



## **Billing Guide for Ohio MyCare Waiver Program- Independent (Non-Agency) Personal Care Aides**

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## Introduction

This guide is designed to assist independent (non-agency) waiver providers in understanding the billing process for the services they provide under Ohio's Medicaid waiver programs. It explains the billing codes, helpful tips, modifiers to use, and how to receive reimbursement.

## Definitions

### 2.1. Personal Care Aide Services (OAC [5160-46-04](#) )and (Rule [173-39-02.11](#) )

"Personal care aide services" are services that help a person with daily activities, as outlined in their person-centered services plan (PCSP). If a provider cannot help with certain activities, they must inform the Ohio Department of Medicaid (ODM) in writing before the services are added to the person's PCSP.

Personal care aide services include:

- Helping with bathing, dressing, grooming, nail care, hair care, brushing teeth, shaving, putting on deodorant, skin care, foot care, feeding, using the toilet, helping with walking, positioning in bed, moving from one place to another, doing range of motion exercises, and keeping track of what the person eats and drinks.
- General household tasks like cooking and cleaning up after meals, doing laundry, making beds, dusting, vacuuming, mopping floors, and taking out the trash.
- Helping pay bills and assisting with personal letters or messages as directed by the person.
- Taking the person medical appointments, community services, or running errands for them

### 2.2. Person-Centered Service Plan (PCSP)

- **Person-Centered Service Plan (PCSP):** This document details the individual goals, objectives, and interventions chosen by the Waiver Service Coordinator, the member, and their interdisciplinary team.
- The PCSP specifies the approved services and supports that are medically necessary for the member, guiding providers on their responsibilities, schedules, billing codes, and the payment amounts they are authorized to receive.
- Providers must be authorized to deliver the services listed in the PCSP before they begin providing any services.

## Provider Network Management (PNM) Module

- The Provider Network Management (PNM) module is a component of the Ohio Medicaid Enterprise System (OMES), which replaced the Medicaid Information Technology System (MITS) provider enrollment subsystem and provider portal.
- CareSource is required to use provider data from the Provider Network Management (PNM) module as it is the official system of record.
- To ensure the provider data sent from the PNM module to CareSource is accurate, it is imperative that providers update all address and affiliation information in the PNM module so that claims payments, provider directories, and network adequacy measurements are not negatively impacted.
- Click on the following links for step-by-step instructions on how to complete these actions:
  - [Updating or Adding Owner Information](#)
  - [Updating or Adding Practice Locations](#)
  - [Updating or Adding a Specialty in PNM](#)

### 3.1. PNM Support:

- Phone: ODM Integrated Helpdesk (IHD) 800-686-1516
- Email: [IHD@medicaid.ohio.gov](mailto:IHD@medicaid.ohio.gov)
- Website: [PNM & Centralized Credentialing | Ohio Medicaid Managed Care](#)

## Billing Codes and Modifiers

### 4.1. Independent (Non-Agency) Personal Care Aide Services

Billing codes for Independent (Non-Agency) Personal Care Aide services:

Billing Code	Modifier	Service Description
T1019		Personal care aide services by a non-agency aide
T1019	HQ	Use the HQ modifier when billing T1019 if the service was given in a group setting. You will be reimbursed 75% of the Medicaid maximum rate.
T1019	TU	Use the TU modifier when billing T1019 and the entire visit is being billed as overtime.
T1019	UA	Use the UA modifier when billing T1019 and only a portion of the visit is being billed as overtime.
T1019	U2	Use the U2 modifier when billing T1019 for a second visit on the same day.
T1019	U3	Use the U3 modifier when billing T1019 for three or more visits on the same day.
T1019	U4	Use the U4 modifier when billing T1019 for a single visit that was longer than 12 hours but not more than 16 hours.

**\*A visit is defined as start and stop times in care, with a lapse in time before returning to begin care with the same member**

## Base Rate & Unit Rate

Rates	Description
Base Rate	- The base rate should be applied and billed for the first 35–60 minutes of the visit - 35 minutes is the minimum amount of time required to bill the base rate and the provider must be active & present the full 35 minutes
Unit Rate	- Use when: <ul style="list-style-type: none"><li>• Visit is ≤ 34 minutes, or</li><li>• Billed for each 15-minute increment following the first hour</li></ul> *Maximum limits apply

**\*T1019 Personal Care should not be billed in date spans. Each date of service (DOS) must be billed on a**

separate line so that the system can correctly calculate and pay the base rate and the unit rate.

### 5.1. Reimbursement Guidelines

- CareSource follows the Ohio Department of Medicaid fee schedule and reimbursement guidelines per the Ohio Administrative Code (OAC) Rules: [Review Fee Schedule Here 5160-46-06](#)
- Claims can be submitted online using the CareSource Provider Portal: <https://providerportal.caresource.com/>
- Timely Filing Requirement: Providers must submit claims within 365 calendar days from the date of service
- Please ensure you are using the appropriate billing codes, modifiers, and rates

### 6.1 Electronic Visit Verification (EVV)

EVV is part of a federal law that requires direct care workers (DCW) who provide certain personal care and home healthcare services to electronically report the following to make sure individuals are receiving the services they need (OAC [chapter-5160-32](#)):

- ✓ The type of service performed
- ✓ The individual receiving the service
- ✓ The date of the service
- ✓ The location of service delivery
- ✓ The DCW providing the service
- ✓ The time the service begins and ends

- ❖ **Independent (Non-Agency) Providers** must use the state-provided Sandata system to document visits
- ❖ **Claims may deny if required EVV data is incomplete, or a mismatch occurs**

### EVV Support:

- Phone: 855-805-3505
- Email: [ODMCustomerCareEmail@Sandata.com](mailto:ODMCustomerCareEmail@Sandata.com)
- Website: [Electronic Visit Verification | Medicaid](#)

### MyCare Waiver Authorization Process

- CareSource requires an authorization for successful payment of all waiver services for which the Provider delivers in accordance with ([OAC 5160-44-31](#)), [OAC 5160-46-04](#) and ([Rule 173-39-02.11](#))
- It is the responsibility of the service provider to check each Person-Centered Service Plan (PCSP) to ensure they are correctly identified as a provider for the amount, scope, and duration of the eligible services listed.
- Being included in the PCSP confirms that the service has been approved and is necessary for providing the services.
- The Authorization Confirmation will serve as additional proof that you are authorized to bill for the services rendered.

### 7.1. MyCare Waiver Provider Signature Requirement

- Waiver service providers for MyCare must sign the member's Person-Centered Service Plan (PCSP).
- The provider's signature indicates their acknowledgment and agreement to deliver the waiver service as outlined in the service plan.

- A signature is necessary when a new service is approved, when there are adjustments to an existing service authorization that will continue for the length of the service plan, or when a new service plan is issued.
- Only the provider directly impacted by the change is required to sign

## **General Billing Guidelines**

### **8.1. Link to General Billing Guidelines**

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