with stress incontinence that is secondary to other disease or injury causing irreversible loss of control of the urinary bladder and/or anal sphincter may be eligible for incontinence garments and related supplies provided that all requirements of this rule are met.~~
- (B) Stress incontinence is considered a type of incontinence, but does not meet the definition of disease or injury as specified in paragraph (A)(3) of this rule. Consumers with stress incontinence that is secondary to other disease or injury causing irreversible loss of control of the urinary bladder and/or anal sphincter may be eligible for incontinence garments and related supplies provided that all other requirements of this rule are met.
- ~~(B)~~(C) A prescription Unless otherwise specified, a fully completed "Certificate of Medical Necessity/Prescription Incontinence Supplies," JFS 02912 (appendix A to this rule) that is written, signed with an original signature, and dated by the treating ~~physician~~prescriber must be obtained at least every twelve months from the date of the prescriber's attestation signature and kept on file by the provider. Existing prescriptions that are in force prior to the effective date of this rule do not require the use of JFS 02912 until the existing prescription is renewed or modified due to medical necessity. The prescription JFS 02912 must be obtained by the provider prior to the first date of service in the applicable twelve-month period and must specify:
- (1) The applicable diagnosis of the specific disease or injury causing the incontinence; or
 - (2) The developmental delay or disability, including applicable diagnoses; ~~and~~
 - (3) The type of incontinence ~~;~~; and
 - (4) The type of incontinence garments or incontinence supplies being prescribed.
- ~~(C)~~(D) A prescription JFS 02912 that only lists incontinence or incontinence supplies and does not specify the disease or injury that has resulted in the incontinence in accordance with paragraph ~~(B)~~(C) of this rule does not meet the requirements of this rule.

~~(D)~~(E) Providers must ~~ascertain~~verify from the consumer or the consumer's designated caregiver on a monthly basis the required type and number of ~~of~~ incontinence garments and/or related supplies.

- (1) The ~~providers~~provider must maintain on file written documentation of the required type and amount of incontinence garments and/or related supplies requested for each month. The documentation must include the date that the provider ~~ascertained~~verified the required type and amount from the consumer or consumer's care giver. The date that the provider ~~ascertained~~verified the required type and amount must be prior to but not more than fourteen days prior to the date that the incontinence supplies are dispensed.
- (2) The type and amount required may be ~~ascertained verbally~~ verified orally or in writing from the consumer or the consumer's designated caregiver. For each month's worth of incontinence garments and supplies, the date of service entered on the medicaid claim (dispensing date) should not be prior to the date that the provider ~~ascertained~~verified the type and amount of incontinence supplies required for the month.
- (3) Documentation of the type and amount of incontinence garments and/or related supplies requested must include the first and last name of the provider's employee that took the request and the first and last name of the consumer, or consumer's care giver, making the request.
- (4) Documentation of the type and amount of incontinence garments and/or related supplies required by a consumer on a monthly basis must be obtained and on file prior to dispensing the incontinence garments and/or related supplies. Under no circumstances may the amount of the incontinence garments and/or related supplies exceed the amount prescribed by the consumer's prescriber as originally documented on the JFS 02912. A new JFS 02912 is required when changes in a consumer's medical condition require an increased amount of incontinence garments or related supplies within twelve months of the date of the most recent prior prescriber's attestation signature.
- (5) Any prescription for incontinence garments and related supplies must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code. This prescriber should be treating the consumer under a comprehensive plan of care that addresses the underlying medical need for any supplies referenced in this rule.
- (6) Any request for incontinence supplies that exceeds the limitation amounts currently referenced in Appendix A to rule 5101:3-10-03 requires that the provider submit a fully completed JFS 02912 as referenced in paragraph (C) of this rule to the department for prior authorization before payment is authorized for the dispensing of these excess supplies.
- (7) Incontinence garments and related supplies are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

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5160-10-22 Volume Ventilators, Positive and Negative Pressure Ventilators, Continuous Positive Airway Pressure (CPAP), Alternating Positive Airway Pressure (APAP), and Intermittent Positive Pressure Ventilation (IPPV)

Formerly 5101:3-10-22 Volume Ventilators, Positive and Negative Pressure Ventilators, Continuous Positive Airway Pressure (CPAP), Alternating Positive Airway Pressure (APAP), and Intermittent Positive Pressure Ventilation (IPPV)

Effective Date: January 1, 2008

Most Current Prior Effective Date: [October 1, 2004](#)

5101:3-10-22 Appendix A: [JFS 01902](#), Certificate of Medical Necessity/Prescription Mechanical Ventilators

5101:3-10-22 Appendix B: [JFS 01903](#), Certificate of Medical Necessity/Prescription IPPV or APAP in Lieu of a Volume Ventilator

- (A) Any provider billing for ventilatory support services (including volume ventilators, positive and negative pressure ventilators, CPAP, APAP and IPPV) shall have on staff or under contract a licensed respiratory care professional (LRCP) available on a twenty-four-hour basis, seven days a week to provide respiratory care, technical support and clinical ventilator services.
- (B) Mechanical ventilator services are covered for ~~recipients~~consumers residing in a personal residence, a nursing facility (NF), or an intermediate care facility for the mentally retarded (ICF-MR). The monthly rental fee includes reimbursement for the use of a mechanical ventilator, all service and maintenance, related ventilator supplies and equipment listed in paragraph (B)(6)(a) of this rule, and the LRCP services listed in paragraph (B)(6)(b) of this rule. For a pressure ventilator used as an alternative to a volume ventilator, noninvasive applications are covered when a tracheostomy is not medically necessary.
 - (1) Ventilator definitions
 - (a) "Invasive mechanical ventilator." An invasive application requires the ventilator be interfaced directly with the ~~patient~~consumer via an artificial airway (e.g., tracheostomy tube). Invasive mechanical ventilators (volume and/or pressure) are life support devices designed specifically for invasive mechanical ventilation applications and must accommodate direct current (DC) backup power supply and include disconnect, high pressure, low pressure and power loss alarms.
 - (b) "Non-invasive mechanical ventilator." Non-invasive mechanical ventilators (volume, or positive or negative pressure) may be used as an alternative to invasive mechanical ventilator services for ~~recipients~~consumers with appropriate medical necessity and when the ~~patient's~~consumer's attending ~~physician~~prescriber has deemed a tracheostomy not medically necessary.
 - (2) Mechanical ventilator coverage criteria
 - (a) To be considered for coverage, ~~patients~~consumers must require periodic or continuous mechanical ventilation (volume, or positive or negative pressure). A ~~patient~~consumer must demonstrate appropriate medical necessity supporting the need for mechanical ventilatory support as treatment for respiratory insufficiency and/or respiratory failure resulting from one or more of the following conditions:
 - (i) Chronic respiratory failure
 - (ii) Spinal cord injury
 - (iii) Neuromuscular diseases
 - (iv) Chronic pulmonary disorders
 - (v) Other neurological disorders and thoracic restrictive diseases

- (3) Medical necessity for pressure support ventilator with volume control is the same as above and also includes the following supportive information:
- (a) Statement from the ~~physician-prescriber~~ that the ~~patient~~ consumer has tried unsuccessfully to be managed with a volume ventilator, and
 - (b) Statement from the ~~physician-prescriber~~ that the advanced technology offered by this pressure ventilator is required for the safe and appropriate management of the ~~patient~~.consumer
- (4) Invasive mechanical ventilator services, with backup rate feature, do not require prior authorization for the first three months of use by any particular consumer. Other ventilator services may be prior authorized for up to six months at the time of initial prior authorization. ~~Patients~~Consumers with chronic nonreversible respiratory insufficiency and/or failure may receive lifetime authorization for rental, ~~capped rental~~ or purchase at the discretion of the department. All requests for prior authorization of ventilator services must include a fully completed "Certificate of Medical Necessity/Prescription Mechanical Ventilators" form JFS 01902, rev. 06/2007 (appendix to this rule)"Prior Authorization" form JFS 03142 and a prescription from a physician who has examined the patient within thirty days prior to the first date of service being requested. The ~~prescription, or an attached~~ certification of medical necessity, must include:
- (a) Medical history (not required if request is for continuation of services),
 - (b) Diagnosis and degree of impairment,
 - (c) Degree of ventilatory support required (e.g., continuous, nocturnal only),
 - (d) Ventilator settings/parameters including mode and type of ventilator ordered at time of prior authorization request,
 - (e) List of other respiratory equipment in use,
 - (f) Documentation that recipient is being weaned (if applicable),
 - (g) Documentation of initial LRCP services described in (B)(6)(b) of this rule, when performed before prior authorization request, and
 - (h) Documentation (e.g., copy of a recent checksheet) that a LRCP routinely checks or changes ventilator settings in compliance with ~~physician-prescriber~~ ordered parameters or protocol (not applicable to initial prior authorization request).
- (5) Any change in the type of equipment provided, other than invasive mechanical ventilators with backup rate feature used with invasive interface, will require a new prior authorization request with supporting documentation as described in paragraph (B)(4) of this rule.
- (6) The monthly rental payment for ventilator services includes reimbursement for the following equipment and supplies and respiratory services:
- (a) Equipment and supplies
 - (i) Mechanical ventilator and accessories, including inlet ventilator filters,
 - (ii) Humidifier bacteria filters,
 - (iii) Humidifier tubing (ventilator to humidifier),
 - (iv) Heated humidifiers,
 - (v) Permanent or reusable ~~patient~~consumer circuits (disposable ~~patient~~ consumer circuits are billable only to NFs and ICFs-MR), and
 - (vi) Related accessory and supply items including tracheostomy flex tubes, and peep valves.
 - (vii) ~~All heated humidifiers for use with mechanical ventilators may be billed separately.~~

- (b) Licensed respiratory care professional (LRCP) services
 - (i) Home evaluation (prior to discharge), and home equipment set-up.
 - (ii) In-home training of the caregiver(s) (e.g. ventilator operation, tracheostomy care, cleaning/sterilization techniques).
 - (iii) LRCP visits to include multiple visits in the first week of service and subsequent visits no less frequent than once per month for the first six months, then not less than every sixty days thereafter, at a frequency determined by the LRCP, in consultation with the ~~patient's physician~~ consumer's prescriber, to be appropriate to the ~~patient's~~ consumer's condition.
 - (iv) Routine maintenance as specified by manufacturer or company protocol and in compliance with industry standards.
 - (v) Twenty-four-hour on call respiratory therapist services with two-hour response for emergency visits to include equipment servicing, repair or replacement.
- (7) Reimbursement for a secondary or back-up mechanical ventilator for a medically necessary mechanical ventilator may be allowed when the ~~recipient~~ consumer meets the following criteria and only when ~~appropriate~~ appropriated documentation is provided:
 - (a) Statement from the ~~physician~~ prescriber that the ~~recipient~~ consumer cannot maintain spontaneous ventilation for four or more hours, or
 - (b) Statement from the ~~physician~~ prescriber that the ~~recipient~~ consumer requires mechanical ventilation during regular mobility (e.g. attends school or outpatient therapy) as prescribed in their plan of care and needs a second ventilator attached to their wheelchair or mobility device, or
 - (c) Statement from the supervisor of the emergency team(s) responsible for serving the ~~recipient's~~ consumer's address that the emergency medical team estimated response time is more than two hours.
- (8) When ventilators are provided to medicaid eligible residents of a NF or ICF-MR, reimbursement shall not be provided for more than one back-up ventilator per eight primary ventilators present in the same facility.
- (C) Service and maintenance on ~~patient~~ consumer-owned ventilators requires prior authorization and may be billed once per month. The prior authorization request and documentation of medical necessity must include a ~~physician~~ prescriber prescription for mechanical ventilatory support, ~~patient~~ consumer diagnosis and degree of impairment. Payment will be authorized only when the department determines that the ventilator is medically necessary.
- (D) Sleep therapy
 - (1) Definitions
 - (a) "Apnea" is the cessation of airflow for at least ten seconds documented on a polysomnogram.
 - (b) "Hypopnea" is an abnormal respiratory event lasting at least ten seconds associated with at least a thirty per cent reduction in thoracoabdominal movement or airflow as compared to baseline, and with at least a four per cent decrease in oxygen saturation.
 - (c) The "apnea-hypopnea index" (AHI) is the average number of episodes of apneas and hypopneas per hour and must be based on a minimum of two hours of recording time without the use of a positive airway pressure device, reported by polysomnogram. The AHI may not be extrapolated or projected.
 - (2) With prior authorization, payment can be made for a continuous positive airway pressure (CPAP) home system. The CPAP system was designed for ~~patients~~ consumers with obstructive sleep apnea. Rental for a six-month period or purchase may be authorized only when a trial

period has proven to be beneficial. Documentation will be necessary to substantiate ongoing rental or purchase.

- (a) A request for prior authorization must contain all of the following information:
 - (i) A statement of medical necessity from the ~~patient's~~ consumer's attending ~~physician~~ prescriber indicating:
 - (a) Diagnosis of obstructive sleep apnea (OSA).
 - (b) Surgery is a likely alternative.
 - (ii) Sleep study reports from both a diagnostic and a titration sleep study (these may be performed as two separate studies or consecutively as a split study) conforming to the following:
 - (a) The sleep studies must be performed in an attended, facility-based sleep study laboratory which is eligible for reimbursement by the department for the study, and not in the home or in a mobile facility. A DME supplier may not perform the study.
 - (b) During at least two hours of recorded sleep for the diagnostic study,
 - (i) The AHI is equal to or greater than fifteen events per hour, or
 - (ii) The AHI is from five to fourteen events per hour with documented symptoms of excessive daytime sleepiness, impaired cognition, mood disorders, insomnia or hypertension, ischemic heart disease, or history of stroke.
 - (c) The titration study of at least three hours duration shows efficacy of the CPAP system by decreasing the number of airway obstructions per hour and
 - (i) Shows a percentage increase in oxygen saturation of at least fifteen per cent (e.g., eighty per cent to ninety-two per cent), or
 - (ii) Shows an increase in oxygen saturation to eighty-nine per cent or greater, or
 - (iii) At the discretion of the department, shows other clinical improvement.
 - (d) If oxygen is needed in addition to CPAP, documentation of effectiveness must be shown by the sleep study.
 - (iii) A statement from the ~~prescribing physician~~ attending prescriber documenting any correctable causes of the ~~patient's~~ consumer's sleep apnea which are present, (e.g., alcohol, bedtime sedatives/hypnotics, weight) and whether or not they are being treated or have been abolished. It must be specified if none exist.
 - (iv) A statement from the ~~prescribing physician~~ attending prescriber, indicating whether the ~~patient~~ consumer is symptomatic or asymptomatic and what impairment(s) secondary to sleep apnea is (are) present. If the ~~patient~~ consumer is symptomatic, improvement must be documented and significant to be considered for coverage.
 - (v) A statement from the ~~prescribing physician~~ attending prescriber certifying that the ~~recipient~~ consumer is using the device regularly as prescribed.
 - (b) If any of the information in paragraph (D)(2)(a) of this rule is missing or provided by the supplier instead of the ~~prescribing physician~~ attending prescriber, prior authorization will be denied. A new request for authorization may be resubmitted with the required information.
- (3) When determined medically appropriate based on a facility-based sleep study, a bi-level/alternating positive airway pressure (APAP) system may be prior authorized for obstructive sleep apnea when a fully completed Certificate of Medical Necessity/Prescription "IPPV or

APAP in lieu of a Volume Ventilator" form [JFS 01903](#), rev. 6/2007 (appendix to this rule) ~~additional documentation~~ is provided that demonstrates:

- (a) CPAP has been tried and is ineffective.
- (b) APAP was titrated during the sleep study, or a one-week trial period using a respiratory support system bi-level/APAP was effective; and
- (c) The ~~prescribing physician~~ attending prescriber certifies in writing the effectiveness of the system and that the ~~patient~~ consumer is using the device regularly as prescribed.

(E) If there is discontinuation of the use of any respiratory assist device at any time, the supplier is expected to ascertain this, and stop billing for the equipment and related accessories and supplies.

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R.C. 119.032 review dates: 10/16/2007 and 01/01/2013

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~~*Formerly*~~ 5101:3-10-23 Pulse Oximeters

[MHTL 3344-07-02](#)

Effective Date: April 16, 2007

Most Current Prior Effective Date: [July 1, 1993](#)

5101:3-10-23 Appendix A: [JFS 03401](#): Certificate of Medical Necessity/Prescription Pulse Oximeter

- (A) A pulse oximeter is a covered medical equipment item eligible for reimbursement when used in a personal residence as an alternative to hospitalization to manage the care of oxygen dependent pediatric recipients. Home pulse oximetry is covered when used to monitor oxygen saturation in order to determine appropriate supplemental oxygen levels. Home pulse oximetry is not covered for the purpose of qualifying or requalifying a patient for home oxygen. ~~All oximeters approved for coverage must have printing capabilities.~~
- (1) All oximeters approved for coverage must have printing capabilities that document an adequate number of sampling hours, per cent of oxygen saturation and an aggregate of the results.
 - (2) The oximeter must be preset, self-sealed and not adjustable by the consumer or anyone in the home.
 - (3) All oximeter printouts must be reliable, legible and maintained in the consumer's medical record.
 - (4) The consumer and/or the consumer's caregiver must be trained in the proper use of the pulse oximeter, the proper recording of measurements, and in whatever action is necessary to reverse a low oxygen saturation level. Documentation of this training must be kept in the provider's files.
- (B) The following methods of home pulse oximetry services are covered:
- (1) "Diagnostic monitoring," which is defined as monitoring for periods of up to twenty-four hours in length. Coverage is limited to a maximum of four monitoring periods per month. Prior authorization is required for diagnostic monitoring; ~~or.~~
 - (2) "Continuous monitoring," which is defined as twenty-four-hour monitoring, seven days a week. Prior authorization is required for rental or purchase of an oximeter for use in continuous monitoring and may be requested for three months at a time when equipment is rented.
- (C) All prior authorization requests must include a fully completed [JFS 03401](#) (rev. 6/2006) "Certificate of Medical Necessity/Prescription Pulse Oximeter" (CMN) (appendix A to this rule) that is signed by an eligible prescriber and dated no more than thirty days prior to the first date of service. ~~"Prior Authorization" form ODHS 3142, a physician prescription which includes certification that the only alternative to home oximeter monitoring is hospitalization, recipient prognosis, and documentation by the provider that the recipient's caregivers have been or will be trained in the appropriate use of the monitoring equipment and that the home environment is conducive to the monitoring.~~ Additionally, the following criteria and documentation requirements must be met to establish medical necessity:
- (1) Diagnostic monitoring.
 - (a) Diagnostic monitoring may be approved for payment to assess oxygen saturation:
 - (i) When a ~~recipient~~ consumer is weaning from oxygen and/or prior to weaning; or
 - (ii) On a periodic basis for oxygen dependent, clinically unstable ~~recipients~~ consumers.
 - (b) Prior authorization requests must include ~~documentation of one or more of the following:~~ legible oximeter printouts of any prior oximeter monitoring and documentation of the resulting impact on the management of the consumer's care.
 - ~~(i) Risk for critical fluctuations in oxygen saturation;~~
 - ~~(ii) History of clinical instability;~~

- ~~(iii) History of chronically compromised respiratory and/or cardiac function;~~
- ~~(iv) History of frequently varying oxygen requirements;~~
- ~~(v) History of dependence on mechanical ventilatory support; or~~
- ~~(vi) Other risk factors which may compromise recipient's ability to wean.~~
- ~~(vii) In addition, oximeter printouts of any prior oximeter monitoring and documentation of the resulting impact on the management of the recipient's care must be provided.~~

(c) Diagnostic monitoring may be considered for authorization when provided to a recipientconsumer in response to a significant clinical event or exacerbation of clinical status ~~which~~that results in a critical change in oxygen saturation or ~~which~~that requires diagnostic monitoring in order to assess oxygen saturation. Since oximeter monitoring under these circumstances must be provided immediately after the clinical event in order to assure timely assessment of oxygen requirements, authorization for payment will only be considered after the service has been provided.

(2) Continuous monitoring.

Continuous oximeter monitoring in the home may be appropriate in the management of pediatric recipientsconsumers with prolonged oxygen dependency who are at risk of a critical fluctuation in oxygen saturation. Requests for prior authorization of continuous home oximeter monitoring ~~should~~ will include documentation by the managing physicianprescriber that the recipientconsumer is clinically unstable with chronically compromised respiration and frequently varying oxygen requirements, at risk for critical fluctuations in oxygen saturation, and experiencing one or more of the following:

- (a) Frequent bradycardia;
- (b) Frequent oxygen desaturation;
- (c) Chronic lung disease;
- (d) Ventilator dependent;
- (e) Poor growth and development and suspect for inadequate oxygenation; or
- (f) Other risk factors ~~which~~that may result in sudden, critical fluctuations in oxygen saturation (hyperoxia, hypoxia).

(D) Rental payments will be made for oximeters used for diagnostic and continuous monitoring. Oximeters will be considered for purchase ~~only~~ when continuous monitoring is authorized for periods in excess of ~~nineteen~~ ten months; subsequent monthly rental payments, less the cost of the probes, will be applied to the purchase price. The monthly rental payment amount includes reimbursement for:

- (1) Set up and instructions;
- (2) Maintenance and repair;
- (3) Emergency service visits or other interim visits;
- (4) Supplies and accessories (cable, printer/printer tape, carrying case, etc.); and
- (5) Permanent, reusable, or disposable probes (transducers) and probe wraps or tape.

(E) Oximeter probes may be purchased when prior authorized for use in conjunction with continuous monitoring when a monitor is purchased by the Ohio department of job and family services (ODJFS) medicaid and when a monitor is owned by the recipientconsumer, if continuous monitoring has been determined to be medically necessary in accordance with this rule. Oximeter probes must be billed using the ~~code~~ codes established for that purpose and listed in appendix A ~~of~~ to rule 5101:3-10-03 of the Administrative Code.

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Prior Effective Dates: 7/1/93

Formerly 5101:3-10-24 Speech Generating Devices (SGD)

[MHTL 3344-12-02](#)

Effective Date: May 1, 2012

Most Current Prior Effective Date [October 1, 2004](#)

Appendix: [JFS 02924](#), Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Initial Certification

Appendix: [JFS 02925](#), Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Recertification

Appendix: [JFS 02926](#), Certificate of Medical Necessity/Prescription Speech Generating Device (SGD)

Unless otherwise specified, the licensing of persons authorized to conduct a formal evaluation of a consumer's communication and related cognitive and physical abilities for the purpose of dispensing an SGD to a medicaid consumer is administered according to Chapter 4753. of the Revised Code. Any provider seeking reimbursement for this service must meet the provisions contained within Chapter 4753. of the Revised Code in order to be eligible for reimbursement for services provided.

(A) Definitions

(1) Speech generating device (SGD): Any electronic aid or device approved for use as an SGD that provides external assistance for communication and is an integral part of a speech-language pathology treatment plan for a consumer with a communication disability who is unable to satisfy his or her basic communication needs.

Basic communication needs are defined as a consumer's ability to communicate needs and wants, transfer information, achieve social closeness, and demonstrate social etiquette.

(2) Speech: The ability to vocalize by coordinating the muscles controlling the vocal apparatus (lips, tongue, jaw and vocal folds). It is the mechanical aspect of oral communication.

(3) Language: Refers to symbolic communication and permits the ability to converse, comprehend, repeat, read, and write. Language ability depends on central processing for either comprehension or formulation for expressing the sounds and symbols of prepositional communication. Difficulty in articulation or vocalization implies a speech disorder, whereas the inability to find words, comprehend, read, or write is indicative of a language disorder.

(4) Speech language pathologist (SLP): The SLP is a licensed health professional, educated at the graduate level in the study of human communication, its development and its disorders. The SLP must comply with all applicable federal and state licensing laws.

(5) Date of service (DOS): The effective DOS for this rule is defined as the date that the consumer is evaluated by the provider for the use of an SGD device.

(B) Coverage determination

(1) Before the delivery of the SGD, the consumer must have a documented face-to-face evaluation of his or her communication abilities by an SLP. The SLP performing the consumer evaluation may not be an employee or have a financial relationship with the supplier of the SGD. The formal, written evaluation must include all of the following elements:

(a) Current communication impairment, including the type, severity, language skills, and anticipated course of the impairment;

(b) An assessment of whether the consumer's daily communication needs could be met using other natural or aided modes of communication;

(c) Clinical documentation supporting the assessment that the consumer possesses the linguistic capability to formulate a message independently;

- (d) Clinical documentation supporting the assessment that the consumer possesses cognitive and physical abilities to effectively use the selected device and any accessories to communicate;
 - (e) A description of the functional communication goals expected to be achieved and treatment options;
 - (f) Rationale for selection of a specific device and any accessories;
 - (g) Demonstration that the consumer possesses a comprehensive treatment plan that includes a training schedule for the selected device;
 - (h) For any subsequent upgrade to a previously issued SGD, information regarding the functional benefit to the consumer of the upgrade compared to the initially provided SGD to include a full device description of the most current SGD being requested;
 - (i) A full disclosure of any SGD equipment that the consumer already possesses to include a statement as to why the current equipment does not currently meet the consumer's needs which is supported by clinical documentation from the consumer's medical record;
 - (j) Documentation supporting the medical necessity of any accessory or add-on equipment, supplies or SGD features being requested;
 - (k) The evaluation must be signed and dated by all parties of the consumer's evaluation team to include professional licensure numbers;
 - (l) The consumer's medical condition is one resulting in a severe expressive speech impairment that is supported by documentation in the consumer's medical record;
 - (m) The consumer's speaking needs cannot be met using natural communication methods;
 - (n) Other forms of speech impairment treatment have been considered and ruled out; and
 - (o) The consumer's speech impairment and communication ability will benefit clinically from the device ordered.
- (2) A copy of the SLP's written evaluation and recommendation must be forwarded to the consumer's treating prescriber before the device is ordered and kept in the consumer's medical records.
- (3) Mounting brackets used in association with the installation of the SGD to a consumer's wheelchair can be billed to the department for separate reimbursement using the appropriate billing codes for these devices.

(C) Eye control SGD accessory

- (1) Eye control technology for use with an SGD commonly employs infrared illumination of the pupil or cornea with digital camera tracking integrated into the SGD.
- (2) Eye control technology for an SGD must only be considered as a last choice after all other methods of operating the SGD device have been evaluated and determined by the evaluating SLP not to meet the consumers needs. The SLP must document on the prior authorization form and in the consumer's medical record that alternative SGD control devices other than eye control were evaluated before requesting eye control technology for a specific SGD device.
- (3) The consumer must have a specific documented medical necessity that supports the request for an eye control SGD accessory including but not limited to the following:
 - (a) Consumer has a documented history of a brainstem stroke;
 - (b) Consumer has Guillain Barre syndrome;
 - (c) Consumer is in the final stages of amyotrophic lateral sclerosis (ALS);
 - (d) Consumer has a documented occurrence of a severe traumatic brain injury that resulted in the complete loss of head movement.

- (4) Approval for an eye control SGD accessory for a consumer is based on medical necessity as determined by the department.
- (5) In order for a request for an eye control SGD accessory to be considered the provider must document that the consumer is able to use an eye control SGD accessory independently and successfully in the environments and situations in which the consumer is using the SGD device.
- (6) Any SGD eye control accessory associated with the consumer's use of an SGD device will not be reimbursed by the department for an amount greater than five thousand six hundred dollars .
- (7) The consumer must be provided with the most cost-effective SGD available to meet the medical needs of the consumer.

(D) Non-coverage determination

- (1) Claims for more than one SGD at a time per qualifying consumer will be denied as not medically necessary.
- (2) Environmental control devices are not separately reimbursable.
- (3) Any non-medical software, accessory, application or hardware to include internet capabilities used in conjunction or compatible with the SGD are not separately reimbursable without the department's prior authorization.
- (4) Personal computers and related hardware are not reimbursable unless the system has been adapted for use primarily as an SGD. The documentation supporting this adaptation must be maintained in the provider's records and on the prior authorization form.
- (5) There will be no separate billing of any interfaces, printers, printer paper, cables, adapters, interconnects, or any other standard component necessary for the accessory to interface with any SGD in conjunction with the initial dispensing of this equipment to the consumer that is non-medical in nature without the department's prior authorization.
- (6) Consumer training expenses related to the operation of the SGD are not separately reimbursable.

(E) Authorization

- (1) The following documentation must be submitted for prior authorization (PA) before reimbursement for an initial SGD will be considered:
 - (a) A fully completed and legible JFS 02924 "Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Initial Certification" (appendix A to this rule) that is signed by the applicable licensed providers and dated no more than ninety days before submission for prior authorization; and
 - (b) Any other documentation required or requested by the department.
- (2) Documentation for the prior authorization of an SGD must be submitted with the appropriate reimbursement codes.

(F) Trial use period

When recommended by the prescribing SLP, a trial use period must be conducted before the department will consider authorizing the purchase of an SGD. Monthly rental payments, limited to the lower of the provider's usual and customary monthly rental charge, are not to exceed ten per cent of the authorized purchase price of the prescribed SGD, and will be paid during the trial use period. Payments authorized during the trial use period are limited to four monthly payments. Long-term rental may be considered for authorization up to a maximum of ten months. If long-term rental is required, documentation must support why a long-term rental is necessary as an alternative to a trial period and/or purchase. Rental payments require prior authorization in accordance with paragraph (E) of this rule. Authorization for rental of SGDs for a trial use period or long-term rental will be limited to one device per month per consumer.

- (G) Requesting purchase of an SGD at the end of a trial use period or subsequent to any rental period.

The following documentation must be submitted for review by PA before reimbursement for an SGD following a trial use period or subsequent to any rental period:

- (1) A fully completed and legible JFS 02925 "Certificate of Medical Necessity/Prescription Speech Generating Device (SGD) Recertification" (appendix B to this rule).
- (2) Documentation for the prior authorization of an SGD must be submitted with the appropriate reimbursement codes.
- (3) Documentation that details any previous rental payments received by the SGD provider made on behalf of the consumer by the department in relation to providing the consumer with an SGD device.
- (4) Any other documentation required or requested by the department.

(H) Repair, upgrade and replacement

(1) Repair

Medicaid reimbursement for repairs is available for no more than one SGD per recipient as detailed in rule 5101:3-10-08 of the Administrative Code. Repair costs for an SGD not originally covered by the department are to be considered on a case-by-case basis and are approved with a prior authorization. Repairs to consumer-owned SGD equipment that meet or exceed one thousand dollars in a twelve-month period will be deemed to extend the useful life of the consumer-owned SGD by one year from the date of the last repair request. No follow-up requests for a new SGD device in association or in conjunction with a repair request will be considered for a consumer during this extension period.

The repair of an SGD (including battery pack replacement) requires prior authorization. The following documentation, including the appropriate reimbursement codes, must be submitted when requesting prior authorization:

- (a) A fully completed and legible JFS 02926 "Certificate of Medical Necessity/Prescription Speech Generating Device (SGD)" (appendix C to this rule); and
- (b) Any other documentation required or requested by the department.

Requests for minor repairs as defined in rule 5101:3-10-08 of the Administrative Code do not require prior authorization. However, the SGD provider must maintain the documentation detailed in this rule in the consumer's medical record in order to document the need for the repair.

- (2) Replacement or modification of a consumer-owned SGD that was originally covered by the department will be authorized only if it is determined by the department that the current SGD does not meet the recipient's basic communication needs in accordance with this rule, regardless of the age of the current equipment, and the current SGD cannot be repaired or modified to meet basic communication needs due to situations such as a change in a consumer's cognitive, communication or physical status. If the current SGD can be modified or repaired, replacement will only be considered when modification or repair of the current equipment is judged by the department to be more costly than replacement. A request for prior authorization for replacement or modification of a recipient-owned SGD must meet all the requirements specified in paragraphs (H)(1)(a) and (H)(1)(b) of this rule. In addition, a description, model number, and the condition of a recipient's current equipment must be specified on the documentation submitted for prior authorization of additional or replacement equipment. (See rule 5101:3-10-05 of the Administrative Code regarding duplicate and conflicting equipment.)

(I) Reimbursement

- (1) SGDs are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code, or the provider's usual and customary charge, whichever is less.

- (2) Under no circumstances will the department pay more than the amount of the cumulative sum of ten rental payments for any SGD made to a provider by the department on behalf of a medicaid consumer. Ownership of any SGD that has had ten rental payments made to the SGD provider by the department on behalf of a consumer immediately transfers to the consumer upon receipt of the tenth rental payment to the SGD provider by the department. The SGD provider is responsible to notify the consumer that the ownership of the SGD was transferred upon completion of the rental or trial agreement as explained in this rule.
- (3) Any compensation paid to an SGD provider on a consumer's behalf in association with the dispensing, repair, replacement or modification of an SGD is inclusive of all professional, technical or administrative services required to supply the SGD to the consumer. These costs cannot be billed to the department separately.

Replaces: 5101:3-10-24

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Formerly 5101:3-10-25 Lactation Pumps

[MHTL 3344-11-02](#)

Effective Date: April 25, 2011

Most Current Prior Effective Date: [August 15, 2005](#)

5101:3-10-25 Appendix A: [JFS 01901](#), Certificate of Medical Necessity/Prescription Lactation Pumps

- (A) Lactation pumps are covered by the medicaid program under the following conditions:
- (1) The requested lactation pump is subject to the coverage and limitations for medical supplies as defined in rule 5101:3-10-02 of the Administrative Code.
 - (2) The requested lactation pump is prescribed by ~~a~~ an eligible prescriber ~~physician or advanced practice nurse (APN)~~ involved in the consumer's or infant's care.
 - (3) The lactation pump is deemed medically necessary by the ordering prescriber when one or more of the following conditions exist:
 - (a) The infant is unable to initiate breast feeding due to a medical condition such as prematurity, oral defect, etc.; or
 - (b) Temporary weaning (i.e., direct breast feeding is not possible) due to:
 - (i) mother/infant separation; or
 - (ii) mother is required to take a medication or undergo a diagnostic test that is contraindicated with breast feeding; or
 - (c) Inadequate milk supply; or
 - (d) Engorgement; or
 - (e) Breast infection.
 - (4) In addition to the aforementioned criteria, the lactation pump must have been authorized by a prescriber who is actively involved in managing the consumer's or infant's medical care through a comprehensive plan of care that addresses the medical need for a lactation pump.
- (B) Prior authorization is not needed for ~~any issuance~~ the purchase of a lactation pump ~~for purchase~~. Providers must keep on file a fully completed [JFS 01901](#), "Certificate of Medical Necessity/Prescription Lactation Pumps" (CMN) (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service. This documentation must be available for review at the request of ODJFS.
- (C) Hospital grade (HG) rental lactation pumps do not require ~~a~~ an initial prior authorization ~~for the first ninety days of the rental period~~. The rental period is ninety consecutive days. The rental period may be extended beyond the initial ninety ~~day days program rental period~~ with ~~receipt of a~~ prior authorization. Total rental period for a ~~HG~~ lactation pump will not exceed one hundred eighty consecutive days to include the initial rental period.
- (D) Reimbursement for ~~lactation pump~~ the purchase of either an electric or a manual lactation pump will include ~~in the equipment cost at a minimum~~, a one-year manufacturer's warranty that covers product malfunction, repair or replacement ~~in the purchase price~~.
- (E) Prior authorization (PA) requests for extension of the initial HG lactation pump rental period must be compliant with rule 5101: 3-10-06 of the Administrative Code. The PA request must include the following documentation:
- (1) ~~A fully completed and most recent revision of the PA form (JFS 03142, rev. 02/2003), including pertinent information such as quantity requested, manufacturer, style or model number and size.~~

- (1) A fully completed JFS 01901, "Certificate of Medical Necessity/Prescription Lactation Pumps" (CMN) (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service.
 - (2) A description, including approximate age and ownership, of any similar equipment currently in possession of the recipient and the reason for the new request if similar equipment ownership is established.
 - ~~(3) Documentation to establish medical necessity of the requested item for the extension of the initial HG rental period.~~
 - ~~(4) Written prescription that is signed by a physician or APN involved in the consumer's care verifying the need for the continued use of a HG lactation pump. This prescription cannot be over thirty days old from the time the PA is requested.~~
 - (3) Any other documentation as required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.
- (F) In order for ~~a breast pump~~ an HG lactation pump to be eligible for program reimbursement, the following criteria must also be met:
- (1) The ~~HG~~ pump must utilize suction and rhythm equivalent to the equipment commonly found in hospital settings. This means it must have an adjustable suction pressure between one hundred ~~mm Hg~~ and two hundred fifty mm Hg and a mechanism to prevent suction beyond two hundred fifty mm Hg.
 - (2) The ~~HG~~ pump must have an adjustable pumping speed capable of reaching fifty- two cycles per minute.
 - (3) The ~~HG~~ pump must be cleaned and serviced as needed between rentals.
- (G) Rental payments for ~~HG~~ lactation pumps are considered ~~"all inclusive,"~~ "bundled," ~~which includes~~ which includes but is not limited to the following components:
- (1) Set up and instructions as to pump and attachment kit usage and cleaning.
 - (2) Maintenance and repair during rental period.
 - (3) ~~HG~~ Any required attachment kit, which must be new and will become the property of the consumer upon issuance.
 - (4) Applicable cleaning/return service charges, unless the unit is returned excessively dirty, which is defined as the unit requires extensive cleaning before it can be utilized by another consumer, in which case the durable medical equipment (DME) vendor may seek reasonable cleaning charges from the consumer.
- (H) ~~"All inclusive"~~ ~~HG~~ Bundled accessories are the responsibility of the DME ~~vendor~~ provider to ~~provide~~ dispense during the ~~consumers~~ consumer's initial rental period. No replacements for lost or damaged supplies and or accessories are billable to Ohio medicaid during the rental period. Any lost or damaged supplies and/or accessories are the responsibility of the consumer to replace.
- (I) Any manual lactation pump that was supplied to a consumer as part of ~~an HG~~ a pump attachment kit cannot be billed to the Ohio medicaid program as a separate item by a DME vendor.
- (J) Any consumer that acquires a manual lactation pump as part of a vendor supplied ~~HG~~ pump attachment kit cannot purchase an additional manual lactation pump at Ohio medicaid program expense.
- (K) All DME providers that submit claims to Ohio medicaid for reimbursement of a ~~HG~~ rental lactation pump must keep in the ~~consumers~~ consumer's medical record documentation to demonstrate that the ~~HG~~ lactation pump was actively being utilized by the consumer during the time frame for which compensation ~~was~~ is sought. The type of documentation that meets this requirement is left to the discretion of the DME ~~vendor~~ provider. This documentation must be available for review at the request of ODJFS.

- (L) Inpatient lactation services or those provided to a resident of a long term care facility (LTCF) or an intermediate-care facility for the mentally retarded and/or DME equipment are not covered under this rule and cannot be billed separately. These services are considered a component of the diagnostic related group (DRG) ~~payment~~ or facility per diem payment.
- (M) Lactation pumps are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

Effective: 04/25/2011

R.C. 119.032 review dates: 01/03/2011 and 04/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 04/13/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 9/1/05

Effective Date: August 2, 2011

Most Current Prior Effective Date: [January 1, 2010](#)

5101:3-10-26 Appendix A: [JFS 01907](#), Certificate of Medical Necessity / Prescription Enteral Nutrition Services

(A) Definition

"Enteral nutrition" is defined as oral or tube-delivered caloric sustenance products for those medicaid consumers demonstrating a disability or life-threatening disease with significant nutritional problems that cannot be managed by ordinary or blenderized foods.

(B) Coverage determination

- (1) For an enteral nutritional product to be considered for coverage, one of the following criteria must be met:
 - (a) The consumer is unable to swallow food due to a damaged or diseased (non-functioning) oral pathway and must be tube-fed, as determined and documented by a licensed prescriber.
 - (b) The consumer has the ability to swallow, but is unable to meet caloric and nutritional requirements from ordinary foods, including pureed or blenderized foods, to maintain life-sustaining functions, as determined and documented by a licensed prescriber.
- (2) Consumers with infants and children age five or younger whose children require enteral nutrition products, breast-feeding consumers with an infant one year of age or younger, or post-partum mothers with a child six months of age or younger, must apply to their county women, infant and children (WIC) program for an eligibility evaluation before coverage by the Ohio department of job and family services (ODJFS) will be considered.

(C) Non-covered products

- (1) Enteral nutrition products that are designed to provide meal replacements, or snack alternatives to be eaten within the context of a consumer's individualized meal plan, are not covered. These products include, but are not limited to:
 - (a) Shakes;
 - (b) Meal bars;
 - (c) Snack bars;
 - (d) Supplement thickeners;
 - (e) Cereals;
 - (f) Puddings;
 - (g) Vitamins/ minerals; and
 - (h) Blenderized or pureed foods prepared in a personal residence or long term care facility (LTCF).
- (2) Enteral nutrition products that are designed as meal replacements, or to be eaten within the context of a consumer's prescribed reduced calorie diet for consumers with diabetes, obesity issues, pre- or post-gastric bypass, or bariatric surgery, are not covered.
- (3) Enteral nutrition products that are administered in an outpatient provider setting (i.e., a dialysis outpatient clinic or a facility receiving per diem payments from the department) are not separately reimbursable.

- (4) Adult and pediatric electrolyte replacement is covered under the pharmacy benefit program as described in Chapter 5101:3-9 of the Administrative Code.
- (5) Any facility receiving per diem reimbursement from the Ohio medicaid program for a consumer's care cannot submit claims to ODJFS for separate reimbursement for enteral nutritional products.

(D) Prior authorization

- (1) The following documentation must be submitted for prior authorization (PA) before reimbursement for enteral nutrition products will be considered:
 - (a) A fully completed form [JFS 01907 \(rev. 3/2008\)](#), "Certificate of Medical Necessity for Enteral Nutrition Services/ Prescription" (CMN) (appendix to this rule) that is signed and dated no more than thirty days prior to the first date of service.
- (2) Prior authorization requests for medicaid consumers who cannot maintain weight must include a current weight history. Providers requesting for a consumer a daily caloric intake of greater than two thousand calories must have "section 9" of form JFS 01907 completed prior to requesting a prior authorization.
- (3) Initial prior authorization requests for enteral nutrition products may be approved for a maximum of twelve months. Subsequent PAs for the same consumer for the same disease state may be approved for a maximum of ~~one year~~twelve months.
- (4) Consumers having a change in their treatment plan that requires the use of an enteral product that is different than a previously authorized enteral product will require a new certificate of medical necessity before a new enteral product will be authorized.

(E) Dispensing

- (1) Enteral nutrition products shall be dispensed in no greater quantity than one month's supply.
- (2) Providers may dispense enteral nutrition products' generic equivalents (e.g., vendor branded or private label equivalent) if available, as long as the substituted product is correctly formulated to meet the needs of the consumer and the consumer's prescriber is notified in advance of dispensing.
- (3) Medicaid providers may not provide a re-supply of enteral nutrition products sooner than one week before a consumer's next scheduled supply dispense date.
- (4) No dispensing, mailing, or delivery fees are separately reimbursable by the Ohio medicaid program.
- (5) The consumer will be supplied with the ordered enteral product that is in the most cost effective formulation that the consumer can tolerate.

(F) Reimbursement

- (1) Unless otherwise specified, enteral nutrition products are reimbursed by the Ohio medicaid program consistent with paragraph (F) of rule [5101:3-10-05](#) of the Administrative Code.
- (2) For enteral nutrition products that do not have a predesignated medicaid maximum allowable on the Ohio medicaid fee schedule as listed in appendix DD to rule [5101:3-1-60](#) of the Administrative Code, the Ohio medicaid program will reimburse the supplier's average wholesale price (AWP) minus twenty-three per cent.
- (3) No more than one month's supply of enteral nutrition products is allowed for one month's prospective billing.
- (4) For enteral nutrition that is administered orally, the modifier BO must be utilized in conjunction with the appropriate "Healthcare Common Procedure Coding System" (HCPCS) code ~~as defined in rule 5101:3-1-19.3 of the Administrative Code~~. This modifier will be authorized for use by the PA department during the initial PA review and documented on the provider's PA letter.

R.C. 119.032 review dates: 09/20/2010 and 08/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 06/06/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, Section 309.30.75 of Am. Sub. H.B. 1, 128th G.A

Rule Amplifies: 5111.01, 5111.02, 5111.021, Section 309.30.75 of Am. Sub. H.B. 1, 128th G.A

Prior Effective Dates: 1/1/06, 8/18/08, 1/1/10

MHTL 3344-11-02

Effective Date: April 25, 2011

Most Current Prior Effective Date: April 1, 2006

(A) Definition

The continuous passive motion (CPM) device is a treatment modality in which knee joint motion is provided by a machine without causing active contraction of muscle groups. The CPM device allows passive movements to be performed to a knee joint for hours at a time. The knee joint area is secured in the CPM machine, and the machine is programmed to passively flex and extend the knee joint through a pre-selected range of motion and rate of repetition. Movement is slow and controlled, and the patient does not actively exert muscle force to move the knee joint.

(B) Coverage determination

The CPM device, when initiated during the immediate post-operative period (beginning within forty-eight hours after surgery), will be considered for coverage if the CPM device is to be utilized following total knee replacement or revision of a total knee replacement and is being sought for use in the consumer's personal residence.

(C) Non-coverage determination

- (1) CPM therapy is not covered for joints other than the knee.
- (2) A CPM device is not separately reimbursable for consumers who are hospitalized or in a long term care facility (LTCF) ~~and must be billed to the facility and included in the cost report.~~
- (3) CPM is not covered as a substitute to conventional provider delivered physical therapy.
- (4) CPM therapy is not appropriate for consumers unable to independently turn the device on and off, or who are not willing to participate in a course of rehabilitation in relation to the medical event prompting the request for CPM therapy.

(D) Authorization

- (1) The use of a CPM device does not require a prior authorization when utilized for a single knee surgery. However, the provider of the CPM device is required to maintain on file a legible written prescription issued by a licensed prescriber that is signed and dated no more than thirty days prior to the first date of service that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.
- (2) The maximum days allowable for the utilization of a CPM device is twenty-one per medical event, per knee.
- (3) If the consumer has the surgery mentioned in paragraph (B) of this rule on both knees concurrently, the following documentation must be submitted for prior authorization (PA) before reimbursement for services rendered with two machines will be authorized in accordance with the provisions set forth in rule 5101:3-1-31 of the Administrative Code:

~~(a) A fully completed, most current version of PA form (JFS 03142, rev. 02/2003); and~~

~~(b)(a)~~ (a) A legible written prescription issued by a licensed prescriber that is signed and dated no more than thirty days prior to the first date of service that defines the specific "from" and "to" dates that reflect the actual days the CPM device is to be utilized.

~~Documentation for the prior authorization of a CPM device must be submitted with the appropriate healthcare common procedure coding system (HCPCS) codes as defined in rule 5101:3-1-19.3 of the Administrative Code for the actual unit and any necessary soft goods supporting the unit present on the same request.~~

(b) Any other documentation as required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

(4) CPM devices must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the medical need for the CPM device.

(E) Dispensing

(1) CPMs are expected to be dispensed with one complete set of supporting soft goods per CPM unit dispensed unless the consumer currently owns the supporting soft goods resulting from a previous medical event.

Soft goods are defined as including at a minimum, thigh and calf pads, foot bootie pad, thigh straps and hook and loop contact closures constructed of quilted sheepskin or moisture wicking materials.

(2) The following components are considered ~~"inclusive"~~ "bundled" with any CPM payment made by ODJFS on behalf of a consumer and cannot be submitted to ODJFS for separate payment:

(a) Any supporting wires, cables, or attachment kits;

(b) ~~CPM Consumer~~ education, training, monitoring, or counseling ~~in support of the consumers ordered therapy~~;

(c) Maintenance, repair, or cleaning charges; or

(d) Delivery, set up, or pick up charges.

(3) The provider of a CPM device must assure that the consumer or the consumer's caregiver ~~utilizing the device~~ is properly instructed on how to use the device ~~in support of his or her ordered therapy and is aware of~~ and understands any emergency procedures regarding the use of the CPM device. The provider must maintain written documentation in the consumer's medical record regarding the consumer's or the consumer's caregiver's instruction on the use of the CPM device ~~in the consumer's medical record~~.

(4) The prescriber of a CPM device must assure and document in the ~~consumer's~~ medical record that the continued use of the CPM device is resulting in the clinical improvement of the consumer ~~utilizing the device~~. The use of the CPM device must be discontinued immediately and an alternative therapy method considered if the consumer demonstrates no progressive clinical improvement during the CPM rental period.

(5) ~~Upon the dispensing of a CPM device the consumer must be supplied by the supplier~~ The provider of a CPM device must supply the consumer or the consumer's caregiver with a twenty-four hour, ~~seven day a week~~ seven-day-a-week telephone number to be utilized in case of an emergency ~~situation during the entire rental period of the CPM device~~. This telephone number must meet all federal Americans with Disabilities Act (ADA) of 1990 requirements.

(F) Reimbursement

CPM devices and associated soft goods are reimbursed according to the ODJFS fee schedule contained in appendix DD ~~of~~ to rule 5101:3-1-60 of the Administrative Code, or the providers usual and customary charge, whichever is less.

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Certification: CERTIFIED ELECTRONICALLY

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Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/1/06

Formerly 5101:3-10-28 Non-Invasive Bone (Osteogenesis) Stimulators

[MHTL 3344-06-03](#)

Effective Date: October 15, 2006

5101:3-10-28 Appendix A - [JFS 07134](#), Certificate of Medical Necessity / Prescription Osteogenesis Bone Stimulators

(A) Definition

- (1) An electrical bone (osteogenesis) spinal or nonspinal stimulator is a device that provides electrical stimulation to augment bone repair. A non-invasive electrical bone stimulator is characterized by an external power source that is attached to a coil or electrodes placed on the skin or on a cast or brace over a fracture or fusion site.
- (2) An ultrasonic bone (osteogenesis) stimulator is a non-invasive device that emits low intensity, pulsed ultrasound. The ultrasound signal is applied to the skin surface at the fracture location via ultrasound conductive coupling gel in order to stimulate fracture healing.

(B) Coverage determination

- (1) A nonspinal electrical bone stimulator is covered only if any of the following criteria are met:
 - (a) Nonunion of a long bone fracture, defined by radiographic evidence that fracture healing has ceased for three or more months prior to starting treatment with the bone stimulator and documented by a minimum of two sets of radiographs obtained prior to starting treatment with the bone stimulator, separated by a minimum of ninety days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;
 - (b) Failed fusion of a joint other than the spine where a minimum of nine months has elapsed since the last surgery; or
 - (c) Congenital pseudarthrosis.
- (2) A nonspinal electrical bone stimulator will be denied as not medically necessary if none of the criteria listed in paragraph (B)(1) of this rule are met.
- (3) A spinal electrical bone stimulator is covered only if any of the following criteria are met:
 - (a) Failed spinal fusion where a minimum of nine months has elapsed since the last surgery;
 - (b) The consumer has undergone a multilevel spinal fusion surgery; or
 - (c) The consumer has undergone spinal fusion surgery where there is a history of a previously failed spinal fusion at the same site.
- (4) A spinal electrical bone stimulator will be denied as not medically necessary if none of the criteria listed in paragraph (B)(3) of this rule are met.
- (5) An ultrasonic bone stimulator is covered only if all of the following criteria are met:
 - (a) Nonunion of a long bone fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the bone stimulator, separated by a minimum of ninety days, each including multiple views of the fracture site, and with a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs;
 - (b) Fracture is not of the skull or vertebrae; and
 - (c) Fracture is not tumor-related.

- (6) An ultrasonic bone stimulator will be denied as not medically necessary if all of the criteria listed in paragraph (B)(5) of this rule are not met.
- (7) In order to qualify for the use of any bone stimulator, a consumer that is twenty years of age or younger must meet all of the following criteria in addition to the medical criteria for the applicable bone stimulator prescribed listed in paragraphs (B)(1), (B)(3) and (B)(5) of this rule:
 - (a) There is radiological documentation that skeletal maturity has been attained;
 - (b) The fracture gap is not more than one-half of the diameter of the bone to be treated; and
 - (c) The fracture does not involve a vertebrae.

(C) Non-coverage determination

- (1) Bone (osteogenesis) stimulators are considered noncovered if any of the following contraindications exist:
 - (a) Fracture of short or flat bones or epiphyses;
 - (b) Fracture as a result of cancer;
 - (c) Fractures that need additional reduction or are comminuted;
 - (d) Fractures with post-reduction displacement of greater than fifty per cent;
 - (e) Fractures with internal or external fixation;
 - (f) Fracture gaps greater than one centimeter;
 - (g) Avascularity, vascular insufficiency or other vascular problems (e.g., thrombophlebitis) or severe osteoporosis;
 - (h) When stimulator is to be used in conjunction with medications that may interfere with or alter bone metabolism and healing;
 - (i) When osteomyelitis, active infections or necrotic bone is present;
 - (j) Paget's disease, renal disease or diabetes;
 - (k) Sensory paralysis; or
 - (l) Synovial pseudoarthritis.
- (2) Consumers with demand type pacemakers in proximity to the proposed treatment site are not eligible for electric bone stimulators.

(D) Prior authorization

A fully completed form **JFS 07134** (rev. 2/2006), "Certificate of Medical Need/Prescription Non-Invasive Bone Growth (Osteogenesis) Stimulator" (CMN) (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service must be submitted for prior authorization (PA) before reimbursement for a bone stimulator will be considered.

(E) Dispensing

- (1) The following components are considered "inclusive" with any bone stimulator device payment made by the department on behalf of a consumer and cannot be submitted to the department for separate reimbursement:
 - (a) Any supporting wires, power supply, cables, attachment kits or disposable items such as electrodes, or in the case of the ultrasound stimulator, coupling gel;
 - (b) Stimulator education, training, monitoring, or counseling in support of the consumer's ordered treatment;
 - (c) Maintenance, repair, or cleaning services; or
 - (d) Delivery or set-up services.

- (2) The provider of the bone stimulator must assure that the consumer utilizing the device is properly instructed on how to use the device in support of the ordered treatment and is aware of and understands any emergency procedures regarding the use of the bone stimulator device. The provider must maintain written documentation regarding the consumer's instruction on the use of the bone stimulator in the consumer's medical record.
- (3) A bone stimulator may not be used concurrently with any other bone stimulator device on the same fracture site.
- (4) Upon dispensing of a bone stimulator device, the consumer must be supplied by the provider with a twenty-four hour, seven day a week telephone number to be utilized in case an emergency situation arises concerning the device. This telephone number must meet all federal Americans with Disabilities Act (ADA) of 1990 requirements.

(F) Reimbursement

Bone stimulator devices are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

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R.C. 119.032 review dates: 10/01/2011

Certification:

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Effective Date: August 18, 2008

Most Current Prior Effective Date: [October 15, 2006](#)

5101:3-10-29 Appendix A - [JFS 07136](#), Certificate of Medical Necessity / Prescription External Insulin Pump

(A) Definition

A standard portable external insulin infusion pump is a small battery-operated pump about the size of a personal pager, is filled with insulin, and is connected to thin tubing ending in a needle. The needle is inserted into the skin around the abdomen, and supplies a regulated dose of insulin to the user for a day or more at a time. The pump may be carried in a pocket or in a case worn attached to a belt fastened around a consumer's waist.

(B) Coverage determination

- (1) Ohio medicaid covers standard portable external insulin infusion pumps for patients with type 1 diabetes mellitus documented by a C-peptide level less than 0.5 and when all of the following medical necessity criteria are met:
 - (a) The consumer has completed a diabetes education program within the last twenty four months of being prescribed an insulin infusion pump;
 - (b) The consumer has been on a program of multiple daily injections of insulin (i.e., at least three injections per day), with frequent self-adjustments of insulin dose, for at least six months before initiation of the insulin infusion pump;
 - (c) The consumer had documented frequency that is kept in the consumer's medical record of glucose self-testing an average of at least four times per day during the two months before initiation of the insulin infusion pump;
 - (d) The consumer is at high risk for preventable complications of diabetes. Early signs of diabetic complications include ~~mico-albuminuria~~ micro-albuminuria and/or documented in the consumer's medical record persistent difficulty in achieving optimal control of blood sugar levels despite good compliance with an intensive multiple injection regimen.
- (2) In addition to the aforementioned criteria, the consumer needs to meet at least one of the following criteria in order to be eligible for a standard portable external insulin infusion pump:
 - (a) Glycated hemoglobin level (HbA1c) greater than seven per cent;
 - (b) History of recurring hypoglycemia;
 - (c) Wide fluctuations in blood glucose before mealtime;
 - (d) Dawn phenomenon with fasting blood sugars frequently exceeding two hundred mg/dL;
or
 - (e) History of severe glycemic excursions.

(C) Non-coverage determination

- (1) Standard portable external insulin infusion pumps are not covered if any of the following contraindications exist:
 - (a) Consumer has non-insulin dependent (NIDDM or IR-NIDDM, Type II) diabetes, even if insulin is taken;
 - (b) Consumer has end-stage complications such as renal failure;
 - (c) Consumer is unable, because of behavioral, psychological problems or functional ability, to technically operate the pump and perform frequent blood glucose monitoring; or

(d) Consumer is being prescribed pump therapy to be used for convenience purposes.

(2) The department will not cover jet pressure or surgically implanted infusion devices or systems, chronic intermittent intravenous insulin therapy (CIIT), or pulsatile IV insulin therapy (PIVIT).

(D) Prior authorization

(1) The following documentation must be submitted for prior authorization (PA) before reimbursement for a standard portable external insulin infusion pump will be considered:

A fully completed form [JFS 07136](#) (rev. ~~2/2006~~ 3/2008) "Certificate of Medical Necessity/Prescription External Infusion Pump" (CMN) (appendix to this rule) that is signed and dated no more than thirty days before the first date of service.

(2) Prior authorization for a standard portable external insulin infusion pump must include a three-month trial rental period conducted in which the consumer has undergone a successful trial period with a pump that demonstrates that the consumer is capable of managing the pump and that the desired improvement in metabolic control can be achieved. If a prescriber certification is submitted to the department at the conclusion of a successful trial rental period, the device will be considered for purchase by the department in accordance with paragraph (I)~~(4)~~ of rule 5101:3-10-05 of the Administrative Code.

(E) Dispensing

(1) The following components are considered "inclusive" with any portable external infusion insulin pump rental or purchase payment made by the department on behalf of a consumer and cannot be submitted to the department for separate reimbursement:

(a) Any supporting wires, power supply, cables, attachment kits, or disposable items associated with the operation of the pump;

(b) Pump education, training, monitoring, or counseling in support of the consumer's ordered treatment;

(c) Maintenance, repair, or cleaning charges in association with the three-month trial rental period; or

(d) Delivery, set-up, or pick-up charges.

(2) The provider of the portable external infusion insulin pump must assure that the consumer utilizing the device is properly instructed on how to use the device in support of his or her ordered treatment and is aware of and understands any emergency procedures regarding the use of the pump. The provider must maintain written documentation regarding the consumer's instruction on the use of the pump in the provider's records.

(3) The prescriber of the portable external infusion insulin pump must assure and document in the consumer's medical record that the continued use of the device is resulting in the clinical improvement of the consumer utilizing the device. The use of the device must be discontinued immediately and an alternative treatment method considered if the consumer demonstrates no progressive clinical improvement during the rental period of the device.

(4) When the department determines that the purchase of a portable external infusion insulin pump is appropriate, the consumer must be provided with a product warranty that covers any required maintenance or repairs for a duration of at least one year and commences on the date the infusion pump was authorized for purchase.

(F) Reimbursement

(1) Portable external infusion insulin pumps are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the providers' usual and customary charges, whichever is less.

(2) Previously utilized or loaner portable external infusion insulin pumps are not eligible for purchase by the department.

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R.C. 119.032 review dates: 10/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 08/04/2008

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Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 10/15/2006

Effective Date: August 17, 2009

(A) Definitions

- (1) Mobility-related activities of daily living (MRADL): MRADL's are considered to be activities relating to toileting, feeding, dressing, grooming, and bathing performed in customary locations in the home.
- (2) Mobility limitation: The consumer is considered to possess a mobility limitation if one of the following criteria is met:
 - (a) The consumer is prevented from accomplishing MRADL's entirely; or
 - (b) The consumer is placed at a reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform MRADL's; or
 - (c) The consumer is prevented from completing MRADL's within a reasonable time frame.

(B) Canes and crutches

- (1) Coverage determination
 - (a) Canes and crutches are covered if all of the following criteria are met:
 - (b) The consumer has a mobility limitation, documented in the consumer's medical record, that significantly impairs his or her ability to participate in one or more MRADL's in the home; and
 - (c) The consumer is able to safely use the cane or crutch; and
 - (d) The functional mobility deficit can be sufficiently resolved by use of a cane or crutch.
- (2) In addition to the aforementioned criteria, the cane or crutch must have been authorized by a prescriber who is actively involved in managing the consumer's mobility difficulties and should be treating the consumer under a comprehensive plan of care that addresses the consumer's mobility difficulties.

(C) Walkers

- (1) Coverage determination
 - (a) Walkers are covered if all of the following criteria are met:
 - (i) The consumer has a mobility limitation, documented in the consumer's medical record, that significantly impairs his or her ability to participate in one or more MRADL's in the home; and
 - (ii) The consumer is able to safely use the walker; and
 - (iii) The functional mobility deficit can be sufficiently resolved by use of a walker.
 - (b) In addition to the aforementioned criteria, the walker must have been authorized by a prescriber who is actively involved in managing the consumer's mobility difficulties and should be treating the consumer under a comprehensive plan of care that addresses the consumer's mobility difficulties.
- (2) Heavy duty walkers
 - (a) A heavy duty walker is covered only for consumers who meet the criteria in paragraph (C) of this rule for a standard walker and who weigh more than three hundred pounds.
 - (b) A heavy duty, multiple braking system, variable wheel resistance walker is covered for consumers who meet the criteria in paragraph (C) of this rule for a standard walker, who

weigh more than three hundred pounds and who are unable to use a standard walker due to a documented severe neurologic disorder or other condition causing the restricted use of one hand. Obesity, by itself, is not a sufficient reason for this type of walker.

(3) Enclosed frame walker

In order to justify reimbursement for an enclosed frame walker, providers must document in the consumer's medical record why this type of walker is medically necessary in place of a standard walker. This documentation must contain the original signature of the ordering prescriber that attests to this medical necessity.

(4) Trunk support walker

In order to justify reimbursement for a walker with trunk support, providers must document in the consumer's medical record why this type of walker is medically necessary in place of a standard walker. This documentation must contain the original signature of the ordering prescriber that attests to this medical necessity.

(5) Walker leg extensions

Walker leg extensions are covered only for consumers six feet tall or more when standing.

(D) Canes, crutches and walker limitations

(1) It is the provider's responsibility to assure that the consumer receives the appropriate mobility assistive device consistent with his or her present medical condition and diagnosis and to verify that the consumer has not previously acquired a duplicate mobility assistive device that exceeds the limitations set forth in appendix A to rule 5101:3-10-03 of the Administrative Code from a different provider.

(2) Canes, crutches and walkers for consumers residing in long term care facilities are reimbursed through the facility's cost report.

(E) Reimbursement

Canes, crutches and walkers are reimbursed the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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Rule Amplifies: 5111.01, 5111.02, 5111.021

***Formerly* 5101:3-10-31 Therapeutic Footwear for Consumers with Diabetes**

MHTL 3344-11-04

Effective Date: August 2, 2011

Most Current Prior Effective Date: October 15, 2006

Unless otherwise specified, the licensing of persons authorized to fit or dispense therapeutic footwear for consumers with diabetes is administered and enforced by Chapter 4779. of the Revised Code. Any provider seeking reimbursement for therapeutic footwear must meet the provisions contained within this rule when applicable in order to be eligible for reimbursement for services provided.

(A) Coverage determination

For a consumer to be eligible for therapeutic footwear the following criteria must be met:

- (1) The consumer has diabetes mellitus ("International Classification of Diseases, Ninth Revision" (ICD-9) diagnosis codes 250.00-250.93); and
- (2) The consumer has one or more of the following conditions:
 - (a) Previous amputation of the other foot, or part of either foot;
 - (b) History of previous foot ulceration of either foot;
 - (c) History of pre-ulcerative calluses on either foot;
 - (d) Peripheral neuropathy with evidence of callus formation of either foot;
 - (e) Foot deformity of either foot; or
 - (f) Poor circulation in either foot; and
- (3) The certifying prescriber who is managing the consumer's systemic diabetes condition has certified that the indications in paragraphs (A)(1) and (A)(2) of this rule are met and that he or she is treating the consumer under a comprehensive plan of care for his or her diabetes and that the consumer needs therapeutic footwear.

(B) Non-coverage determination

- (1) Items represented by code A5510 refer to inserts that are compression molded to the consumer's foot over time through the heat and pressure generated by wearing a shoe with the insert present. Since these inserts are not considered total contact at the time of dispensing, they do not meet the requirements of the benefit category and will be denied as noncovered.
- (2) Inserts used in noncovered shoes are noncovered.
- (3) Deluxe features of diabetic shoes (A5508) are noncovered.
- (4) Shoes, inserts and/or modifications that are provided to patients who do not meet the coverage criteria are noncovered.

(C) Authorization

- (1) The following documentation must be submitted for prior authorization (PA) before reimbursement for therapeutic footwear will be considered in accordance with the provisions set forth in rule 5101:3-10-31 of the Administrative Code:
 - ~~(a)~~ A fully completed prior authorization request form (JFS 03142, rev. 02/2003);
 - ~~(b)~~(a) Documentation to establish medical necessity of the requested item or service; and
 - ~~(c)~~(b) Any other documentation as required or requested by ODJFS for certain specific medical supplier services, as detailed in Chapter 5101:3-10 of the Administrative Code.

- (2) Documentation for the prior authorization of therapeutic footwear must be submitted with the appropriate healthcare common procedure coding system (HCPCS) codes ~~as defined in rule 5101:3-1-19.3 of the Administrative Code.~~

(D) Dispensing

- (1) The particular type of footwear that is necessary must be prescribed by a podiatrist or other qualified prescriber knowledgeable in the fitting of therapeutic footwear. The footwear must be fitted and dispensed by a podiatrist, pedorthist, orthotist, or prosthetist meeting the qualifications specified in Chapter 4779. of the Revised Code. Documentation that the provider is authorized to fit and dispense therapeutic footwear pursuant to Chapter 4779. of the Revised Code must be kept in the provider's records.
- (2) The certifying prescriber (i.e., the prescriber who manages the systemic diabetic condition) may not furnish the footwear unless he or she practices in a defined rural area or a defined health professional shortage area.
- (3) Separate inserts may be covered and dispensed independently of diabetic shoes if the provider of the shoes verifies in writing that the consumer has appropriate footwear into which the insert can be placed. This footwear must meet the industry definition for a depth or custom-molded shoe.
- (4) A custom molded shoe (A5501) is covered when the consumer has a foot deformity that cannot be accommodated by a depth shoe. The nature and severity of the deformity must be well documented in the provider's records and such records may be requested by the Ohio department of job and family services (ODJFS) for review. If there is insufficient justification for a custom molded shoe but the general coverage criteria are met, reimbursement for services will be based on the allowance for the least costly medically appropriate alternative (A5500).

(E) Reimbursement

- (1) There is no separate reimbursement for the fitting of shoes, inserts or modifications or for the certification of need or prescription of the footwear.
- (2) Therapeutic footwear is reimbursed according to the ODJFS fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code, or the provider's usual and customary charge, whichever is less.

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Prior Effective Dates: 10/15/2006

Formerly 5101:3-10-32 Ostomy and Urological Supplies

[MHTL 3344-11-04](#)

Effective Date: August 2, 2011

Most Current Prior Effective Date: [August 17, 2009](#)

(A) Ostomy supplies

(1) Coverage determination

- (a) The quantity of ostomy supplies needed by a consumer is determined primarily by the type of ostomy, its location and construction, and the condition of the skin surface surrounding the stoma. The department recognizes that there will be variation according to individual consumer need and that this need may vary over time.
- (b) The provider must maintain documentation in the consumer's medical record that clearly supports the medical necessity for ostomy supplies.
- (c) Ostomy supplies must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the need for ostomy supplies on a continual basis. This prescription must contain the original signature of the ordering prescriber that attests to this medical necessity and clearly designates the quantity and type of ostomy supplies being prescribed.
- (d) Any change to a consumer's care plan regarding the quantity or type of ostomy supplies requires a new prescription be obtained by the provider that details the changes to the care plan. The provider must keep any new orders regarding the consumer's ostomy care plan in the consumer's medical record to be available for review by the department upon request.

(2) Coverage limitations

- (a) Provision of ostomy supplies is limited to a one-month supply per calendar month. Consumers are eligible for re-supply on a calendar month basis starting with the initial dispensing date. The provider is responsible for determining the appropriate amount of ostomy supplies on any given month based on consumer need. The stockpiling of ostomy supplies by a consumer is not allowed.
- (b) Providers are responsible for determining whether additional ostomy supplies have been acquired by the consumer from a different provider during any given month. Ostomy supplies dispensed over and above the stated maximum allowables as listed in appendix A to rule 5101:3-10-03 of the Administrative Code will not be reimbursed without prior authorization.
- (c) Ostomy supplies for consumers residing in long term care facilities are reimbursed through the facility's cost report.
- (d) When a liquid barrier is necessary, either liquid or spray or individual wipes or swabs is appropriate. Only a single type is reimbursable by the department at a given time.
- (e) Consumers with continent stomas may use either a stoma cap, stoma plug, or gauze pads to prevent/manage drainage. Only a single type is reimbursable by the department at any given time.
- (f) Consumers with urinary ostomies may use either a bag or bottle for drainage at night. Only a single type is reimbursable by the department at any given time.

(B) Urological supplies

(1) Coverage determination

- (a) The provider must document in the consumer's medical record the medical necessity for urological supplies.
- (b) Urological supplies must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the need for urological supplies on a continual basis. This prescription must contain the original signature of the ordering prescriber that attests to this medical necessity and clearly designates the quantity and type of urological supplies being prescribed.
- (c) Any change to a consumer's care plan regarding the quantity and type of urological supplies requires that a new prescription be obtained by the provider that details the changes to the care plan. The provider must maintain any new orders regarding the consumer's urological care plan in the consumer's medical record to be available for review by the department upon request.
- (d) Indwelling catheters
 - (i) No more than one catheter per month is covered for routine catheter maintenance. Non-routine catheter changes are covered when documentation substantiates medical necessity, such as for the following indications:
 - (a) Catheter is accidentally removed (e.g., pulled out by consumer); or
 - (b) Malfunction of catheter (e.g., balloon does not stay inflated, hole in catheter); or
 - (c) Catheter is obstructed by encrustation, mucous plug or blood clot; or
 - (d) History of recurrent obstruction or urinary tract infection for which it has been established by the prescriber that an acute event is prevented by a scheduled change frequency of more than once per month.
 - (ii) When a specialty indwelling catheter or an all-silicone catheter is used, documentation must be maintained in the consumer's medical record that attests to the medical necessity for that catheter rather than a straight foley type catheter with coating.
 - (iii) A three-way indwelling catheter either alone or with other components will be covered based on medical necessity documentation in the consumer's medical record.
- (e) Catheter insertion tray
 - (i) One insertion tray will be covered per episode of indwelling catheter insertion. More than one tray per episode will not be reimbursed by the department.
 - (ii) One intermittent catheter with insertion supplies will be covered per catheterization episode based on supporting documentation of medical necessity in the consumer's medical record.
- (f) Urinary drainage collection system
 - (i) Coverage is authorized for the routine changes of the urinary collection system based on supporting documentation of medical necessity in the consumer's medical record.
 - (ii) Leg bags are covered for consumers who are ambulatory or are chair or wheelchair bound. The use of leg bags for bedridden consumers is not authorized.
 - (iii) If there is a catheter change and an additional drainage bag change within a month, the combined utilization for these supplies should be considered by the provider when determining if prior authorization is necessary due to the consumer's medical need to exceed the monthly maximum allowable that is

designated for these supplies in appendix A to rule 5101:3-10-03 of the Administrative Code.

- (iv) Payment will not be made for concurrent use of a vinyl and a latex bag.
- (g) Intermittent irrigation of indwelling catheters
 - (i) Supplies for the intermittent irrigation of an indwelling catheter are covered by the department when they are used on an as-needed (non-routine) basis in the presence of acute obstruction of the catheter. Documentation supporting medical necessity must be maintained in the medical record and available for review by the department. Routine intermittent irrigations of a catheter are not reimbursable by the department. Routine irrigations are defined as those performed at predetermined intervals.
 - (ii) Covered supplies for non-routine irrigation of a catheter include either an irrigation tray or an irrigation syringe, and sterile water/saline. Syringes, trays, sterile saline or water are not reimbursable by the department when used for routine irrigation. Irrigation solutions containing antibiotics and chemotherapeutic agents and solutions such as acetic acid or hydrogen peroxide used for the treatment or prevention of urinary obstruction are not reimbursable by the department.
- (h) Continuous irrigation of indwelling catheters
 - (i) Supplies for continuous irrigation of a catheter are covered if there is a history of obstruction of the catheter and the patency of the catheter cannot be maintained by intermittent irrigation in conjunction with medically necessary catheter changes. Supplies used as a result of continuous irrigation being utilized as a primary preventive measure are not reimbursable by the department. Documentation that verifies the medical necessity of catheter irrigation and in particular continuous irrigation as opposed to intermittent irrigation must be maintained in the consumer's medical record. This documentation must indicate the rate of solution administration and the consumer's duration of need.
 - (ii) Covered supplies for medically necessary continuous bladder irrigation include a three-way foley catheter, irrigation tubing set, and sterile water/saline. The department does not reimburse for more than one irrigation tubing set per day for continuous catheter irrigation.
 - (iii) Irrigation solutions containing antibiotics and chemotherapeutic agents are not reimbursable by the department. Reimbursement claims for irrigating solutions such as acetic acid or hydrogen peroxide should be billed using the appropriate healthcare common procedure coding system (HCPCS) code for sterile water/saline ~~as defined in rule 5101:3-1-19.3 of the Administrative Code.~~
 - (iv) Continuous irrigation is considered by the department to be a temporary measure. Continuous irrigation for more than two weeks duration requires supporting medical necessity documentation in the consumer's medical record.
- (i) Intermittent catheterization
 - (i) Intermittent catheterization is covered by the department when the basic coverage criteria in paragraph (B)(1)(i)(ii) of this rule are met and the consumer or consumer's caregiver can perform the procedure. Documentation supporting the capability of the consumer or consumer's caregiver to perform this procedure must be included in the consumer's medical record.
 - (ii) For each episode of covered catheterization, the department will reimburse for one catheter or one sterile catheter kit if the following additional coverage criteria are met:
 - (a) The consumer is immunosuppressed; or

- (b) The consumer has radiologically documented vesico-ureteral reflux while on a program of intermittent catheterization; or
 - (c) The consumer is a spinal-cord injured female with neurogenic bladder who is pregnant (covered for duration of pregnancy only); or
 - (d) The consumer has had distinct, recurrent urinary tract infections, while on a program of sterile intermittent catheterization, two or more times within the twelve months prior to the initiation of using sterile intermittent catheter kits.
 - (iii) A consumer is considered to have a urinary tract infection if he or she has a documented urine culture with greater than ten thousand colony forming units of a urinary pathogen and concurrent presence of one or more of the following signs, symptoms or laboratory findings:
 - (a) Fever (oral temperature greater than thirty-eight degrees Celsius or 100.4 degrees Fahrenheit); or
 - (b) Systemic leukocytosis; or
 - (c) Change in urinary urgency, frequency, or incontinence; or
 - (d) Appearance of new or increase in autonomic dysreflexia (sweating, bradycardia, blood pressure elevation); or
 - (e) Physical signs of prostatitis, epididymitis, orchitis; or
 - (f) Increased muscle spasms; or
 - (g) Pyuria (greater than five white blood cells (WBCs) per high powered field).
 - (iv) If the medical necessity of sterile catheterization is not documented in the consumer's medical record, sterile supplies associated with this procedure are not reimbursable by the department.
 - (v) Use of a coude (curved) tip catheter in females is considered to be rarely necessary. When a coude tip catheter is used (for either males or females), there must be documentation of medical necessity in the consumer's medical record for the use of this type of catheter rather than a straight tip catheter.
 - (j) External catheters or urinary collection devices
 - (i) Male external catheters (condom-type) or female external urinary collection devices are covered for consumers who have permanent urinary incontinence when used as an alternative to an indwelling catheter.
 - (ii) Male external catheters or female external urinary collection devices will not be reimbursable if the consumer is currently also using an indwelling catheter.
 - (iii) Specialty type male external catheters such as those that inflate or that include a faceplate or extended wear catheter systems are covered only when documentation in the consumer's medical record establishes the medical necessity for such a catheter.
 - (iv) For female external urinary collection devices, more than one metal cup per week or one pouch per day is not reimbursable.
 - (k) Miscellaneous supplies
 - (i) Appliance cleaner (A5131) is covered when used to clean the inside of certain urinary collecting appliances (e.g., A5102 or A5112). Reimbursement is not approved for this cleaner unless the consumer is also using one of the specified corresponding appliances.
 - (ii) Adhesive catheter anchoring devices and catheter leg straps for indwelling urethral catheters are covered. A catheter/tube anchoring device is covered and separately

reimbursable only when it is used to anchor a covered suprapubic tube or nephrostomy tube.

(2) Coverage limitations

- (a) Provision of urological supplies is limited to a one-month supply per calendar month. Consumers are eligible for re-supply on a calendar month basis starting with the initial dispensing date. The provider is responsible for determining the appropriate amount of urological supplies on any given month based on consumer need. The stockpiling of urological supplies by a consumer is not allowed.
- (b) Providers are responsible for determining whether additional urological supplies have been acquired by the consumer from a different provider during any given month. Urological supplies dispensed over and above the stated maximum allowables as listed in appendix A to rule 5101:3-10-03 of the Administrative Code will be not be reimbursed without prior authorization.
- (c) Urological supplies for consumers in long term care facilities are reimbursed through the facility's cost report.

(C) Reimbursement

Ostomy and urological supplies are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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Effective Date: August 17, 2009

(A) Coverage determination

- (1) The provider must document medical necessity in the consumer's medical record that clearly supports the need for a commode.
- (2) Commodes must be prescribed by a prescriber actively involved in managing the consumer's medical care through a comprehensive plan of care that addresses the need for a commode. This prescription must contain the original signature of the ordering prescriber that attests to the medical necessity of the commode.
- (3) A commode is covered when the consumer is physically incapable of utilizing regular toilet facilities and is physically able to use a commode, otherwise a bedpan is indicated. This limitation must be documented in the consumer's medical record and available for review upon request by the department. One or more of the following situations must be present in order for a commode to be justified for reimbursement:

 - (a) The consumer is confined to a single room due to a documented medical condition; or
 - (b) The consumer is confined to one level of the home due to a documented medical condition and there is no toilet on that level; or
 - (c) The consumer is confined to the home due to a documented medical condition and there are not toilet facilities in the home.
- (4) An extra wide/heavy duty commode chair is covered for consumers who weigh three hundred pounds or more. If a consumer weighs less than three hundred pounds, the consumer's medical record must document the medical necessity of this type of commode chair.
- (5) A commode chair with detachable arms is covered only if this feature is necessary to facilitate transferring the consumer or if the consumer has a body configuration that requires extra width. The consumer's medical record must document the medical necessity of this type of commode chair.

(B) Coverage limitations

- (1) Providers are responsible, prior to dispensing a commode, to determine whether the consumer previously acquired this item from another provider.
- (2) Commodes for consumers residing in long term care facilities are reimbursed through the facility's cost report.
- (3) Providers cannot bill for the concurrent supply of both a commode and a bedpan.

(C) Reimbursement

Commodes are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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Effective Date: January 7, 2010

(A) Definitions

Unless otherwise specified, the staging of pressure ulcers used in this rule is as follows:

- (1) Suspected deep tissue injury: Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
- (2) Stage I: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.
- (3) Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
- (4) Stage III: Full thickness loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
- (5) Stage IV: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
- (6) Unstageable: Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

(B) Coverage determination

- (1) Surgical dressings are covered for as long as medical necessity exists. Dressings over a percutaneous catheter or tube (e.g., intravascular, epidural, nephrostomy, etc.) are covered as long as the catheter or tube remains in place and after removal until the wound heals.
- (2) Any prescription for surgical dressings and related supplies must be prescribed by a prescriber actively involved in managing the consumer's medical condition as indicated in paragraph (A)(2) of rule 5101:3-10-05 of the Administrative Code. The prescriber should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any supplies referenced in this rule.
- (3) When a wound cover with an adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be documented by the provider. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.
- (4) Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary. The reasons for use of more than one type of wound filler or wound cover must be well documented by the provider. An exception is an alginate or other fiber gelling dressing or a saline, water, or hydrogel impregnated gauze dressing which might need an additional wound cover.
- (5) It may not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g., hydrogel and alginate).
- (6) When used as a secondary dressing, composite dressings, foam and hydrocolloid wound covers, and transparent film are meant to be changed at frequencies less than daily and appropriate clinical judgment must be used to avoid their use with primary dressings which

require more frequent dressing changes. When claims are submitted for these dressing for changes greater than once every other day, the quantity in excess of that amount will not be reimbursable by the department for a period not to exceed thirty days during the initial treatment. While a highly exudative wound might require such a combination initially, with continued proper management the wound usually progresses to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of non-impregnated gauze being used as a primary dressing.

- (7) Dressing size must be based on and appropriate to the size of the wound. For wound covers, the pad size is usually about two inches greater than the dimensions of the wound.
- (8) The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change, and the recent use of dressings.
- (9) Dressing needs may change frequently (e.g., weekly) in the early phases of wound treatment and/or with heavily draining wounds. Providers are expected to have a mechanism for determining the quantity of dressings that the consumer is actually using and to adjust their provision of dressings accordingly. No more than one month's supply of dressings may be provided at one time. The stockpiling of surgical dressings and related supplies by a consumer is not allowed.
- (10) Providers are responsible for determining whether additional surgical dressings and related supplies have been acquired by the consumer from a different provider during any given month. Surgical dressings and related supplies dispensed over and above the stated maximum allowables as listed in appendix A to rule 5101:3-10-03 of the Administrative Code will be not be reimbursed without prior authorization.
- (11) Surgical dressings must be tailored to the specific needs of an individual consumer. When surgical dressings are provided in kits, only those components of the kit that meet the definition of a surgical dressing and are specifically ordered by a prescriber and are medically necessary are covered. Components included in a kit such as scissors and/or tape may not be billed separately to the department.

(C) Alginate or other fiber gelling dressing

Alginate or other fiber gelling dressing covers are covered for moderately to highly exudative full thickness wounds (e.g., stage III or IV ulcers), and alginate or other fiber gelling dressing fillers for moderately to highly exudative full thickness wound cavities (e.g., stage III or IV ulcers). They are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. One wound cover sheet of the approximate size of the wound or up to two units of wound filler (one unit equals six inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels.

(D) Composite dressing

Usual composite dressing change is up to three times per week, one wound cover per dressing change.

(E) Contact layer dressing

Contact layer dressings are used to line the entire wound and are not intended to be changed with each dressing change. Usual dressing change is up to once per week.

(F) Foam dressing

Foam dressings are covered when used on full thickness wounds (e.g., stage III or IV ulcers) with moderate to heavy exudate. Usual dressing changes for a foam wound cover used as a primary dressing is up to three times per week. When a foam wound cover is used as a secondary dressing for wounds with a very heavy exudate, dressing change may be up to three time per week. Usual dressing change for foam wound fillers is up to once per day.

(G) Gauze, non-impregnated dressing

Usual non-impregnated gauze dressing change is up to three times per day for a dressing without a border and once per day for a dressing with a border. It is usually not necessary to stack more than two gauze pads on top of each other in any one area.

(H) Gauze dressing, impregnated, with other than water, normal saline, hydrogel, or zinc paste

Usual dressing change for this type of dressing is up to once per day.

(I) Hydrocolloid dressing

Hydrocolloid dressings are covered for use on wounds with light to moderate exudate. Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to three times per week.

(J) Hydrogel dressing

Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudate (e.g., stage III or IV ulcers). Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressing for stage II ulcers (e.g., location of ulcer in sacrococcygeal area). Usual dressing change for hydrogel wound covers without adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers with adhesive border is up to three times per week.

The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Provider documentation must substantiate the medical necessity for this product billed in excess of three units (fluid ounces) per wound in thirty days.

Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.

(K) Specialty absorptive dressing

Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (e.g., stage III or IV ulcers). Usual specialty absorptive dressing change is up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border.

(L) Transparent film dressing

Transparent film dressings are covered when used on open partial thickness wounds with minimal exudate or closed wounds. Usual dressing changes is up to three times per week.

(M) Wound filler, not elsewhere classified

Usual dressing change is up to once per day.

(N) Wound pouch

Usual dressing change is up to three time per week.

(O) Tape

Tape is covered when needed to secure a wound cover, elastic roll gauze or non-elastic roll gauze. Tape is usually not required when a wound cover with an adhesive border is used. The medical necessity for tape in these situations must be documented by the provider. Tape change is determined by the frequency of change of the wound cover. Quantities of tape must reasonably reflect the size of the wound cover being secured. Usual use for wound covers measuring sixteen square inches or less is up to two units per dressing change; for wounds covers measuring sixteen to forty-eight square inches, up to three units per dressing change; for wound covers measuring greater that forty-eight square inches, up to four units per dressing change.

(P) Light compression bandage, moderate/high compression bandage, self-adherent bandage, conforming bandage, padding bandage

Most compression bandages are reusable. Usual frequency of replacement would be no more than one per week unless they are a part of a multi-layer compression bandage system.

Conforming bandage dressing change is determined by the frequency of change of the selected underlying dressing.

(Q) Non-coverage determination

- (1) Surgical dressings are not separately reimbursable for consumers in long term care facilities (LTCFs) as these supplies are included the facility's cost report.
- (2) Gauze, impregnated, water or normal saline
There is no medical necessity for these dressings compared to non-impregnated gauze moistened with bulk saline or sterile water. These dressings are not separately reimbursed by the department.
- (3) Providers can not bill the department for any surgical dressing or a related supply item past the date of medical necessity.

(R) Authorization

- (1) A fully completed and legible prescription signed by an eligible prescriber must be kept on file by the provider and made available for review upon request by the department and sent to the department for review as a part of a prior authorization request for surgical dressings or supplies.
- (2) The prescription must specify the type of dressing being prescribed, the size of the dressing being prescribed, the number/amount to be used at one time (if more than one), the frequency of dressing change, and the expected duration of need for the surgical dressings and related supplies.
- (3) A new prescription is needed if any new dressing is added or if the quantity used of an existing dressing is increased. A new prescription is not needed if the quantity of dressings used is decreased. However, a new prescription is required at least every three months for each dressing being used even if the quantity used has remained the same or decreased.
- (4) The prescription for the dressing must identify the number of wounds being treated and the reasons for the dressing (e.g., a primary or secondary dressing to cover a surgical or debrided wound, or for wound cleansing). Dressing use or the use of a related supply item must be documented in the provider's records and include the date and source of this information (e.g., prescriber or home care nurse).
- (5) The prescription must contain clinical information not more than one year old supporting the necessity of the type and quantity of surgical dressings provided and must be maintained in the consumer's medical records. An evaluation of the consumer's wound (s) must be performed at least on a monthly basis by a qualified health care provider unless there is documentation in the consumer's medical record which justifies why an evaluation could not be done within this timeframe and what other monitoring methods were used to evaluate the continuing need for dressings. Evaluation is expected on a more frequent basis (e.g., weekly) if a consumer has a heavily draining or infected wound. The wound evaluation must include the type of each wound (e.g., surgical wound, pressure ulcer, burn, etc.), its location, size (length and width in centimeters) and depth, the amount of drainage, and any other relevant clinical information. This information must be available for review upon department request.

(S) Reimbursement

Surgical dressings and related supplies are reimbursed at the lesser of the department's fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge.

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MHTL 3344-11-05

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Any provider seeking reimbursement for this service must meet the provisions contained within Chapter 4779. of the Revised Code in order to be eligible for reimbursement for services provided.

(A) Definitions

- (1) A cranial orthotic remolding device is an orthotic helmet that can progressively mold the shape of the cranium. Treatment is typically initiated around five to six months of age and continues for an average of four to six months.**
- (2) Cephalic index is the ratio of the maximum width of the head multiplied by one hundred divided by its maximum length (i.e., in the horizontal plane, or front to back).**

(B) Coverage determination

- (1) A cranial orthotic remolding device is covered for treatment of positional (non-synostotic) plagiocephaly only if all of the following criteria are met:**
 - (a) Consumer is at least three months of age but not greater than eighteen months of age; and**
 - (b) Marked asymmetry has not been substantially improved following conservative therapy of at least two months duration with cranial repositioning therapy and/or physical therapy; and**
 - (c) Asymmetry of the cranial base as documented by any of the following:**
 - (i) Skull Base Asymmetry: At least six millimeter (mm) right/left discrepancy measured subnasally to the tragus, defined as the cartilaginous projection of the auricle at the front of the ear; or**
 - (ii) Cranial Vault Asymmetry: At least a ten mm right/left discrepancy measured from the frontozygomatic point (identified by palpation of the suture line above the upper outer corner of the orbit) to the euryon, defined as the most lateral point on the head located in the parietal region; or**
 - (iii) Asymmetry of the orbitotragial distances, as documented by at least a four mm right/left asymmetry.**
- (2) A cranial orthotic remolding device is covered for treatment of positional (non-synostotic) braciocephaly if the cephalic index is greater than ninety one per cent.**
- (3) A cranial orthotic remolding device is covered for the treatment of positional (non-synostotic) scaphocephaly if the cephalic index is less than seventy five per cent.**
- (4) A cranial orthotic remolding device is covered for treatment of synostotic deformity if all of the following criteria are met:**
 - (a) Consumer is between the ages of birth and eighteen months; and**
 - (b) Premature closing of the cranial structures is documented by treating prescriber and surgery with post-operative treatment including remolding orthotic helmeting is medically indicated and documented in the consumers medical record.**
- (5) All documentation supporting the above medical criteria must be kept in the provider's file and be available for review at the request of the Ohio department of job and family services (ODJFS).**

(6) Cranial orthotic remolding devices 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 a cranial orthotic remolding device. This prescription must contain the original signature of the ordering prescriber that attests to medical necessity of this device.

(C) Non-coverage determination

A cranial orthotic remolding device is non covered for consumers who cannot document an appropriate medical need based on the provisions of this rule.

(D) Prior Authorization

No prior authorization is necessary for the dispensing of a cranial orthotic remolding device.

(E) Dispensing

(1) The following components are considered "inclusive" with any payment made by the department for a cranial orthotic remolding device on behalf of a consumer, cannot be submitted to the department for separate reimbursement and must be dispensed and/or maintained by the billing provider:

(a) Labor;

(b) Orthotic remolding device;

(c) Casting, fitting, or measuring fees;

(d) Charges for travel; and

(e) Charges for shipping and mailing.

(2) Providers must document that the consumer's primary care giver is instructed as to the proper use and wear of the cranial orthotic remolding device and documentation of this instruction must be kept in the provider's file.

(3) Any dispensed cranial orthotic remolding device must be of a type and fabricated at a facility approved for consumer use as an approved class II medical device by the food and drug administration (FDA).

(4) Any provider dispensing and fitting a cranial remolding orthotic device must have the appropriate documentation on file that demonstrates the appropriate training necessary to fit the device properly.

(5) Consumers are eligible for only one cranial orthotic remolding device per lifetime.

(F) Reimbursement

Cranial orthotic remolding devices are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the providers usual and customary charge, whichever is less.

Effective: 09/01/2011

R.C. 119.032 review dates: 09/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 08/22/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

MHTL 3344-12-01

Effective Date: March 29, 2012

Most Current Prior Effective Date: April 16, 2007

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 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. Purchase requests also must include a~~ 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.

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R.C. 119.032 review dates: 01/13/2012 and 03/01/2017

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~~*Formerly*~~ 5101:3-10-08 Repair of Medical Equipment

[MHTL 3334-13-13](#)

Effective Date: December 31, 2013

Most Current Prior Effective Date: [October 29, 2009](#)

~~Wheelchair repairs are not directly reimbursable for consumers residing in a nursing facility (NF) as defined in section 5111.20 of the Revised Code. Such repairs are the responsibility of the NF and reimbursed to the NF through the facility per diem. Wheelchair repairs for residents of an intermediate care facility for the mentally retarded (ICF-MR) as defined in section 5111.20 of the Revised Code are covered through direct reimbursement as provided in this rule. The provisions in this rule do not apply to the repair of resident wheelchairs by nursing facilities.~~

- (A) Durable medical equipment covered under rule ~~5101:3~~[5160](#)-10-03 of the Administrative Code and speech generating devices.
- (1) Department coverage for repair of medical equipment has been established for major and minor repairs.
- (a) "Major repairs" are ~~defined as~~ those repairs for which the combined charges for materials and labor exceed one hundred dollars. Prior authorization is required for major repairs to durable medical equipment. Prior authorization requests must include complete itemization of parts and labor.
- (b) "Minor repairs" are ~~defined as~~ those repairs for which the combined charges for materials and labor are one hundred dollars or less. For a maximum of one repair per recipient per one hundred twenty-day period, prior authorization is not required for minor repairs to durable medical equipment. Prior authorization must be obtained for minor repairs in excess of one per recipient per one hundred twenty-day period and for minor repairs within ninety days after the dispensing date of equipment or prior to the expiration of any applicable warranty. Prior authorization requests must include complete itemization of parts and labor.
- (c) Providers must submit the appropriate procedure code(s) including modifiers as required for all equipment repair claims submissions and prior authorization requests. For the reimbursement of repairs requiring materials and labor, the appropriate procedure codes must be submitted together on the same claim for the same date of service.
- (i) For the reimbursement of repairs or replacement parts without a specific procedure code, use code E1399 modified with the ~~"RP"~~ RB modifier in combination with labor code E1340 as appropriate.
- (ii) For the reimbursement of repairs requiring only the time of a technician, without a specific labor code, use labor code ~~E1340~~ K0739.
- (iii) For the reimbursement of repairs or replacement of parts of wheelchairs without a specific procedure code, use code K0108 modified with the ~~"RP"~~ RB modifier in combination with labor code ~~E1340~~ K0739 as appropriate.
- (d) All wheelchair and power operated vehicle (POV) repairs must be billed in accordance with rule ~~5101:3~~[5160](#)-10-16 of the Administrative Code.
- (2) Unless otherwise specified, a fully completed "Certificate of Medical Necessity/Prescription Repair of Durable Medical Equipment (DME)" form [JFS 01904](#)₇ (rev. 04/2009)₁ (~~appendix A to this rule~~) is required if the item requiring repair:
- (a) Was not paid for by the department; or₇
- (b) Was originally approved through the department's prior authorization procedure and the repair would substantially change the appearance or function of the item; or₇

(c) Did not require prior authorization but was paid for by the department and is a major repair.

- (3) A written prescription is required if the item requiring repair did not require prior authorization but was paid for by the department and is a minor repair. This documentation must be kept in the consumer's medical record.
- (4) "Labor" is ~~defined as~~ the time required by a technician to repair, refurbish, or provide nonroutine service on medical equipment more than ninety days after the dispensing date of that equipment and after the expiration of any applicable warranty.
- (5) Requests for prior authorization of repairs (both minor repairs in excess of one per one hundred twenty days and major repairs) must itemize parts and labor separately. Prior-authorized labor will be reimbursed at the lesser of the billed hourly rate or the medicaid maximum rate for labor listed in appendix DD to rule ~~5101:35160~~-1-60 of the Administrative Code, prorated for periods of less than one hour.
- (6) Requests for prior authorization of major repairs for durable medical equipment must specify who owns the equipment, the date of purchase or the approximate age of the equipment, and the applicable warranty period.
- (7) No reimbursement may be made for:
 - (a) Any repairs covered under manufacturer or dealer warranty; or
 - (b) Repair of rental equipment covered by the rental payment; or
 - (c) Costs associated with providing temporary replacement equipment due to repair; or
 - (d) Costs associated with postage, pick-up, delivery and set-up or installation.
- (8) Reimbursement may be provided for major repair of medical equipment not purchased by the department only if that equipment is determined by the department to be medically necessary, evidence of expiration of warranty is submitted with the "Prior Authorization" request, and the department has not provided reimbursement for repair of duplicate or conflicting equipment in the prior twelve months.
- (9) The department will not cover new items when simple repairs are all that are necessary. However, providers shall advise the department when, in their professional opinion, replacement of an item would be more cost-effective than repair.
- (10) ~~Repairs of recipient-owned durable medical equipment, other than wheelchairs, are eligible for direct reimbursement for recipients residing in nursing facilities (NFs) or intermediate care facilities for the mentally retarded (ICFs-MR) may be billed to the department. Repairs of all wheelchairs for consumers residing in a nursing facility (NF) are not directly reimbursable by the department. Such repairs are the responsibility of the NF and reimbursed to the NF through the facility per diem. Repairs of wheelchairs for consumers residing in an intermediate care facility for the mentally retarded (ICF-MR) with the exception of minor wheelchair repairs as specified in rule 5101:3-10-16 of the Administrative Code are directly reimbursable by the department.~~ Claims may be submitted to the department for repairs made to durable medical equipment owned by recipients residing in long-term care facilities (LTCFs) except minor wheelchair repairs.
- (11) No charge for labor will be reimbursed for repair or replacement of items identified by an asterisk in the appendix to rule 5101:35160-10-20 of the Administrative Code.
- (12) Routine maintenance on equipment owned by the recipient is the responsibility of the recipient or the recipient's caretaker. "Routine maintenance" is ~~defined as those things~~ any action described in the equipment owner's manual as routine and necessary to maintain optimum functioning of the equipment, and which do not require a skilled or trained technician to perform.

(B) Hearing aids.

- (1) "Major repair of hearing aids" is ~~defined as~~ a repair for which the combined charges for materials and labor exceed one hundred dollars. No more than one major repair may be reimbursed in any three hundred sixty-five-day period. Prior authorization is required for major repairs to hearing aids. Payment for a major repair of a hearing aid includes a warranty described in rule ~~5404:35160~~-10-11 of the Administrative Code to cover all repairs and all related service calls and follow-up during the warranty period. Charges billed to the department shall not exceed:
 - (a) The provider's usual and customary combined charges when the provider performs the repairs; or,
 - (b) One hundred twenty-five per cent of the provider's cost as indicated on the invoice for repair issued to the provider when the provider does not perform the repairs.
- (2) "Minor repair of hearing aids" is ~~defined as~~ a repair for which the combined charges for materials and labor is equal to or less than the medicaid maximum for a hearing aid repair listed in rule ~~5404:35160~~-1-60 of the Administrative Code. No more than one minor repair may be reimbursed in any one hundred twenty day period without prior authorization. Charges billed to the department shall not exceed:
 - (a) The provider's usual and customary combined charges when the provider performs the repairs; or,
 - (b) One hundred twenty-five per cent of the provider's cost as indicated on the invoice for repair issued to the provider when the provider does not perform the repairs.
- (3) The cost of postage, pick-up, or delivery of a hearing aid is considered a cost of doing business and may not be billed separately.
- (4) Routine maintenance of hearing aids is the responsibility of the recipient or the recipient's caretaker. "Routine maintenance of hearing aids" is ~~defined as those things~~ any action described in the owner's manual as routine and necessary to maintain optimum functioning of the hearing aid, including cleaning and checking.
- (5) Requests for prior authorization of repairs (both minor repairs in excess of one every one hundred twenty days and major repairs) must specify the nature of the repair, the date of purchase or the approximate age of the equipment, and previous dates of both major and minor repair services.

(C) Orthotic and prosthetic devices.

- (1) In addition to the requirements of paragraphs (A)(2) to (A)(12) of this rule, coverage and claims submission for the repair or replacement of parts for orthotic devices is specifically defined in rule ~~5404:35160~~-10-20 of the Administrative Code.
- (2) In addition to the requirements of paragraphs (A)(2) to (A)(12) of this rule, coverage and claims submission for the repair or replacement of parts for prosthetic devices is specifically defined in rule ~~5404:35160~~-10-20 of the Administrative Code.

- (D) Prior authorization requests for the repair of 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 for the repair when the department determines it is unreasonable to make further program payment under the circumstances presented to the department in support of the equipment repair request. Providers will provide any information regarding requests for the repair of medical equipment that the department deems necessary in order to evaluate the repair request.

Effective:

R.C. 119.032 review dates: 10/15/2013

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5164.70, 5165.01, 5165.47

Prior Effective Dates: 04/07/1977, 12/21/1977, 01/01/1980, 03/01/1984, 10/01/1988, 05/15/1989, 05/01/1990, 12/10/1993, 01/01/1995, 09/01/2002, 10/01/2004, 01/13/2006, 04/09/2009, 07/31/2009 (Emer), 10/29/2009

Effective Date: October 15, 2006

Most Current Prior Effective Date: December 5, 2002

(A) Definitions.

- (1) "Apnea monitors" are defined as cardiorespiratory monitoring devices capable of providing continuous or periodic two channel monitoring of heart rate and respiratory rate and must meet current food and drug administration guidelines for products in this class. Apnea monitors must have alarming mechanisms to alert ~~care givers~~ caregivers of cardiorespiratory distress or other events ~~which~~ that require immediate intervention and must be capable of recording and storing events (sometimes known as memory monitoring) and of providing event recording downloads or printouts of such data.
- (2) "Download" is defined as a ~~print out~~ printout of the two channel (or greater) event recordings from a memory monitor. Normally a download contains waveform printouts, event logs, and compliance and utilization information.
- (3) "Sudden infant death syndrome (SIDS)" is defined as the sudden death of any infant or young child under one year of age that remains unexplained after the performance of a complete postmortem investigation, including an autopsy, an examination of the scene of death, and a review of the case history.
- (4) "Apparent life threatening event (ALTE)" is defined as an episode that is frightening to the observer and that is characterized by some combination of apnea (central or obstructive), color change (usually cyanotic or pallid but occasionally erythematous), marked changes in muscle tone (usually limpness), choking or gagging. In some cases, the observer fears the infant has died. Terminology such as aborted crib death or near miss SIDS should be abandoned because it implies a possible misleading close association between an ALTE and SIDS.

(B) Apnea monitors are reimbursed on a ~~capped rental~~ rent-to-purchase basis in accordance with rule 5101:3-10-05 of the Administrative Code ~~and require prior authorization for reimbursement in excess of four months. The maximum months of rental which may be reimbursed is limited to, or capped at, twelve months.~~ The ~~monthly~~ monthly medicaid fee includes payment for professional time, event recording (download), and all maintenance and supplies. ~~After the initial four months of rental, additional months of rental may be authorized for patients which meet the criteria in paragraph (D) of this rule.~~

(C) The following criteria must be met for coverage of an apnea monitor:

- (1) The provider must maintain on file a certificate of medical necessity (CMN) signed by the attending physician documenting at least one or more of the following:
 - (a) One or more apparent life-threatening events (ALTEs) requiring mouth-to-mouth resuscitation or vigorous stimulation; ~~or~~
 - (b) Symptomatic preterm infant (active medical management of apnea of prematurity); ~~or~~
 - (c) Sibling of one or more sudden infant death syndrome (SIDS) victims; ~~or~~
 - (d) Infant requires home oxygen therapy or invasive or non-invasive ventilatory support (technology dependent); ~~or~~
 - (e) Tracheotomized infant (technology dependent); ~~or~~
 - (f) Infant with abnormal pneumogram at discharge; ~~or~~
 - (g) Multiple birth SIDS survivor(s); ~~or~~
 - (h) Infants with severe gastroesophageal reflux with associated apneas; ~~or~~

- (i) Infants with severe upper airway abnormalities (e.g., achondroplasia, Pierre-Robin syndrome, etc.); or
 - (j) Infants with other disorders, specified on the CMN, that demonstrate a need for close cardiorespiratory monitoring to facilitate a more timely discharge to home.
- (2) Requirements for use of home monitoring include but are not limited to the following:
- (a) Infant cardiopulmonary resuscitation (CPR) training of ~~care-givers~~caregivers by certified trainers;
 - (b) Education regarding mechanical aspects of monitors;
 - (c) In-hospital experience;
 - (d) Twenty-four hour availability of monitor service staff; and
 - (e) Attestation by the attending physician that the ~~care-givers~~caregivers are capable of being trained to use the monitor properly.
- (3) The following diagnoses or conditions alone are not indications for monitoring:
- (a) Seizure disorders (without life threatening events);
 - (b) Hydrocephalus, uncomplicated;
 - (c) Mental retardation;
 - (d) Irreversible terminal conditions;
 - (e) Congenital heart defects, with or without associated arrhythmias;
 - (f) Distant family history of apnea or SIDS (other than an immediate sibling);
 - (g) History of apnea monitor use with other siblings;
 - (h) History of apnea with other sibling(s);
 - (i) Parental anxiety or family request for a monitor; and
 - (j) Monitoring of blood oxygen saturation.
- (D) Length of need. Coverage of apnea monitors is generally limited to four months. Apnea monitors should be discontinued as soon as there is no medical indication to support the need for continued home monitoring. If the attending physician recommends continued monitoring beyond the initial ~~four months of rental which are covered without prior authorization~~, evidence to support the medical need must be submitted with the request for subsequent rental or purchase authorization in accordance with paragraphs (D)(1) to (D)(3) of this rule. ~~Authorization may be granted for up to eight months of rental.~~
- (1) Nontechnology dependent infants. Requests for authorization should include:
- (a) Evidence that there has been clinically significant apnea or bradycardia within two months ~~prior to~~before the date of the prior authorization request. Supportive evidence may include a copy of a recent download noting apneas or bradycardias; documentation of a recent pneumogram noting apneas or bradycardias; documentation of a recent emergency room visit or hospital admission for an ALTE;
 - (b) Download report or download summary information with download report available on request by the department; and
 - (c) Certificate of medical necessity signed by the attending physician stating the need for continued home monitoring.
- (2) Technology dependent child. Requests for authorization should include:
- (a) Evidence that the patient is still in need of the high technology products/services. Supportive evidence may include copies of recent clinician follow-up reports noting equipment and services still in use, copies of home nursing agency visits reports noting equipment and services still in use, etc.;

- (b) Download report or download summary information with download report available on request by the department; and
 - (c) Certificate of medical necessity signed by the attending physician stating the need for continued home monitoring.
- (3) SIDS sibling. Requests for authorization should include:
- (a) Same criteria as noted in paragraph (D)(1)(a) of this rule; or
 - (b) Patient is not beyond age of the death of the sibling who died of SIDS;
 - (c) Download report or download summary information with download report available on request by the department; and
 - (d) Certificate of medical necessity signed by the attending physician documenting the need for continued home monitoring.

~~(E)~~ **Capped rental.**

- ~~(1) Apnea monitors are designated as capped rental equipment. If medical necessity requires use after twelve months, the rental is capped (no additional rental payments) and supplies may then be billed separately under the appropriate code. Because the apnea monitor rental fee includes payment for all supplies and maintenance, the apnea supply code may not be billed in any month in which the apnea rental code is billed. This includes any month in which the six-month maintenance fee is billed.~~
- ~~(2) After twelve monthly rental payments have been made, rental payments will cease. If authorized for reimbursement beyond the twelfth month, at the end of each six-month period following the initial twelve-month rental period the provider may bill a single maintenance service charge to the department, not to exceed the monthly rental fee. The provider retains ownership of the equipment.~~
- ~~(3) The billing code modifier CR should be used in billing capped rental items for the initial twelve months. When billing for the maintenance service charge, use the billing code modifier MS.~~

~~(F)~~(E) Downloads. Recording monitor downloads are covered for recipients receiving home apnea monitor services as part of any payment for service rendered by the department. Downloads are normally used to determine the presence of continued symptoms (apnea/bradycardia) and document such information. They may also be used to document compliance with home monitoring requirements. Download reports provide appropriate, objective medical information that may aid the physician in deciding to discontinue home monitoring or document the need for continued home monitoring.

- ~~(1) Recording monitor downloads are covered for recipients receiving home apnea monitor services. Downloads are normally used to determine the presence of continued symptoms (apnea/bradycardia) and document such information. They may also be used to document compliance with home monitoring requirements. Download reports provide appropriate, objective medical information that may aid the physician in deciding to discontinue home monitoring or document the need for continued home monitoring.~~
 - ~~(a) A maximum of two outpatient recording monitor downloads per recipient per year is reimbursable without prior authorization.~~
 - ~~(b) Requests for additional downloads require prior authorization and may be approved when determined to be medically necessary. The maximum number of downloads per recipient per year is four.~~
 - ~~(c) Reimbursement for downloads is limited to one per calendar month.~~

~~(G)~~(F) Pneumograms ~~-home~~. For dates of service beginning on or after April 1, 2006, consumers requiring a pneumogram must seek the care of a qualified licensed prescriber in order to have the pneumogram reimbursed by the department. The order for a pneumogram must be based on the presence of appropriate symptoms or conditions as defined by accepted medical standards. Pneumograms used

as screening tests without the presence of appropriate symptoms for conditions are not reimbursable by the department.

- ~~(1) To qualify for reimbursement, a pneumogram must be ordered and evaluated by a licensed physician. The order must be based on the presence of appropriate symptoms or conditions as defined by accepted medical standards. Pneumograms used as screening tests without the presence of appropriate symptoms or conditions are not reimbursable.~~
- ~~(2) The department's reimbursement for an outpatient pneumogram includes the rental of the monitor, the technician time involved, the physician's evaluation of the pneumogram, and a copy of any interpretive reports.~~
- ~~(3) A maximum of one outpatient pneumogram per recipient per year is reimbursable without prior authorization. Requests for prior authorization of additional pneumograms may be approved when determined to be medically necessary.~~

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R.C.119.032 review dates: 06/15/2006

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Prior Effective Dates: 3/1/84, 5/1/90, 7/1/97, 10/2/97, 12/5/02

5160-10-10 Dialysis Equipment

Formerly 5101:3-10-10 Dialysis Equipment

Effective Date: January 1, 2008

Most Current Prior Effective Date: [April 16, 2007](#)

- (A) Unless otherwise indicated, equipment and all related medical supplies necessary for the home dialysis consumer are covered under the Ohio medicaid program when billed by suppliers/providers, except when the consumer elects to receive dialysis under "Method I," as referenced in rule ~~5101:3-13-07~~5101:3-13-01.9 of the Administrative Code.
- (B) Dialysis equipment and supplies are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code.

Effective: 01/01/2008

R.C. 119.032 review dates: 04/01/2012

Certification: CERTIFIED ELECTRONICALLY

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*Formerly * 5101:3-10-11 Hearing Aids

[MHTL 3344-13-01](#)

Effective Date: December 1, 2013

Most Current Prior Effective Date: [September 1, 2005](#)

(A) Definitions.

(1) "Audiologist."

A person licensed to practice audiology in Ohio under Chapter 4753. of the Revised Code, or who is licensed and practicing in another state and is employed by an eligible Ohio medicaid provider. This individual is authorized to provide hearing screening consistent with the provisions detailed in rule 4753-6-01 of the Administrative Code and audiologic evaluation consistent with the provisions detailed in ~~division (G) of~~ section 4753.01 of the Revised Code.

(2) "Licensed hearing aid dealer/fitter."

A person licensed in Ohio under Chapter 4747. of the Revised Code, or who is licensed and practicing in another state and is an eligible Ohio medicaid provider. This individual is authorized to provide hearing screening and testing consistent with the provisions detailed in rules 4747-01-02 and 4747-01-19 of the Administrative Code.

(3) "Programmable."

A hearing aid that utilizes analog technology that is controlled by modifying the frequency and output characteristics using a computer. It may contain multiple microphones, multiple memories and multiple channels, and may operate with a remote control.

(4) "Digital."

A digital hearing aid analyzes incoming sound, transforms it by converting the sound into digital bits and manipulates the frequency and output characteristics of the sound before the sound is amplified. Digital hearing aids are programmed with a computer and contain multiple memories, microphones, and channels. The digital processor permits the hearing aid to change its parameters, to reduce background noise, and/or ~~eliminate~~ manage feedback without adversely affecting the benefits for the user.

(5) "Conventional."

Conventional hearing aids have a microphone that gathers sound, an amplifier that increases the volume of sound, and a receiver that transmits this amplified sound to the ear. These instruments may have a manual volume control for the user. These devices have screw-set controls mounted onto the hearing aids for the ~~hearing health care professional~~ licensed provider to adjust.

(B) Hearing aids of any type must be prior authorized before being eligible for reimbursement by Ohio medicaid. The prior authorization (PA) request must include all of the following documentation:

(1) A fully completed and legible [JFS 01915](#) "Certificate of Medical Necessity/Prescription Hearing Aids" (appendix A to this rule) signed by the prescriber and dated no more than ninety days before dispensing of the hearing aid.

~~(1) A fully completed, most current version of prior authorization (PA) form (JFS-03142, rev. 02/2003);~~

~~(2) A description, including approximate age and ownership, of any similar equipment in possession of the consumer and the reason for the new request if similar equipment ownership is established; and~~

- ~~(3) A current physician's prescription that verifies the need for a hearing aid by certifying that the provided hearing test results, when interpreted as a set, clearly demonstrate hearing loss and includes a written statement verifying that the performance of a medical examination has indicated that the hearing loss is not due to a temporary, correctable physical condition; e.g., ear infection or impacted wax. The physician's prescription cannot be dated more than six months prior to the date of the PA request.~~

~~For the purposes of medicaid reimbursement, the exception allowing the opportunity to waive the medical evaluation for a medical referral or medical evaluation for a consumer eighteen years of age or older specified in paragraph (A)(10) of rule 4747-1-19 of the Administrative Code or paragraph (C)(2) of rule 4753-8-03 of the Administrative Code cannot be applied to medicaid consumers;~~

- ~~(4)(2)~~ Documentation of a hearing evaluation that supports the consumer's need for a hearing aid and includes all of the following components:

- (a) A hearing test that was performed and signed by a physician specializing in otology or otolaryngology, an audiologist, or a hearing aid fitter;
- (b) The hearing test report which reflects the specific hearing values resulting from the test; and
- (c) A written summation of the hearing test results, performed and signed by a physician specializing in otology or otolaryngology, or an audiologist.

The individual performing either the hearing test, the written summation of the hearing test results, or both, must provide a legible name and provider type with his or her documentation (i.e., physician, audiologist or hearing aid fitter). This information must accompany the provider signature. The hearing evaluation must not have been performed more than six months prior to the date of the PA request; and

- ~~(5) Documentation from the physician who is authorizing a digital/programmable hearing aid for a consumer twenty years of age or younger that states the digital/ programmable hearing aid will offer superior performance over a conventional hearing aid for the specific consumer in question. This documentation should also include statements attesting that the particular consumer requires functions that are not found in a conventional hearing aid (i.e., automatic feedback reduction, automatic noise reduction, programmable volume control) and that the digital/programmable hearing aid is necessary for the consumer's success in educational development; and~~

- ~~(3) Any other documentation that demonstrates medical necessity.~~

- ~~(4) Documentation for the prior authorization of a hearing aid must be submitted to the office with the appropriate healthcare common procedure coding system codes.~~

- ~~(6) Dispensing fee codes as referenced in paragraph (M) of this rule and hearing aid codes must be submitted together on the same prior authorization (PA) request and if approved must be billed together with the same date of service.~~

(C) Required hearing evaluation.

- (1) Hearing tests for consumers twenty-one years or older shall include, at a minimum, all of the following for a basic hearing test:
- (a) At least four thresholds for air conducted stimuli of five hundred Hz, one thousand Hz, two thousand Hz, and four thousand Hz;
 - (b) Air conducted speech awareness, or speech reception threshold;
 - (c) Most comfortable and uncomfortable listening level; and
 - (d) Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing.

Hearing test results shall be obtained bilaterally unless the recipient's behavior/condition does not permit bilateral evaluation. If bilateral testing cannot be done, supporting documentation regarding this issue must be provided. All tests shall be performed in an appropriate sound environment in accordance with the standards accepted by the American national standards institute. ~~national standards institute (ANSI S3.1-1999, R2003).~~

- (2) ~~Evaluation of results for consumers twenty-one years or older must show a best pure-tone average of thirty-one dB HL or greater and in conjunction with the remainder of the hearing evaluation, results that demonstrate the need for a hearing aid. If physical or developmental limitations preclude these evaluation results an explanation and alternative evaluation results must be provided.~~
- (2) Hearing test results for consumers aged twenty-one years or older must indicate a best pure-tone average of thirty-one dB HL or greater and, when interpreted in conjunction with the remainder of the hearing test results that constitute a basic hearing test, must demonstrate the need for a hearing aid. If physical or developmental limitations preclude these evaluation results, an explanation and alternative evaluation results must be provided.
- (3) Hearing tests for consumers age twenty years or younger shall include, at a minimum, all of the following for a basic hearing test:
- (a) At least four thresholds for air conducted stimuli of five hundred Hz, one thousand Hz, two thousand Hz, and four thousand Hz;
 - (b) Air conducted speech awareness, or speech reception threshold;
 - (c) Most comfortable and uncomfortable listening level;
 - (d) Bone-conducted pure-tone evaluation, unless the consumer's cognitive abilities do not permit such testing;
 - (e) Tympanometry;
 - (f) Acoustic reflex battery; and
 - (g) Otoacoustic emissions testing.

Hearing test results shall be obtained bilaterally unless the recipient's behavior/condition does not permit bilateral testing. If bilateral testing cannot be done, supporting documentation regarding this issue must be provided. All tests shall be performed in an appropriate sound environment in accordance with ~~the standards accepted by the (ANSI S3.1-1999, R2003).~~the standards accepted by the American national standards institute.

- (4) Hearing test results for consumers aged twenty years or younger must show a best pure-tone average of twenty six dB HL or greater and when interpreted in conjunction with the remainder of the hearing test results, that constitute a basic hearing test, must demonstrate the need for a hearing aid. If physical or developmental limitations preclude these evaluation results, an explanation and alternative evaluation results must be provided.

Hearing test results for consumers ~~aged twenty years or younger~~ are valid ~~for prior authorization purposes~~ only if the testing was conducted by a provider authorized to perform the complete battery of hearing tests that are listed ~~in paragraph (C)(3) of~~ in this rule as part of their respective scope of practice.

(D) The following types of hearing aids are not covered by Ohio medicaid:

- (1) All types of "in the canal" and "completely in the canal" hearing aids;
- (2) All types of disposable hearing aids;
- (3) "Used" or reconditioned hearing aids, which are defined as hearing aids that have been previously utilized by another individual. ~~and~~
- (4) ~~Digital and programmable hearing aids for adults twenty-one years or older.~~

(E) Conventional hearing aids.

- ~~(1)~~ ~~Adults twenty one years or older are eligible for conventional hearing aids only.~~
- ~~(2)~~(1) Hearing evaluation results referenced in ~~paragraph (C)(1) of~~ this rule must clearly demonstrate the need for a hearing aid.
- ~~(3)~~(2) All conventional hearing aids dispensed must be covered by a one-year warranty to include coverage provisions for all parts (except earmolds and batteries), comprehensive loss, damage, and labor.
- ~~(4)~~(3) Providers must maintain copies of ~~the manufacturer's cost estimate and~~ the final manufacturer's invoice, including discounts and shipping costs, in the consumer's record and make them available to the ~~Ohio department of job and family services (ODJFS)~~ office upon request.
- ~~(5)~~(4) All provisions of this rule apply to conventional hearing aids with the exception of paragraph (F) of this rule.
- ~~(6)~~(5) Payment for a conventional hearing aid is the lesser of the medicaid maximum listed in rule 5101:3-1-60 of the Administrative ~~code~~ Code for a conventional aid or the provider's acquisition cost, which consists of the manufacturer's invoice price minus any discounts received by the vendor plus shipping costs.
- ~~(7)~~(6) If the manufacturer's final invoice price does not match the cost estimate submitted as part of the prior authorization request for the conventional hearing aid for any reason, the provider must submit a new prior authorization request reflecting the changed price in order to be eligible for reimbursement.
- ~~(8)~~(7) Providers must maintain copies of the manufacturer's cost estimate and the final manufacturer's invoice including discounts and shipping costs in the patient's record and make them available to ~~ODJFS~~ the office upon request.

(F) Programmable and digital hearing aids.

- (1) Programmable and digital hearing aids are only eligible for reimbursement if the ~~consumer is twenty years of age or younger and a~~ programmable and digital hearing aid is medically necessary as defined in paragraph (B) of this rule.
- (2) Hearing evaluation results referenced in ~~paragraph (C)(4) of~~ this rule must clearly demonstrate the need for a hearing aid.
- (3) All programmable and digital hearing aids dispensed must be covered by a ~~two-year~~ one-year warranty to include coverage provisions of all parts (except earmolds and batteries), comprehensive loss, damage, and labor.
- (4) Payment for a digital or programmable hearing aid is the lesser of the medicaid maximum listed in rule 5101:3-1-60 of the Administrative ~~code~~ Code for a programmable or digital aid or the provider's acquisition cost, which consists of the manufacturer's invoice price minus any discounts received by the vendor plus shipping costs.
- (5) Reimbursement for codes V5256, V5257, V5260 and V5261 for consumers twenty-two years of age or older is the lesser of the amount indicated in appendix DD to rule 5101:3-1-60 of the Administrative Code reduced by fifty per cent or the providers usual and customary charge.
- ~~(5)~~(6) If the manufacturer's final invoice price does not match the programmable or digital hearing aid cost estimate submitted as part of the prior authorization request due to any reason, the provider must submit a new prior authorization request reflecting the changed price in order to be eligible for reimbursement.
- ~~(6)~~(7) Providers must maintain copies of the manufacturer's cost estimate and the final manufacturer's invoice including discounts and shipping costs in the patient's record and make them available to ~~ODJFS~~ the office upon request.

~~(7)~~(8) Payment for a programmable or digital hearing aid includes two adjustments per year for the duration of the ~~first-year~~ warranty for comprehensive loss, damage and repair, ~~and two adjustments per year under a second-year warranty for comprehensive loss, damage and repair.~~ If adjustment is necessary due to documented changes in measured hearing sensitivity or the growth of the ear canal, payment for adjustment will be authorized as a repair if this is the third adjustment during a warranty period for comprehensive loss, damage, and repair. In addition, the repair provisions stated in rule 5101:3-10-08 of the Administrative Code must be met.

(G) ~~Binaural hearing aids, "CROS," "CROS" and "BiCROS" hearing aids~~ are not routinely covered by the medicaid program but may be authorized for ~~persons~~ consumers twenty years of age or younger with special documented needs; e.g., child for whom binaural hearing is necessary for development of speech or with difficulty hearing in adverse or noisy environments. ~~This documentation must be submitted at the time of the original PA request in order to be considered for coverage.~~

"CROS" and "BiCROS" hearing aids for consumers twenty years of age or younger require prior authorization.

(H) Hearing aids may be dispensed by a ~~physician~~ prescriber, a licensed audiologist, or a licensed hearing aid fitter who is enrolled as a durable medical equipment (DME) provider or enrolled as a ~~physician~~ prescriber or clinic type provider who has also been assigned a DME category of service.

(I) All earmolds must be warranted for ninety days. After the warranty period, necessary earmolds or repairs that are within the maximum allowances specified in rule 5101:3-10-20 of the Administrative Code will not require prior authorization. Prior authorization requests for earmolds in excess of the maximum allowed will be considered for special cases when appropriate documentation of medical necessity is provided. Visits to a hospital, home, nursing facility (NF), or intermediate care facility for the mentally retarded (ICF-MR) for the purpose of taking an earmold impression are covered but subject to limitations specified in rule 5101:3-10-20 of the Administrative Code.

(J) Each ~~consumer~~ recipient of a hearing aid shall be scheduled for a recheck to assess the performance and ~~consumer~~ acceptability of the aid within thirty days of receipt of the aid, ~~by the consumer.~~ A copy of the recheck report, countersigned by the consumer or an explanation of why the recheck was not performed, shall be maintained in the provider's file for a period of four years. No claim for payment should be made prior to a recheck or thirty days from the initial fitting of the aid, whichever comes first.

(K) When a recheck is performed within thirty days and the hearing aid is deemed unacceptable by ~~both~~ the hearing aid provider and/or the consumer, the cost of the earmold, ~~batteries, and one month's use of the instrument will be borne by the ODJFS.~~ and batteries will be reimbursed by the office. On the rare occasions that this may happen, the original authorization form must be forwarded to ~~ODJFS for cancellation and subsequent issuance~~ the office in order for the provider to receive ~~of~~ a revised authorization reflecting the new cost. If payment has been made on the original authorization, ~~no adjustment to payment will be authorized.~~ the provider must arrange a cost adjustment which reflects the correct amount for the services rendered.

(L) Payment for all types of hearing aids includes all of the following:

- (1) Hearing aid, cleaning kit, earmold insert when required for behind the ear style hearing aids, and a one-month supply of batteries;
- (2) Shipping and handling;
- (3) All required warranty costs; and
- (4) Hearing tests as specified in ~~paragraphs (C)(1) and (C)(3) of~~ this rule. Only providers specified in paragraph (B) ~~(4)~~ of this rule may bill ~~ODJFS~~ the office for hearing tests in conjunction with the fitting and dispensing of any type of hearing aid.

(M) Requests for two hearing aids on the same date of service will be reimbursed using binaural reimbursement codes only.

~~(M)~~ Effective for dates of service on and after the effective date of this rule, ODJFS will pay a separate fee for dispensing a hearing aid. These fees can be located in rule 5101:3-1-60 of the Administrative code. ODJFS will reimburse only one dispensing fee code per consumer every four years for a conventional hearing aid or once every five years for a programmable or digital hearing aid.

(N) Payment for any hearing aid dispensing fee includes all of the following:

- (1) Earmold impression(s);
- (2) Hearing aid selection and fitting(s);
- (3) Up to three hours of counseling;
- (4) All visits necessary for the dispensing and fitting of the aid (regardless of place of service); ~~and~~
- (5) All service calls and follow-up during the warranty period; ~~and~~
- (6) Charges for travel to dispense the hearing aid.

(O) Providers must document that the consumer and/or the consumer's primary care giver have been instructed in the proper use, wear and care of the hearing aid. Documentation of this instruction must be maintained by the provider.

(P) Conventional (analog) hearing aids can be replaced every four years. Digital hearing aids can be replaced every five years. Requests for replacements any sooner can be made through the prior authorization process. Replacement requests can be denied in instances of malicious damage, neglect, culpable irresponsibility or wrongful disposition. The office will not be responsible for any replacement charges, including deductibles, upon the loss of a hearing aid still covered under warranty.

~~(Q) In general, reimbursement for a hearing aid will be limited to a maximum of one aid in any four-year period for a conventional hearing aid. Reimbursement for a digital or programmable hearing aid will be limited to a maximum of one hearing aid in any five-year period. Requests for more frequent replacement for medically necessary reasons will be considered when appropriate documentation is provided.~~

~~A request for replacement of a hearing aid for non-medical reasons will be considered. However, cases suggesting malicious damage, neglect, culpable irresponsibility, or wrongful disposition of the hearing aid will be investigated and denied where ODJFS determines it is unreasonable to make program payment under the circumstances. If a hearing aid is lost and is still covered by warranty, ODJFS will not cover any deductible or replacement charges not covered by warranty.~~

~~(P)~~(Q) A copy of the manufacturer's warranty and any applicable insurance coverage shall be maintained in the provider's file for a period of five years and copies shall be provided to ~~ODJFS~~ the office on request.

~~(Q)~~(R) No hearing aid will be authorized for replacement until ~~ODJFS~~ the office has received proof that replacement is not covered by the manufacturer's warranty or insurance. A request for prior authorization of a replacement hearing aid outside of the warranty period must meet all the requirements of this rule. No hearing aid will be authorized for replacement if repair or reconditioning would be more cost-effective.

~~(R)~~(S) A provider may bill ~~ODJFS~~ the office for necessary repair of a hearing aid only if the following conditions exist:

- (1) The aid had been acquired through ~~ODJFS~~ the office; or
- (2) ~~ODJFS~~ The office has determined that the aid, not acquired through the program, is medically necessary; and
- (3) The repair is not covered by warranty or insurance; and
- (4) The repair is not associated with routine maintenance or cleaning of the hearing aid; and

~~(4)~~(5) All of the requirements for repairs listed in rule 5101:3-10-08 of the Administrative Code are met.

~~(S) ODJFS will pay for only one hearing aid code and only one unit per consumer per date of service in a four-year period as discussed in paragraph (O) of this rule for a conventional hearing aid or only one hearing aid code and only one unit per consumer per date of service in a five-year period for a programmable or digital hearing aid.~~

Effective: 12/01/2013

R.C. 119.032 review dates: 08/19/2013 and 12/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 10/31/2013

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 12/21/77, 12/30/77, 1/1/80, 3/1/84, 5/1/90, 2/1/93, 12/10/93, 1/1/95, 9/1/05

Formerly 5101:3-10-12 Orthopedic Shoes and Foot Orthoses

MHTL 3344-07-01

Effective Date: January 1, 2007

Most Current Prior Effective Date: October 1, 1988

(A) Definitions.

- (1) "Orthopedic shoes" are shoes that are specially constructed to aid in the correction of a deformity of the muscular skeletal structure of the foot; and for the preservation and restoration of the function of the skeletal system of the foot.
- (2) "Molded shoes" are orthopedic shoes that are directly molded of leather, plastic, or a similar material, to a patient model.
- (3) "Mismatched shoes" are one pair of orthopedic shoes in which one shoe is a whole size and/or width larger than the other.

(B) Covered services and limitations.

- (1) Prior authorization is required before orthopedic shoes will be considered for payment. Prior authorization requests must contain a precise description of the shoe to be dispensed and must include the manufacturer and/or laboratory, style and size of the item.
- (2) Orthopedic shoes are covered only if the shoe is an integral part of a brace with the following exceptions: molded, mismatched, and club foot shoes or shoes for children under the age of eight, diagnosed as having a deformity or condition as listed in paragraph (C) of this rule.
- (3) Shoe modifications or additions shall be covered if they are medically necessary and are prescribed by a physician (D.P.M., D.O. or M.D.), or an advanced practice nurse (APN) subject to the limitations as specified in appendix A ~~of~~to rule 5101:3-10-20 of the Administrative Code.
- (4) Reimbursement for foot orthoses includes all casting and shall only be billed by the individual who performs the actual casting.
- (5) For medicaid-eligible recipients age eight and older, a maximum of two pairs of shoes every three hundred sixty-five days shall be considered for payment.
- (6) For children under the age of eight, to accommodate growth, a maximum of three pairs of shoes every three hundred sixty-five days shall be considered for payment.
- (7) Depth inlay shoes are covered only if the shoe is an integral part of a brace.

(C) Orthopedic shoes, not attached to a brace, for children under the age of eight, will be covered only for the following diagnoses:

- (1) Talipes equino varus (club foot).
- (2) Metatarsus adductus.
- (3) Femoral torsion.
- (4) Tibial torsion.
- (5) Vertical talus.
- (6) Fracture (major bones).
- (7) Osteochondroses.
- (8) Post-surgical control.

(D) Non-coverage determination.

Orthopedic shoes are denied as non-covered if the shoe is put on over a partial foot prosthesis or other lower extremity prosthesis that is attached to the residual limb.

Effective: 01/01/2007

R.C. 119.032 review dates: 09/27/2006 and 01/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 12/18/2006

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, 10/1/88, 2/17/91, 12/30/93 (Emer), 3/31/94

***Formerly* 5101:3-10-13 Oxygen: Covered Services and Limitations in a Private Residence**

MHTL 3334-13-13

Effective Date: December 31, 2013

Most Current Prior Effective Date: August 2, 2011

5160-10-13 - Appendix A

(A) Definitions.

- (1) "Blood gas study" is the measurement of such characteristics of blood as the partial pressure of oxygen (PO₂) or oxygen saturation. The term applies either to an arterial blood gas (ABG) study, which is performed on blood from an artery, or to pulse oximetry, which is the noninvasive measurement of hemoglobin oxygen saturation
- (2) "Group I" and "group II" criteria are sets of clinical indicators used to determine the coverage of oxygen services without prior authorization.

 - (a) Group I criteria.

 - (i) If the individual is tested while awake and at rest, the following measures apply:

 - (a) Arterial PO₂ of fifty-five mm Hg or less; or
 - (b) Arterial oxygen saturation at or below eighty-eight per cent.
 - (ii) If the individual is tested while exercising (ambulating), the following measures apply:

 - (a) Arterial PO₂ of fifty-five mm Hg or less during ambulation without oxygen, with documented improvement during ambulation with oxygen; or
 - (b) Arterial oxygen saturation at or below eighty-eight per cent during ambulation without oxygen, with documented improvement during ambulation with oxygen.
 - (iii) If the individual is tested while asleep, the following measures apply:

 - (a) Arterial PO₂ of fifty-five mm Hg or less;
 - (b) Arterial oxygen saturation at or below eighty-eight per cent;
 - (c) A decrease in arterial PO₂ of more than ten mm Hg, associated with symptoms of or signs reasonably attributable to hypoxemia; or
 - (d) A decrease in arterial oxygen saturation of more than five per cent, associated with symptoms of or signs reasonably attributable to hypoxemia.
 - (b) Group II criteria.

 - (i) Either of the following measures applies:

 - (a) Arterial PO₂ of at least fifty-six mm Hg and not more than fifty-nine mm Hg; or
 - (b) Arterial oxygen saturation at or above eighty-nine per cent.
 - (ii) In addition, at least one of the following conditions applies:

 - (a) Dependent edema suggestive of congestive heart failure;
 - (b) Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or the presence of P pulmonale on an EKG; or
 - (c) Erythrocythemia with a hematocrit greater than fifty-six per cent.

(3) "Transfill unit" is a device that transfers oxygen from a source such as an oxygen concentrator or liquid oxygen canister to portable tanks.

(B) Prescribers and suppliers of oxygen services.

(1) The following eligible medicaid providers may prescribe oxygen services:

(a) An independent physician;

(b) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner); or

(c) A physician assistant.

(2) The following eligible medicaid providers may render oxygen services:

(a) A durable medical equipment (DME) supplier;

(b) A pharmacy;

(c) An independent physician;

(d) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(e) A physician assistant; or

(f) An ambulatory health care clinic.

(3) The following eligible medicaid providers may receive medicaid payment for submitting a claim for an oxygen service on behalf of a rendering supplier:

(a) A DME supplier;

(b) A pharmacy;

(c) An independent physician;

(d) An advanced practice nurse with a relevant specialty (e.g., clinical nurse specialist, nurse practitioner);

(e) A physician assistant;

(f) An ambulatory health care clinic; or

(g) A professional medical group.

(C) Certificate of medical necessity.

(1) Payment for oxygen services can be made only if an authorized provider certifies on a form, the certificate of medical necessity (CMN), that the services are medically necessary for an individual. For purposes of this rule, the CMN is form [JFS 01909](#), "Certificate of medical necessity/prescription: oxygen services" (rev. 06/2005). A completed CMN must be signed and dated by the prescriber before a claim for a service is submitted. The certification period is limited to a maximum of twelve months after the first date of service for an individual meeting group I criteria and three months after the first date of service for an individual meeting group II criteria. According to the purpose for which a CMN is used, it may be called an initial CMN, a recertifying CMN, or a revised CMN.

(2) An initial CMN is used to document certification for new service.

(a) An initial CMN must be completed in the following circumstances:

(i) The supplier will be rendering oxygen services to an individual for the first time on a fee-for-service basis, even if the individual was using oxygen before gaining medicaid eligibility or oxygen was previously supplied through a medicaid managed care plan;

- (e) Oxygen contents, gaseous, including supplies (LTCF only);
 - (f) Oxygen contents, liquid, including supplies (LTCF only);
 - (g) Oxygen concentrator, single delivery port;
 - (h) Oxygen concentrator, dual delivery port;
 - (i) Portable oxygen concentrator (private residence only); and
 - (j) Transfill unit (private residence only).
- (2) A supplier must furnish the least expensive oxygen delivery system that meets an individual's medical and personal needs.
- (3) Separate payment for a portable oxygen delivery system may be made in addition to payment for a stationary system only if the following criteria are met:
- (a) The individual must have a demonstrable need for a separate portable system, either to maintain mobility in a private residence or to accomplish out-of-home activities;
 - (b) The individual's stationary oxygen delivery system cannot be used as a portable delivery system; and
 - (c) The prescribed oxygen flow is four LPM or less. If the prescribed oxygen flow is greater than four LPM, then no separate payment is made for the portable oxygen delivery system.
- (4) Separate payment will not be made, however, for both a stationary and a portable oxygen concentrator.
- (5) Prior authorization is not required when a supplier has obtained a properly completed CMN and renders oxygen services to an individual who either meets group I or group II criteria or is a resident of a LTCF.
- (6) Prior authorization is required when a supplier has obtained a properly completed CMN and renders oxygen services to an individual who meets neither group I nor group II criteria and is not a resident of a LTCF. If approval is given, then the length of the approval period will be based on medical necessity and cannot exceed the timeframe indicated by the prescriber. The request for prior authorization must include a copy of the completed CMN.
- (7) An oxygen service will be denied as not medically necessary if it is prescribed for any of the following conditions:
- (a) Angina pectoris in the absence of hypoxemia;
 - (b) Dyspnea without cor pulmonale or evidence of hypoxemia;
 - (c) Severe peripheral vascular disease that results in clinically evident desaturation in one or more extremity but does not produce systemic hypoxemia; or
 - (d) A terminal illness that does not affect the respiratory system.

(E) Payment.

- (1) All appropriate procedure codes and modifiers must be reported on claims.
- (2) Payment for oxygen services is made on a monthly basis and includes the following related items and services:
 - (a) Setup and instruction on use;
 - (b) Equipment and supplies;
 - (c) Maintenance and repair, including the replacement of any part or attachment (such as tubing, cannula, mask, or filter) that is integral to the oxygen system or the operation of the system;
 - (d) Transportation or delivery charges;

- (e) Emergency service, including the provision of backup equipment and supplies;
 - (f) Oxygen consumed (when applicable); and
 - (g) Equipment monitoring visits.
- (3) The maximum fee for an oxygen service is the amount set forth in the appendix to this rule.
- (a) When the prescribed oxygen flow is greater than four LPM, the payment amount is increased by fifty per cent.
 - (b) When the prescribed oxygen flow is greater than four LPM and portable oxygen is also prescribed, the payment amount is increased by fifty per cent.

Replaces: 5160-10-13, 5160-10-13.1

Effective:

R.C. 119.032 review dates:

Certification

Date

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Formerly 5101:3-10-14 Compression Garments

[MHTL 3344-07-01](#)

Effective Date: January 15, 2007

Most Current Prior Effective Date: [March 31, 1994](#)

Appendix A: [JFS 01905](#), Certificate of Medical Necessity / Prescription Compression Garments

(A) Compression garments.

~~(A)(1)~~ Compression garments are specialized garments prescribed for ambulatory persons with diagnoses listed under paragraph (A)(2) of this rule. Compression ~~hose~~garments ~~can be obtained through the prior authorization process~~ must be obtained through prior authorization. Only compression ~~hose~~garments equal to or greater than ~~25mm~~18mm Hg. will be considered for approval. All prior authorization requests for compression ~~hose~~garments must contain the manufacturer and catalogue number. ~~No payment will be made for light-weight hose or support belts.~~

~~(B)(2)~~ Coverage of compression ~~hose~~garments is limited to the following diagnoses; ~~unless significant medical justification is presented to the department.~~

~~(a)~~ Lymphedema.

~~(1)(b)~~ Elephantiasis.

~~(2)(c)~~ Milroy's disease.

~~(3)(d)~~ Orthostatic hypotension.

~~(4)(e)~~ Pregnancy with associated symptomatic venous insufficiency.

~~(5)(f)~~ Stasis dermatitis.

~~(6)(g)~~ Stasis ulcers.

~~(7)(h)~~ Symptomatic chronic venous insufficiency (for example, pain, swelling, ulcers, severe varicose veins).

~~(8)(i)~~ Thrombophlebitis.

~~(j)~~ Post-thrombotic syndrome.

~~(C)~~ ~~The number of hose, either single or pairs, which can be approved for each recipient is limited to three per year. Exceptions to this rule are possible only with the presentation of adequate justification.~~

(B) Surgical stockings are specialized stockings covered when ordered by a prescriber to prevent embolisms in the legs of non-ambulatory (e.g., bed-confined) consumers. Surgical stockings are used as a short-term treatment (up to three months) after a surgical event. Surgical stockings must be obtained through prior authorization. If required for treatment during an inpatient hospital stay or outpatient hospital visit, the product will be reimbursed in accordance with Chapter 5101:3-2 of the Administrative Code.

(C) Compression burn garments are covered only when they are used to reduce hypertrophic scarring and joint contractures following a burn injury. Compression burn garments must be obtained through prior authorization.

(D) Providers fitting and dispensing compression garments, surgical stockings, or compression burn garments that are custom-made or custom-fitted must be certified to do so according to industry standards. A provider will not be eligible for reimbursement for custom-made or custom-fitted garments if the provider does not have a certified fitter on staff or under contract. Providers must keep

on file documentation subject to review by ODJFS verifying that they have a trained fitter on staff or under contract.

- (E) In addition to a fully completed prior authorization form [JFS 03142](#) (rev. 2/2003), a fully completed form [JFS 01905](#) (11/2006), "Certificate of Medical Necessity/Prescription Compression Garments (CMN)" (appendix A to this rule) that is signed and dated no more than thirty days prior to the first date of service must be submitted for prior authorization before reimbursement for compression garments, surgical stockings, or compression burn garments will be considered.

Effective: 01/15/2007

R.C. 119.032 review dates: 09/27/2006 and 01/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 01/02/2007

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, 10/1/88

Formerly 5101:3-10-15 Transcutaneous Electrical Nerve Stimulators (TENS)

Effective Date: April 1, 2009

Most Current Prior Effective Date: [April 16, 2007](#)

JFS 03402): Certificate of Medical Necessity/Prescription Transcutaneous Electrical Nerve Stimulator (TENS)

- (A) ~~Requests~~ Unless otherwise stated, the dispensing for ~~the initial prior authorization of~~ a TENS unit to a Medicaid consumer must include the following documentation to be kept in the provider's records:
- (1) A fully completed form [JFS 03402](#) (rev. ~~6/2006~~10/2008) "Certificate of Medical Necessity/Prescription Transcutaneous Electrical Nerve Stimulator (TENS)" (CMN) (appendix A to this rule) that is signed and dated by an eligible prescriber no more than thirty days prior to the first date of service that documents nerve-related chronic intractable pain of at least six months duration. The CMN must specify a complete diagnosis;"chronic intractable pain" in itself is not a sufficient diagnosis to warrant coverage; and
 - (2) Attestation by the prescriber that a ~~nonreimbursable~~non-reimbursable trial period of at least ~~fourteen days~~thirty days resulted in substantial relief from pain (except for postoperative consumers). When a TENS unit is used specifically for acute post-operative pain, the medical necessity of the TENS unit is limited and reimbursable by the department for thirty days from the day of surgery, and no further reimbursement for this reason is authorized.
- (B) Only the following conditions are recognized by the Ohio department of job and family services (ODJFS) as being eligible for consideration for the use of a TENS unit due to medical necessity after other appropriate treatment modalities have been tried and have failed. Use of a TENS unit and related services other than for those listed as covered in this rule are not eligible for reimbursement because the medical effectiveness of such therapy has not been established:
- (1) Herpes zoster with other nervous system complications;
 - (2) Reflex sympathetic dystrophy;
 - (3) Other nerve root and plexus disorders;
 - (4) Mononeuritis of upper limb and mononeuritis multiplex;
 - (5) Mononeuritis of lower limb and unspecified site;
 - ~~(6)~~ ~~Temporomandibular joint disorders;~~
 - ~~(7)~~(6) Osteoarthritis and allied disorders;
 - ~~(8)~~(7) Spondylosis of unspecified site;
 - ~~(9)~~(8) Intervertebral disc disorders;
 - ~~(10)~~(9) Brachial neuritis or radiculitis, not otherwise specified;
 - ~~(11)~~(10) Spinal stenosis, other than cervical;
 - ~~(12)~~(11) Lumbago;
 - ~~(13)~~(12) Sciatica;
 - ~~(14)~~ ~~Disorders of sacrum;~~
 - ~~(15)~~(13) Myalgia and myositis, unspecified;
 - ~~(16)~~(14) Neuralgia, neuritis, and radiculitis, unspecified; or
 - ~~(17)~~(15) Other postsurgical status when used for acute post-operative pain for thirty days from the day of surgery.

- (C) The conditions listed in this rule may not be associated with consumers treated with acupuncture, nor may they be associated with any variation of acupuncture techniques.
- (D) A rental period of thirty days ~~only may will~~ be authorized for the initial ~~prior authorization request~~ use of the TENS unit. An additional period of ninety days minimum may be ~~approved~~ billed to the department if the following criteria are met and documentation is kept in the provider's records:
- (1) All criteria listed in paragraph (A) of this rule, and
 - (2) Documentation of specific reduction in medications; e.g., muscle relaxants, narcotics, analgesics directly resulting from the use of the TENS unit.
- (E) TENS units are covered as rental only for a maximum of four months. All rental payments made by ODJFS for the use of a TENS unit by a medicaid consumer are applied to any subsequent purchase ~~requests~~ of the TENS unit by ODJFS.
- (F) Payment for rental includes all necessary accessories and supplies, and includes fitting and instructions/education in the proper use of the TENS unit. The provider must have a physical location available to the consumer for the initial face to face fitting and instruction/education efforts.
- (G) The provider of the TENS unit must assure that the consumer utilizing the device is properly instructed in how to use the device in support of his or her ordered treatment plan and is aware of and understands any emergency procedures regarding the use of the TENS unit. The provider must maintain written documentation regarding the consumer's instruction on the use of the TENS unit in the consumer's medical record.
- (H) TENS units provided to recipients must have two or four leads with more than one modality and must be covered by a warranty of two years or more when purchased on behalf of a medicaid consumer. Purchases or rentals of used TENS units are not authorized by the department unless the TENS unit was specifically utilized previously by the consumer whom the purchase or rental is being billed for. No sharing of TENS units is allowed by ODJFS. If a TENS unit is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the consumer's needs.
- (I) A ~~request for prior authorization of a~~ purchase of a TENS unit may be ~~submitted~~ billed to the department minus any previous rental payments received by the provider only after three months rental and must be documented in the provider's records and accompanied by the prescriber's current signed statement of efficacy of TENS treatment, medical necessity of continued treatment, and documentation of the criterion specified in paragraphs (A) and (D)(2) of this rule.
- (J) Supplies for a TENS unit owned by a consumer must be dispensed and billed on a monthly basis in quantities no greater than actually needed by the recipient as no automatic shipments or stockpiling of these supplies are allowed. No supplies shall be billed before they have been provided to the consumer. Reimbursement for supplies shall be made under a single all-inclusive code, subject to a monthly maximum as specified in appendix DD to rule 5101:3-1-60 of the Administrative Code. TENS supplies may not be billed for any month for which rental payment is requested.

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R.C. 119.032 review dates: 04/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 03/20/2009

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Statutory Authority: 5111.02

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~~*Formerly* 5101:3-10-16 Wheelchairs~~

MHTL 3334-13-13

Effective Date: December 31, 2013

Most Current Prior Effective Date: October 29, 2009

~~Wheelchairs, including all parts, options, accessories and repairs, are not directly reimbursable for consumers residing in a nursing facility (NF) as defined in section 5111.20 of the Revised Code. Wheelchairs are the responsibility of the NF and reimbursed to the NF through the facility per diem. Wheelchairs for residents of an intermediate care facility for the mentally retarded (ICF-MR) as defined in section 5111.20 of the Revised Code are covered through direct reimbursement as provided in this rule. The provisions in this rule do not apply to wheelchairs provided to the residents of nursing facilities.~~

(A) Definitions.

- (1) "Standard wheelchair" is a wheelchair, ~~including a hemi (low-seat) wheelchair,~~ that would generally satisfy the needs of a child or adult; ~~pediatric or adult individual, including hemi (low seat wheelchairs);~~ is constructed to withstand normal daily use; has the dimensions specified in paragraph (A)(6) of this rule; and is equipped with standard seat and back, with wheel locks, with fixed, swingaway or detachable armrests, and with fixed, swingaway or detachable footrests.
 - (a) "Standard manual wheelchair" is a wheelchair that meets the specifications in paragraph (A)(1) and paragraph (A)(3) of this rule.
 - (b) "Standard power wheelchair" is a wheelchair that meets the specifications in paragraph (A)(1) and paragraph (A)(4) of this rule.
- (2) "Specially constructed (SC) wheelchair/specially sized (SS) wheelchair" is a wheelchair that does not meet the dimensions of the standard wheelchair as described in paragraph (A)(6) of this rule; is equipped, at a minimum, with standard seat and back, with wheel locks, and with fixed, swingaway or detachable armrests, and with fixed, swingaway or detachable footrests; and is constructed to generally satisfy the needs of populations which require special features (e.g., extra-wide, amputee, reclining, lightweight, high strength ~~light~~ lightweight, ultra-lightweight, heavy-duty, and extra heavy-duty wheelchairs).
 - (a) "Specially constructed wheelchair/specially sized manual wheelchair (SCM/SSM-wheelchair)" is a wheelchair that meets the specifications in paragraph (A)(2) and paragraph (A)(3) of this rule.
 - (b) "Specially constructed wheelchair/specially sized power wheelchair (SCP/SSP-wheelchair)" is a wheelchair that meets the specifications in paragraphs (A)(2) and (A)(4) of this rule.
- (3) "Manual wheelchair" is a wheelchair that is designed and constructed to be manually operated and meets the requirements of either paragraph (A)(1) or (A)(2) of this rule. The term manual wheelchair includes:
 - (a) Any manual wheelchair that has been (or has been requested to be) converted to a motorized wheelchair with the addition of a power add-on accessory; and
 - (b) Any manual wheelchair that has been (or has been requested to be) revised with a push-rim activated power assist device.
- (4) "Power wheelchair" is a wheelchair that:
 - (a) Has been originally designed and constructed to be powered by batteries in order to meet the needs of persons physically unable to operate a manual wheelchair;
 - (b) Meets the requirement of either paragraph (A)(1) or paragraph (A)(2) of this rule; and₇

(c) Is not a manual wheelchair that has been converted to a motorized wheelchair with the addition of a power add-on accessory or has been converted to a push-rim wheelchair with the addition of a push-rim activated power assist device.

(5) "Push-rim wheelchair" or a "push-rim activated power assisted wheelchair (PAPAW)" is a wheelchair that has a push-rim activated power assist device added to it.

(6) The dimensions for a standard wheelchair are as follows:

(a) The weight is greater than thirty-six pounds;

(b) The seat height is nineteen inches or greater;

(c) The weight capacity is two hundred and fifty pounds or less;

(d) For adult wheelchairs:

(i) The seat width is fifteen inches to nineteen inches; and

(ii) The seat depth is fifteen inches to nineteen inches;

(e) For pediatric wheelchairs, the seat width ~~and~~/or depth must be fourteen inches or less.

(7) "Consumer" is a medicaid-eligible individual.

(8) "Custom seating system" is a wheelchair seating system ~~which that~~ is individually ~~made for a patient using~~ constructed from a plaster model ~~of a patient~~, a computer generated model ~~of the patient~~ (e.g., CAD-CAM technology), or the detailed measurements of ~~the patient~~ an individual to create either:

(a) A molded, contoured, or carved (foam or other suitable material) ~~custom-fabricated~~ seating system that is incorporated into the wheelchair base; or,

(b) A ~~custom~~-seating system made from multiple pre-fabricated components or a combination of custom fabricated materials and pre-fabricated components ~~which that~~ have been configured and attached to the wheelchair base or incorporated into a wheelchair seat ~~and~~/or back in such a manner that the wheelchair could not be easily re-adapted for use by another individual.

(9) "Adaptive positioning devices" are components that are attached to a wheelchair to facilitate medically necessary, individual-specific posture control, and functioning and are listed as "adaptive positioning devices" under "Wheelchair Part I or Part II" in ~~appendix A to this rule~~ the appendix to rule 5160-10-03 of the Administrative Code.

(10) "Personal residence" means the consumer's place of residence, if such residence is not a hospital or long-term care facility.

(11) "Long-term care facility (LTCF)" means a nursing facility (NF), which is defined in section 5165.01 of the Revised Code, or an intermediate care facility for ~~the mentally retarded (ICF-MR)~~ individuals with intellectual disabilities (ICF/IID), ~~as which is defined in section 5111.20-5124.01~~ of the Revised Code.

(12) "Moderate impairment" means ~~the individual has a moderate~~ an impairment of strength and tone ~~which result in an inability that render a person unable to maintain functional or symmetrical postures; and/or flexible scoliosis; and/or flexible kyphosis; and/or dislocated hip with a leg length discrepancy of less than two inches; and/or fixed contractures of the hips/knees that cannot be accommodated by standard components (e.g., footrests, legrests).~~

(13) "Severe impairment" means ~~the individual has~~ a severely abnormal (hyper or hypo) tone that prevents ~~him or her~~ a person from obtaining or maintaining symmetrical postures, or abnormally fixed curvature of the spine.

(14) "Custom wheelchair" is any wheelchair with a custom seating system as defined in paragraph (A)(8) of this rule.

(B) Prior authorization.

- (1) Except as set forth in paragraph (C) of this rule, prior authorization pursuant to rule ~~5101:35160-~~10-06 of the Administrative Code is required for the wheelchair to be covered and reimbursed under medicaid. All requests for authorization for the purchase of a wheelchair must indicate the length of the warranty period and what is covered under the warranty.
 - (2) Wheelchairs will not be authorized for individuals under the age of one year. Only those wheelchairs that are designed to expand to accommodate the growth of an individual will be considered for authorization for growing children who do not fit into an adult sized wheelchair, unless there is a more cost effective, medically necessary alternative appropriate to meet the individual's need. Additional parts required to grow a wheelchair, that are not included with the purchase of the wheelchair, are eligible for reimbursement by the department, if the cost of the additional parts is less than the cost of a new wheelchair.
 - (3) Wheelchairs, wheelchair parts and accessories, and wheelchair modifications that are beneficial primarily in allowing the consumer to perform leisure or recreational activities are not considered medically necessary and will not be authorized.
 - (4) Prior authorization of wheelchairs (inclusive of all parts, options, ~~and/~~or accessories) shall be limited to the wheelchair which has been determined by the department to provide mobility to an individual who is either non-ambulatory or who can ambulate for only a brief period of ~~ambulation~~time, and any self-ambulation ~~and/~~or assisted ambulation takes considerable physical effort ~~and/~~or causes considerable physical pain; and who, without the specifically approved wheelchair, would be confined to a sedentary state (i.e., lying or sitting, bed-confined or chair-confined). Any bed-confined or chair-confined individual would be considered confined to a sedentary state.
 - (5) Certain wheelchair parts, accessories, ~~and/~~or modifications that are distinctly and separately requested from the original wheelchair request require prior authorization. Refer to rule ~~5101:35160-~~10-03 of the Administrative Code to determine which codes require prior authorization.
 - (6) ~~ODJFS~~ The department may deny prior authorization requests when the required forms have not been fully completed or the required form does not provide sufficient information to establish medical necessity or to determine that the criteria for coverage has been met.
 - ~~(7) Nursing facilities (NFs) are responsible for wheelchairs, including all parts, options, accessories and repairs, for their residents. A prior authorization request received or approved by the department prior to the effective date of this paragraph of this rule for a wheelchair which has already been dispensed or where actual construction of the wheelchair has been initiated by the provider in association with a prescriber's prescription for a wheelchair will be reimbursed directly to the provider by the department. Coverage and payment requests for wheelchairs that do not meet the above criteria are the responsibility of the NF where the consumer resides.~~
- (C) ~~ODJFS~~ The department will cover the rental of standard manual, hemi manual and lightweight manual (adult or pediatric) wheelchairs for a period of time not to exceed a maximum of three months without prior authorization. The wheelchair bases eligible for rental are denoted by a double asterisk (**) in ~~the~~ appendix ~~A~~ to rule ~~5101:35160-~~10-03 of the Administrative Code. For the wheelchair rental to be covered:
- (1) The wheelchair must be prescribed by a physician; and,
 - (2) The "Letter of Medical Necessity for Manual Wheelchairs without a Custom Seating System" form ([JFS 03414](#), revised 10/2004) must:
 - (a) Be completed with sufficient information to support that the wheelchair is medically necessary to provide mobility to an individual who, without the specific wheelchair, would be confined to a sedentary state (e.g., lying or sitting, bed-confined or chair confined) for all but very brief periods of ambulation and to ~~support~~ confirm that any self-ambulation ~~and/~~or assisted ambulation takes considerable physical effort ~~and/~~or causes considerable physical pain;

- (b) Be signed by the prescribing physician; and;
- (c) Be maintained on file by the wheelchair provider.

~~(3) Rental wheelchairs are not directly reimbursable by the department for consumers residing in a nursing facility. Such services are the responsibility of the NF and reimbursable through the facility cost report mechanism.~~

(D) LTCFs ~~residents~~: wheelchair coverage and limitations.

~~(1) Wheelchairs of any type whether manual, power or custom and power operated vehicles (POVs) including all parts, options, and accessories for consumers residing in a nursing facility are not directly reimbursable by the department. Such equipment is the responsibility of the NF and reimbursed to the NF through the facility per diem.~~

~~(2)~~(1) Except as provided for under paragraph (D)~~(3)~~(2) of this rule, all standard and specially constructed or specially sized manual wheelchairs without custom seating systems and all standard and specially constructed or specially sized power wheelchairs without custom seating systems, which are necessary for the appropriate care of the residents of an ICF-MR a LTCF are the responsibility of the facility. Reimbursement of any wheelchairs described in this paragraph is made by the department to the ICF-MR LTCF through the cost-report mechanism. Except as provided for under paragraph (D)~~(3)~~(2) of this rule, eligible providers of DME services may not bill or be reimbursed by the medicaid program for wheelchairs dispensed to residents of the ICF-MR LTCF.

~~(3)~~(2) Only custom wheelchairs as defined in paragraph (A)(14) of this rule (i.e., those wheelchairs with a custom seating system as defined in paragraph (A)(8) of this rule) and determined by the department to be medically necessary for the resident, in accordance with paragraph (F) of this rule, are eligible for direct payment to the provider. Wheelchairs and wheelchair parts and accessories, prescribed for ICF-MR LTCF residents who do not meet all of the medical necessity criteria listed in paragraph (F) of this rule, are the responsibility of the facility and are reimbursed through the per diem rate calculated under ~~sections 5111.20 to 5111.33~~ Chapter 5124. or 5165. of the Revised Code.

(a) A standard or specially constructed or specially sized manual wheelchair may be authorized for direct reimbursement to an eligible DME provider for a resident of an ICF-MR a LTCF only if the resident meets the coverage requirements for a custom seating system in accordance with paragraphs (D)~~(3)~~(2) and (F) of this rule.

(b) A standard or specially constructed or specially sized power wheelchair may be authorized for direct reimbursement to an eligible DME provider for a resident of an ICF-MR a LTCF only if the resident meets the coverage requirements for a custom seating system in accordance with paragraphs (D)~~(3)~~(2) and (F) of this rule, and also meets the requirements for power wheelchairs in accordance with paragraph (G) of this rule.

~~(4)~~(3) Reimbursement of any parts, options and accessories for wheelchairs described in paragraph (D)~~(2)~~(1) of this rule is made by the department to the ICF-MR LTCF through the cost-reported mechanism.

~~(5)~~(4) Parts, options and accessories for the wheelchairs described in paragraph (D)~~(3)~~(2) of this rule and meeting the criteria for coverage as set forth in paragraph (D)~~(3)~~(2)(a) or (D)~~(3)~~(2)(b) are eligible for direct reimbursement to the DME provider.

(E) Personal ~~residencies~~ residences: Wheelchair coverage and limitations.

For a consumer who resides in a personal residence, the following criteria must be met for the authorization of a wheelchair:

(1) For a standard manual or specially constructed/specially sized manual wheelchair without a custom seating system to be covered:

(a) The consumer must be evaluated by a physician, licensed physical therapist or licensed occupational therapist who is fiscally, administratively and contractually independent from

the DME provider and receives no form of compensation (monetary or otherwise) from the billing DME provider.

- (i) The evaluation must be performed ~~no longer~~ not earlier than ninety days prior to the submission of the prior authorization request;
 - (ii) The results of the evaluation must support the information submitted on the ~~ODJFS~~-required form (JFS 03414, ~~revised 10/2004~~); and;
 - (iii) A copy of the dated and signed written evaluation must be maintained by the billing provider. The results of the evaluation must be written, signed and dated by the individual who evaluated the consumer as required in paragraph (E)(1)(a) of this rule. If the evaluator personally reported the results of the evaluation on the ~~ODJFS~~-required "~~Letter of Medical Necessity for Manual Wheelchairs without a Custom Seating System~~" form (JFS 03414, ~~revised 10/2004~~) and signed and dated the form, a copy of the form will be considered the written evaluation.
- (b) The wheelchair must be prescribed by a physician who personally performed the evaluation or who has reviewed and agreed with the results of the evaluation of the qualifying physician, physical therapist or occupational therapist, in accordance with paragraph (E)(1)(a) of this rule.
- (c) ~~The "Letter of Medical Necessity for Manual Wheelchairs without a Custom Seating System" form (Form JFS 03414, revised 10/2004)~~ must:
- (i) Be completed and submitted, based on the results of the evaluation required in paragraph (E)(1)(a) of this rule, and with sufficient information to support that the specific wheelchair is medically necessary to provide mobility to an individual who, without the specifically prescribed wheelchair, would be confined to a sedentary state (e.g., lying or sitting, bed-confined or chair-confined) for all but very brief periods of ambulation and to support ~~confirm~~ that any self-ambulation ~~and/or~~ assisted ambulation takes considerable physical effort ~~and/or~~ causes considerable physical pain; and;
 - (ii) Be signed by the prescribing physician.
- (2) For standard power wheelchairs and specially constructed/sized power wheelchairs without a custom seating system to be covered for consumers who reside in (or who will be residing in) a personal residence:
- (a) The consumer must meet all the requirements set forth in paragraph (G) of this rule; and;
 - (b) A visit must be performed in the home (i.e., personal residence) and documented in a written report (~~see part E of the JFS 03411 form~~) by a person qualified to determine that the consumer or the consumer's caregiver(s) has(have) the ability to properly maintain the power wheelchair; there is electricity available and easily accessible to maintain power to the batteries; transportation of this wheelchair is available, as necessary; the consumer's home (place of residence) is accessible by the power wheelchair; and there is sufficient space and storage area for the wheelchair or power operated vehicle (POV) to assure that it is protected from the elements. The written report may be completed in part E of the "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., with a Custom Seating System)" form (JFS 03411, revised 10/2004). The home will be considered accessible only if the consumer can enter and leave the home by power wheelchair or POV; and, within the home the consumer can enter and leave without assistance the ~~following rooms:~~ living room, kitchen/dining area, the consumer's bedroom (or the room with the consumer's bed), and a bathroom.
- (i) Except as provided for in paragraph (E)(2)(b)(iii) of this rule, a power wheelchair or POV will not be authorized if all of the conditions set forth in paragraph (E)(2)(b) of this rule are not met.

- (ii) A power operated vehicle will not be authorized if the POV is needed only for outside the home or if, because of its size ~~and~~/or other features, the vehicle is intended primarily for outside use.
- (iii) A power wheelchair or power operated vehicle may still be authorized as long as the written report supports that access to some of the rooms listed in paragraph (E)(2)(b) of this rule are not necessary because special accommodations have been made to meet the consumer's activities of daily living.

- (3) For any manual wheelchair with a custom seating system to be covered, the criteria set forth in paragraph (F) of this rule must be met.
- (4) For any power wheelchair with a custom seating system to be covered, the criteria set forth in paragraphs (F) and (G) of this rule must be met.

(F) Custom wheelchairs (i.e., wheelchairs with custom seating systems): coverage and limitations.

The following criteria and documentation requirements must be met for authorization of a wheelchair with a custom seating system:

- (1) The consumer must be evaluated by a physician who is licensed and board certified as a physiatrist, an orthopedic surgeon, or a neurologist; or by a licensed physical therapist or a licensed occupational therapist. In ~~an ICF-MR~~ a LTCF, the evaluator also must be fiscally, administratively and contractually independent from the DME provider, and must not receive any form of compensation (monetary or otherwise) from the billing DME provider.
 - (a) The evaluation must be performed ~~no longer~~ not earlier than ninety days prior to the submission of the prior authorization request;
 - (b) The results of the evaluation must support the information submitted on ~~the "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., with a Custom Seating System)" form (JFS 03411, revised 10/2004); and,~~
 - (c) A copy of the dated and signed written evaluation must be maintained by the billing provider. The evaluation must be written, signed and dated by the individual who evaluated the consumer as required in paragraph (F)(1) of this rule. If the evaluator personally reported the results of the evaluation on the ~~ODJFS~~-required form ~~(JFS 03411, revised 10/2004)~~ and signed and dated the form, a copy of the form would be considered the written evaluation.
- (2) The wheelchair must be prescribed by a physician who personally performed the evaluation or who has reviewed and agreed with the results of the evaluation of the qualifying physician, physical therapist or occupational therapist in accordance with paragraph (F)(1) of this rule; and,
- (3) ~~The "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., with a Custom Seating System)" form (Form JFS 03411, revised 10/2004)" must:~~
 - (a) Be completed and submitted based on the results of the evaluation required in paragraph (F)(1) of this rule and with sufficient information to support that the wheelchair is medically necessary to provide mobility to an individual who is either non-ambulatory, or who can ambulate for only very brief periods of ambulation, and any self-ambulation ~~and~~/or assisted ambulation takes considerable physical effort ~~and~~/or causes considerable physical pain, and who, without the specifically prescribed wheelchair, would be confined to a sedentary state (e.g., lying or sitting, bed-confined or chair-confined); and with sufficient information to support that the consumer meets the criteria set forth in paragraph (F)(4) of this rule; including information that is consistent with the consumer's reported diagnosis (or diagnoses), medical history, medical records; and current plan of care; and,
 - (b) Be signed by the prescribing physician.

- (4) To ~~support~~ establish the medical necessity for an individually customized of a custom wheelchair (i.e., a wheelchair with a custom seating system), the following criteria must also be met and documented:
- (a) The consumer must have a moderate impairment as defined in paragraph (A)(12) of this rule or a severe impairment as defined in paragraph (A)(13) of this rule;
 - (b) The consumer must have:
 - (i) Moderately to severely abnormal tone that prevents him or her from obtaining or maintaining symmetrical postures, or fixed curvature of the spine, for which a custom seating system is necessary; or,
 - (ii) Skeletal ~~and/or~~ physical deformities or abnormalities that require a custom seating system;
 - (c) The addition of a custom seating system to the wheelchair must create a wheelchair that is made to fit the consumer's body ~~and/or~~ positioning needs so specifically that the wheelchair can only be used by the individual for whom it was designed; and,
 - (d) The consumer's need for prolonged sitting tolerance, postural support to permit functional activities, or pressure reduction cannot be met adequately by a planar type seat, a lap tray, ~~and/or~~ a spinal orthotic. To meet this condition, the documentation must explain why a specialized seat, a lap tray, ~~and/or~~ a spinal orthotic is not adequate for the consumer, and include a statement of the number of hours per day that the patient is expected to be in the wheelchair. If a custom seating system is being prescribed for a consumer who also requires a spinal orthotic, document why both the seating system and the orthotic are medically necessary for the consumer.

(5) Equipment prescription.

An equipment prescription (see part C of JFS form 03411, ~~revised 10/2004~~) specifying that the wheelchair and a custom seating system that is medically necessary must be completed. The equipment prescription must be prepared by the same professional that performs the assessment, in conjunction with the prescribing physician, and must be signed by all team members involved in the wheelchair prescription process and by the equipment supplier.

(G) Power wheelchairs and power operated vehicles (POVs): coverage and limitations.

For a power wheelchair or a power operated vehicle to be covered, all the requirements specified in this paragraph must be met:

- (1) The consumer must be evaluated by a physician, licensed physical therapist or licensed occupational therapist who is fiscally, administratively or contractually independent from the DME provider and receives no form of compensation (monetary or otherwise) from the DME provider billing for the wheelchair.
 - (a) The evaluation must be performed ~~no longer~~ not earlier than ninety days prior to the submission of the prior authorization request;
 - (b) The results of the evaluation must support the information submitted on ~~the "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., with a Custom Seating System)"~~ form (JFS 03411, ~~revised 10/2004~~); and
 - (c) A copy of the dated and signed written evaluation must be maintained by the billing provider. The results of the evaluation must be written, signed and dated by the individual who evaluated the consumer as required in paragraph (G)(1) of this rule. If the evaluator personally reported the results of the evaluation on the required ~~ODJFS~~ form (~~see~~ JFS 03411, ~~revised 10/2004~~) and signed and dated the form, a copy of the form will be considered the written evaluation.
- (2) The wheelchair must be prescribed by a physician who personally performed the evaluation or who has reviewed and agreed with the results of the evaluation performed by the qualifying

physician, the physical therapist or occupational therapist in accordance with paragraph (G)(1) of this rule.

- (3) ~~The "Letter of Medical Necessity for Power Wheelchairs and/or Custom Wheelchairs (i.e., with a Custom Seating System)" form (Form JFS 03411, revised 10/2004)~~ must:
- (a) Be completed and submitted based on the results of the evaluation required in paragraph (G)(1) of this rule, with sufficient information to support that the wheelchair is medically necessary to provide mobility to an individual who, without the specifically prescribed wheelchair, would be bed-confined or chair-confined; with sufficient information to support that the consumer meets the criteria set forth in paragraph (G)(4) of this rule; and with information that is consistent with the consumer's reported diagnosis (or diagnoses), medical history, medical records, or current plan of care;
 - (b) Include the consumer's diagnosis (or diagnoses) and the estimate of expected hours of use per day; and,
 - (c) Be signed by the prescribing physician.
- (4) Except as provided for in paragraph (G)(6) of this rule, the following criteria must be met and documented to establish medical necessity:
- (a) The consumer is totally non-ambulatory and has severe weakness of the upper and lower extremities due to an orthopedic, neurological, or muscular condition;
 - (b) The consumer has no physical ability to operate a manual wheelchair;
 - (c) The consumer has both the physical and mental ability to safely operate a power wheelchair. Provide documentation addressing head control, upper extremity functioning, joy stick control steering, directionality-steering skill, visual/spatial perception, safety, mobility skills in power wheelchair operation;
 - (d) The consumer is dependent upon a power wheelchair for functional activities, or there is a significant delay in the acquisition of independence in functional activities that can be positively impacted by a power wheelchair. Document functional status describing how the power wheelchair will allow the consumer to be independent in mobility and allow substantial improvement in achieving independence in one or more of the following functional activities (include a description of how a power wheelchair will increase the consumer's ability to perform these functional activities):
 - (i) Bathing;
 - (ii) Grooming;
 - (iii) Toileting/toilet hygiene;
 - (iv) Meal preparation;
 - (v) Housekeeping;
 - (vi) Laundry;
 - (vii) Telephone use;
 - (viii) Medication management;
 - (ix) Finance management;
 - (x) Transfers;
 - (xi) Use and care of equipment; or,
 - (xii) Activities for which the power wheelchair facilitates independent functioning while in school or work.

- (5) When applicable, the following additional criteria must also be met:

- (a) For consumers residing in a personal residence, a power wheelchair will be covered only if the criteria set forth in paragraphs (E)(2)(b) to (E)(2)(b)(iii) of this rule are met;
- (b) For consumers residing in ~~an ICF-MR~~ a LTCF, the power wheelchair will be covered only if the criteria set forth in paragraph (F) of this rule are met; and,
- (c) Power operated vehicles will ~~only~~ be covered only for consumers residing in a personal residence and only if the criteria set forth in paragraphs (E)(2)(b)(i) to (E)(2)(b)(iii) of this rule are met.

(6) The department may determine that coverage of a power wheelchair is necessary under the following circumstances:

- (a) The consumer has severe weakness of the upper and lower extremities due to an orthopedic, neurological, or muscular condition but is not totally non-ambulatory; and meets the criteria set forth in paragraphs (G)(4)(b) to (G)(4)(d) of this rule; and meets the criteria set forth in paragraph (G)(5) of this rule, as applicable; and meets the criteria for limited ambulation as set forth in paragraph (B)(4) of this rule; or,
- (b) The consumer does not meet the criteria set forth in paragraph (G)(4)(b) of this rule, but has limited ability to operate a manual wheelchair; and the consumer meets the criteria set forth in paragraphs (G)(4)(a), (G)(4)(c), and (G)(4)(d) of this rule; and, as applicable, the consumer meets the criteria set forth in paragraph (G)(5) of this rule.

(H) Duplicate equipment.

Medicaid reimbursement is not available for the purchase of more than one wheelchair for current use by a consumer; ~~(see paragraph (G) of rule 5101:35160-10-05 of the Administrative Code).~~ A wheelchair will not be authorized if the consumer is in possession of a wheelchair or any other equipment, regardless of payer source, which serves the same or similar purpose.

(I) Provider responsibility.

- (1) The cost of any changes or modifications of a specially constructed/specially sized wheelchair, a custom seating system, or adaptive positioning devices purchased by the department, which are found to be necessary within the first ninety days following dispensing, must be borne in full by the provider.
- (2) Wheelchair authorizations are specific as to manufacturer/make and model, parts, accessories, adaptive positioning devices, modular components, and custom-molded seating. Providers may only bill the department for the specific wheelchair and manufacturer/make and model, parts, accessories, adaptive positioning devices and custom-molded seating that are authorized and subsequently dispensed to the consumer.

(J) Repair and replacement.

- (1) Medicaid reimbursement for repairs is limited to one wheelchair per consumer. Payment for loaner wheelchairs, in addition to reimbursement for repairs, is not covered. Repairs for multiple wheelchairs will not be authorized, regardless of the payer source of the wheelchairs. To be eligible for coverage for repairs, the wheelchair must have been determined by the department to be medically necessary, except as provided for in paragraph (J)(7) of this rule. (See rule ~~5101:35160-10-08~~ of the Administrative Code regarding reimbursement for repairs.)
- (2) For residents of ~~NFs and ICFs-MR~~ LTCFs the cost of wheelchair maintenance and minor repairs is reimbursed through the per diem rate calculated under ~~sections 5111.20 to 5111.33 Chapter 5124. or 5165.~~ of the Revised Code and as specified in rules ~~5101:35160-3-19 and 5101:3-3-19.1~~ 5123:2-7-11 of the Administrative Code.
- (3) For residents of ~~ICFs-MR~~ LTCFs direct medicaid reimbursement for repairs is limited to the following "major repairs" as defined in rule ~~5101:35160-10-08~~ of the Administrative Code.

- (a) Major repair of a wheelchair which would be eligible for direct purchase (i.e., only major repairs for custom wheelchairs) in accordance with this rule and is owned by an eligible consumer; and,
 - (b) Major repairs/replacement of custom seating systems purchased by the department.
- (4) Direct reimbursement is limited to a maximum of one wheelchair in five years per consumer. However, if the consumer's condition changes and warrants new or different equipment within the five-year period, the department may authorize new or replacement equipment. Appropriate medical necessity documentation must be submitted when prior authorization is requested for new or different equipment within the five-year period. (See paragraph (B)(2) of this rule regarding growing wheelchairs.)
- (5) The replacement of any type of wheelchair, replacement of any custom seating system, or the replacement of adaptive positioning devices will only be prior authorized when medically necessary, regardless of the age of the current equipment, and only when modification or repair of the current equipment is judged ~~to be not cost effective by ODJFS~~ by the department not to be cost-effective. A request for authorization for replacement of a consumer-owned wheelchair must meet all the requirements of this rule for the type of chair being requested.
- (6) A description, model number, manufacturer serial number, date of purchase, and the condition of a consumer's current equipment must be specified on a request for authorization of additional or replacement equipment. (See paragraph (G) of rule ~~5101:35160~~-10-05 of the Administrative Code regarding duplicate and conflicting equipment.)
- (7) A current prescription must be submitted with a request for authorization of a repair when the department did not authorize the purchase of the wheelchair. In this case, a current prescription and documentation of medical necessity must be submitted with the initial request for repair. If the wheelchair is determined to be medically necessary and the repair is authorized, subsequent repairs may be authorized without the submission of a current prescription and documentation of medical necessity.
- (8) For a consumer who resides in a personal residence, reimbursement may be authorized for the repair of a consumer-owned wheelchair that is not eligible for purchase in accordance with this rule, if it is determined that the wheelchair meets the seating/wheeled mobility needs of the consumer and it would be more cost effective for the department to authorize the repair rather than the replacement of the wheelchair. Authorization for the repair of a wheelchair does not necessarily indicate that the wheelchair would be authorized for purchase. Replacement of any consumer-owned wheelchair will be authorized in accordance with this rule.
- (9) When requesting prior authorization (PA) for a major wheelchair repair service requiring the replacement/repair of wheelchair parts or accessories on or after the effective date of this rule, the process set forth in this paragraph will apply.
- (a) Providers must itemize in the request for PA all the parts/accessories in need of repair or replacement using the procedure codes listed in part I or part II of the "Wheelchair" section of the appendix A to rule ~~5101:35160~~-10-03 of the Administrative Code with the modifier RP RB. If the part does not have a specific procedure code listed ~~in appendix A of this rule~~, use K0108 modified by the modifier RP RB and provide a description of the part(s). The RP RB modifier attached to a wheelchair procedure code indicates that the item described by the code is to be repaired or replaced as part of the major wheelchair repair service.
 - (b) Providers must itemize in the request for PA the labor services associated with the major wheelchair repair services using the labor code ~~E1340~~ K0739. The PA request should state the estimated labor time. ~~—~~
 - (c) Under the prior authorization process, ~~ODJFS~~ the department will continue to issue the repair and labor codes for wheelchair repair services as listed in the appendix A to rule ~~5101:35160~~-10-03 of the Administrative Code. Both the repair/replacement part(s)

component and the labor component of any major wheelchair repair will be bundled into the all-inclusive major wheelchair repair codes. When deemed appropriate, ~~ODJFS~~ the department may separately authorize any of the codes listed in "Wheelchairs: Part I" of ~~appendix A to this rule~~ the appendix to rule 5160-10-03 of the Administrative Code, if no additional labor, parts, or accessories are being requested.

(10) Providers must continue to submit claims, and be paid, for both the repair/replacement part(s) and the labor components as an all-inclusive major or minor wheelchair repair service using the wheelchair repair and labor codes specified in the appendix A to rule ~~5101:35160~~ 5160-10-03 of the Administrative Code. The procedure codes/modifiers for claims submitted for major repair services must match the codes issued in the prior authorization approval issued by the department.

(K) Valid wheelchair modifiers.

(1) The following modifiers are valid for wheelchair services:

(a) RR - short term rental; or,

~~(b) -RP- repair and/or replacement of part(s) or labor for a major repair.~~

(b) RB - major repair or replacement of part(s).

(2) The appropriate modifier, as listed in paragraph (K)(1) of this rule, must be added to the procedure when requesting authorization for payment for wheelchair rentals or major repair services.

(3) Codes and modifiers submitted on the claim must match the codes and modifiers issued in the prior authorization approval letter.

Effective:

R.C. 119.032 review dates: 10/15/2013

Certification

Date

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Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5165.01, 5165.47

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5160-10-16.1 Wheelchair Rentals

Formerly 5101:3-10-16.1 Wheelchair Rentals

[MHTL 3344-11-02](#)

Effective Date: April 25, 2011

Most Current Prior Effective Date: [October 27, 2005](#)

(A) Definition

A "Rental Wheelchair" is defined in accordance with paragraph (C) of rule [5101:3-10-16](#) of the Administrative Code.

(B) Billing

The procedure necessary for billing the Ohio medicaid program for a wheelchair rental is defined in appendix A ~~of~~to rule [5101:3-10-03](#) of the Administrative Code.

(C) Reimbursement

(1) The reimbursement rate for wheelchair base codes utilizing the following "Healthcare Common Procedure Coding System" (HCPCS) codes in conjunction with the "RR" modifier are as follows:

- (a) E1235 reimburses at sixty-five dollars per month.
- (b) E1236 reimburses at sixty-five dollars per month.
- (c) E1237 reimburses at sixty-five dollars per month.
- (d) E1238 reimburses at sixty-five dollars per month.
- (e) K0001 reimburses at forty-five dollars per month.
- (f) K0002 reimburses at fifty-five dollars per month.
- (g) K0003 reimburses at sixty-dollars per month.

(2) ~~Ohio medicaid~~The department will reimburse submitted claims at the ~~providers~~ provider's usual and customary charge or at the maximums listed in this paragraph, whichever is less.

(3) The department will authorize only one rental wheelchair per consumer per month.

(4) Wheelchair rental codes are not to be used for temporary replacement equipment due to repair of consumer's primary transportation equipment.

(5) Wheelchair rental codes are not to be billed in conjunction with any other wheelchair codes referenced in appendix A to rule 5101:3-10-03 of the Administrative Code.

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Prior Effective Dates: 10/27/05

Formerly 5101:3-10-18 Hospital Beds, Pressure-Reducing Support Surfaces and Accessories

[MHTL 3344-09-01](#)

Effective Date: April 9, 2009

Most Current Prior Effective Date: [October 1, 2004](#)

5101:3-10-18 [Appendix A](#) - Pressure Sores - Four Stages of Tissue Breakdown

Appendix B - [JFS 02904](#): Certificate of Medical Necessity/Prescription Decubitus Care Equipment (Pressure Reducing Support Surfaces)

Appendix C - [JFS 02910](#): Certificate of Medical Necessity/Prescription Hospital Beds

(A) Hospital beds.

Generally Unless otherwise stated, coverage of hospital beds will be limited to ~~patients~~ consumers who meet the following criteria.

(1) Variable height hospital bed.

A "variable height" hospital bed is one with manual height, head and leg elevation adjustments. A request for prior authorization must include accompanying documentation signed by the ~~prescribing physician~~ prescriber which specifies the medical condition, severity and frequency of symptoms and the estimated duration of need and documents that:

- (a) The ~~patient's~~ consumer's diagnosis/condition (including but not limited to the weight of the ~~patient~~consumer) warrants the consistent need for a variable height hospital bed in ways not feasible with an ordinary bed in order to provide elevation in excess of thirty degrees to the consumer due to congestive heart failure, chronic pulmonary disease, or documented problems with aspiration. Pillows or wedges must have been considered and ruled out as elevation of the head or upper body at less than thirty degrees does not require the use of a hospital bed (e.g., a variable height hospital bed is required to position the body in ways not feasible with an ordinary bed), or
- (b) The ~~patient~~ consumer requires traction equipment which can only be attached to a hospital bed, or
- (c) The bed is required to assist the ~~patient~~consumer with mobility and/or transfers (e.g., to a chair, wheelchair or standing position), or
- (d) The bed is required to facilitate frequent interventions by a care giver in order to alleviate pain and prevent bed sores (e.g., turning the ~~patient~~ consumer every two hours).

(2) Semi-electric bed.

A "semi-electric" bed is one with manual height adjustment and with electric head and leg elevation adjustments. A semi-electric hospital bed may be approved with supporting documentation when the ~~patient~~consumer meets the general requirements in paragraph (A)(1) of this rule and requires frequent changes in body position and has an immediate need for a change in body position ~~there is documentation that the specific medical needs of the patient cannot be met in any other way.~~

(3) Total electric bed.

A "total electric" bed is one with electric height, head and leg elevation adjustments. Total electric beds and other institutional type beds are not **ordinarily** covered by the medicaid program.

(4) A heavy duty extra wide hospital bed is covered if the consumer meets the general requirements in paragraph (A)(1) of this rule and the consumer's weight is more than three hundred fifty pounds, but does not exceed six hundred pounds.

(5) An extra heavy duty hospital bed is covered if the consumer meets the general requirements in paragraph (A)(1) of this rule and the consumer's weight exceeds six hundred pounds.

(B) Bed accessories.

(1) Trapeze equipment is covered if the consumer needs this device to sit up because of a respiratory condition, to change body position for other medical reasons, or to get in or out of bed.

(2) Heavy duty trapeze equipment is covered if the consumer meets the criteria in paragraph (B)(1) of this rule and the consumer's weight is more than two hundred fifty pounds.

(3) Side rails are covered when they are required by the consumer's condition and they are an integral part of, or an accessory to, a covered hospital bed.

(4) A replacement innerspring mattress or foam rubber mattress is covered for a consumer-owned hospital bed if a consumer's condition requires it.

(C) Hospital beds, accessories or support surfaces are not separately reimbursed for consumers in LTCFs (long term care facilities) as this equipment is reimbursed to the specific facility through the facility's cost report.

(D) Any prescription for hospital beds, accessories or support surfaces must be prescribed by a prescriber actively involved in managing the consumer's medical condition as defined in paragraph (A) (2) of rule 5101-3-10-05 of the Administrative Code and should be treating the consumer under a comprehensive plan of care which addresses the underlying medical need for any equipment referenced in this rule.

~~(B)~~(E) Pressure-reducing support surfaces.

Coverage of pressure-reducing support surfaces is **generally** limited to those group 1, group 2, and group 3 codes specified on the medicaid supply list found in appendix A ~~of~~ **to** rule 5101:3-10-03 of the Administrative Code. A support surface must have a group 1, group 2 or group 3 healthcare common procedure coding system (HCPCS) HCPCS code as defined in rule 5101:3-1-19.3 of the Administrative Code assigned by the medicare statistical analysis durable medical equipment regional carrier (SADMERC) in order to be considered for coverage. Prior authorization is required for all group 2 and group 3 surfaces. ~~Refer to the medicaid supply list found in appendix A of rule 5101:3-10-03 of the Administrative Code, for prior authorization requirements for group 1 surfaces.~~

(1) Group 1.

(a) Definition.

"Group 1" pressure reducing support surfaces are typically defined as non-powered pressure reducing mattress overlays. These devices are designed to be placed on top of an ordinary hospital bed or home mattress. Group-1 pressure reducing support surfaces may be, but are not limited to, gel or gel-like overlays, air pressure or dry pressure, synthetic sheepskin, or lambswool sheepskin overlays. Group 1 may also include some powered pressure reducing mattress overlay systems (alternating pressure or low air loss), which are not included in group 2 pressure reducing support surfaces.

(b) Coverage criteria.

A group 1 mattress overlay or mattress is covered if **the patient has any of the following apply: limited mobility, i.e., patient cannot independently make changes in body position significant enough to alleviate pressure. For those group 1 surfaces that do not require prior authorization, the provider must maintain on file the physician prescription documenting the patient's mobility limitations. If prior authorization is required, the physician prescription documenting the patient's mobility limitations must be submitted with the prior authorization form (JFS-03142).**

(i) Consumer is completely immobile, i.e., cannot make changes in body position without assistance, or

- (ii) Consumer has limited mobility, i.e., cannot independently make changes in body position significant enough to alleviate pressure, or
- (iii) Consumer has any stage pressure ulcer on the trunk or pelvis, or
- (iv) The consumer has compromised circulatory status.

Any support surface or bed provided by the department will be one in which the consumer does not "bottom out." Bottoming out is the finding that an outstretched hand, placed palm up between the undersurface of the overlay or mattress and the consumer's bony prominence (coccyx or lateral trochanter), can readily palpate the bony prominence. This bottoming out criterion will be tested by the provider with the consumer in the supine position with their head flat, in the supine position and their head slightly elevated (no more than thirty degrees), and in the side-lying position.

(2) Group 2.

(a) Definition.

"Group 2" pressure reducing support surfaces are typically defined as: a powered air floatation bed (low air loss therapy); a powered pressure-reducing air mattress; a nonpowered advanced pressure reducing overlay for a mattress of standard length and width; a powered air overlay for a mattress of standard length and width; or a nonpowered advanced pressure reducing mattress. ~~A "low air loss bed" is defined as a hospital bed with a fully integrated power pressure reducing mattress which has all of the following characteristics:~~

A "low air loss bed" is defined as a hospital bed with a fully integrated power pressure reducing mattress which has all of the following characteristics:

- (i) An air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress;
- (ii) Air cells with an inflated ~~inflated~~ cell height ~~of the air cells~~ through which the air being circulated ~~of is~~ five inches or greater;
- (iii) Height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate patient lift, reduce pressure and prevent bottoming out;
- (iv) A surface designed to reduce friction and shear; and,
- (v) Can be placed directly on a hospital bed frame or ordinary bed frame.

(b) Coverage criteria.

Generally, a group 2 support surface (i.e., an air-floatation bed) for use by an eligible ~~recipient~~ consumer in a private residence ~~or a long-term care facility (LTCF)~~ may be prior-authorized when the ~~patient~~ consumer has:

- (i) Pressure sore(s) in stage III or stage IV of tissue breakdown, as defined in appendix A ~~of~~ to this rule, located on the trunk, or
- (ii) Burns of third degree with or without graft sites, or
- (iii) Multiple wounds at stage II, or
- (iv) Had a recent surgical procedure (within sixty days prior to the date of the authorization request) of wound closure involving skin grafts and/or skin flaps. (Note: for the first thirty days following a skin graft and/or a skin flap procedure, an original copy of a ~~physician's~~ provider's prescription shall be considered sufficient documentation for medical necessity. Subsequent approvals must meet the requirements of this rule.)

(3) Group 3.

(a) Definition.

"Group 3" pressure reducing support surfaces are typically defined as air-fluidized beds. An "air-fluidized bed" is a device employing the circulation of filtered air through silicone coated ceramic beads creating the characteristics of fluid. It is utilized for the treatment of a patient who has stage III or stage IV pressure sores.

(b) Coverage criteria.

A group 3 support surface (i.e., an air-fluidized bed) may be prior authorized when the patient has a stage III wound or a stage IV wound. The department's prior authorization unit will review the request and determine if an alternative support surface, such as a group 2 support surface, may be more appropriate.

~~(C)~~(F) Pressure reducing support surfaces and hospital beds - medical necessity documentation requirements.

The following current (within the last thirty days), signed and dated documentation must be submitted to the department with ~~the~~ a fully completed ~~prior authorization~~ medical necessity form: ~~(JFS 03142) for all group 2 and group 3 support surfaces, except for surfaces prescribed for the first thirty days after skin graft/skin flap surgery, as per paragraph (B)(2)(b)(iv) of this rule. Each piece of documentation must be labeled with the resident's name.~~

(1) JFS 02904 (4/2009), "Certificate of Medical Necessity/Prescription Decubitus Care Equipment (Pressure Reducing Support Surfaces)" (CMN) appendix B to this rule for all group 2 and group 3 support surfaces except for support surfaces prescribed for the first thirty days after skin graft/skin flap surgery, as per paragraph (E)(2)(b)(iv) of this rule; or

(2) JFS 02190 (4/2009), "Certificate of Medical Necessity/Prescription Hospital beds" (CMN) appendix C to this rule for all hospital beds.

Each additional piece of documentation submitted to the department as an attachment to the CMN must be labeled clearly and legibly with the consumer's name and medicaid identification number.

~~(1)~~(3) A current ~~physician's~~ prescriber's prescription or order for the support surface or hospital bed; and;

~~(2)~~(4) A current ~~physician's~~ prescriber's prescription or order for treatment of wounds for a support surface; and;

~~(3)~~(5) The ~~patient's~~ consumer's current diagnosis for a support surface or hospital bed; and;

~~(4)~~(6) The ~~patient's~~ consumer's weight history for at least sixty days prior and up to the request for a support surface; and;

~~(5)~~(7) The ~~patient's~~ consumer's current comprehensive nutritional assessment by a licensed/registered dietitian for a support surface; and;

~~(6)~~(8) Laboratory reports of blood tests, performed within twenty one days prior to submission of the authorization request for a support surface, showing, at a minimum:

- (a) Serum protein,
- (b) Serum albumin/prealbumin,
- (c) Hemoglobin, and
- (d) Hematocrit.

~~(7)~~(9) ~~The patient's~~ A detailed current wound description of the consumer's with a comprehensive current wound descriptions and history describing wound appearance, length, width, depth, and location, prepared by a licensed ~~nurse~~ health practitioner, and describing wound stage as defined in appendix A ~~of~~ to this rule if applicable for a support surface.

- ~~(8) Photograph(s) taken of the patient's wound(s), within twenty one days prior to the submission of the authorization request. Each photograph should be labeled as follows:~~
- ~~(a) Patient's name;~~
 - ~~(b) Date the photograph was taken; and,~~
 - ~~(c) Wound location(s).~~
- ~~(9) A statement from the LTCF which specifies the end date of the patient's medicare part A benefits must be submitted for patients who are eligible for medicare.~~

~~(D)~~(G) When the medical necessity for the pressure-reducing support surface or hospital bed has been established, the ~~patient's~~consumer's overall health status and any complicating conditions will be considered when authorizing the most appropriate and cost-effective support surface (air-fluidized or low air loss) or hospital bed.

~~(E)~~(H) For those support surfaces requiring prior authorization, the initial and any subsequent periods of coverage will be authorized at the discretion of the department.

(I) Hospital beds, accessories or support surfaces are reimbursed according to the department fee schedule contained in appendix DD to rule 5101:3-1-60 of the Administrative Code or the provider's usual and customary charge, whichever is less.

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***Formerly* 5101:3-10-19 Definitions of Terms Associated with Orthotic and Prosthetic Services**

MHTL 3344-09-05

Effective Date: January 7, 2010

Most Current Prior Effective Date: October 1, 2004

The following are definitions used in rule 5101:3-10-20 of the Administrative Code.

- (A) "Base procedure" - The basic procedure which indicates the simplest form of service being provided.
- (B) "Additions to" - The "add-on" codes are added to the base procedure code if additional and more complicated services are provided. Normally the value assigned to the "add-on" codes does not represent the actual value of the component but only the difference in value between the base component found in the base procedure code and the "add-on" component being substituted. Those codes with asterisks can be billed either as "add-on" or as replacement items.
- (C) "Molded socket" - In orthotics, this means an impression was taken, modified, and a socket of thermoplastic or other materials was made over the model. This same phrase in prosthetics indicates generally accepted fitting procedures, such as a PTB or quadrilateral socket that have been molded over a modified patient model.
- (D) "Molded to patientconsumer model" - A plaster cast is taken of the involved portion of the patient'sconsumer's body from which a positive cast is then developed. This positive mold represents the patient model from which the ultimate appliance is fabricated.
- (E) "Molded to patientconsumer" - Direct molding of plastic or similar material on involved portion of patient'sconsumer's body. This material is ultimately used in the appliance being fabricated.
- (F) "Direct formed" - Direct molding of plastic or similar material on involved portion of patient'sconsumer's body. This material is ultimately used in the appliance being fabricated.
- (G) "Nonmolded" - No casting or molding techniques used in the fabrication of the appliance in question. It can be a stock item or made from measurements and/or patterns only.
- (H) "Premolded" - No casting or molding techniques used in the fabrication of the appliance in question. It can be a stock item or made from measurements and/or patterns only.
- (I) "Custom fitted" - No casting or molding techniques are used in the fabrication of the appliance in question. It is normally a stock item that is fitted and adjusted to the patient. All custom-fitted items that require prior authorization must include make and model number.
- (J) "Custom fabricated" - The appliance in question has been made for the patientconsumer from measurements and/or patterns only.
- (K) "Interface material" - Lining material used in any appliance. It is inserted between the body and the structural support.
- (L) "Flexible" - Normally refers to surgical garments or corsets made from material, with reinforcing stays and para-spinal spring steels.
- (M) "Thermoplastic or equal" - The device is fabricated from one of the various forms of thermoplastic materials that are commercially available, or in some instances may even refer to a thermosetting plastic resin approach.
- (N) "Endoskeletal" - In prosthetics, this implies the modular approach and is all-inclusive of the various manufacturers of endoskeletal components.
- (O) "Exoskeletal" - The traditional plastic laminated approach to finishing a prosthesis.
- (P) "Immediate fit" - The application of a prosthesis in the operating or recovery room, and the appropriate cast changes.

- (Q) "Initial prosthesis" - The application of a plaster direct formed BK or AK prosthesis that was not an immediate fit, and is not intended for extensive use. This is a noncovered service by medicaid.
- (R) "Preparatory prosthesis" - A device that will allow for extensive gait training for lower limb amputees, and extensive functional training for upper limb amputees. A patient with a preparatory prosthesis need not be in the hospital, but is still undergoing changes to the amputation that preclude the fitting of the definitive prosthesis. Preparatory prostheses for lower limb amputees with the potential to be ambulatory will be considered for coverage by medicaid only when extensive training is medically necessary prior to the fitting of the definitive prosthesis.
- (S) "Medical event" - A physical occurrence or aberration which necessitates medical intervention requiring the one-time use of an orthosis specific to the diagnosis as prescribed by a physician.
- (T) "NC" - A noncovered service by medicaid.

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5101:3-10-20 - Appendix A, List of Orthotic and Prosthetic Procedures

Unless otherwise specified, any provider seeking reimbursement for orthotic and prosthetic services must meet the provisions contained within Chapter 4779. of the Revised Code or be exempt from licensure under section 4779.02 of the Revised Code in order to be eligible for reimbursement for services provided.

- (A) Medically necessary orthotic and prosthetic services are covered as listed in appendix A to this rule.
- (B) The allowed reimbursement amount for any orthotic or prosthetic device listed in appendix A to this rule includes, but is not limited to, the following:
 - (1) Labor;
 - (2) Casting, fitting, or measuring fees;
 - (3) Charges for travel; and
 - (4) Charges for shipping and mailing.
- (C) It is the provider's responsibility to assure that any orthotic or prosthetic device fits properly for three months from the date of dispensing. Any modifications, adjustments, or replacements within the three months are the responsibility of the provider that supplied the item and no additional charge may be made to the department or the consumer. The provision of these services by another provider will not be separately reimbursed.
- (D) "Unlisted procedure" and "not otherwise specified (NOS)" codes require complete description and itemization of charges when being submitted for prior authorization.
- (E) Coverage of repair or replacement of parts for orthotic or prosthetic devices.
 - (1) Orthotic devices.
 - (a) Prior authorization is not required for the repair or replacement of minor parts for orthotic devices, which includes the amount for labor, when the repair or replacement of the orthotic device is less than or equal to one hundred twenty dollars with the exception listed in paragraph (F) of this rule.
 - (b) Prior authorization is required for the repair or replacement of major parts for orthotic devices, which includes the amount for labor, when the repair or replacement of the orthotic device is greater than one hundred twenty dollars.
 - (c) To bill for the repair of orthotic devices or the replacement of minor or major parts for orthotic devices, the provider must bill the appropriate code listed in appendix A to this rule.
 - (2) Prosthetic devices.
 - (a) Prior authorization is not required for the repair or replacement of minor parts for prosthetic devices, which includes the amount for labor, when the repair or replacement of the prosthetic device is less than or equal to one hundred twenty dollars.
 - (b) Prior authorization is required for the repair or replacement of major parts for prosthetic devices, which includes the amount for labor, when the repair or replacement of the prosthetic device is greater than one hundred twenty dollars with the exception listed in paragraph (F) of this rule.

- (c) To bill for the repair of prosthetic devices or the replacement of minor or major parts for prosthetic devices, the provider must bill the appropriate code listed in appendix A to this rule.
- (3) Prior authorization is required for orthotic and prosthetic device repair or replacement less than or equal to one hundred twenty dollars when the repair or replacement of the orthotic or prosthetic device is in excess of one repair or replacement per consumer per one hundred twenty day period.
- (4) Coverage and claims submission for the repair or replacement of parts for orthotic and prosthetic devices are subject to the requirements listed in paragraphs (A)(2) to (A)(12) of rule 5101:3-10-08 of the Administrative Code.
- (F) For those codes listed in appendix A to this rule that are preceded by an asterisk, all costs of repair are included in the reimbursement amount.
- (G) Preparatory prostheses will be considered for authorization when documentation is provided at the time of submission of the prior authorization. The documentation should include the reason for the amputation, the date of the amputation, and a statement of why the patient will benefit by the application of a preparatory prosthesis prior to the design of the definitive. It is recognized that not every amputee is a candidate for a preparatory prosthesis prior to the fitting of a definitive; however, he or she will be considered where unusual physical changes are anticipated or cardiovascular or other physical conditions require evaluation to determine if a patient will be successful as a user of a definitive prosthetic.
- (H) Twister (torsion) cables may be approved for only the treatment of children with neuromuscular diseases, and related diagnoses. Requests for torsion cables to treat positional deformities will not be covered by the Ohio department of job and family services (ODJFS) because of anticipated resolution that occurs with maturation.

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