5123:2-7-11 **Intermediate care facilities - relationship of other covered medicaid services.**

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by an intermediate care facility. Reimbursement of services through the "facility cost report mechanism" referenced in this rule is governed by rule 5123:2-7-12 of the Administrative Code. References to "intermediate care facilities" in paragraphs (A) to (I) of this rule do not include state-operated intermediate care facilities for which reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code.

(A) Dental services

All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Chapter 5101:3-5 of the Administrative Code. Personal hygiene services provided by facility staff or contracted personnel are reimbursed through the facility cost report mechanism.

(B) Laboratory and x-ray services

Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility cost report mechanism. All laboratory and x-ray procedures covered under the medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Chapter 5101:3-11 of the Administrative Code.

(C) Medical supplier services

Certain medical supplier services are reimbursable through the facility cost report mechanism and others directly to the medical supply provider as follows:

(1) Items that must be reimbursed through the facility cost report mechanism include:

(a) Costs incurred for "needed medical and program supplies," defined as items that have a very limited life expectancy, such as, atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.

(b) Costs incurred for "needed medical equipment" (and repair of such equipment), defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for the use in the facility. Such medical equipment items include hospital beds, wheelchairs, and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.

(c) Costs of equipment associated with oxygen administration, such as, carts,

regulators/humidifiers, cannulas, masks, and demurrage.

(2) Services that are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code, include:

(a) Certain durable medical equipment items, specifically, ventilators, and custom-made wheelchairs that have parts which are actually molded to fit the recipient.

(b) "Prostheses," defined as devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as, artificial arms or legs, electro-larynxes, and breast prostheses.

(c) "Orthoses," defined as devices that assist in correcting or strengthening a distorted part, such as, arm braces, hearing aids and batteries, abdominal binders, and corsets.

(d) Contents of oxygen cylinders or tanks, including liquid oxygen, except emergency stand-by oxygen which is reimbursed through the facility cost report mechanism.

(e) Oxygen producing machines (concentrators) for specific use by an individual recipient.

(D) Pharmaceuticals

(1) Over-the-counter drugs not listed in appendix A to rule 5101:3-9-12 of the Administrative Code, for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.

(2) Pharmaceuticals reimbursable directly to the pharmacy provider are subject to the limitations found in Chapter 5101:3-9 of the Administrative Code, the limitations established by the Ohio state board of pharmacy, and the following conditions:

(a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.

(b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to an intermediate care facility must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy.

(E) Physical therapy, occupational therapy, speech therapy, audiology services,

psychologist services, and respiratory therapy services

Costs incurred for physical therapy, occupational therapy, speech therapy, audiology services, psychology services and respiratory therapy services provided by licensed therapists or therapy assistants or provided by licensed psychologists or psychology assistants and that are covered for residents of intermediate care facilities either by medicare or medicaid, are reimbursable through the facility cost report mechanism. Reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered to intermediate care facility residents by contracted staff or facility staff and the overhead costs to support the provision of such services are reimbursable through the rate determined in accordance with sections 5111.20 to 5111.33 of the Revised Code. Costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for psychologist services shall be made to a provider other than the intermediate care facility, or a community mental health center certified by the Ohio department of mental health. Services provided by an employee of the community mental health center must be billed directly to medicaid by the community mental health center. Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the facility cost report mechanism. No reimbursement for respiratory therapy services shall be made to a provider other than the intermediate care facility.

(F) Physician services

(1) A physician may be directly reimbursed for the following services provided to a resident of an intermediate care facility by a physician:

(a) All covered diagnostic and treatment services in accordance with Chapter 5101:3-4 of the Administrative Code.

(b) All medically necessary physician visits in accordance with rule 5101:3-4-06 of the Administrative Code.

(c) All required physician visits as described in this rule when the services are billed in accordance with rule 5101:3-4-06 of the Administrative Code.

(i) Physician visits must be provided to a resident of an intermediate care facility and are considered timely if they occur not later than ten days after the date the visit was required.

(ii) For reimbursement of the required physician visits, the physician must:

*(a)* Review the resident's total program of care including medications and treatments, at each visit required by this rule;

*(b)* Write, sign, and date progress notes at each visit;

*(c)* Sign all orders; and

*(d)* Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.

(iii) At the option of the physician, required visits after the initial visit may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and alternate between physician and visits by a physician assistant or certified nurse practitioner.

(iv) Physician delegation of tasks.

*(a)* A physician may delegate tasks to a physician assistant or certified nurse practitioner as defined by Chapter 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code for physician assistants, and Chapter 4723. of the Revised Code and Chapter 4723-4 of the Administrative Code for certified nurse practitioners who are in compliance with the following criteria:

*(i)* Are acting within the scope of practice as defined by state law; and

*(ii)* Are under supervision and employment of the billing physician.

*(b)* A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.

(2) Services directly reimbursable to the physician must:

(a) Be based on medical necessity, as defined in rule 5101:3-1-01 of the Administrative Code, and requested by the resident of the intermediate care facility with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and

(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Every entry must be signed and dated by the physician.

(3) Services provided in the capacity of overall medical direction are reimbursable only to an intermediate care facility and may not be directly reimbursed to a

physician.

(G) Podiatry services

Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Chapter 5101:3-7 of the Administrative Code. Payment is limited to one visit per month for residents in an intermediate care facility.

(H) Transportation services

Costs incurred by the intermediate care facility for transporting residents by means other than covered ambulance or ambulette services are reimbursable through the facility cost report mechanism. Payment is made directly to authorized providers for covered ambulance and ambulette services as set forth in Chapter 5101:3-15 of the Administrative Code.

(I) Vision care services

All covered vision care services, including examinations, dispensing, and the fitting of eyeglasses, are reimbursed directly to authorized vision care providers in accordance with Chapter 5101:3-6 of the Administrative Code.

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