Billing Guide for Ohio MyCare Waiver Program- Home Care Attendant

Table of Contents

Introduction

This guide is designed to assist 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. Home Care Attendant Services (OAC 5160-44-27)

Home care attendant services are services provided to an individual enrolled on a waiver by an unlicensed non-agency provider in accordance with this rule. Home care attendant services are tasks that would otherwise be performed by an RN or an LPN at the direction of an RN. Home care attendant services include:

(1) Assistance with self-administration of medications

(2) Assistance with the performance of nursing tasks

(3) Tasks performed as part of personal care aide services as described in rule **5160-46-04** of the Administrative Code when performed during a home care attendant service visit. Personal care aide tasks are not reimbursable separately as personal care aide services when they are performed during a home care attendant service visit.

Home care attendant services may be provided:

(1) In the individual's home or in the community; and

(2) To assist an individual to function in the workplace without duplicating workplace accommodations.

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
- Website: PNM & Centralized Credentialing | Ohio Medicaid Managed Care

Billing Codes and Modifiers

4.1. Home Care Attendant Services

Billing codes for Home Care Attendant services:

Billing Code	Modifier	Service Description
S5125		Home Care Attendant Services – Nursing (HCAS/N)
S5125	**U8**	Home Care Attendant Services – Personal Care (HCAS/PC)
S5125	**HQ**	Use the HQ modifier when billing S5125 if the service was given in a group setting. You will be reimbursed 75% of the Medicaid maximum rate.
S5125	**TU**	Use the TU modifier when billing S5125 and the entire visit is being billed as overtime.
S5125	**UA**	Use the UA modifier when billing S5125 and only a portion of the visit is being billed as overtime.
S5125	**U2**	Use the U2 modifier when billing S5125 for a second visit on the same day.
S5125	**U3**	Use the U3 modifier when billing S5125 for three or more visits on the same day.

***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: • Visit is ≤ 34 minutes, or • Billed for each 15-minute increment following the first hour *Maximum limits apply

*** There is no base rate for S5125U8 (HCAS/PC). The S5125U8 (HCAS/PC) service can only be rendered in conjunction with an HCAS/N service.**

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

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 Providers** must use the state-provided Sandata system to document visit capture
- ❖ **Agency Providers** can choose to use the state-provided Sandata system or an Ohio certified alternate EVV system.
- ❖ **Claims may deny if required EVV data is incomplete or a mismatch occurs**

6.1. EVV Support:

- Phone: 855-805-3505
- Email: 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 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