PAYMENT POLICY STATEMENT: MYCARE

Original Effective Date	Next Annual Review Date	Last Review / Revision Date
06/16/2016	06/16/2017	06/16/2016- 06/30/2021

Policy Name	Policy Number
Independent Provider	PY-0055

Policy Type		
☐ Medical	☐ Administrative	☒ Payment

Payment Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry- standard claims editing logic, benefits design and other factors are considered in developing Payment Policies.

In addition to this Policy, payment of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

A. SUBJECT

Independent Provider

B. BACKGROUND

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code does not imply any right to reimbursement or guarantee claims payment.

C. DEFINITIONS

Service Plan - is the service coordination and prior authorization document that identifies specific goals, objectives and measurable outcomes for consumer health and functioning expected as a result of services provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the consumer.

- At a minimum, the All Services Plan shall include:
  1. Essential information needed to provide care to the consumer that assures the consumer's health and welfare;
  2. Billing authorization; associated codes for services approved
- The All Services Plan is not the same as the physician's plan of care.

Prior Authorization - authorization obtained prior to services and supports provided on the All Service Plan and is based on a combination of medical necessity, medical appropriateness and benefit limits.

Care Manager - is the Care Manager that works with the member and transdisciplinary team to develop the services and supports and authorization on the All Service Plan

Trans-Disciplinary Care Team (TDCT) - is the primary team responsible for assessment, planning, and evaluation of the member care needs.

D. POLICY

I. CareSource provides coverage for Waiver services when it meets the criteria outlined in this policy. The Waiver Care Manager and member work collaboratively to establish Long Term Services and Supports (LTSS) in the home.

II. CareSource will reimburse independent providers for services utilized through the MyCare/Waiver program when approved by Caresource Care Manager and on service plans.

III. Independent providers must obtain prior authorization for services before services are performed.

IV. Prior Authorization is required for Waiver services that include long term services supports including: Waiver Nursing and Waiver homecare attendant/aide service and RN assessment/consultation

V. Independent providers must submit their prior authorization number with their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with Ohio Administrative code.

VI. Independent providers must submit their claims using their CareSource Waiver Tax ID number.

CONDITIONS OF COVERAGE

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers.

AUTHORIZATION PERIOD

If applicable, reimbursement is dependent upon products and services frequency, duration and timeframe set forth by Ohio Medicaid.

Further information can be found at:
http://codes.ohio.gov/oac/5160-12-08
http://codes.ohio.gov/oac/5160-46-06
http://codes.ohio.gov/oac/5160-46-06.1
http://www.medicaid.ohio.gov/Portals/0/Providers/ODM-IP-Update.pdf

E. RELATED POLICIES/RULES

F. REVIEW/REVISION HISTORY

Date Issued:	06/16/2016
Date Reviewed:	06/16/2016
Date Revised:	

G. REFERENCES

1. Ohio department of Medicaid (ODM) -administered waiver program: Definitions. (2015, July). Retrieved May 23, 2016, from http://codes.ohio.gov/oac/5160-45-01
2. Ohio Home Care Waiver Services. (2016, April 1). Retrieved May 23, 2016, from http://medicaid.ohio.gov/Portals/0/For Ohioans/Programs/HCBS/WaiverServices-Logo .pdf
3. Prior Authorization. (2015, March). Retrieved May 23, 2016, from https://www.caresource.com/providers/ohio/ohio-providers/member-care/prior-authorization/

The Payment Policy Statement detailed above has received due consideration as defined in the Payment Policy Statement and is approved.