Frequently Asked Questions
Ohio Admin. Code 5123-9-25

"Home and community-based services waivers – specialized medical equipment and supplies under the individual options and level one waivers."

Department of Developmental Disabilities

This rule applies to individuals enrolled on the Individual Options and Level One waivers. The following is a list of frequently asked questions and answers, which are intended to help the field understand this Ohio Administrative Code (OAC) rule.

What are specialized medical equipment and supplies?

Specialized medical equipment and supplies (SME) is adaptive and assistive equipment and other equipment and supplies such as devices, controls, or appliances, which enable a person to increase their ability to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live.

Specialized medical equipment and supplies does not include:

- Items that are not of direct medical or remedial benefit to the individual.
- Items otherwise available as assistive technology
- Equipment and supplies that are available under the Medicaid state plan or Healthchek.

What is the Medicaid state plan?

All individuals served by a home and community-based services (HCBS) waiver also have Medicaid state plan coverage through the Ohio Department of Medicaid (ODM). Medicaid state plan is an insurance plan, like private insurance, but paid for through federal and state funding. To be covered under the Medicaid state plan, services must be determined medically necessary. Due to federal and state requirements, people on an HCBS waiver must utilize services offered through the Medicaid state plan prior to utilizing HCBS waiver services.

Medicaid state plan may be provided through the fee-for-service option or through a managed care organization (MCO). Payment for certain items is always subject to Medicaid prior authorization. Payment for other items may require prior authorization only when the amount needed is over the threshold.

What is Healthchek?

"Healthchek," is Ohio's early and periodic screening, diagnosis, and treatment (EPSDT) program. Healthchek services include screening, diagnosis, and treatment services to Medicaid 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.

How is medical necessity determined?

A basic principle of Medicaid payment described in OAC 5160-1-01 is that for an item to be medically necessary, it must:

- Meet generally accepted standards of medical practice.
- Be clinically appropriate in type, frequency, extent, duration and delivery setting.
- Be appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
- Be the lowest cost alternative that effectively addresses and treats the medical problem.
- Provide unique, essential, and appropriate information if it is used for diagnostic purposes.
- Not be provided primarily for the economic benefit of the provider or convenience of the provider or anyone other than the recipient.

How do I know if an item is covered under the Medicaid state plan?

Equipment covered through the Medicaid state plan benefit is described in OAC Chapter 5160-10 titled "Medical Supplies, Durable Medical Equipment, Orthoses, and Prosthesis Providers." Durable Medical Equipment (DME) includes things like wheelchairs, bathing seats, ambulation aids and supplies like incontinence supplies.

To determine whether an item should be covered by Medicaid state plan, ask the following questions:

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 no, proceed to question #2.
2. Does the item have a HCPCS code? – If yes, always submit to ODM. If no, proceed to question #3.
3. Does the item serve a recognized medical purpose? If no, consider coverage under the waiver using the most appropriate waiver service. Items not intended for a medical purpose may be covered under services such as PDGS or assistive tech, instead of SME. 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.
    c. For children under the age of 21, ODM or the MCO will review the request in accordance with Healthchek, Ohio Medicaid's EPSDT program.

*Information about CPT and HCPCS uniform coding systems used for medical services can be found on CMS's website.

Are there items that should not be submitted to ODM for coverage under Medicaid state plan?

Examples of items that may be covered directly through a developmental disabilities (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 lift systems attached to the home, 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, lifts, and power kneeling.

I want to assist the person with obtaining DME through the Medicaid state plan. How can I help them find a DME provider?

ODM maintains an online Medicaid Provider Directory. The search function allows you to select the zip code, whether the person has fee-for-service Medicaid or an MCO, and additional service or demographic details. Select "Durable Medical Equipment Supplier" from the Provider Type drop down menu and click "search".

If the person has both Medicare and Medicaid, how should we obtain needed equipment?

OAC 5160-1-05 is the Medicare/Medicaid coordination of benefits (COB) rule. When the person is covered by other third-party payers including Medicare, Medicaid (and the HCBS waiver) is the payer of last resort. Providers must bill all other third-party payers prior to submitting to ODM or covering as a waiver service. ODM will not pay for services denied by Medicare for lack of medical necessity but may pay claims denied for reasons other than lack of medical necessity if the services are Ohio Medicaid services.

If the person has Medicare, Medicaid and is on a DODD waiver, they are exempt from managed care. ODM will not pay for any service payable by, but not billed to, Medicare. Send questions regarding COB to waiverpolicyta@dodd.ohio.gov.

Can an SME provider submit a DME claim or request to ODM?

Only a Medicaid-enrolled DME provider can submit a prior authorization request or claim to ODM for state plan covered equipment. Some SME providers are also enrolled as DME providers.

Where can I find a list of equipment, supplies, and payment rates?

OAC rule 5160-10-01 includes the general provisions for DME and the rule appendix is the Medicaid fee schedule. ODM also maintains the Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) Level II Procedure Code Changes website.

Which miscellaneous code is the right one to use?

There are several miscellaneous codes on the DME fee schedule. These misc. codes include A9900-miscellaneous DME supply, E1399-miscellaneous durable medical equipment, K0900-customized durable medical equipment, and A4335-miscellaneous incontinence supplies, as examples. The DME provider should choose the HCPCS code that best describes the item.

Is assistive technology, such as a tablet used as a communication device, available through the Medicaid state plan?

Yes, certain assistive technology is available through the Medicaid state plan under rule 5160-10-24 "DMEPOS: speech-generating devices." The rule includes commercially available software and, if necessary, hardware to run it (e.g., a portable or tablet computer).

What if the item needed to address the person's needs is more expensive than the Medicaid payment rate?

When the person has a need for a supply or equipment that will cost more than the Medicaid fee schedule reimbursement amount, the item must still be submitted to ODM for prior authorization review. The provider may use a miscellaneous code but should reference the corresponding DME code and provide supporting documentation that clearly describes why the specific item is medically necessary.

When the supply or 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 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.

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.

Can the cost of an item be split between the Medicaid state plan and HCBS waiver funds?

No. Medicaid payment is considered payment in full. There is no opportunity to split the cost of a single item between Medicaid and waiver funds. If Medicaid covers a portion of the total cost the waiver or local funding are not able to cover the remaining amount.

What is required for submission of a prior authorization to Medicaid?

When state plan medical equipment requires prior authorization, ODM or the person's MCO will process the prior authorization. When submitting to ODM for coverage under fee-for-service, 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.

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.

What is required for submission of a prior authorization to DODD?

When the person's total costs are over their developmental disabilities profile (DDP) funding range or if the cost of the SME is over $10,000, a prior authorization request can be sent to DODD for approval. The DODD Prior Authorization Unit will review all submitted documentation prior to making a determination. The request must include:

- The current or proposed individual service plan (ISP). The prior authorization and ISP must agree. If the ISP doesn't reflect the need for the equipment or supply, DODD cannot approve the request.
- Supporting documentation providing evidence that the requested services are medically necessary.
- Documentation of the prior authorization submission to ODM and their response.
- Any changes of address and/or living arrangement.

The DODD Prior Authorization FAQ is available here.

OAC rule 5123-9-25 requires the SSA to document when an item is not covered under the Medicaid state plan. What is appropriate documentation?

The SSA can document that an item is not covered by Medicaid either through notification received from ODM that a prior authorization has been processed or by using this FAQ and guidance published by DODD. The documentation could be a simple statement like "SME item purchased using waiver funds following DODD guidance document and FAQ. This item was determined to not be covered under state plan using the SME decision tree provided by DODD and ODM. It is not on the Medicaid fee schedule, does not have a HCPCS code and is not used for a recognized medical purpose."

If a person is receiving reoccurring supplies (diapers, bandages, etc.) that are authorized through Specialized Medical Equipment during a previous span and the team feels they are still needed, can we continue to authorize those services with a new quote? Or do we need the provider to resubmit to ODM for coverage?

Items that were not previously covered by the Medicaid state plan that are currently covered as SME, should be reviewed by the CBDD when the new waiver span begins. The CBDD should use the decision tree and when appropriate make another attempt to obtain the items through the Medicaid state plan. The DME coverage policy is frequently updated so items that were not covered previously may be covered now.

The person is enrolled in an MCO for their state plan services. What is the process to get equipment?

When the person is enrolled in an MCO, the DME provider must be an MCO network provider. When searching for a provider, select the MCO from the payer dropdown menu. Each MCO has a prior authorization process and plan-specific criteria. MCOs also follow Medicaid medical necessity rules. See the managed care activity grid for MCO contact information.

How long does it take after a prior authorization is submitted?

When covered medical equipment under the Medicaid state plan requires prior authorization, ODM or the person's 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 which have a 48-hour turnaround time.

When the prior authorization request is submitted to DODD, within 10 business days of receiving the request, the DODD PA Unit will notify the CBDD if additional information is needed to complete their review. The CBDD has five business days to submit the requested information. The DODD PA Unit will review and make a determination within 10 business days of receiving all necessary information. The DODD PA Unit may request a conference call with the CBDD to discuss the prior authorization request. The CBDD may withdraw the request and resubmit at any time.

If an item is denied by DODD, is there an appeal process?

The DODD PA Unit may:

- Approve the request in its entirety;
- Deny the request; or
- Partially approve the request.

A denial or partial approval will result in DODD issuing written notification of state hearing rights.

If an item is denied by ODM, is there an appeal process?

Yes, per OAC rule 5160-1-31, when a request for prior authorization is denied, ODM or its designee will issue a notice of medical determination and a right to a state hearing to the individual and the provider.

If an item is denied by the MCO, is there an appeal process?

Yes, per OAC rule 5160-26-08.4, the MCO must issue a notice of action to the individual when issuing an adverse benefit determination (i.e., PA denial). The notice of action must include their appeal rights through the MCO. Once MCO appeal rights are exhausted, the individual has the right to request a state hearing.