



## Ohio Medicaid Benefits

Service/Procedure	Covered	Not Covered	Prior Auth Required	Comments
Abortions			√	Must have signed JFS 03197 Abortion form prior to authorization of services. Very Limited coverage
Acupuncture		√		Do not offer appeal of this non-covered service.
Alcohol & Substance Abuse (Detox)	√		√	Inpatient-Usual coverage is for 3 days needs review for longer stay. Outpatient-Self refer to ODADAS certified program for outpatient services. If member is unwilling to access community behavioral health services or cannot do so on a timely basis, then the MCP is responsible for providing or arranging for MCP-covered services.
Alcohol & Substance Abuse (Rehabilitation)		√		Self refer to ODADAS certified program. Use county ADAMHS services. CareSource will not authorize.
Allergy Care	√			May need standing referral.
Ambulance, Ambulette, Air transportation	√		√	PA required unless emergency transportation. No PA for Non-emergent ambulance from hospital to hospital and SNF to any provider and return. See Medicaid Guidelines for criteria and billing codes. ***** See Transportation section for medical appointment transportation.
Ambulatory Surgery Centers	√			
Anesthesia	√			
Assistant Surgeons	√			Physician Assistants - not covered, all other assistants paid at 25%.
Autopsy		√		Per provider agreement with the state, MCP is not required to pay for this service
Biofeedback		√		Per provider agreement with the state, MCP is not required to pay for this service.
Cardiac Rehab	√			
Chemotherapy	√		√ Inpatient only	Inpatient requires prior authorization. See chemotherapy section of OAC ruling for complete ruling
Chiropractic	√			Manipulation & radiographs only. Benefit limit: 15 visits per calendar year for members 21 yrs and over; 30 visits per calendar year for members under 21. May not dispense any DME without PA. Per ODJFS, chiropractic x-rays are limited to two units of service during any six-month period for cervical, thoracic, thoracolumbar, and lumbosacral spine. Entire spine x-rays are limited to two units per one year. Any requests above the benefit limit require prior authorization.
Contact Lens	√		√	Requires written PA. See criteria in Vision section.
Cosmetic Surgery (Plastic Surgery)	√		√ limited	Covered for medical necessity. Requires PA from Medical Director. See cosmetic surgery criteria.
County/City/Health Dept Immunization STD Clinic	√			Self referred. Specialty immunizations (like for travel) would be referred here. These clinics do not bill CareSource.
Depro Provera Injections	√			



## Ohio Medicaid Benefits

Service/Procedure	Covered	Not Covered	Prior Auth Required	Comments
Dental	√		√ limited	Self referred. See criteria in Dental section. Certain dental benefits require PA. The following dental services will require prior authorization as of 8/1/08 Root Canals - if 3 or more root canal procedures are scheduled within 6 months All dentures All partial dentures Porcelain crown fused to noble metal (authorized for permanent anterior teeth only) Cast post and core in addition to crown (authorized for permanent anterior teeth without sufficient tooth structure to support a crown only) Frenulectomy/frenulotomy Apexification/recalcification Excision hyperplastic tissue Gingivectomy/plasty Impacted tooth removal – completely bony with complications Surgical removal of a residual tooth root Surgical removal of supernumerary tooth Removal of exostosis Unspecified TMJ therapy Unspecified TMJ films Removable appliances Fixed appliances therapy All unspecified/miscellaneous dental codes - Orthodontia
Diagnostic Testing	√			
Dialysis, Renal	√		<b>No for par and nonpar</b>	No prior authorization is required for par or nonpar providers
Diapers** Incontinent Supplies	√			Covered for members > 3 yrs of age up to 300 per month for diapers and 150 per month for incontinent supplies.
Diet pills and Liquid diets		√		
Durable Medical Equipment	√		√	PA required for rental items that have a purchase price of \$750 or more, all customized/ powered wheelchairs, manual wheelchairs rental >3 months, hearing aids, contact lens & all miscellaneous codes. Enteral feeds >30 cans per month.
Electro-Convulsive Therapy	√		√	
Emergency Room Services	√			Life threatening emergencies only.
EPSDT	√			
Family Planning Services	√			Self referral to qualified provider. All pregnancy prevention supplies covered without a PA.
Hearing Aids and Hearing Evaluations	√		√*	* Hearing aid requires PA Requires written PA including copy of hearing test and medical clearances. See Hearing Aid section.
Home Health Services	√		√	
Home Maker		√		
Hospice	√		√	
Hospitalizations				



## Ohio Medicaid Benefits

Service/Procedure	Covered	Not Covered	Prior Auth Required	Comments
- Inpatient	√		√	All inpatient admissions require authorization and will be followed concurrently by Medical Management. - MH admissions to *Freestanding Psych hospitals (Institution of Mental Disease=IMD)--CareSource is responsible for reimbursement of professional fees only for members admitted to these facilities. The confinement charges are billed to the state. * Belmont Pines * Ohio Hospital for Children & Adolescents * Windsor/Laurelwood
- Observation	√		√ nonpar only	Auth required if facility and/or physicians are non-par
- Outpatient	√		√ nonpar only	
Hyperbaric Oxygen Services	√			Billed as respiratory therapy
Immunizations	√			Immunizations for travel outside of the United States are not covered.
Infertility		√		CareSource is not required to pay for infertility treatments according to provider agreement with ODJFS.
Injections (J-codes through Speciality Pharmacy department)	√			PA required if injections provided through home care services; if performed in par MD office then no PA required.
Investigational Drugs, Devices, Services		√		CareSource is not required to pay according to provider agreement with the ODJFS.
Labs (Independent), Other Lab & X-Ray Providers	√			
Lamaze Classes	√			
Long Term Care Nursing Home	√		√	
Mammogram	√			1 screening mammogram covered for over age 34 and under age 40. 1 Screening mammogram covered per calendar year for over the age of 39. Mammogram covered for diagnosis and treatment for clinical symptoms indicative of breast cancer regardless of age.
Mental Health	√			See Psychological Services.
MRI/Open MRI	√			MRI studies require prior authorization through our Radiology Benefit Management Program-NIA. Effective for services performed on or after July 1, 2009, ordering physicians must obtain a Prior Authorization for the following non-emergent, outpatient diagnostic imaging procedures: MRI/MRA scans, CT/CTA scans and PET scans. Note: Imaging procedures performed during an inpatient admission, hospital observation stay, or emergency room visit are not included in this program. Ordering physicians: Are responsible for obtaining Prior Authorization before scheduling an imaging exam for the non-emergent, outpatient diagnostic procedures listed above. It is essential that you ensure that the appropriate authorization number(s) has been obtained. Payment will be denied for procedures performed without a required Prior Authorization, and the member cannot be balance-billed for such procedures. It is the responsibility of the rendering facility to confirm that Prior Authorization was obtained prior to performing the diagnostic procedure.
Nurse Midwife	√			
Nutritional Dietary Consults	√			Covered for diabetes, pregnancy, complications of obesity surgery or other approved diagnoses. Office visits/consultations at PAR provider would not require PA. Treatment or any procedures that result from consultation would require PA. Coverage is provided for 1 nutritional counseling visit per year for diagnosis of obesity.
Nutritional Supplements	√		√	Up to 30 cans/month or 1 can/day may be provided by a PAR pharmacy or DME without prior authorization if billed to the PBM or participating DME and is <\$750 billed. >30 cans/mo does require PA through Pharmacy or DME provider.



## Ohio Medicaid Benefits

Service/Procedure	Covered	Not Covered	Prior Auth Required	Comments
Obesity Health Services	√ Coverage may be provided for surgery if determined to be medically necessary	√ Not routinely covered		Covered: Nutritional counseling, complications of obesity surgery. Exclusions: Diet pills, liquid diets. See Nutritional Dietary consults above.
Occupational Therapy	√		√ All Occupational Therapy done in the home requires prior authorization.	Outpatient therapy is limited to 30 visits per calendar year. The year starts counting from the first day of treatment.
Orthotics/ Prosthetics	√		√	PA required if >\$750 or miscellaneous codes
Out of Area Urgent & Emergency Care	√			Urgent Cares and ER visits do not require PA. Physician office visits require PA.
Pain Management Services	√		√* Inpatient admissions for pain control require prior authorization.	Hospital pain clinic covered. Comprehensive pain programs not covered.
Pap Smears	√			
Partial Hospitalizations-(PHP) Psychiatric Outpatient Programs (IOP) Psychiatric Intensive	√		√	General Hospital-Based on medical necessity review with Medical Director. Use contracted facility where available. Freestanding Psych facility (Institution for Mental Disease=IMD) or CMHC-Partial Hospital Programs in these treatment centers are available to our members. CareSource is not responsible for reimbursement for services provided @ these centers. These services are billed directly to the state.
Paternity Testing		√		
Penile implants	√		√	
Pharmaceutical Services	√		√* Some	See Pharmaceutical section of Provider Manual
Physical Therapy	√		√* All Physical therapy done in the home requires prior authorization	Outpatient therapy is limited to 30 visits per calendar year. The year is counted from the first day of treatment.
Physical Exams	√			Well child and adult physicals allowed 6 per calendar year; all ages.
Physician Assistants	√*			* Under supervision of physician  Services/procedures provided by a physician assistant under the supervision and direction of his/her supervising physician(s) are covered if the services are listed as standard functions for a physician assistant approved by the state medical board.
Podiatry	√			No coverage for treatment of flat feet. 48 visits/yr for acute conditions, 12 visits/yr for chronic conditions. See Podiatry section for further benefit details of the Provider Manual.
Prenatal Services	√			Self-referred. Lamaze classes covered - no PA required.
Psychiatric Residential Treatment Centers		√		Funded through County, requires county involvement



## Ohio Medicaid Benefits

Service/Procedure	Covered	Not Covered	Prior Auth Required	Comments
Psychological/ Psychiatry Services	√		√ Inpatient, partial hospitalization and OP visit exceeding benefit limit of 25 visits/year. NonPar Psychiatrist visit	Self referred to community mental health centers and psychologists. Inclusive of LISW and LPCC. PCP referral required for psychiatrist. Inpatient and partial hospitalizations require PA. PAR psychiatrist-no PA and no visit limit. Limit of 25 psychology (OP therapy) visits per year (beginning with a member's first visits date). <b>• Inpatient mental health hospitalizations in a general hospital continue to require prior authorization.</b> <b>• Inpatient mental health hospitalizations in a Freestanding Psychiatric Hospital (Institution of Mental Disease) do not require prior authorization.</b> <i>*Please note that this benefit is limited to member's 21 years of age and under and/or 65 years of age and over. If the member is between 22 and 64 years of age, services are non-covered Medicaid services and the physician fees are not the responsibility of the CareSource.</i>
Rehab Services				
- Inpatient	√		√	Covered for physical rehab-not alcohol/drug addiction rehab
- Outpatient	√			See PT/OT/ST outpatient benefit limits.
Second Opinions	√			
Skilled Nursing Facility (SNF)	√		√	
Sleep Study	√			
Speech and Hearing Therapies	√		√ All speech therapy performed in the home requires prior authorization.	Outpatient Speech therapies are limited to 48 per calendar year. Hearing evaluation limited to one per calendar year.
Sterilization	√			Consent is signed at least 30 days and no more than 180 days prior to the procedure. Consent form JFS 03198. 1. Must be 21 years of age or older. 2. Must be legally capable of consent. 3. Does not require PA. 4. Must sign ODHS sterilization consent form at least 30 days prior to procedure. 5. Sterilization reversals not covered.
Transplants	√		√	
Transportation	√			Ambulance/Ambulette services are authorized by Med Management. See Ambulance, Ambulette, Air Transportation rules. Cab transportation authorized by Service Center. 30 one-way trips per member, per 12 months to all health care visits, redetermination and WIC appointments. If traveling more than 50 miles one way, prior auth required. Provide-A-Ride will request authorization from CareSource.
Ultrasound	√			
Vision	√		√	Benefit Limit: Age 21 and older but younger than age 60 is limited to 1 comprehensive vision exam per calendar year and 1 complete frame and 1 pair of lens every 2 years; Age 20 and younger or age 60 and older is limited to 1 comprehensive vision exam per calendar year and 1 complete frame and 1 pair of lens every year. Contact lens and miscellaneous codes require PA. As of 3/1/09 the PA requirement for polycarbonate lens >18 years of age has been removed.



## Medicare Advantage Benefits

Service/Procedure	Covered	Not Covered	Medical Necessity Review Required	CoPay and Deductibles/Comments
Abortions (limited indications apply)	√		√	Only covered if mother's life is threatened or in case of reported rape or incest.
Acupuncture		√		
Alcohol and substance abuse treatment at ODADAS-certified agencies, outpatient	√			<b>20% of the cost of Medicare-covered individual or group visits</b>
Alcohol and substance abuse treatment, inpatient	√		√	<b>For each 90 day benefit period \$0 or Days 1-60: \$1,100 deductible, Days 61-90: \$275 co-pay per day, Days 91-150: \$550 per lifetime reserve day.</b>
Allergy care	√			
Ambulance for emergency transport	√			<b>20% of the cost for Medicare covered ambulance benefits</b>
All other ambulance services (Non Emergency)	√		√	
Autopsy		√		
Birth Control		√		
Biofeedback		√		
Bone mass measurement	√			<b>20% of the cost for Medicare-covered bone mass measurement. 1/24 months covered.</b>
C-section (elective primary or repeat)	√			Notification of birth required
Cardiac Rehabilitation	√			<b>20% co pay</b> Phase I and II covered
Cardiovascular Disease Testing	√			<b>\$0 co pay.</b> Blood tests for the detection of cardiovascular disease( or abnormalities associated with an elevated risk of cardiovascular disease) are covered every 5 years.
Care for disabilities associated with military service when member received care in a VA hospital or other facility		√		
Certified Nurse Midwife (CNM) services	√			
Certified Nurse Practitioner (CNP) services	√			
Chemotherapy	√			
Chiropractic services for manual manipulation of the spine to correct subluxation.	√		√ >12	<b>20% of the cost for Medicare covered visits.</b> Only chiropractic services for manual manipulation of the spine to correct subluxation are covered. <b>PA required for &gt;12 Medicare covered chiropractic visits per calendar year.</b>
Chiropractic care, beyond for services other than manual manipulation of the spine to correct subluxation.		√		
Colorectal screening exams	√			<b>20% of the cost for Medicare-covered colorectal screenings.</b>
Cosmetic procedures		√		Only if medically necessary with prior authorization
Custodial care and services for basic needs such as bathing or feeding at home or another location		√		
Dental routine care - <b>Ohio Only</b>		√		<b>Preventative Dental Services not covered.</b>
Dental care, beyond routine care - <b>Ohio Only</b>	√			<b>20% of the cost for Medicare covered dental benefits.</b> Dental services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease or services that would be covered when provided by a doctor.
Diabetes self-monitoring training, nutrition therapy, and supplies	√			<b>20% of the costs for self management training, nutritional therapy and diabetes supplies. Up to 10 hours of self management training is covered. Up to 3 hours of nutrition classes may be covered.</b>
Diagnostic tests, x-rays, and lab services	√		√ >\$100 for miscellaneous and unlisted	<b>0% of the cost for Medicare covered lab services. *20% of the cost for Medicare-covered diagnostic procedures and tests *20% of the cost for Medicare-covered x-rays. * 20% of the cost for Medicare-covered diagnostic radiology services. * 20% of the cost for Medicare-covered therapeutic radiology services. Miscellaneous/Unlisted codes &gt;\$100 needs prior authorization</b>
Diet pills, liquid diets, lab tests associated with liquid diets, and weight loss programs		√		



## Medicare Advantage Benefits

Service/Procedure	Covered	Not Covered	Medical Necessity Review Required	CoPay and Deductibles/Comments
Durable medical equipment	√		√	<b>20% of the cost of Medicare covered items.</b> Prior authorization is required for Durable Medical Equipment if the cost is greater than \$750.00 billed charges. Prior authorization is required for all Durable Medical Equipment if these services are provided by a non-plan provider.
Health Education	√			<b>\$0 copay for Asthma Education(3/yr) -</b>
ESRD/Dialysis	√ Dialysis			<b>20% of the cost for in and out of network dialysis - 20% of the cost of nutrition for renal disease - this applies to existing members. Our plan does not accept new members with ESRD</b>
Emergency medical response system	√		√	Authorization rules apply. <b>\$0 co pay for the Emergency Response System.</b> Member must be enrolled in Case Management. Prior Authorization required.
Emergency room services	√			<b>\$50 co pay for Medicare covered emergency room visits.</b>
Eye exams, routine		√		
Eyeglasses	√			See vision services
Health/Wellness education	√			This plan covers health/wellness education benefits including: <ul style="list-style-type: none"> <li>• written health education materials, including newsletters</li> <li>• nutritional training</li> <li>• nutritional benefit</li> <li>• smoking cessation</li> <li>• nurse advice line</li> </ul>
Hearing aids and Hearing Services	√			<b>\$500 every 2 years benefit allowed for routine hearing aids, batteries and maintenance of hearing aids. \$0 copay for up to 1 hearing aid every 2 years. 20% of the cost for Medicare-covered diagnostic hearing exams.</b>
Home health services	√		√	<b>0% of the cost for each Medicare covered visit</b>
Hospice care	√			Hospice services are paid by Medicare. Must get care from a Medicare certified hospice. Please call our Provider Services to obtain a list of Medicare Certified hospice provider.
Hospitalization - Inpatient	√		√	<b>For each 90 day benefit period \$0 or: Days 1-60: \$1,100 deductible' Days 61-90 \$275 co-pay per day Days 91-150 \$550 per lifetime reserve day. Including substance abuse, detox and medical rehabilitation.</b>
Hospitalization - Outpatient	√			<b>20% Co-pay for Medicare covered services</b>
Hospitalizations, for observation	√			<b>20% Co-pay for Medicare covered services</b>
Hospital transfers, non-emergent	√		√	
Immunizations	√			<b>\$0 co pay for flu and pneumonia vaccines. No referral needed for flu and pneumonia vaccines; 20% of the cost for Hepatitis B vaccine</b>
Infertility services, artificial insemination and in-vitro fertilization		√		
Influenza vaccine	√			
Injections	√		√	Some injectable drugs require prior authorization Please call a CareSource pharmacy coordinator at 1-800-488-0134 with requests.
Inpatient rehab services, medical	√		√	<b>For each 90 day benefit period \$0 or: Days 1-60: \$1,100 deductible, Days 61-90 \$275 co-pay per day, Days 91-150 \$550 per lifetime reserve day.</b>
Inpatient rehab services for alcohol and chemical dependency		√		Inpatient detoxification services are covered
Investigational drugs, devices and services		√		



## Medicare Advantage Benefits

Service/Procedure	Covered	Not Covered	Medical Necessity Review Required	CoPay and Deductibles/Comments
Lab work	√			Requires a physician's order. Miscellaneous/Unlisted codes >\$100 needs prior authorization
Mammograms, diagnostic	√			<b>Women age 40 and older - 20% of the cost for Medicare covered screening mammograms</b>
Mammograms, screening	√			<b>\$0 co pay 20% of the cost for Medicare covered screening mammograms</b> Benefit limit – 1 per lifetime for ages 0-39; 1 per year for ages 39 and older
Mental Health - Inpatient - <b>Ohio Only</b>	√		√	<b>For each 90 day benefit period \$0 or: Days 1-60: \$1,100 deductible, Days 61-90 \$275 co-pay per day, Days 91-150 \$550 per lifetime reserve of 60 days. Max of 190 days per lifetime in a psychiatric unit of a general hospital.</b>
Mental Health - Outpatient - <b>Ohio Only</b>	√		√ >20 outpt	<b>45% of the cost for each Medicare covered individual or group therapy visit. &gt;20 outpatient visits needs prior authorization.</b>
Mental Health - Michigan (Inpatient/Outpatient)				Refer Michigan members to CompCare at 1-800-435-5348 for mental health services and benefits.
Non Participating Provider services	√		√	All services rendered by non participating providers require prior authorization.
Nutritional therapy	√			<b>20% of the cost for medical nutritional therapy for members with diabetes and renal disease ( not on dialysis) and after a transplant. 1st yr - 3hrs of 1:1 training. 2hrs for subsequent yrs</b>
Nutritional supplements	√			CareSource pays for no more than one month's supply of enteral nutrients at any one time
Obesity health services		√		
Occupational therapy,	√		√ Homecare & >20 outpt	<b>20% of the cost of Medicare covered outpatient occupational therapy. OT in the home setting requires PA &gt;20 outpatient visits needs prior authorization.</b>
Office visits, PCPs	√			<b>0% copay for office visits for Medicare covered benefits</b>
Office visits, specialists	√			<b>20% of the cost for each specialist visit for Medicare covered benefits</b>
Organ transplants	√		√	
Outpatient Surgery	√		√	<b>20% of the cost for each Medicare covered ambulatory surgical center visit. 20% of the cost for each Medicare covered outpatient hospital facility visit.</b> Prior authorization is required for outpatient cosmetic procedures and for all services rendered by non participating providers.
Out-of-plan provider services or procedures	√		√	All services rendered by non participating providers require prior authorization.
Out-of-area urgent and emergency care	√			
Pap Smears and Pelvic Exams	√			<b>0% of the cost for Medicare covered pap smears. 20% of the cost for Medicare covered pelvic exams. For all woman, Pap tests, pelvic exams and clinical breast exams are covered once every 24 months</b>
Paternity testing		√		
Pharmaceuticals covered under our pharmacy benefit program	√			Copays may apply. PA step therapy or quantity limits may apply. Exceptions to quantity limits may be granted with medical necessity as prescribed by the provider.
Pharmaceuticals not covered under our pharmacy benefit program	√		√	
Physical therapy	√		√ Homecare & >20 outpt	<b>20% of the cost for Medicare covered outpatient physical therapy. PT in the home setting requires PA &gt;20 outpatient visits needs prior authorization.</b>
Physical exams	√			<b>20% of the cost for Medicare covered service. 1 per calendar year</b>
Podiatric services	√		√ >8	<b>20% of the cost for each Medicare covered visit. PA required for &gt;8 Medicare covered podiatry office visits per calendar year.</b>
Prenatal exams	√			<b>Unlimited</b>



## Medicare Advantage Benefits

Service/Procedure	Covered	Not Covered	Medical Necessity Review Required	CoPay and Deductibles/Comments
Prostate Cancer Screening Exams	√			<b>20% of the cost for Medicare covered prostate cancer screening.</b> For men age 50 and older, digital rectal exam and PSA are covered once every 12 months.
Prosthetic devices	√		√	<b>20% of the cost for Medicare covered items.</b> Prior authorization is required for prosthetic devices with a cost of greater than \$750 billed charges.
Reversal of voluntary sterilization		√		
Second opinion from a participating provider	√			Prior authorization is required for second opinions from an out-of-plan provider.
Services for conditions covered by Worker's Compensation or for which care or reimbursement is available from a government agency		√		
Services determined not medically appropriate by CareSource		√		Decisions can be appealed. See Appeal Procedures section.
Services associated with surrogate parenting		√		
Sex change operations		√		
Skilled nursing facility admissions	√		√	<b>\$0 or Days 1-20: \$0 per day / Days 21-100: \$137.50 per day. 100 days covered per benefit period. 3 day admission requirement is waived (not required)</b>
Smoking Cessation	√			<b>8 sessions per 12 month period covered</b>
Speech therapy and hearing testing	√		√ Homecare & >15 outpt	<b>20% of the cost for Medicare covered outpatient speech therapy. ST in the home setting requires PA. &gt;15 outpatient visits need prior authorization.</b>
Substance Abuse - Outpatient	√		√ >12	<b>20% of the cost of Medicare covered individual or group visits. &gt;12 outpatient visits require prior authorization.</b>
Substance Abuse - Inpatient	√		√	<b>For each 90 day benefit period \$0 or: Days 1-60: \$1,100 deductible' Days 61-90 \$275 co-pay per day' Days 91-150 \$550 per lifetime reserve day. Including substance abuse, detox and medical rehabilitation.</b>
Telephone, TV, barber, beauty and similar incidental services, inpatient		√		
Transportation	√			<b>\$0 copay for up to 30 round trip(s) to plan-approved locations every year.</b> Prior authorization is required for services beyond 30 round trips per year through the Case Management Department.
Ultrasounds, for pregnancy	√			
Ultrasounds, other	√			
Urgent care visits	√			<b>20% of the cost for Medicare covered urgent need care visits.</b>
Voluntary sterilization of persons (both male and female) over 21 and legally capable of consent	√			
Vision Services	√			<b>\$0 copay and \$100 limit every 2 years for: 1 pair of eyeglasses or contact lenses after cataract surgery; up to 1 pair of glasses every 2 years; up to 1 pair of lenses every 2 years; up 1 frame every 2 years 20% of the cost of exams to diagnose and treat disease and conditions of the eye. ***Routine eye exam are not covered.</b>
Visitor/Travel program	√			When you travel outside of CareSource Advantage's service area, special conditions apply. <b>CareSource Advantage's visitor/travel program includes a full range of medical services covered at up to \$5,000 per year. ***Limited to care within the United States.</b>



## Children's Buy In Program

Service/Procedure	Covered	Not Covered	Prior Auth Required	Comments	Member Language	Provider Language
Abortions	√		√	Must have signed JFS 03197 Abortion form prior to authorization of services. Very Limited coverage	subject to deductible and/or copays and coinsurance	subject to deductible and/or copays and coinsurance
Acupuncture		√		Inform caller that this is a non covered benefit.		
Alcohol & Substance Abuse (Detox)	√		√	Usual coverage is for 3 days – Behavioral Health Med Mgmt may extend stay.		
Alcohol & Substance Abuse (Rehabilitation)		√		Self refer to ODADAS certified program. Use county ADAMHS services. CareSource will not authorize.		
Allergy Care	√			May need standing referral.		
Ambulance Services for Emergency Care	√			Covered for emergency care		
Ambulatory Surgery Centers	√					
Anesthesia	√					
Assistant Surgeons	√			Physician Assistants - not covered, all other assistants paid at 25%.		
Autopsy		√		Advise caller that this is not a covered benefit. Per provider agreement with the state, MCP is not required to pay for this service.		
Biofeedback		√		Advise caller that this is not a covered benefit. Per provider agreement with the state, MCP is not required to pay for this service.		
Cardiac Rehab	√					
Chemotherapy	√		√ Inpatient only	Inpatient requires prior authorization. See chemotherapy section of OAC ruling for complete ruling		
Chiropractic		√		Advise caller that this is not a covered <b>CBI</b> benefit		
Contact Lens		√		Advise caller that this is not a covered <b>CBI</b> benefit		
Cosmetic Surgery (Plastic Surgery)	√		√ limited	Covered for medical necessity. Requires PA from Medical Director. See cosmetic surgery criteria.		
County/City/Health Dept Immunization STD Clinic	√			Self referred. Specialty immunizations (like for travel) would be referred here. These clinics do not bill CareSource.		
Depro Provera Injections	√			covered in a physician office setting		
Dental		√		Advise caller that this is not a covered <b>CBI</b> benefit		
Diagnostic Testing	√					
Dialysis, Renal	√					
Diapers** Incontinent Supplies	√			Covered for members > 3 yrs of age up to 300 per month.		
Diet pills and Liquid diets		√				
Durable Medical Equipment	√		√	PA required for rental items that have a purchase price of \$750 or more, all customized/ powered wheelchairs, manual wheelchairs rental >3 months, hearing aids & all miscellaneous codes and enteral feeds >30 cans per month.		
Electro-Convulsive Therapy	√		√			
Emergency Room Services	√			Life threatening emergencies only.		
Enuresis Alarms	√		√	Requires PA. Candidates are children over 5 years of age.		
EPSDT	√					
Family Planning Services	√			Self referral to qualified provider. All pregnancy prevention supplies covered without a PA.		
Hearing Aids and Hearing Evaluations	√		√*	* Hearing aid requires PA  Requires written PA including copy of hearing test and medical clearances. See Hearing Aid section.		



## Children's Buy In Program

Home Health Services	√		√	Skilled Services Only. Custodial or non skilled care is not a CBI covered benefit.		
Home Maker		√		Advise caller that this is not a covered benefit		
Hospice	√		√			
Hospitalizations						
- Inpatient	√		√	All inpatient admissions require authorization and will be followed concurrently by Medical Management.		
- Observation	√		√ nonpar only	Auth required if facility and/or physicians are non-par		
- Outpatient	√		√ nonpar only			
Hyperbaric Oxygen Services	√		√	Billed as respiratory therapy		
Immunizations	√			Immunizations for travel outside of the United States are not covered.		
Infertility		√		Advise caller that this is not a covered benefit. CareSource is not required to pay for infertility treatments according to provider agreement with ODJFS.		
Injections (J-codes through Speciality Pharmacy department)	√			PA required if injections provided through home care services; if performed in par MD office then no PA required.		
Investigational Drugs, Devices, Services		√		Inform caller that this is not a covered benefit. CareSource is not required to pay according to provider agreement with the ODJFS.		
Labs (Independent), Other Lab & X-Ray Providers	√					
Lamaze Classes	√					
Long Term Care Nursing Home		√		Advise caller that this is not a covered benefit		
Mammogram	√			Mammogram covered for diagnosis and treatment for clinical symptoms indicative of breast cancer regardless of age.		
Mental Health				See Psychological Services.		
MRI/Open MRI	√					
Nurse Midwife	√					
Nutritional Dietary Consults	√			Covered for diabetes, pregnancy, complications of obesity surgery or other approved diagnoses. Office visits/consultations at PAR provider would not require PA. Treatment or any procedures that result from consultation may require PA. Coverage is provided for 1 nutritional counseling visit per year for diagnosis of obesity.		
Nutritional Supplements	√		√	Up to 30 cans/month or 1 can/day may be provided by a PAR pharmacy or DME without prior authorization if billed to PBM or participating DME and is <\$750 billed. >30 cans/mo does requires PA through Pharmacy or DME provider.		
Obesity Health Services		√ Not routinely covered		Not covered unless deemed medically necessary		
Occupational Therapy	√		√ All Occupational Therapy done in the home requires prior authorization.	Outpatient therapy is limited to 20 visits per year. Greater than 20 visits per year are not a covered benefit. The year is counted from the first day of treatment.		
Orthotics/ Prosthetics	√		√	PA required if >\$750		
Out of Area Urgent & Emergency Care	√			Urgent Care and ER visits do not require PA. Physician office visits require PA.		



## Children's Buy In Program

Pain Management Services	√		√* Inpatient admissions for pain control require prior authorization.	Hospital pain clinic covered. Comprehensive pain programs not covered.		
Pap Smears	√					
Partial Hospitalizations (Psychiatric)		√		Inform caller that this is not a covered CBI benefit.		
Paternity Testing		√				
Pharmaceutical Services	√		√* Some	See Pharmaceutical section of Provider Manual		
Physical Therapy	√		√* All Physical therapy done in the home requires prior authorization	Outpatient therapy is limited to 20 visits per year. Greater than 20 visits per year are not a covered benefit. The year is counted from the first day of treatment.		
Physician Assistants	√*			* Under supervision of physician  Services/procedures provided by a physician assistant under the supervision and direction of his/her supervising physician(s) are covered if the services are listed as standard functions for a physician assistant approved by the state medical board.		
Podiatry	√					
Prenatal Services				Self-referred. Lamaze classes covered - no PA required.		
Psychiatric Residential Treatment Centers		√		Covered under ODADAS.		
Psychological/ Psychiatry Services	√		√	Greater than 25 psychology visits per rolling year (beginning with a member's first visits date) require prior authorization. Self referred to community mental health centers and psychologists. Inclusive of LISW and LPCC. PCP referral required for psychiatrist. Inpatient hospitalizations require PA.		
Rehab Services						
- Inpatient	√		√	Covered for physical rehab-not alcohol/drug addiction rehab		
- Outpatient	√			See PT/OT/ST outpatient benefit limits.		
Second Opinions	√					
Sex Change Operations		√				
Skilled Nursing Facility (SNF)	√		√	Covered with prior auth as medically necessary.		
Sleep Study	√					
Speech and Hearing Therapies	√		√ All speech therapy performed in the home requires prior authorization.	Outpatient therapy is limited to 20 visits per year. Greater than 20 visits per year are not a covered benefit. The year is counted from the first day of treatment.		
Transplants	√		√			
Transportation		√		Inform caller that this is not a covered CBI benefit. Emergency Transportation (ambulance) only covered.		
Ultrasound	√					
Vision		√		Inform caller that this is not a covered CBI benefit		