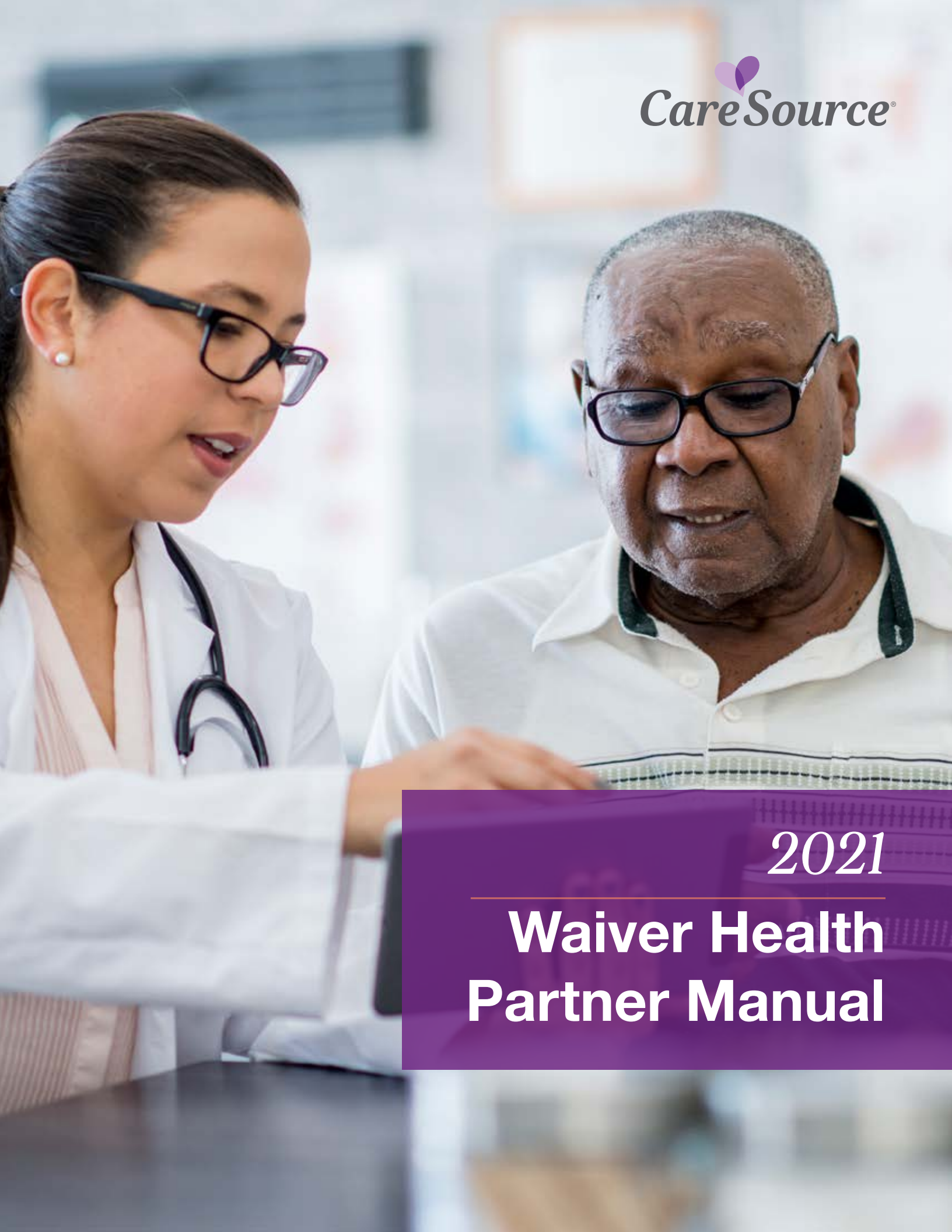
CareSource®



2021

Waiver Health Partner Manual

Dear CareSource Waiver Health Partner,

CareSource values our relationship with you and is actively working to strengthen our relationship to make it easier for you to deliver quality care to our members. 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.

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About CareSource

Welcome

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
- 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

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 are mandated by the Health Insurance Portability and Accountability Act (HIPAA) to secure Personal 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 of PHI and PII left out in the open in your workspace, and shred this content when no longer needed.
- Encrypt laptops and other portable media like CD-ROMs and USB flash drives.
- 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, like you, is a covered entity under HIPAA. It is permissible for covered entities to share patient information 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.

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	Lorain	Stark
Cuyahoga	Mahoning	Summit
Geauga	Medina	Trumbull
Lake	Portage	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.

All MyCare providers are required to complete Model of Care training on an annual basis. This training can be found on the Provider portal and providers will be required to attest once they hit their rolling 12.

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

Communicating with CareSource

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

Phone and Hours of Operation:		
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	M-F 8am – 8pm
TTY for the Hearing Impaired:	1-800-750-0750 or 711	M-F 8am – 8pm
Fax:		
Care Management Referral:	1-877-946-2273	
Credentialing:	1-866-573-0018	
Fraud, Waste and Abuse:	1-800-418-0248	
Medical Prior Authorization Fax:	1-844-417-6157	
Health Partner Appeals:	1-937-531-2398	
Health Partner Maintenance	1-937-396-3076	

Addresses:			
General Correspondence:	CareSource P.O. Box 8738 Dayton, OH, 45401-8738	Claims	CareSource P.O. Box 8730 Dayton, OH 45401
Medical Prior Authorizations:	CareSource P.O. Box 1307 Dayton, OH 45401-1307	Fraud, Waste and Abuse:	CareSource Attn: Special Investigations Department P.O. Box 1940 Dayton, OH 45401-1940
Health Partner Appeals:	CareSource Attn: Health Partner Appeals P.O. Box 2008 Dayton, OH 45401-2008	Health Partner Demographic Changes:	CareSource Attn: Health Partner Maintenance P.O. Box 8738 Dayton, OH 45401-8738
Member Appeals & Grievances:	CareSource Attn: Member Appeals P.O. Box 1947 Dayton, OH 45401		

Web Services:

Website: **CareSource.com**

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

Claims Payment and EFT Enrollment

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 training is also offered for providers.

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: Enroll with ECHO for payment and choose EFT as your payment preference for CareSource. You can also complete the ECHO enrollment form and fax, email, or mail it back to ECHO.

Questions?

Call ECHO Customer Support at **1-888-834-3511** 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 regulations and policies of the state. They must read and understand all Ohio Administrative Code (OAC) rules that pertain to their health partner type and the services they deliver.

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

- State plan home health and private duty nursing services
  - Chapter 5160-12, Ohio Home Care Program
- Waiver health partners and services
  - Chapter 5160-45 Administered Waiver Service health partners
  - Chapter 5160-46, Ohio Home Care Waiver

Covered Waiver Services

NOTE – All Waiver Services require Prior Authorization

All Waiver services must be approved 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.

Medicare and Medicaid coverage is applied before the waiver. The waiver is the payer of last resort.

Assisted Living Services

"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

"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

In Ohio, a Medicaid waiver may cover the cost of transportation separately from the Adult Day Service authorization but in the case of S5012 with no modifier, transportation is covered in the reimbursement for the Adult Day Service. 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. It is CareSource's policy to utilize round trip coverage or one way coverage vs. per mile coverage, except with a new transition of care.

- 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

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 173-39-02.11 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 5160-46-04 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.

- Legacy Ohio Home Care 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). CareSource follows OAC rule 5160 — 46 – 06.
- Legacy Passport Personal Care Services
  - T1019UA – Per 15 Minutes

Homemaker

"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.

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. 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);

4. Assessing, monitoring, and supervising the individual to ensure the individual's safety, health, and welfare.

5. Light cleaning tasks in areas of the home used by the individual.

6. 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.

7. Personal laundry; and

8. 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

Home Maintenance and Chore Services

"Home maintenance and chore services" means a service that maintains a clean and safe living environment through the performance of tasks in the individual's home that are beyond the individual's capability. Home maintenance and chore services shall not exceed a total of ten thousand dollars in a calendar year per individual. Covered home maintenance and chore services include:

1. Minor home maintenance and repair including inspecting, maintaining, and repairing furnaces, including pilot lights and filters; inspecting, maintaining, and repairing water faucets, drains, heaters, and pumps; replacing or installing electrical fuses; plumbing and electrical repairs; repair or replacement of screens or window panes; fixing floor surfaces posing a threat to the individual's health, safety, and welfare; and moving heavy items to provide safe ingress and egress.

2. Heavy household cleaning, including washing walls and ceilings; washing the outside of windows; non-routine washing of windows; removing, cleaning and rehanging curtains or drapery; and shampooing carpets or furniture.

3. Non-routine disposal of garbage posing a threat to the individual's health, safety, and welfare.

4. Non-routine yard maintenance including snow removal posing a threat to the individual's health, safety, and welfare.
5. Pest control and related tasks to prevent, suppress, eradicate, or remove pests posing a threat to the individual's health, safety, and welfare.

- S5121 – Per Job

Supplemental Adaptive & Assistive Devices

"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
- ***Note* The Please note the member has $100 per quarter the ability to order services through the Pharmacy Benefit. our pharmacy benefit with no cost to the member. $100 per quarter. This benefit must be used prior to any approval on the Waiver Service Plan.**
- Nutritional Supplements – Maximum Allowable Per Item
  - T2029UC

Home Modifications & Environmental Accessibility Adaptations

"Home modifications" are environmental adaptations to the private residence(s) of the individual required by the individual's person-centered services plan, that are necessary to ensure the health, welfare and safety of the individual or that enable the individual to function with greater independence in the home. Such adaptations include, but are not limited to, the installation of ramps and grab-bars, widening of doorways, modification of bathroom or kitchen facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Home modifications also include replacement of previous home modifications when it is determined the modification cannot be repaired through another resource. Home modifications shall not exceed a total of ten thousand dollars in a calendar year per individual. The Ohio department of Medicaid (ODM), Ohio Department of Aging (ODA) or their designee shall approve the lowest cost alternative that meets the individual's assessed needs.

- Home modifications do not include:

1. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual including, but not limited to, carpeting, roof repair and central air conditioning.
2. Adaptations that add to the total square footage of the home, except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
3. New, replacement home modifications or repair of previously approved home modifications that have been damaged as a result of apparent misuse, abuse or negligence.

Home modifications may be authorized up to one hundred and eighty consecutive days prior to an individual's transition from an institutional setting into the community. The modification is not considered complete until, and the date of services for purposes of reimbursement shall be, the date on which the individual leaves the institutional setting. If an individual fails to transition into the community, the modification is still reimbursable.

- Limitations.

1. ODM, ODA or their designee shall ensure safeguards are in place to minimize any potential conflicts of interest between the person(s) conducting any evaluations required pursuant to paragraphs (D)(3) and (D)(4) of this rule and the home modification provider.
2. The provider shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the home modification proposal. Reimbursement may only be adjusted if the job specifications are modified pursuant to the requirements set forth in paragraph (D)(4)(b) of this rule.
3. Home modifications do not include removing modifications and returning the property to its prior condition when an individual vacates the premises. The property shall be left in the modified state.
4. The provider shall not be the owner of the individual's residence.
5. The payment will be authorized following member's verification of satisfaction with the home modification.

- Home Modifications
  - S5165 – Maximum Allowable Per Calendar Year

Personal Emergency Response Systems (PERS)

Personal emergency response systems (PERS) is a service with a monitoring, reminder and/or reporting component available to support individuals' independence in the community. PERS include telecommunications equipment, a central monitoring station (station), and a medium for two-way, hands-free communication between the individual and the station. Personnel at the station respond to an individual's alarm signal via the individual's PERS equipment.

PERS equipment shall be appropriate to meet the assessed needs of the individual as authorized on the individual's person-centered services plan and shall include:

1. Activation devices that are wearable and water-resistant. Water resistance shall meet a generally accepted industry standard for water resistance to a level matching the individual's assessed needs and preferences.
2. An internal battery providing at least twenty-four hours of power without recharging. Notification shall be sent to the station if the battery level is low.
3. Devices to accommodate varying needs and preferences of the individual.

PERS does not include:

1. Remote video monitoring of the individual in his or her home.
2. Systems that only connect to emergency service personnel.

PERS provider requirements. The provider shall:

1. Ensure the availability of language assistance in the event the individual has limited English language proficiency.
2. Prior to activating PERS equipment, the provider shall work with the individual and case manager to develop an initial written response plan regarding how to proceed when an alarm is signaled. The plan shall be updated upon the individual's request.
3. Notify ODM, ODA or their designee when a pattern of frequent false alarms has been established for an individual.

- ERS System Installation & Testing
  - S5160
- Monthly Rental
  - S5161 – Monthly Fee
  - S5161U1 – ERS Rental

Home Delivered Meals

"Home delivered meals" is a meal delivery service based on an individual's need for assistance with activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs) in order to safely prepare meals, or ensure meals are prepared to meet the individual's dietary needs or specialized nutritional needs, including kosher meals, as ordered by a licensed healthcare professional within his or her scope of practice.

Meals shall not be:

1. Processed, frozen, pre-packed and commercially available to the general public for purchase; or
2. Provided in order to supplant or replace the purchase of food or groceries for others.
3. A provider may deliver specifically identified items that are packaged in larger than single servings.
4. The type of meal and frequency of delivery shall not be for provider convenience.
5. Home Delivered meal provided is maximum 2 meals per day

- Home Delivered Meal
  - S5170 – Per Meal

Special Diet

"Special diet" means a diet ordered by a licensed healthcare professional whose scope of practice includes ordering special diets based upon, and adjusted to, the individual's assessed needs. A special diet is limited to:

1. Nutrient adjusted diets, including high protein, no added salt and no concentrated sweets.
2. Volume adjusted diets, including small, medium and large portions.
3. The use of finger foods or bite-sized pieces for an individual's physical needs; or
4. Mechanically altered food (i.e., the texture of food is altered by chopping, grinding, mashing or pureeing so that it can be successfully chewed and safely swallowed).

Therapeutic Diet

"Therapeutic diet" means a diet ordered by a licensed healthcare professional whose scope of practice includes ordering therapeutic diets, including:

1. As part of the treatment for a disease or clinical condition.
2. To modify, eliminate, decrease or increase certain substances in the diet; or.
3. To provide mechanically altered food when indicated.

Providers shall furnish each individual with home delivered meals that, as much as possible, accommodate the individual's religious, cultural, ethnic, and dietary preferences, including kosher meals.

- Therapeutic and Kosher Meals
  - S5170U6 – 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 of the Administrative Code; and/or
5. HOME choice nursing services as set forth in rule 5160-51-10 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 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 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 5160-51-10 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. 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

"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

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

"Out-of-home respite" means services delivered to an individual in an out-of-home setting to allow respite for caregivers normally providing care. The service shall 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

"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

"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

"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

Community Integration

Community integration services are independent living assistance and community support coaching activities that necessary to enable an individual to live independently and have access to, choice of, and an opportunity to participate in, a full range of community activities. Independent living assistance helps individuals manage their households and personal affairs, self-administer medications, and retain their community living arrangements. Independent living assistance can be furnished through telephone support, in-person support or travel attendant activities, as applicable to the tasks performed.

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.

- S5135

Community Transition Service

"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 these 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.

Community transition services shall not exceed $2,000.00 per individual per waiver enrollment. Services must be provided no later than 30 days after the waiver enrollment date.

- T2038

Choices Home Care Attendant Services – Employer & Budget Authority

"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 "Overtime" Rates

On Dec. 10, 2015, the Ohio Department of Medicaid (ODM) issued a Memorandum explaining that it intends to pay "overtime" to certain independent providers when those providers submit claims to ODM 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. ODM has directed CareSource to adopt a similar practice for claims submitted to CareSource for authorized services delivered to CareSource members by independent providers that exceed 40 hours (160 fifteen-minute units) in a week.

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 overtime.

- (NOTE: For PDN T1000 overtime 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 overtime 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 overtime hours will be billed on a second line with the U2 modifier . 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 overtime 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 overtime occurs 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 qualify (no prior authorization required).

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

Non-Medical Waiver Transportation

"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. Waiver transportation is a negotiated rate. Typically, for trips under 30 miles, $65 is the reimbursement and If over 30 milese, $85 is the reimbursement.

- 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

"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)

Please Note: The services in this manual are only offered within the Ohio MyCare line of business. Please reference the Ohio Provider Manual at CareSource.com > Providers > Provider Manual for more plan information.

References

Assisted Living:

http://www.ohioassistedliving.org/al_medicaid_waiver.html

Adult Day Health Services:

http://codes.ohio.gov/oac/5160-1-06.1
http://codes.ohio.gov/oac/5160-46-06

Personal Care:

http://codes.ohio.gov/oac/5160-46-06
http://codes.ohio.gov/oac/5160-1-06.1
http://www.medicaid.ohio.gov/Portals/0/Providers/ODM-IP-Update.pdf

HomeMaker:

http://codes.ohio.gov/oac/5160-1-06.1

Chore Services:

http://codes.ohio.gov/oac/5160-1-06.1

Pest Control:

http://codes.ohio.gov/oac/5160-1-06.1

Supplemental Adaptive & Assistive Devices:

http://codes.ohio.gov/oac/5160-46-06
http://codes.ohio.gov/oac/5160-1-06.1

Specialized Medical Equipment & Supplies:

http://codes.ohio.gov/oac/5160-1-06.1

Home Modifications & Environmental Accessibility Adaptations:

http://codes.ohio.gov/oac/5160-46-06
http://codes.ohio.gov/oac/5160-1-06.1

Emergency Response Services/Personal Emergency Response System:

http://codes.ohio.gov/oac/5160-46-06
http://codes.ohio.gov/oac/5160-1-06.1

Home Delivered Meals:

http://codes.ohio.gov/oac/5160-46-06
http://codes.ohio.gov/oac/5160-1-06.1
http://codes.ohio.gov/oac/5123-9-29
http://codes.ohio.gov/oac/5123-9-

RN Assessment/Consultation:

http://codes.ohio.gov/oac/5160-12-08

Waiver Nursing:

http://codes.ohio.gov/oac/5160-46-06
http://www.medicaid.ohio.gov/Portals/0/Providers/ODM-IP-Update.pdf

Home Care Attendant:

http://codes.ohio.gov/oac/5160-46-06.1
http://www.medicaid.ohio.gov/Portals/0/Providers/ODM-IP-Update.pdf

Out of Home Respite:

http://codes.ohio.gov/oac/5160-46-06

Enhanced Community Living:

http://codes.ohio.gov/oac/5160-1-06.1

Social Work Counseling:

http://codes.ohio.gov/oac/5160-1-06.1

Nutritional Counseling:

http://codes.ohio.gov/oac/5160-1-06.1

Independent Living Assistance:

http://codes.ohio.gov/oac/5160-1-06.1

Community Transition:

http://codes.ohio.gov/oac/5160-1-06.1

Choices Home Care Attendant – Employer & Budget Authority:

http://codes.ohio.gov/oac/5160-1-06.1

Non-Emergency Transportation:

http://codes.ohio.gov/oac/5160-1-06.1

Waiver Transportation:

http://codes.ohio.gov/oac/5160-46-06

http://codes.ohio.gov/oac/5160-1-06.1

ODM Certification of Necessity Form for Transportation by Wheelchair Van:

http://medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM03452fillx.pdf

ODM Ambulette Certification of Medical Necessity Form:

https://www.myamerikare.com/wp-content/uploads/2015/03/ODJF-Ambulette-Certification-of-Medical-Necessity.pdf

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