

Updated 7-25

The Ohio Department of Developmental Disabilities (DODD) and the Ohio Department of Medicaid (ODM) have been collaborating to address concerns from stakeholders regarding prior authorization (PA) requests for equipment available through the Medicaid state plan. DODD is providing this guidance to county boards of developmental disabilities (CBDD) and providers to assist people with obtaining medically necessary equipment, while continuing to follow federal and state requirements.

The CBDD should ensure Medicaid state plan funding is used when available for any equipment prior to authorizing the equipment or submitting a prior authorization request to DODD.

Background

Federal requirements outlined in the application for a 1915c home and community-based services (HCBS) waiver specify that *services under a waiver are provided when the limits of the state plan service under the approved state plan are exhausted*. When equipment or supplies are available under the state plan, they will not be covered through an HCBS waiver.

DODD is clarifying in Ohio Administrative Code (OAC) Rule [5123-9-25](#) “Home and community-based services waivers - specialized medical equipment and supplies under the individual options and level one waivers” that prior to authorizing specialized medical equipment and supplies, a person’s service and support administrator will document that the item is not covered through the Medicaid state plan.

Medicaid Prior Authorization Process

Most specialized medical equipment and supplies are covered by Medicaid state plan under OAC Chapter [5160-10](#) titled “Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers.” When covered medical equipment under the Medicaid state plan requires prior authorization, ODM or the person’s Managed Care Organization (MCO) will process the prior authorization. Ohio Revised Code (ORC) Section [5160.34](#) sets forth prior authorization requirements for ODM and the MCOs. ODM and MCOs have ten calendar days to respond to prior authorization requests unless the request is urgent in nature. Urgent requests require a response within 48 hours.

For prior authorization requests being submitted to ODM, a completed [certificate of medical necessity \(CMN\)](#) is required by ODM for certain equipment. The practitioner(s) completing the CMN must explain why the specific item is needed. If the CMN documents that a less costly item will meet the person’s needs, that is what ODM will authorize. Requests for individuals enrolled in managed care are sent directly to the MCO.

The provider submits the prior authorization, CMN, and supporting documentation to ODM via the PNM provider portal. Requests must specify all relevant information, such as procedure code, manufacturer, and model. Providers must select the assignment in the prior authorization request form that corresponds to the billing code, ensure the provider information is accurate, and the person's demographics are correct. If any of the fields are incorrect, the request will be rejected by the system and will not be reviewed.

When the equipment does not meet the description of the code, i.e., special construction is needed to meet the person's needs, the provider will request the equipment using the appropriate miscellaneous code and explain how the equipment is different from the item on the fee schedule. The provider should provide the acquisition cost (the cost to acquire the equipment) to ensure ODM can assess the payment amount to the provider for the item. The medical necessity of the special construction or additional parts must be clearly stated.

If the request is reviewed for medical necessity and denied by ODM, the item may be covered using waiver funds. If the person's DDP funding range is exceeded or if the total cost of the equipment exceeds \$10,000, the request may be submitted to DODD to be considered for coverage under the person's waiver as described in OAC [5123-9-07](#). The submission to DODD should include all supporting documentation including the ODM denial. An ODM PA denial for incomplete submission is not an acceptable reason to use waiver funding for equipment. A denial from ODM does not guarantee payment through a waiver.

Coverage and Payment

The Medicaid durable medical equipment, prostheses, orthoses, and supplies (DMEPOS) state plan fee schedule is in the [appendix](#) to OAC [5160-10-01](#) and on the Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System ([HCPCS](#)) Level II Procedure Code Changes [website](#). Payment for certain items is always subject to Medicaid prior authorization. Payment for other items is subject to prior authorization when the dispensing frequency needs to be exceeded.

A basic principle of Medicaid payment described in OAC [5160-1-01](#) is that for an item to be medically necessary, it must be the lowest cost alternative that effectively addresses and treats the medical problem. If more than one item meets a person's needs, the maximum payment amount is set as the least costly alternative.

OAC [5160-10-01](#) describes certain items that are presumed to not be durable medical equipment (DME) when they are not medical in nature. These items include but are not limited to environmental control devices (ex: dehumidifier or air purifier), physical fitness equipment (ex: exercise bike or suspension training items), and educational aids (ex: software

applications or educational puzzles). Items may be added to the DME coverage list at any time and MCOs may cover items as [value added services](#).

To determine whether an item should be submitted to ODM for prior authorization under the state plan DME rules, consider the following:

1. Is the item listed on the DMEPOS fee schedule or the CPT and HCPCS Level II Procedure Code Changes website? – If yes, always submit to ODM. If not, proceed to question #2.
2. Does the item have a HCPCS code? – If yes, always submit to ODM. If not, continue to question #3.
3. Does the item serve a recognized medical purpose? If not, consider coverage under the waiver. If yes or maybe, submit to ODM using the appropriate miscellaneous code.
 - a. The “maybe” category includes items that are similar in form or function to DMEPOS items listed on the payment schedule.
 - b. The person’s ISP must clearly indicate the medical or remedial benefit for the individual, be supported by a clinical assessment, and not be for recreational purposes or general utility.

Examples of items that may be covered directly through a DD HCBS waiver include:

- Sensory type items - often described as potentially assisting individuals to self-regulate, provide comfort, or calm. Examples: LED lights, vibrating pillows, and weighted blankets.
- Items that fall under the umbrella of environmental accessibility adaptations as described in OAC rule [5123-9-23](#). Examples: installation of ramps, permanent lifts and systems to operate an individual’s medical equipment in a person’s home.
- Items that fall under the umbrella of specialized medical equipment that are modifications to vehicles. Examples: ramps, vehicle lifts, and power kneeling.
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New information to consider prior to submitting:

- ODM has added an atypical list which are items that are not often covered but can be and those items should be submitted for a decision. These are items such as wipes (codes are on atypical list) for a person with a medical condition, not solely for hygiene or provider convenience, stair lifts, chair lifts (see additional guidance for chair lifts) and the lift portion only of a ceiling lift. The home modification portion of this installation must be covered by the HCBS waiver.
- Generators are not considered DME so can be submitted directly to the waiver, however if the person is covered by a managed care company or is a child with life sustaining equipment, this should be submitted.

In response to provider questions, DODD confirmed that when the person has a need for a supply or equipment that will cost more than the Medicaid fee schedule reimbursement amount, ODM requires that the provider submit the item to ODM for prior authorization review. The provider may use a miscellaneous code but should reference the corresponding DME code and supporting documentation must clearly describe why the specific item is medically necessary (i.e., the lowest cost alternative to meet the person’s needs). Providers cannot decide whether an item or service would not be covered. Providers should submit a Medicaid prior authorization request to obtain ODM’s official decision.

Healthchek & EPSDT

OAC Rules [5160:1-2-15](#) and [5160-1-14](#) describe “Healthchek,” Ohio’s early and periodic screening, diagnosis, and treatment (EPSDT) program. Healthchek services include screening, diagnosis, and treatment services to members under the age of 21. Healthchek services include all mandatory and optional medically necessary services (including equipment) and items listed in 42 USC 1396d(a) to correct or ameliorate defects, and physical and mental illness and conditions discovered by a Healthchek screening. In short, medically necessary services and supplies for people under the age of 21 are covered by Medicaid state plan either through ODM or an MCO. The prior authorization process is the same regardless of the age of the individual.

Resources

ODM maintains a [Medicaid provider directory](#).

SME policy questions may be sent to DODD at waiverpolicyta@dodd.ohio.gov

SME prior authorization questions may be sent to DODD at padoc2@dodd.ohio.gov

DME policy questions may be sent to ODM at noninstitutional_policy@medicaid.ohio.gov

For questions regarding DME prior authorizations, contact the Gainwell IHD at 800-686-1516 or IHD@medicaid.ohio.gov

Healthcare Common Procedure Coding System (HCPCS) [CMS Website](#) with explanation.