Ohio Administrative Code

Rule 5160-9-02 Pharmacy services: medical supplies and durable medical equipment.

Effective: April 1, 2017

(A) Eligible pharmacies in the Ohio medicaid program may bill for medical supplies and durable medical equipment in accordance with Chapter 5160-10 of the Administrative Code, with the following stipulations:

(1) The provider must apply to, and be approved by, the Ohio department of medicaid (ODM) to be eligible to dispense medical supplies/durable medical equipment.

(2) All products require a prescription written by a practitioner authorized to prescribe. The prescription must be obtained by and kept on file at the pharmacy.

(3) The provider must use the same medicaid provider number as when billing for pharmaceuticals.

(4) The provider must be licensed, registered, or exempt from licensure or registration under Chapter 4761. of the Revised Code to bill for home medical equipment that is subject to regulation under Chapter 4752. of the Revised Code.

(B) Claims submitted for medical supplies/durable medical equipment must be billed in the appropriate claim format designated by ODM for those services.

(C) Medical supplies, durable medical equipment, prosthetic, and orthotic devices may be billed by pharmacy providers in accordance with Chapter 5160-10 of the Administrative Code.

(D) Only eligible providers of pharmacy services as described in rule 5160-9-01 of the Administrative Code are eligible to bill for the medical supplies listed in the appendix to this rule, except as specified in paragraph (G) of this rule. Eligible providers of pharmacy services may bill for these items without applying to ODM to be eligible to dispense medical supplies/durable medical equipment as described in Chapter 5160-10 of the Administrative Code.

(E) The quantity billed should be equal to the number of items dispensed (e.g., the quantity of test strips billed should be the number of individual test strips, not the number of boxes). The table in the appendix to this rule includes five columns to indicate supply item coverage and payment.

(1) Item description. This column describes the supply item.

(2) Medicaid coverage status. This column has one of two possible indicators for each item. "Y" indicates the item is covered by medicaid for all individuals eligible for medicaid and may be billed directly to ODM by the provider. "H" indicates that the item may be billed directly to ODM only if the item is intended for use by the individual in their personal residence, with the exception of individuals who reside in a nursing facility (NF), as defined in section 5165.01 of the Revised Code, or intermediate care facility for individuals with intellectual disabilities (ICF/IID), as defined in section 5124.01 of the Revised Code. For individuals residing in a NF or ICF/IID, the supply is the responsibility of the NF or ICF/IID and is included in the NF or ICF/IID facility per diem payment.

(3) Covered for dual eligible. This column indicates whether the supply is covered under the medicaid program for an individual who is a dual eligible as defined in rule 5160-1-05 of the Administrative Code. "Y" indicates the supply is covered for a dual eligible. "N" indicates the supply is not covered for a dual eligible.

(4) Maximum units. This column indicates the largest number of units of the supply that may be dispensed within the time period indicated. Claims submitted that exceed the maximum units shall be denied. Denials may be overridden by ODM or its designee in cases where medical necessity has been determined through prior authorization obtained by the prescriber from the ODM point-of-sale vendor.

(5) Maximum payment. This column indicates the medicaid maximum payment per item as defined in rule 5160-1-60 of the Administrative Code. Supplies with "*" in this column indicate that maximum payment will be calculated based on the wholesale acquisition cost (WAC) as defined in rule 5160-9-05 of the Administrative Code.

(a) For dates of service before the effective date of this rule, the maximum payment shall be one hundred seven per cent of WAC.

(b) For dates of service on or after the effective date of this rule, the maximum payment shall be one hundred per cent of WAC.

(F) The supplies listed in the appendix to this rule should be billed through the pharmacy point of sale claims system using the national drug code (NDC) on the container from which the product was dispensed. Payment shall be the lesser of the submitted charge or the calculated allowable. The calculated allowable is the medicaid maximum payment as described in paragraph (E)(5)(a) of this rule. For dates of service on or after the effective date of this rule, the calculated allowable is the medicaid maximum payment as described in paragraph (E)(5)(b) of this rule plus the professional dispensing fee applicable to the provider as described in paragraph (E)(1)(b) of rule 5160-9-05 of the Administrative Code.

(G) Exceptions to pharmacy billing requirement.

(1) Contraceptive supplies listed in the appendix to this rule may be billed by both pharmacy providers and providers eligible to bill in accordance with rule 5160-10-01 of the Administrative Code. Pharmacy providers shall bill these supplies in accordance with paragraph (F) of this rule.

(2) Supplies billed to medicare as the primary payer and crossed over to medicaid using the medicare crossover process described in paragraph (B) of rule 5160-1-05 of the Administrative Code may be billed by any provider eligible for the medicare crossover process.

(H) Preferred medical supplies

(1) Selected products from the medical supply categories included in the appendix to this rule have been designated as preferred brands, as specified on the ODM web site at http://pharmacy.medicaid.ohio.gov.

(2) Products that have not been designated as preferred require prior authorization.

(a) Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

(b) The prescriber shall document medical necessity for the non-preferred brand and why a preferred brand cannot be used.

(c) When a request for prior authorization is denied, the consumer will be informed in writing of the denial and the right to a state hearing.