2018

Waiver Health Partner Manual

CareSource®

CareSource®
Health Care with Heart

Dear CareSource Waiver Health Partner,

CareSource values our relationship with you. That's why we are always working to make it easier for you to deliver quality care to our members. Waiver provider provides Home and Community based services that allow for alternatives to facility based care settings (nursing facility or intermediate care center). These programs are called "waivers" and allow for our members to remain in the community with these services. The following outlines CareSource's waiver service coverage rules. The Waiver Handbook is part of an initiative to improve efficiency and consistency in member's care.

The CareSource Waiver Health Partner Manual is intended as a resource for you and a helpful link between you and CareSource. It provides important information on topics, such as covered waiver services, member benefits, claims submission, services that require prior authorization and how to obtain prior authorization. Our intention is to make it easier for you to do business with us.

As always, we are interested in your feedback. We will continue to update information periodically and as necessary.

Our secure online Waiver Provider Portal is FREE and available 24 hours a day. We are pleased to offer enhanced functionality on the Waiver Provider Portal which includes the most up-to-date information, Service Plan access, waiver claim submission, and claims information. You can access it by going to the CareSource Provider Portal at **https://providerportal.caresource.com/OH/**.

If you have inquiries about claims issues, covered services, patient eligibility or other member-related concerns, please check our website or contact CareSource Health Partner Services at **1-800-488-0134**, 8 a.m. to 6 p.m., Monday through Friday, Eastern Standard Time.

We know great health care begins with you. Together we can help attain better outcomes for our CareSource members.

Sincerely,

CareSource

Table of Contents

About CareSource

Welcome and thank you for participating as a health partner with CareSource. We strive to work with our health partners collaboratively to ensure that we make it easy to do business with us. This strong partnership helps facilitate a high quality of care and respectful experience for our members.

We are a non-profit, community-based health plan that serves consumers of:

- Ohio Medicaid, including families with low incomes, children, pregnant women, and people who are aged, blind or have disabilities. Ohio Medicaid also includes Healthy Start and Healthy Families.
- CareSource® MyCare Ohio, a managed care plan coordinating physical, behavioral, and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare.

Our goal is to create an integrated medical home for our members. We focus on prevention and partnering with local health partners to offer the services our members need to remain healthy.

As a managed health care organization, we improve the health of our members by utilizing a contracted network of high-quality participating health partners. Primary Care Physicians (PCPs) within the network provide a range of services to our members, and also coordinate patient care by referring them to specialists when needed, ensuring that members have timely access to health care services and receive all appropriate preventive services.

CareSource also distributes the member rights and responsibility statements to the following groups upon their enrollment and annually thereafter:

- New members
- Existing members
- New practitioners
- Existing practitioners

ABOUT US

CareSource was founded on the principles of quality and service delivered with compassion and a thorough understanding of caring for underserved consumers. As a non-profit, we are mission-driven to provide quality care to our members. We offer process efficiencies and value-added benefits for our members and participating health partners.

Vision and Mission

- Our Vision is transforming lives through innovative health and life services.
- Our Mission is to make a lasting difference in our members' lives by improving their health and well-being.
- At CareSource, our mission is one we take to heart. In fact, we call our mission our "heartbeat." It is the essence of our company, and our unwavering dedication is the hallmark of our success.

Our Services Include:

- Health partner services and support
- Member eligibility/enrollment information
- Claims processing
- Credentialing/Recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory
- Compliance
- Special investigations for fraud, waste and abuse
- Member services, including a member call center and a 24-hour nurse advice line

In addition to the above, our Care Management programs include the following:

- High-Risk Case Management
- Onsite Case Management (clinics and facilities)
- Emergency Department Diversion
  - High Emergency Department Utilization Focus (targeted at members with frequent utilization)
- CareSource24® (Nurse Advice Line)
- Health Care Home
- Maternal and Healthy Baby Program
  - Dedicated NICU Care Management Nurses
  - Outreach programs in partnership with community agencies to target members at greatest risk
- Care Transitions
  - Bridge to Home® (discharge planning and transitional care support)
- Disease Management program for asthma and diabetes management

For more information on these programs, see the "Member Support Services and Benefits" section.

MYCARE CARESOURCE SERVICE AREA

CareSource MyCare Ohio

- **Northeast Region:** Cuyahoga, Lake, Medina, Geauga, Lorain counties
- **Northeast Central Region:** Columbiana, Trumbull, Mahoning counties
- **East Central Region:** Portage, Summit, Stark, Wayne counties

CARESOURCE FOUNDATION

CareSource has a close connection to our members. We listen, we learn, and we are driven to action. As a result, the CareSource Foundation was launched in 2006 to add another component to our professional services: community response. Areas of focus are closely aligned with the greatest needs of our member demographic including children's health, special populations such as seniors and individuals with disabilities, the uninsured and life issues such as hunger, domestic violence and homelessness.

Since its inception, the Foundation has responded at significant levels and created strategic partnerships with hundreds of non-profit organizations and other charitable funders who were equally committed to better health for all communities. We are addressing tough issues together.

Over the last ten years, the CareSource Foundation has awarded grants totaling over $10 million to non-profit organizations throughout our service area.

CORPORATE COMPLIANCE

At CareSource, we serve a variety of audiences – members, health partners, government regulators, community partners and each other. We serve them best by working together with honesty, respect and integrity. Our Corporate Compliance Plan, along with state and federal regulations, outline the personal, professional, ethical and legal standards we must all follow.

Our Corporate Compliance Plan is an affirmation of CareSource's ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize CareSource's commitment to honest communication within the company and within the community.
- Develop and maintain a culture that promotes integrity and ethical behavior.
- Facilitate compliance with all applicable local, state and federal laws and regulations.

Implement a system for early detection and reporting of noncompliance with laws, regulations or CareSource policy.

This allows us to resolve problems promptly and minimize any negative impact on our members or business, such as financial losses, civil damages, penalties and criminal sanctions.

CareSource's Corporate Compliance Plan is a formal company policy that outlines how everyone who represents CareSource should conduct themselves. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as health partners, consultants and vendors.

HEALTH PARTNER EXPECTATIONS

- Act according to these standards
- Let us know about suspected violations or misconduct
- Let us know if you have questions
- Comply with federal, state, and local laws, this Manual and CareSource policies

For questions about health partner expectations, please call Provider Services at **1-800-488-0134**.

The CareSource Corporate Compliance Plan is posted on the CareSource website at **CareSource.com** for your reference.

Please let us know if you have questions regarding the CareSource Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

PERSONALLY IDENTIFIABLE INFORMATION

In the day-to-day business of patient treatment, payment and health care operations, CareSource and its health partners routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a health partner, you should be taking measures to secure your sensitive data, and you may be mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure Protected Health Information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

- Utilize a secure message tool or service to protect data sent by email.
- Limit paper copies containing PHI and PII.
- Secure any and all paper copies containing PHI and PII at all times; and properly shred when no longer required to maintain.
- Encrypt laptops and other portable media like CD-ROMs and USB flash drives.

- Take reasonable precautions to ensure conversations involving patient information cannot be overheard by others.
- Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource, is a covered entity under HIPAA. It is permissible for covered entities to share patient information without authorization when necessary for treatment, payment, or health care operations.

ACCREDITATION

CareSource is accredited by the National Committee for Quality Assurance (NCQA) for Ohio Medicaid. NCQA is a private, non-profit organization dedicated to improving healthcare quality through measurement, transparency and accountability. Accreditation status indicates that our service and clinical quality meet NCQA's rigorous requirements for consumer protection and quality improvement.

CareSource is accredited by URAC for the Health Call Center Accreditation standards. URAC, an independent, non-profit organization, is known as a leader in promoting health care quality through its accreditation and certification programs.

What is MyCare Ohio?

MyCare Ohio is the state of Ohio's Dual Demonstration. MyCare Ohio is a system of managed care plans selected to coordinate the physical, behavioral, and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare. This includes people with disabilities, older adults and individuals who receive behavioral health services.

The MyCare Ohio program connects Medicare and Medicaid Benefits for Medicare-Medicaid Enrollees. The goal of MyCare Ohio program is to comprehensively manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including long-term services and supports.

MyCare Ohio stresses a team approach to health care. The care team includes the individual, the individual's family and/or caregiver, the CareSource care manager, the waiver service coordinator (if appropriate) the primary care physician, specialists and other health partners as appropriate to support and coordinate the member's care. CareSource MyCare Ohio is serving people in these 12 Ohio counties:

Columbiana	Medina
Cuyahoga	Portage
Geauga	Stark
Lake	Summit
Lorain	Trumbull
Mahoning	Wayne

PURPOSE OF THIS CARESOURCE MYCARE OHIO SECTION

The information provided within this section of the Health Partner Manual is to address health partner issues specific to the CareSource MyCare Ohio plan. This information should be used in tandem with the health partner information provided elsewhere throughout this manual. Please refer to other areas of this manual for health partner information about traditional Medicaid.

Health partners of personal care, long-term support, home modifications, home care-givers and other similar services apart from physicians, physician assistants, hospitals and similar health care services will find this section particularly important for information about submitting claims for payment, appeals, certification, referrals and prior authorization for services.

OPTING OUT OF CARESOURCE MYCARE MEDICARE COVERAGE

MyCare Ohio allows for individuals to opt-out of Medicare coverage from the plan managing their MyCare benefits. Individuals will have the option to have CareSource provide their Medicare benefits or to opt out of the Medicare portion of the program, and stay with their current Medicare Advantage plan or traditional Medicare.

Health partners need to confirm the MyCare Ohio member's option for Medicare coverage. If a member chooses a different plan for their Medicare benefits, CareSource will only manage Medicaid benefits, and will only reimburse claims for Medicaid services. Claims for Medicare must be submitted to the plan managing their Medicare benefits.

Provider Services Department: 1-800-488-0134

QUICK REFERENCE INFORMATION

Note – the information below is available from the website as a printable **PDF file.**

Important Phone Numbers:

Provider Services:	1-800-488-0134	M-F 8am – 6pm
Prior Authorizations:	1-800-488-0134	M-F 8am – 5pm
Claims Inquiries:	1-800-488-0134	M-F 8am – 6pm
Member Services:	1-855-475-3163	M-F 8am – 8pm
CareSource 24, 24-Hour Nurse Advice Line:	1-866-206-7861	24/7/365
TTY for the Hearing Impaired:	1-800-750-0750 or 711	M-F 8am – 8pm

Important Fax Numbers:

Care Management Referral:	1-877-946-2273
Credentialing:	1-866-573-0018
Fraud, Waste and Abuse:	1-800-418-0248
Medical Prior Authorization Fax:	1-888-752-0012
Health Partner Appeals:	1-937-531-2398

IMPORTANT ADDRESSES

General Correspondence:
CareSource
P.O. Box 8738
Dayton, OH, 45401-8738

Medical Prior Authorizations:
CareSource
P.O. Box 1307
Dayton, OH 45401-1307

Health Partner Appeals:
CareSource
Attn: Health Partner Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Member Appeals & Grievances:
CareSource
Attn: Member Appeals
P.O. Box 1947
Dayton, OH 45401

Claims:
CareSource
P.O. Box 8730
Dayton, OH 45401

Fraud, Waste and Abuse:
CareSource
Attn: Special Investigations Department
P.O. Box 1940
Dayton, OH 45401-1940

Health Partner Demographic Changes:
CareSource
Attn: Health Partner Maintenance
P.O. Box 8738
Dayton, OH 45401-8738

Web Services:

Website: **CareSource.com**

Secure Provider Portal: **https://providerportal.caresource.com**

Claims Payment and EFT Enrollment

Pended claims require a manual intervention from our staff which does not require anything from the providers behalf. For questions about a claim that was submitted less than 45 days ago, please use the Claims Inquiry function on the Provider Portal. Claims pended for more than 60 days, please call Provider Services at **1-800-488-0134**. Formal claim appeals can be submitted within 365 days of DOS.

If a check is sent to you in error, please contact Provider Services at **1-800-488-0134**.

CareSource Payer ID = 31114

Benefits of Enrolling in EFT

Simple – Receive fully reconciled remittances electronically; eliminate paper checks and Explanation of Payments (EOPs), which will increase efficiency with payment processing.

Convenient – Available 24/7; works in conjunction with EMR systems. **Free** EFT training is also available to CareSource providers through InstaMed during the enrollment process.

Reliable – Claim payments electronically deposited into your bank account.

Secure – Access your account through CareSource's secure Provider Portal to view (and print if needed) remittances and transaction details.

Medical Providers: Simply complete the enrollment form and fax it back to InstaMed, who will work directly with providers to enroll in EFT. **Free** EFT training is also available to CareSource providers through InstaMed during the enrollment process. Accessible on any computer without any additional software.

Questions? Call InstaMed at 877-834-8462 or CareSource Provider Services at **1-800-488-0134**.

Health Partners: Home and Community-Based Services Waiver Programs

The Ohio Department of Aging (ODA) is responsible for the certification of health partners who provide services for Medicaid waiver programs administered through the Community Long-Term Care Division. In addition to holding a Medicaid Provider Agreement, providers of services must meet Ohio Administrative Code 173-39-02 Conditions of participation.

Health partner sanctions are specifically addressed in the Ohio Administrative Code 173-39-05, Disciplinary Actions.

OAC Waiver Rules
Health partners are obligated to abide by the Ohio regulations and CareSource policies. They must read and understand all Ohio Administrative Code (OAC) rules that pertain to their health partner type and the services they deliver. Specifically, OAC 5160-58-04 "MyCare Ohio HCBS Waiver Program Covered Services and Providers' states that:

- "Providers seeking to furnish services in the MyCare Ohio HCBS waiver program shall meet the requirements in Chapters 173-39 or 5160-45 of the Administrative Code, as appropriate, prior to furnishing services in the MyCare Ohio HCBS waiver."

The OAC limits covered services to those services listed in the following pages.

The following OAC chapters can be used as reference for health partners.

- State plan home health and private duty nursing services
- Waiver health partners and services

Reimbursement for Waiver Services are dependent upon compliance with the OAC, this Manual and CareSource Policies. Compliance activities include, but are not limited to, maintaining ODA provider certification, obtaining prior authorizations, meeting service plan requirements, obtaining and maintaining the required documentation and submission of accurate, complete and timely claims to CareSource.

In accordance with the Social Security Act, CareSource assists in conducting program integrity reviews. This may include the pre-payment or post-payment auditing of claims and payments. As a managed care plan who is contracted with federal and state government for the MyCare Ohio program, it is important for health partners to know that CareSource is bound by these obligations.

Helpful Hints for Appeals

- Include the member's name
- CareSource member ID number
- Provider's name and ID number
- Provide the billing code and reason why you feel this should be reconsidered
- If you are submitting a Timely Filing appeal, please send proof of the original submission receipt

Covered Waiver Services

NOTE – All Waiver Services require Prior Authorization

All Waiver services must go through the member's Waiver Care Manager and entered via a Service Plan. Please contact the member's assigned CareSource MyCare Ohio Care Manager for assistance.

Assisted Living Services
OAC 173-39-02.16

"Assisted living service" means a service that promotes aging in place by supporting a consumer's independence, choice, and privacy through the provision of one or more components of the service which are a personal care service, a supportive service, an on-duty response service, coordination of meals, social and recreational programming, a non-medical transportation service, and a nursing service.

- T2031U1 – Tier 1
- T2031U2 – Tier 2
- T2031U3 – Tier 3

Adult Day Services
OAC 173-39-02.1 or OAC 5160-46-04

"Adult day service" ("ADS") means a regularly-scheduled service delivered at an ADS center, which is a non-institutional, community-based setting. ADS includes recreational and educational programming to support a consumer's health and independence goals; at least one meal, but no more than two meals per day that meet the consumer's dietary requirements; and, sometimes, health status monitoring, skilled therapy services, and transportation to and from the ADS center.

Adult Day Service Levels:

Enhanced ADS: Enhanced ADS includes structured activity programming, health assessments, supervision of all ADLs, supervision of medication administration, hands-on assistance with ADL activities (except bathing) and hands-on assistance with medication administration, comprehensive therapeutic activities, intermittent monitoring of health status; and, hands-on assistance with personal hygiene activities (except bathing).

Intensive ADS: Intensive ADS includes all the components of enhanced ADS plus hands-on assistance with two or more ADLs; hands-on assistance with bathing; regular monitoring of, and intervention with, health status; skilled nursing services (e.g., dressing changes and other treatments) and rehabilitative nursing procedures; rehabilitative and restorative services, including physical therapy, speech therapy, and occupational therapy; and, social work services.

- Adult Day Care Services; Per 15 Minutes
  - Enhanced
    - S5100UA
    - S5100UB
  - Intensive
    - S5100U1

- Adult Day Care Services; Per Half Day
  - Half Day
    - S5101
  - Enhanced Half Day
    - S5101UA
    - S5101UB
  - Intensive Half Day
    - S5101U2

- Adult Day Care Services; Per Day
  - Full Day
    - S5102
  - Enhanced Day
    - S5102UA
    - S5102UB
  - Intensive Day
    - S5102U3

Adult Day Transportation
OAC 173-39-02.1(B)(2)(b)

In Ohio, a Medicaid waiver covers the cost of transportation for participants to and from Adult Day Services. The payment is separate from the reimbursement for the adult day services. There is a round trip and one way rate. There is no state–run transportation network that can be used for adult day providers to transport participants for adult day services. The Veterans Administration Medical Centers cover transportation to the Adult Day Center. The local Area Agencies on Aging do not pay for transportation needed for adult day services.

- Adult Day Services Transportation; Per Mile
  - A0080UA
  - A0080U2 (2nd Person)
  - A0090UB
  - A0090U2 (2nd Person)

- Adult Day Services Transportation; One Way
  - T2003UA
  - T2003UB
  - T2003U2 (2nd Person)
  - T2003U3 (2nd Person)

- Adult Day Services Transportation; Round Trip
  - T2025U5
  - T2025U2 (2nd Person)
  - T2025U4 (2nd Person)

Personal Care Aide Services
OAC 173-39-02.11 or OAC 5160-46-04

Personal care is a service designed to enable a consumer to achieve optimal functioning with activities of daily living (ADL) and instrumental activities of daily living (IADL), and includes personal care services and homemaking tasks appropriate to a consumer's needs. Personal care services must be provided in the consumer's place of residence.

Personal care activities may include, but are not limited to:

1. Assisting the consumer with managing the household, handling personal affairs, and providing assistance with self-administration of medications, as defined in rule 173-39-01 of the Administrative Code;
2. Assisting the consumer with eating, bathing, dressing, personal hygiene, grooming, and other activities of daily living and instrumental activities of daily living described in rule 5101:3-3-08 of the Administrative Code;
3. The preparation of the consumer's meals;
4. Housekeeping chores, as defined in rule 173-39-02.8 of the Administrative Code, when they are specified in the consumer's service plan and are incidental to the services furnished, or are essential to the health and welfare of the individual, rather than the individual's family; and,
5. The provision of respite services to the consumer's caregiver.

- Personal Care Provided by Agency and Non-Agency
  - T1019 – First Visit of Personal Care Service
  - T1019U2 – Second Visit of Personal Care Service Provided on Same Day as First Visit
  - T1019U3 – Three or More Visits of Personal Care Service Provided on Same Day as First Visit
  - T1019U4 – Single Visit More Than 12 Hours; No More Than 16 Hours in Length of Personal Care Services Provided
  - T1019HQ – Personal Care Service Delivered in a Group Setting (Reimbursement as a Group Rate Shall be the Lesser of the Provider's Billed Charge or Seventy-Five Percent of the Medicaid Maximum)

Homemaker/Personal Care
OAC 173-39-02.8

"Homemaker/personal care" means the coordinated provision of a variety of services, supports, and supervision necessary for the health and welfare of an individual which enables the individual to live in the community. These are tasks directed at increasing the independence of the individual within his or her home or community. The service includes tasks directed at the individual's immediate environment that are necessitated by his or her physical or mental (including emotional

and/or behavioral) condition and are of a supportive or maintenance type. Homemaker/personal care helps the individual meet daily living needs, and without the service, alone or in combination with other waiver services, the individual would require institutionalization.

The homemaker/personal care provider performs tasks such as assisting the individual with activities of daily living, personal hygiene, dressing, feeding, transfer, ambulatory needs, or skills development. Skills development is intervention that focuses on both preventing the loss of skills and enhancing skills that are already present that will lead to greater independence within the residence or the community. The provider may also perform homemaking tasks for the individual. These tasks may include cooking, cleaning, laundry, money management, and shopping, among others. Homemaking and personal tasks are combined into a single service titled homemaker/ personal care because, in actual practice, a provider performs both services and does so as part of the natural flow of the day.

Examples of supports that may be provided as a component of homemaker/personal care include:

1. Basic personal care and grooming, including bathing, care of the hair, and assistance with clothing;
2. Assistance with bladder and/or bowel requirements or problems, including helping the individual to and from the bathroom or assisting the individual with bedpan routines;
3. Assisting the individual with self-medication or provision of medication administration for prescribed medications and assisting the individual with, or performing, health care activities;
4. Performing household services essential to the individual's health and comfort in the home (e.g., necessary changing of bed linens or rearranging of furniture to enable the individual to move about more easily in his or her home);
5. Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare;
6. Light cleaning tasks in areas of the home used by the individual;
7. Preparation of a shopping list appropriate to the individual's dietary needs and financial circumstances, performance of grocery shopping activities as necessary, and preparation of meals;
8. Personal laundry; and
9. Incidental neighborhood errands as necessary, including accompanying the individual to medical and other appropriate appointments and accompanying individual for walks outside the home.

- S5130UA – Per 15 Minute

Chore Services
OAC 173-39-02.5

"Chore service" means a service that improves, restores, or maintains a clean, sanitary, and safe living environment through the performance of tasks in the consumer's home that are beyond the consumer's capability, and the removal of hazards posing a threat to the consumer's health and welfare. Examples of a chore service are:

1. Heavy household cleaning: washing walls and ceilings; washing the outside of windows,

washing the inside of windows that are difficult to reach; removing, cleaning, and re-hanging curtains or drapery; and, shampooing carpets or furniture.
2. Simple household maintenance: repairing a water faucet; unclogging a drain; lighting and relighting a pilot light; and, replacing a furnace filter.
3. Disposal of garbage or recyclable materials; and,
4. Seasonal maintenance: cleaning gutters and downspouts; removing snow or ice; trimming shrubs, cutting grass, and removing leaves; and installing existing storm windows.

- S5121UA – Per Job

Pest Control
OAC 173-39-02.3
"Pest control" means a service that improves, restores, or maintains a clean, sanitary, and safe living environment through the performance of tasks in the home that are beyond the consumer's capability and the removal of pests posing a threat to the consumer's health and welfare.

- S5121UB – Per Job

Supplemental Adaptive & Assistive Devices
OAC 5123:2-9-57

"Supplemental adaptive and assistive devices" means medical equipment, supplies, and devices and vehicle modifications to a vehicle owned by the individual, the individual's family member, or someone who resides in the same household as the individual, that are not otherwise available through any other funding source and that enable an individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. Supplemental adaptive and assistive devices shall not include:
1. Items considered by the federal food and drug administration to be experimental or investigational;
2. Funding of down payments toward the purchase or lease of equipment or devices;
3. Equipment, supplies, or services furnished in excess of what is approved pursuant to, and as specified in, the individual service plan;
4. New equipment or supplies or repair of previously-approved equipment or supplies that have been damaged as the result of confirmed misuse, abuse, or negligence.

- Supplemental Adaptive & Assistive Devices
  – T2029 – Maximum Allowable Per Calendar Year
- Equipment Repair
  – T2029UB – Maximum Allowable Per Item
- Ambulatory
  – T2029U1 – Maximum Allowable Per Item
- Non-Ambulatory
  – T2029U4 – Maximum Allowable Per Item
- Hygiene & Dispense – Maximum Allowable Per Item
  – T2029U7
- Nutritional Supplements – Maximum Allowable Per Item
  – T2029UC

Home Modifications & Environmental Accessibility Adaptations
OAC 173-39-02.9 or OAC 5160-46-04

"Home-modification services" means environmental accessibility adaptations to structural elements of the interior or exterior of an individual's home as identified in the individual service plan that enable the individual to function with greater independence in the home and remain in the community. Home modification services shall not otherwise be available through any other funding source and shall enable the individual to function with greater independence, avoid institutionalization, and reduce the need for human assistance. Home modification services may include repair of previous home modifications excluding those necessitated as a result of confirmed misuse, abuse, or negligence. Home modification services shall not include:

1. Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the individual (e.g., carpeting, roof repair, and central air conditioning);
2. Adaptations that add to the total square footage of the home;
3. Services performed in excess of what is approved pursuant to, and specified in, the individual service plan;
4. The same type of home modification for the same individual during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the individual's medical and/or physical condition that requires the replacement; or
5. Additional modification or repair of previous home modifications necessitated as a result of confirmed misuse, abuse, or negligence.

- Home Modifications
  - S5165 – Maximum Allowable Per Calendar Year
- Environmental Accessibility Adaptations
  - S5165UA – Maximum Allowable Per Completed Work Order
  - S5165UB – Maximum Allowable Per Completed Work Order

Emergency Response Services (ERS)/Personal Emergency Response System (PERS)
OAC 173-39-02.6 and OAC 5160-46-04

"Emergency response service" ("ERS") means an emergency intervention service comprised of telecommunications equipment ("ERS equipment"), an emergency response center, and a medium for two-way, hands-free communication between the consumer and the emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment. ERS does not include:

1. Remote monitoring (e.g., granny cam, closed-circuit television); or,
2. Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment, regardless of whether the equipment is connected to ERS equipment.

- ERS System Installation & Testing
  - S5160 – Installation
  - S5160UA – Installation
  - S5160UB – Installation

- Monthly Rental
  - S5161 – Monthly Fee
  - S5161U1 – ERS Rental
  - S5161U2 – ERS Partial Month Rental
  - S5161U3 – ERS Second Pendant Rental
- Alternative Device
  - S5162 – ERS Device

Home Delivered Meals
OAC 173-39-02.14 and OAC 5160-46-04

"Home-delivered meal service" means the service that provides up to two meals per day to a consumer who has a need for a home-delivered meal based on a deficit in an ADL or IADL that a case manager identifies during the assessment process. The service includes the preparation, packaging, and delivery of safe and nutritious meals to the consumer at his or her home.

- Home Delivered Meal
  - S5170 – Per Meal
  - S5170UA – Per Meal
  - S5170UB – Per Meal

Therapeutic Diet
OAC 173-39-02.14

A provider shall only provide a home-delivered meal with a therapeutic diet to a consumer if:

1. A licensed physician has ordered the therapeutic diet because the consumer requires a daily amount of, or distribution of, one or more specific nutrients in order to treat the consumer's disease or clinical condition, or to eliminate, decrease, or increase certain substances in the consumer's diet;
2. The provider provides the therapeutic diet the physician ordered instead of a diet that complies with paragraphs (B)(1)(b)(i) and (B)(1)(b)(ii) of this rule;
3. (The provider only provides the therapeutic diet for up to ninety days after the date of the physician's order, unless the provider receives a subsequent order from the physician for any subsequent ninety-day period; and,
4. The provider retains a record of the physician's order, and subsequent orders, in the consumer's clinical record.

- Therapeutic Meal
  - S5170U2 – Per Meal
  - S5170U6 – Per Meal

Kosher Meals
OAC 173-39-02.19

If a case manager authorizes a home-delivered meal for a consumer under rule 173-39-02.14 of the Administrative Code, the consumer has the option to request a home-delivered kosher meal. The provider of a home-delivered kosher meal shall comply with rule 173-39-02.14 of the

Administrative Code as much as possible while complying with kosher practices for meal preparation and dietary restrictions.

The provider shall furnish evidence to ODA's designee that the home-delivered kosher meals that it furnishes are certified as kosher by a recognized kosher certification or a kosher establishment under orthodox rabbinic supervision.

- Kosher Meal
  – S5170U7 – Per Meal

Alternative Meal
OAC 173-39-02.2

"Alternative meal service" means a service that sustains a consumer's health by enabling the consumer to procure up to two meals per day from a non-traditional provider, such as a restaurant.

- Alternative Meal
  – S5170U3 – Per Meal

RN Assessment/Consultation

A "registered nurse (RN) assessment" is the Medicaid service performed by an RN. It may include a recommendation subject to orders written by the treating physician, but not a determination of the amount or duration of nursing services.

The RN Assessment is not required to be on the service plan and does not require a prior authorization. This can be billed thru the State Plan link on the Provider Portal.

An RN assessment service shall be performed on an individual participating in the Medicaid program prior to the individual receiving the following services for the first time, prior to any change being made to an individual's current package of the following services, and any time the RN is informed that the individual receiving the following services has experienced a significant change, including an improvement or a decline in condition:

1. State plan home health services as set forth in rule 5160-12-01 of the Administrative Code;
2. Private duty nursing services as set forth in rule 5160-12-02 of the Administrative Code;
3. Waiver nursing services as set forth in rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code;
4. Personal care aide services furnished by a Medicare-certified home health agency or an otherwise accredited agency as set forth in rules 5160-46-04, 5160-50-04, and 5123:2-9-56 of the Administrative Code; and/or
5. HOME choice nursing services as set forth in rule 5160-51-04 of the Administrative Code.

An RN performing an RN assessment service shall:

1. Possess a current, valid and unrestricted license with the Ohio board of nursing.
2. Only provide services within the RN's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted thereunder.
3. Be an active Medicaid provider or be employed by an entity that is an active Medicaid provider.

Be either:

1. Employed by a Medicare-certified home health agency when identifying an individual's need for state plan home health services as set forth in rule 5160-12-01 of the Administrative Code;
2. Employed by Medicare-certified home health agency or an otherwise accredited agency when identifying an individual's need for personal care aide services as set forth in rules 5160-46-04, 5160-50-04, and 5123:2-9-56 of the Administrative Code;
3. Employed by a Medicare-certified home health agency or an otherwise accredited agency, or be an non-agency RN when identifying an individual's need for private duty nursing services as set forth in rule 5160-12-02 of the Administrative Code;
4. Employed by a Medicare-certified home health agency or an otherwise accredited agency, or be a non-agency RN when identifying an individual's need for waiver nursing services as set forth in rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code; or
5. Employed by a Medicare-certified home health agency or an otherwise accredited agency, or be a non-agency RN when identifying an individual's need for HOME choice nursing services as set forth in rule 5160-51-04 of the Administrative Code.

The RN assessment service shall:

1. Provide the basis for the RN to make independent decisions and nursing diagnoses, plan nursing interventions and evaluate the need for other interventions, develop the plan of care and assess the need to communicate and, as applicable, consult with other team members as defined in rule 5160-45-01 of the Administrative Code.
2. (b) Include a face-to-face interview with, and observation of, the individual in his or her place of residence. Place of residence has the same meaning as defined in rule 5160-12-01 of the Administrative Code. During the interview, the RN shall assess the individual's verbal and nonverbal communication abilities, medical and social history, medications, living arrangements, supportive assistance equipment needs, and any other information available and relevant to the development of the individual's plan of care. At a minimum, the RN should capture the following information relative to the individual's health status:
3. The physical condition of the individual including vital signs, skin color and condition, motor and sensory nerve function, cognitive status, respiratory status, and the nutritional, rest, sleep, activity, elimination habits and consciousness of the individual; and
4. The social and emotional condition of the individual, including religious preference, if any, occupation, mood, emotional state, and family ties and responsibilities.

- RN Assessment
  – T1001 – Provided by an Agency and Non-Agency RN

RN Consultation

An "RN consultation" is a face-to-face or telephone contact between a directing RN and a licensed practical nurse (LPN), when an individual experiences a significant change that necessitates a change in the existing interventions the LPN must perform during a nursing service visit, and that will result in a change in the individual's plan of care. RN consultation does not replace routine direction and supervision provided by an RN to an LPN where evidence of significant change does not exist and/or does not necessitate a change in the LPN's intervention or the individual's plan of care.

An RN consultation service must be conducted between the directing RN and LPN either face-to-face or over the telephone.

- RN Consultation
  - T1001U9 – Provided by an Agency and Non-Agency

Waiver Nursing
OAC 173-39-02.22 or OAC 5160-46-04

"Waiver nursing services" are defined as nursing tasks and activities provided to Ohio home care waiver individuals who require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN.

All nurses providing waiver nursing services to Ohio home care waiver individuals shall:
1. Possess a current, valid and unrestricted license with the Ohio board of nursing;
2. Possess an active Medicaid provider agreement or be employed by an entity that has an active Medicaid provider agreement; and
3. Provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted thereunder.

Nursing tasks and activities that shall only be performed by an RN include, but are not limited to, the following:
1. Intravenous (IV) insertion, removal or discontinuation;
2. IV medication administration;
3. Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);
4. Insertion or initiation of infusion therapies;
5. Central line dressing changes; and
6. Blood product administration.

- RN Waiver Nursing Provided by Agency and Non-Agency
  - T1002 – First Visit of RN Waiver Nursing
  - T1002U2 – Second Visit of RN Waiver Nursing Provided on Same Day as First Visit
  - T1002U3 – Third or More Visits of RN Waiver Nursing Provided on Same Day as First Visit
  - T1002U4 – Single Visit More than 12 Hours; No More than 16 Hours in Length of RN Waiver Nursing Services Provided

  - T1002HQ – RN Waiver Nursing Services Delivered in a Group Setting (Reimbursement as a Group Rate Shall be the Lesser of the Provider's Billed Charge or Seventy-Five Percent of the Medicaid Maximum)
  - T1002U1 – Infusion Therapy
- LPN Waiver Nursing Provided by Agency and Non-Agency
  - T1003 – First Visit of LPN Waiver Nursing
  - T1003U2 – Second Visit of LPN Waiver Nursing Provided on Same Day as First Visit
  - T1003U3 – Third or More Visits of LPN Waiver Nursing Provided on Same Day as First Visit
  - T1003U4 – Single Visit More than 12 Hours; No More than 16 Hours in Length of LPN Waiver Nursing Services Provided
  - T1003HQ – LPN Waiver Nursing Services Delivered in a Group Setting (Reimbursement as a Group Rate Shall be the Lesser of the Provider's Billed Charge or Seventy-Five Percent of the Medicaid Maximum)

Home Care Attendant Service
OAC 173-39-02.24 and OAC 5160-46-04

Attendant care services provide help with the activities of daily living to a patient with a physical disability, for example, help with eating, bathing, dressing, toilet and bathroom needs, and taking medications that are self-administered.

- Home Care Attendant – Nursing
  - S5125 – First Visit of Attendant Nursing Provided
  - S5125U2 – Second Visit of Attendant Nursing Provided on Same Day as First Visit
  - S5125U3 – Third or More Visits of Attendant Nursing Provided on Same Day as First Visit
  - S5125HQ – Attendant Nursing Services Delivered in a Group Setting (Reimbursement as a Group Rate Shall be the Lesser of the Provider's Billed Charge or Seventy-Five Percent of the Medicaid Maximum)
- Home Care Attendant – Personal Care
  - S5125U8 – Per 15 Minute of HCAS/PC Delivered During the Visit

Out of Home Respite
OAC 173-39-02.23 or OAC 5160-46-04

"Out-of-home respite" means services delivered to an individual in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay. A provider of out-of-home respite shall make the following services, which shall not be reimbursed as separate services, available:

1. Three meals per day that meet the individual's dietary requirements;
2. Personal care aid services; and
3. Waiver nursing services.

- H0045 – Per Day

Enhanced Community Living
OAC 173-39-02.20

"Enhanced community living service" ("ECL") means a service that promotes aging in place, in multi-family affordable housing, through the furnishing of on-site access to individually-tailored health-related and supportive interventions for consumers who have functional deficits resulting from one or more chronic health conditions. The following are the components of the service:

1. The establishment of measurable health goals;
2. The identification of modifiable healthcare risks;
3. The furnishing of regular health-status monitoring interventions. "Health-status monitoring interventions" mean taking and recording vital signs, weight, nutrition, and hydration statuses;
4. Assistance with accessing additional allied health services;
5. The furnishing of, or arrangement for, education on self-managing chronic diseases or chronic health conditions;
6. Daily wellness checks. "Daily wellness check" means a component of the service through which a direct-service staff member has face-to-face contact with the consumer to observe any changes in the consumer's level of functioning and determine what, if any, modifications to the day's service delivery plan are needed;
7. Access to planned and intermittent assistance with the personal care service under rule 173-39-02.11 of the Administrative Code, excluding respite care; and,
8. Activities to assist a consumer who is returning home following a hospital or nursing facility stay.

- T2025U1 – Per 15 Minute Unit

Social Work Counseling
OAC 173-39-02.12

"Social work counseling service" means a service to an individual or to an individual's family caregiver to promote the individual's physical, social, or emotional well-being. The service promotes the development and maintenance of a stable and supportive environment for the individual. The service includes crisis interventions, grief counseling, and other social-service interventions that support the individual's health and welfare.

- G0155UA – Per 15 Minute Unit

This is the only G code that is required to be on the Service Plan

Nutritional Consultation
OAC 173-39-02.10

"Nutritional consultation service" means a service that provides individualized guidance to a consumer who has special dietary needs. A nutritional consultation service takes into consideration the consumer's health; cultural, religious, ethnic, socio-economic background; and dietary preferences and restrictions.

- S9470UA – Per 15 Minute Unit

Independent Living Assistance
OAC 173-39-02.15

Independent living assistance (ILA) is a service that consists of activities that assist consumers to manage their households, handle their personal affairs, self-administer medications, and help ensure that consumers retain their community living arrangements and avoid institutionalization due to loss of shelter or other essential environmental services. There are three types of ILA: telephone support, in-person support activities and travel attendant activities.

In-person support includes one or more of the following:

1. Assisting consumers with banking to include making routine deposits and withdrawals;
2. Cashing a consumer's benefit checks;
3. Purchasing money orders for consumers;
4. Writing personal checks for consumers;
5. Paying bills in person or by mail on behalf of a consumer;
6. Balancing a consumer's checkbooks and reconciling the consumer's monthly checking account statements;
7. Organizing and coordinating health insurance records for consumers;
8. Assisting or acting as a consumer's authorized representative in order to obtain and/or maintain public benefits;
9. Applying for programs such as homestead exemption, home energy assistance program (heap) and subsidized housing on behalf of a consumer;
10. Monitoring and replenishing a consumer's stock of needed groceries; and,
11. Assisting a consumer with business and personal correspondence including writing letters, purchasing postage stamps and delivering correspondence to the post office.

Travel attendant activities include:

1. Accompanying consumers to medical and other appointments; and,
2. Accompanying consumers on errands and to other activities outside the home.

Telephone support includes:

1. Calling consumers according to a preset schedule to remind them to take prescribed and over-the-counter medications at specified times; and,
2. Calling consumers at times that no other in-home services are being provided to confirm that consumers are functioning safely in the home environment.

- S5135UA – In Person Activities
- S5135U5 – Travel Attendant
- T2025UA – Telephone Assistant – Per Completed Call

Community Transition Service
OAC 173-39-02.17

"Community transition services" means non-recurring set-up expenses for a consumer who is transitioning from an institutional setting or another provider-operated living arrangement to a living arrangement in a private residence where the consumer is directly responsible for his or her own living expenses. Expenses are furnished only if the service plan clearly identifies the expenses as reasonable and necessary for the consumer to establish a basic household, if the

expenses don't constitute room and board, and if the consumer is unable to meet the expenses or to obtain them from other sources. Non-recurring set-up expenses that meet this criteria may include any of the following:

1. Security deposits required to lease an apartment or home. (For the purposes of this rule, mortgages and rents are room and board, but security deposits are non-recurring set-up expenses.)
2. Household furnishings required to occupy and use a private residence, including furniture, window coverings, food preparation items, and bed and bath linens.
3. Set-up fees or deposits required for utility or service access, including telephone, electricity, heating, and water. (For the purposes of this rule, regular utility charges are room and board, but set-up fees and deposits are non-recurring set-up expenses.)
4. Services required for the consumer's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
5. Moving expenses.
6. Home accessibility adaptations required for the consumer that are not the landlord's responsibility.
7. Activities to arrange for and to procure other non-recurring set-up expenses.

- T2038UA – Community Transition Services – Completed Job or Deposit Made
- T2038U4 – Community Transition for Nursing Home Residents Enrolling in Waiver – Completed Job or Deposit Made
- Funds can only be used within the first 90 days on the Waiver per rule

Choices Home Care Attendant Services – Employer & Budget Authority
OAC 173-39-02.4

"Choices home care attendant service" ("CHCAS") means a participant-directed service that furnishes specific activities to support the needs of an individual with impaired physical or cognitive functioning. Activities of the service include the following:

1. Personal assistance with bathing; dressing; grooming; caring for nail, hair and oral hygiene; shaving; deodorant application; skin care; foot care; ear care; feeding; toileting; ambulation; changing position in bed; assistance with transfers, normal range of motion, and nutrition and fluid intake.
2. General household assistance with the planning; preparation and clean-up of meals; laundry; bed-making; dusting; vacuuming; shopping and other errands; the replacement of furnace filters; waste disposal; seasonal yard care; and snow removal.
3. Heavy household chores including washing floors; windows and walls; tacking down loose rugs and tiles; moving heavy items of furniture to furnish safe access and egress.
4. Assistance with money management and correspondence as directed by the individual.
5. Escort and transportation to community services, activities, and resources. This activity is offered in addition to medical transportation available under the medicaid state plan, and may not replace it.

- T2025UB – Per 15 Minute Unit

Ohio Independent Provider Enhanced Rates

On December 10, 2015, the Ohio Department of Medicaid (ODM) issued a Memorandum explaining that it intends to pay "enhanced rates" to certain independent providers when those providers submit claims to CareSource for units of service provided after 40 hours (160 fifteen-minute units) of services in a week. ODM is using the TU and UA modifiers for this purpose.

To whom does this apply?
This applies to Independent Providers. "Independent Providers" means personal care aides, home care attendants, private duty nurses (LPN or RN) or waiver nurses (LPN or RN), who provide authorized home care services to a CareSource member, and who are not employed by a home care agency.

How is "week" defined?
A week begins Sunday at 12:00 am and ends Saturday at 11:59 pm.

What hours or units of service are to be included when determining whether or not an Independent Provider exceeded 160 fifteen-minute units of service in a week for any combination of CareSource members?
Only time spent delivering services to CareSource members as an Independent Provider may be included. Time spent delivering services for which a claim is being submitted to another managed care plan or on a Medicaid fee for service basis may not be included. Independent Providers are responsible for tracking their time and claims submissions and submitting claims to CareSource appropriately.

What procedure code should be used with the TU or UA modifier?
Independent Providers should use the procedure code that relates to whatever service was being delivered at the time the Independent Provider exceeded 160 fifteen-minute units in a week, including the T1019, S5125, T1002, T1003, or T1000 procedure codes.

The TU modifier indicates that the entire visit is being billed as enhanced rates. The new UA modifier indicates that a visit was split between regular time and enhanced rates. The UA modifier indicates the units of the split visit that are being billed as enhanced rates.

- (NOTE: For PDN T1000 enhanced rates claims for dates of service 1/1/16-3/31/16 the TD and TE modifiers MAY NOT be used. For dates of service 4/1/16 or later, the TD and TE modifiers MUST be used.)

How do independent providers bill when enhanced rates is reached during a second visit of the day, for the same individual?
The provider will need to split the 2nd visit into two lines. The regular hours of the visit will be billed on one line with the U2 modifier. The enhanced hours will be billed on a second line with the U2

and UA modifier. The UA modifier is used to indicate a split visit with enhanced rates. All other appropriate modifiers should be used. Only one regular hour base rate will be received for the visit. All UA modified lines will be paid at the 15-Minute unit rate for the applicable service.

How do Independent Providers who serve multiple people during a single visit submit claims for units of service over 160 fifteen-minute units per week?
Independent Providers must continue to use the "HQ" modifier when delivering services to groups of 2 – 3 people.

When delivering more than 160 fifteen-minute units of service, Independent Providers must submit the appropriate code with the TU modifier, along with the group modifier, in order to be reimbursed at the appropriate rate.

What if an Independent Provider forgets to submit the code with the TU modifier and only submits the regular code?
The Independent Provider will be reimbursed at the regular unit rate. However, the Independent Provider may adjust the claim in order to receive the appropriate payment for units of service over 160 fifteen-minute units per week. All adjustments to claims must be submitted within 365 calendar days of the date of service.

What if an Independent Provider accidentally submits a claim with the TU modifier when Independent Provider did not actually deliver more than 160 fifteen-minute units of service in a week?
The Independent Provider must correct the claim and resubmit within 365 calendar days of the date of service.

Does CareSource reimburse for travel time?
No. As before, rates will be calculated based on actual time spent delivering services to our members and does not include travel time.

How do independent providers bill for a RN Consultation that includes regular and enhanced rates hours?
RN consultation (T1001) may be conducted face to face or by phone. Units are billed per 15 minutes, (example 30 minutes equals 2 units). If enhanced rates occur during the consultation, the provider will need to split the consultation into two lines.

- (Note: For dates of service 1/1/16-3/31/16 the TU modifier must be used. For dates of service 4/1/16 or later the UA modifier must be used.)

Transportation

The CareSource transportation benefit is different ***depending upon the type of MyCare Ohio coverage the member has with CareSource.*** The member may have either Medicare and Medicaid coverage (opt-in) with CareSource, or Medicaid-only (opt-out) coverage with CareSource. Additionally, the member may be eligible for waiver services, including waiver transportation, ***provided the waiver transportation is approved (prior authorization) and included in the member's service plan.***

Member Status	Transportation Benefits
Medicare & Medicaid (Opt In)	• CareSource provides up to 30 round trips of less than 30 miles; if the trip is over 30 miles, there is no limit and CareSource provides transportation. • After 30 round trips have been exhausted, Non-Emergency Transportation (NET) may be available from Job and Family Services (JFS). • After NET is exhausted, waiver-eligible members can get van/car or ambulance/ambulette service (depending on member mobility) through waiver transportation.
Medicaid Only (Opt Out)	• NET is available from JFS unless the trip is over 30 miles or the member is waiver-eligible. • If the trip is over 30 miles, CareSource provides services. • Waiver-eligible members can get van/car or ambulance/ambulette service (depending on member mobility) through waiver transportation

Additional points:

- CareSource transportation is arranged by calling 1-855-475-3163.
- JFS transportation is arranged by calling the member's local JFS office.
- Waiver transportation must be coordinated through the member's Care Manager (requires prior authorization and updated service plan).
- Ambulette services must be billed using medical codes and via Electronic Data Interchange (EDI) or paper claims.

The following ambulette services are covered without prior authorization.

Emergent and Facility transfers; Hospital to hospital	Hospital based dialysis facility to nursing facility; Nursing facility to hospital based dialysis facility	Residence/Nursing Facility to Non-hospital based dialysis facility; Non-hospital based dialysis facility to residence/ nursing facility
Residence to Physician's office; Physician's office to residence	Hospital to nursing facility; Nursing facility to hospital	Nursing facility to physician's office; Physician's office to nursing facility

- **Ambulance services are a covered benefit by the member's Medicare plan. If the member does not have CareSource for Medicare (opt-out status), providers are responsible for working with the member's Medicare carrier/plan for payment.**

Waiver Transportation: All waiver transportation requires Prior Authorization

Non-Medical Waiver Transportation
OAC 173-39-02.18 or OAC 5160-46-04

"Non-medical transportation" means transportation that is used by individuals enrolled in individual options, level one, and self-empowered life funding waivers to get to and/or from a place of employment or to access adult day support, integrated employment, supported employment-community, supported employment-enclave, and/or vocational habilitation. Whenever possible, family, neighbors, friends, or community agencies that provide transportation without charge shall be utilized.

Non-medical transportation shall be provided by an independent provider, an agency provider, or an operator of commercial vehicles that meets the requirements of this rule and that has a Medicaid provider agreement with the Ohio department of Medicaid.

- Supplemental Transportation – Per Mile
- A0100UA – Non-Medical 1 Way
- A0100U2 – Non-Medical 1 Way (2nd Person)
- A0200UA – Non-Medical Round Trip
- A0200U2 – Non-Medical Round Trip (2nd Person)

Non-Emergency Transportation
OAC 173-39-02.13 or OAC 5160-46-04

"Non-emergency medical transportation service" means a service that transports a consumer from one place to another for a non-emergency medical purpose through the use of a provider's vehicle and driver. Examples of places to which the service may transport a consumer are a doctor's office or a pharmacy.

- T2003U5 – 1 Way Transportation
- T2003U4 – 1 Way Transportation (2nd Person)
- T2025U6 – Round Trip Transportation
- T2025U3 – Round Trip Transportation (2nd Person)

CareSource.com
1-800-488-0134 (TTY: 1-800-750-0750 or 711)