REIMBURSEMENT POLICY STATEMENT
OHIO MYCARE

Original Issue Date	Next Annual Review	Effective Date
08/24/2017	08/24/2018	05/01/2018
Policy Name		**Policy Number**
Assisted Living Facilities		PY-0348
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement 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 Reimbursement Policies.

In addition to this Policy, Reimbursement 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 Reimbursement 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.

Contents of Policy

A. SUBJECT

Assisted Living Facilities

B. BACKGROUND

CareSource will reimburse Assisted Living Facilities for the services provided to CareSource MyCare Ohio members as set forth in this policy.

C. DEFINITIONS

- **Nursing Facility** – one of many settings for long term care, inclusive of other services and supports, outside of an institution, provided by Medicaid or other state agencies.
- **Patient Liability** – as referred to in this policy is outlined and defined in its entirety in Ohio Administrative Code 5160-3-64.1.
- **Assisted Living Waiver Program** – pays the cost of care in an Assisted Living Facility for certain people with Medicaid, allowing the consumer to use his or her resources to cover "room and board" expenses. Assisted Living Facilities vary considerably, but most provide meals, housekeeping, laundry, transportation and social activities. They also offer personal care, such as assistance with eating, bathing, grooming and person hygiene. Some nursing care is also provided, including medication administration and dressing changes.

D. POLICY

I. A Prior Authorization is required for Assisted Living Facility care provided to any CareSource MyCare Ohio member.

II. For MyCare Ohio members who have elected CareSource to administer both their Medicare and/or Medicaid benefits, CareSource will reimburse the Assisted Living Facility as follows:
   A. Provider must bill on HCFA 1500 claim form with correct HCPCS code(s).
   B. Provider must submit claim as a single line with Date of Service span and units billed to match.
   C. If the member has cost/patient liability, that information must be documented on the claim in field 29 (HCFA 1500 Amount Paid), however, patient liability will be applied based on the current 834 report supplied by the Ohio Department of Medicaid.
   D. A claim submitted which does not include this information may be rejected as unable to be processed.

E. CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

N/A

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	08/24/2017	New Policy.
Date Revised		
Date Effective	05/01/2018	

H. REFERENCES

1. Lawriter - OAC. (n.d.). Retrieved August 10, 2017, from http://codes.ohio.gov/oac 173-51-02

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