ADMINISTRATIVE POLICY STATEMENT
OHIO MYCARE

Policy Name		Policy Number	Date Effective
Independent Provider		AD-1062	07/01/2021-07/31/2023
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy 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 Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do 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 in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement 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.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Independent Provider

B. Background

NA

C. Definitions

- **All Service Plan** - is the service coordination and prior authorization document that supports care plan 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:
    - Essential information needed to provide care to the consumer that assures the consumer's health and welfare;
    - Billing authorization; associated codes for services approved
  - The All Services Plan is not the same as the physician's plan of care.
- **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.
- **Independent Provider** - is an individual who has met the criteria to obtain an Ohio Department of Medicaid provider number and has been approved as a Waiver provider by the Ohio Dept. of Medicaid. An independent must also have a CareSource provider ID in order to provide Waiver Services to MyCare Waiver members. This type of provider is not affiliated with an agency.
- **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.
- **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 or designee and on service plans.

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

IV. Independent providers must complete their review of the All Service Plan (ASP) on the Waiver portal and attest and acknowledge ASP for all service plan changes.

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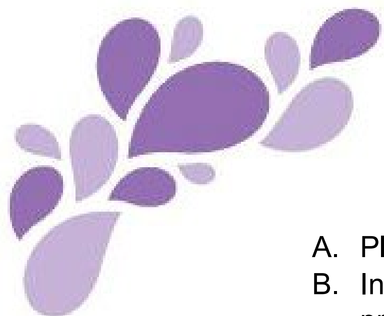

A. Please note attestation is required by CareSource and ODM
B. In order to comply with 42 CFR 441.301, the MCOPs will be required to obtain provider signatures on the waiver service responsible for its implementation effective 12/31/18. This policy is not retroactive and is applicable to waiver service plans developed and/or updated on or after 12/31/18.

V. Prior Authorization is required for all Waiver services that include long term services supports including: Waiver Nursing and Waiver homecare attendant/aide, as well as other waiver services. RN assessment/consultation does not require PA at this time thru UM and are state plan codes.

VI. 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 and valid ICD10 diagnosis codes in accordance with Ohio Administrative Code (OAC).

VII. Independent providers must submit their claims using their CareSource Waiver Tax ID number and NPI.

VIII. All Waiver providers must have an NPI number
A. Effective November 25, 2019 ODM implemented a policy under Administrative Code 5160-1-17 requiring all providers to obtain a National Provider Identifier (NPI) and keep it on file with ODM.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

DATES		ACTION
Date Issued	02/17/2021	New policy
Date Revised		
Date Effective	07/01/2021	
Date Archived	07/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References
1. Code of Federal Regulations. (2011, October 1). Title 42 - Public Health: Contents of request for a waiver. Retrieved 02/15/2021 from www.govinfo.gov.

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2. Ohio Administrative Code. (2019, November 25). Eligible providers. Retrieved 02/15/2021 from www.codes.ohio.gov.
3. Ohio Administrative Code. (2017, January 1). Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures 5160-46-06.1. Retrieved 02/15/2021 from www.codes.ohio.gov.
4. Ohio Administrative Code. (2020, March 23). Ohio home care waiver program: reimbursement rates and billing procedures 5160-46-06. Retrieved 02/15/2021 from www.codes.ohio.gov.
5. Ohio Administrative Code. (2018, January 1). Registered nurse assessment and registered nurse consultation services 5160-12-08. Retrieved 02/15/2021 from www.codes.ohio.gov.

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

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