

Provider Services LTSS Manual

<u>Home and Community-Based Services (HCBS)</u>	2
<u>Waiver Services and Molina Healthcare</u>	4
<u>Waiver Benefit and Definition of Approved Services</u>	8
<u>Getting Care, Getting Started</u>	24
<u>Transition of Care (TOC) Policy and Requirements</u>	28
<u>Self-Directed Care Services</u>	33
<u>Contracting and Credentialing</u>	34
<u>Appeals & Grievances</u>	35
<u>Incident Reporting and Investigation</u>	38
<u>Provider Compliant Oversight</u>	39
<u>Fighting Fraud, Waste and Abuse</u>	39
<u>Claims and Encounter Data</u>	40
<u>Billing Molina Healthcare Members</u>	47
<u>OAC References for LTSS Services and Covered Benefits</u>	48
<u>Appendix</u>	49

Home and Community-Based Services (HCBS)

Home and community-based services programs provide alternatives to living in facility-based care settings (such as a nursing home or intermediate care facility). These programs are called “waivers” and allow for consumers to have an active role in their health care and to remain in the community. Waivers serve people who are elderly, who have mental retardation and/or developmental disabilities, and who have physical disabilities.

Consumer Eligibility?

The Ohio Home Care Waiver Program (OHCW) program is designed to meet the needs of financially eligible consumers who are eligible for Ohio Medicaid and who have been assessed to require an intermediate or skilled level of care and who are age 59 or younger.

The **Transitions Carve Out Waiver** is for individuals on the Ohio Home Care Waiver who have reached age 60 and above. This waiver is not open to new enrollees and the prequalification is enrollment in the Ohio Home Care Waiver Program.

MyCare Ohio is Ohio’s Integrated Care Delivery System (ICDS), which is a system of managed care plans designed to coordinate physical, behavioral and long-term care services for individuals over the age of 18 who are eligible for both Medicaid and Medicare.

Enrollment in MyCare Ohio is mandatory for people who:

- Eligible for all parts of Medicare (Parts A, B and D) and be fully eligible for Medicaid; and
- Over the age of 18; and
- Reside in one of the 29 demonstration counties which are located in seven regions of Ohio (NW, NE, EC, NEC, Central, WC and SW)

Who is exempt from MyCare Ohio

- Individuals receiving services through a developmental disability waiver through their DD board (Have the option to self-enroll)
- Individuals who are eligible for Medicaid through a delayed spend-down
- Individuals who have third-party insurance

Consumer Enrollment Process

Individuals who are eligible for MyCare Ohio, and are receiving services in one of Medicaid waivers, will be transitioned into MyCare Ohio waiver. Not all individuals currently enrolled in these waivers are eligible for MyCare Ohio, which means there may be some individuals that you currently service on the Medicaid waiver that will not be moved into MyCare Ohio.

Eligible individuals will choose their managed care plan available in the region they live through Ohio’s enrollment provider, Automated Health systems. Once the enrollment period is open, individuals will be given sufficient time to review their plan options and decide which plan works best for them.

If a plan is not chosen within the allotted time frame, the state will choose a plan for them. Individuals who did not choose a plan by the cutoff date will be given a 90 day window to change plans.

This benefit package consists of adult day supports, day habilitation, environmental accessibility and adaptations, homemaker/personal care, personal emergency response system, informal and institutional respite care, specialized medical equipment and supplies, supported employment (community and enclave), adaptive equipment, transportation, and vocational rehabilitation.

Medicare Opt-out

Individuals will have the option to have the managed care plan 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. However, individuals must still choose a MyCare Ohio plan to provide and pay for all their Medicaid services.

MyCare Ohio participants must actively Opt-In if they want their MyCare Ohio plan to include their Medicare benefits before January 1, 2015. They will have until the end of 2014 to Opt-In.

Beginning January 1, 2015, Medicare benefits will automatically be included in participants MyCare Ohio plans. Participants must actively Opt-Out to keep their Medicare benefits separate.

What is the Level of Care?

Level of care is one component of Medicaid eligibility in order to approve enrollment on a Medicaid waiver or authorize Medicaid payment to a nursing facility.

A person who wants to be enrolled on a Medicaid waiver must meet the specific level of care that is required for that waiver. All individuals must meet and exceed the requirements of a Protective level of care, which includes a need for assistance with instrumental activities of daily living (IADLs) and/or supervision of one activity of daily living (ADL) or medication administration.

There are currently two levels of care associated with Medicaid waivers:

- 1.** Intermediate Care Facility for persons with Mental Retardation (ICF-MR) level of care. This level of care includes a presence of a substantial developmental delay or a severe, chronic disability. A Medicaid waiver that requires an ICF-MR level of care provides services as an alternative to institutional care.
- 2.** Nursing Facility-Based (NF-Based) level of care. A Medicaid waiver that requires a NF-Based level of care provides services as an alternative to nursing facilities, hospitals, or rehabilitation facilities. This level of care includes the Intermediate and Skilled levels of care:

- Intermediate level of care includes a need for assistance with activities of daily living, medication administration, and/or a need for at least one skilled nursing or skilled rehabilitation service.
- Skilled level of care indicates a higher level of need than the Intermediate and ICF-MR levels of care and includes presence of an unstable medical condition and a need for a specific amount of skilled nursing or skilled rehabilitation services.

Waiver Services and Molina Healthcare

When a member comes to Molina and they are eligible under a “waiver” program, the member is able to continue under the umbrella of that waiver’s benefit through a “Transition of Care” period. Once the transition is complete and the member has been assessed by Molina’s Care Management Team, the member may be eligible for other “waiver” services due to medical need. These “new” waiver services are benefits under what is now called the “Combined Waiver.” The traditional or “original” waiver benefits are combined into one benefit thus the term “Combined Waiver.”

An example of this logic is as follows: A member may be eligible for only homemaker services but once the Care Manager delves into the member’s case and examines the member’s needs, it may be true that now the member requires home modifications and/or home-delivered meals. These services are not benefits the member received on the original waiver. However, now that the member is in Care Management and medical need is established, the member is eligible for additional services offered under the Combined Waiver. Once the Transition of Care is completed, the “new” Molina benefit will become effective. There will no longer be services split under multiple waiver programs; one waiver will cover all applicable services.

Waiver of Origin: **Choices Program**

Who is Eligible? Medicaid eligible individuals who are age 60 and older and who require at least an intermediate level of care and live in an approved service area.

Description: Consists of adult day health programs, alternative meal services, environmental accessibility adaptations, home care attendants, home-delivered meals, personal emergency response systems, pest control, and specialized medical equipment and supplies.

Services provided:

- Adult day health
- Alternative meals service
- Environmental accessibility adaptations
- Home care attendant
- Home-delivered meals
- Personal emergency response systems

- Pest control
- Specialized medical equipment and supplies

Assisted Living Waiver Program

Who is Eligible? Medicaid eligible individuals at least 21 years old, , and need at least an intermediate level of care.

Description: Pays the costs of care in an Assisted Living facility for certain people with Medicaid, allowing the individual to use his or her resources to cover “room and board” expenses. The Assisted Living Waiver is administered by the Ohio Department of Aging.

Services provided:

- Assisted living services
- Community transition (for nursing facility residents only)

Transitions II Aging Carve-Out Waivers

Who is Eligible? Medicaid eligible individuals who are age sixty 60 or older and have either intermediate level of care or a skilled level of care in accordance with the OAC.

Description: Waiver nursing services such as a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of an RN. Personal care aide services are also covered under this waiver.

Services provided:

- Adult Day Health Center Services
- Personal Care Aide Services
- Supplemental Adaptive and Assistive Devices
- Home Modifications
- Emergency Response Services
- Home Delivered Meals
- Supplemental Transportation
- Waiver Nursing
- Home Care Attendant Services
- Out of Home Respite Services

Ohio Home Care Waiver Program

Who is Eligible? Medicaid eligible individuals who are younger than age 59 and who require an intermediate or skilled level of care.

Description: Allows Medicaid consumers to receive Long-Term care services at home instead of in a hospital or nursing home.

Services provided:

- Adult day health
- Emergency response
- Home care attendant
- Home-delivered meals
- Home modification
- Out-of-home respite care

- Personal care aide
- Supplemental adaptive and assistive devices
- Supplemental transportation
- Waiver nursing

PASSPORT (Pre-Admission Screening System Providing Options and Resources Today)

Who is Eligible? Medicaid eligible individuals who are age 60 or older and require at least an intermediate level of care.

Description: Helps Medicaid-eligible Ohioans get the long-term care services and support they need to stay in their homes instead of in a hospital or nursing home.

Services provided:

- Adult day health
- Chores
- Community transition
- Enhanced community living
- Environmental accessibility adaptations
- Home care attendant
- Home-delivered meals
- Homemaker services
- Independent living assistance
- Non-medical transportation
- Nutritional consultation
- Personal care services work
- Personal emergency response systems
- Pest control
- Social work and counseling
- Specialized medical equipment and supplies
- Transportation

*****Keep in mind that after the initial Transition of Care period has concluded, all benefits associated with the above Waivers will now be included in one benefit:

Combined Waiver Services and their benefit:

- Adult Day Health
- Alternative Meals Service
- Assisted Living Service
- Choices - Home Care Attendant Service
- Chore Services
- Community Transition Service
- Emergency Response Services
- Enhanced Community Living Service
- Home Care Attendant
- Home Delivered Meals

- Homemaker
- Home Medical Equipment and Supplemental Adaptive and Assistive Device Services
- Home Modification, Maintenance and Repair
- Independent Living Assistance
- Nutritional Consultation
- Out-of-Home Respite
- Personal Care
- Pest Control
- Social Work Counseling
- Waiver Nursing Service
- Waiver Transportation

The chart below represents each waiver with the correlated service:

Waivers & Services	Choices Waiver	Assisted Living Waiver	Transitions II Waiver	Ohio Home Care Waiver	PASSPORT Waiver	Combined Waiver
Adult Day Health	x		x	x	x	x
Alternative Meals	x			x	x	x
Assisted Living		x				x
Home Care Attendant	x		x	x	x	x
Chore Services					x	x
Community Transition Service		x			x	x
Emergency Response Services	x		x	x	x	x
Enhanced Community Living Service					x	x
Environmental accessibility adaptations					x	x
Home Delivered Meals	x		x			x
Homemaker					x	x
Home Medical Equipment and Supplemental Adaptive and Assistive Device Services	x		x	x		x
Home Modification, Maintenance and Repair			x	x		x
Independent Living Assistance					x	x
Nutritional Consultation					x	x
Out-of-Home Respite			x	x		x
Personal Care			x	x	x	x

Pest Control	x				x	x
Social Work Counseling					x	x
Waiver Nursing Service			x	x		x
Specialized Medical Equipment & Supplies					x	x
Waiver Transportation			x		x	x
Non-Medical Transportation					x	x

Waiver Benefit and Definition of Approved Services

Adult Day Health Services

Adult Day Health Services (ADHS) are regularly scheduled services delivered at an ADHS center to individuals age eighteen or older. Services are provided in a non-institutional, community-based setting. The ADHS provider may provide waiver nursing and/or personal care services. The provider must also furnish recreational and educational activities to support individual health and independence. Providers must also furnish at least one meal, but no more than two meals, per day that meet the individual’s dietary requirements. The ADHS center may also make available skilled therapy services and transportation of the individual to and from ADHS center.

Limits: ADHS do not duplicate coverage provided under the State plan and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are not duplicated

Provider Type: Adult Day Center, Social Service Agency, Nursing facilities, Community Action Agency, Churches, Medicare certified or Joint Commission accredited agency.

Alternative Meal Services:

The alternative meals service assists the individual with procuring one to two nutritious meals per day. Alternative meals service offers the individual the option to obtain meals from non-traditional providers, such as restaurants.

Alternative meals are not meals served at an Adult Day Center. Alternative meals are purchased from nontraditional providers, such as restaurants. Unlike the agency-based home delivered meals service, the alternative meals service is a self-directed service.

Provider Type: Restaurants, Senior Centers, Social Service Agency, Churches. Must be an ODA certified provider.

Assisted Living Services:

The service furnishes 24-hour on-site response capability, personal care, supportive services (homemaker and chore), and the coordination of the provision of three meals a day and snacks.

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service. Required nursing services include health assessment and monitoring, medication management including medication administration, and the delivery of part-time intermittent nursing and skilled nursing up to the maximum allowed in Ohio Administrative Code (OAC) Rule 3701:17-59 and 3701-17-59.1, when not available through a third party.

The scope of the service does not include 24-hour skilled care, one-on-one supervision, or the provision of items of comfort or convenience, disposable medical supplies, durable medical equipment, prescription medications or over the counter medications.

Limits: The service is limited to one unit per calendar day.

Provider Type: Residential Care Facility. Must be an Ohio Department of Aging certified provider.

Choices - Home Care Attendant Service

The Choices - Home Care Attendant Service consists of supportive activities specific to the needs of a medically stable, disabled adult, which are designed to address activities of daily living and instrumental activities of daily living impairments. Choices Home Care Attendant substitutes for the absence, loss, diminution or impairment of a physical or cognitive function and may include one or more of the following types of activities:

- Personal Care including: assistance with bathing, dressing, and grooming, caring for nail, hair and oral hygiene, shaving, deodorant application, skin care with lotions and/or powders, foot care and ear care, feeding, assistance with elimination, assistance with ambulation, changing position in bed, assistance with transfers, normal range of motion, and adequate nutrition and fluid intake;
- General Household Activities including: planning, preparation and clean-up of meals, laundry, bed making, dusting, vacuuming, shopping and other errands, replacing furnace filters, waste disposal, seasonal yard care and snow removal, and other routine household maintenance activities and other routine household chores;
- Heavy Household Chores including: washing floors, windows, and walls, tacking down loose rugs and tiles, moving heavy items or furniture to provide safe access and egress, and other heavy household activities;
- Assistance with money management and correspondence;

- Escort services and transportation to enable consumers to gain access to waiver and other community services, activities, and resources. This activity is offered in addition to medical transportation available under the State Plan and does not replace it. Whenever possible, other sources will be utilized.

Limits: This service cannot be used concurrently with personal care services.

Provider Type: Home Health Agency, Social Service Agency, Hospitals. Must be an Ohio Department of Aging certified provider.

License: Motor Vehicle (as needed)

Chore Services:

Chore services include those needed to maintain a home in a clean, sanitary and safe condition. This service includes heavy household chores such as washing floors, windows and walls, tacking down loose rugs and floor tiles, moving heavy items of furniture in order to provide safe access and egress. These services are provided only when neither the participant nor anyone else in the household is capable of performing or financially providing for them, and when no other relative, caregiver, landlord, community/volunteer agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to a lease agreement, is examined prior to any authorization of service.

Provider Type: Individual-Handymen, House cleaners, Maids, Home Repair Workers Agency, Social Service Agency, Home Health Agency. Must be an Ohio Department of Aging certified provider.

Community Transition Services:

Community Transition Services are non-recurring set-up expenses for individuals who are transitioning from an institutional setting or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include:

- security deposits that are required to obtain a lease on an apartment or home;
- essential household furnishing and moving expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens;
- set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;
- services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy;
- moving expenses;
- necessary home accessibility adaptations "that are not the responsibility of the landlord"; and
- activities to arrange for and procure needed resources.

Community Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the waiver service plan development process. All items and services obtained through this service must be clearly identified in the waiver service plan.

Community transition services may be available to up to 180 days prior to the individual's discharge from an institution.

Limits: This service is only available if the individual is unable to meet such expenses or when the services cannot be obtained from other sources.

Community Transition Services do not include monthly rental or mortgage expenses; food; regular utility charges; and/or household appliances or items that are intended for purely diversion/recreational purposes.

Individuals may use this service in lieu of, but not in addition to the community transition service available through Ohio's Home Choice (MFP) Demonstration Program.

Provider Type: Individual-Social Workers; Health Care Professionals; Community-Based Social Service Provider; Human Service Agencies; Social Service Agencies; Senior Centers; Community Action Organizations; Home Health Agencies. Must be an ODA certified provider.

License: As required by profession

Emergency Response Services:

Emergency Response Services (ERS) are emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the individual and an emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment.

ERS can meet the needs of individuals who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision. ERS includes installation, testing and equipment rental, and monitoring fees.

ERS equipment shall include a variety of remote or other specialty activation devices from which the individual can choose in accordance with their specific needs. All ERS equipment shall have an internal battery that provides at least 24 hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:

- Wearable waterproof activation devices; and
- Devices that offer:
 - Voice-to-voice communication capability,

- Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
- Audible indication of an alarm that may be appropriate if the consumer is visually impaired.

Limits: ERS does not include the following:

- Equipment that connects the individual directly to 911.
- Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.
- Remote monitoring services.
- Services performed in excess of what is approved pursuant to the individual's waiver services plan.
- New equipment or repair of previously-approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence.
- ERS and the providers of such services must be identified on the waiver service plan.
- ERS does not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Provider Type: Social Service Agency, Medical Equipment & Supply Company, Durable Medical Equipment Suppliers, Medicare-certified HHA; ACHC, CHAP or Joint Commission accredited agencies, other ERS agencies. Must be an ODA certified provider.

Enhanced Community Living Services

The Enhanced Community Living service is provided by a designated team of nurses and direct care staff in a multi-family housing setting, and integrates the delivery of direct service interventions and health status monitoring activities. The ECL service includes eight elements:

- The establishment of measurable health goals;
- The identification of modifiable health care risks;
- The implementation and regular monitoring of specific interventions related to achieving the measurable health goals and modifiable health care risks;
- Assistance with accessing additional allied health services;
- The provision of, or arrangement for, education on self-managing chronic diseases or chronic health conditions;
- 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 individual to observe any changes in the individual's level of functioning and determine what, if any, modifications to the day's service delivery plan are needed;
- Access to planned and intermittent assistance with the personal care service (PCS) under rule 173-39-02.11 of the Administrative Code. The scope of personal care tasks includes assistance with ADLs (mobility, bathing, grooming,

toileting, dressing, and eating) and the provision of any component of the homemaker service (HMK) under rule OAC 173-39-02.8 to assist the consumer with IADLs if the component is incidental to the care furnished or essential to the health and welfare of the consumer. The scope of homemaker tasks include assistance with meal planning, laundry, and house cleaning. Since personal care and homemaker service tasks are included in the scope of the enhanced community living service, the concurrent use by an individual of either the personal care service or the homemaker service as a distinct additional service is not permitted. The service authorization process will prevent the care manager from authorizing PCS and HMK services that are concurrent with an ECL service authorization.

- Activities to assist an individual who is returning home following a hospital or nursing facility stay.

The Enhanced Community Living (ECL) service provides the individual who resides in their own private residence in a multi-family housing setting, with on-site access throughout the day to individually-tailored supportive and health-related interventions necessary to avoid institutionalization and maintain optimal health status.

- Multi-family housing is defined as a housing site that uses a landlord-tenant rental agreement, provides a minimum of six units of housing under one roof; and receives assistance through a federally-assisted housing program (as defined under 24 C.F.R.5.100), a project-based voucher program (as defined in 24 C.F.R. 983) or a low-income housing tax credit program (that is based on Section 42 of the Internal Revenue Code). This waiver service is not furnished in facilities that are subject to Section 1616(e) of the Social Security Act.
- On-site access to the service produces increased service flexibilities for an individual by delivering the elements of the service in smaller blocks of time and more frequently throughout the day; and the scope/duration/and frequency of the service delivery can be quickly modified in response to the individual's intermittent and/or unplanned needs.
- The integration of the delivery of direct service interventions and health status monitoring activities is intended to support the transition of individuals from institutional settings and to reduce the risk for permanent institutionalization by: expanding access to services and supports delivered on an intermittent basis; empowering the individual to be an active participant in achieving his/her health care goals and reducing modifiable health risks; increasing the likelihood of timely identification of changes in health status; reducing the risks for acute exacerbation of chronic health conditions that result in hospitalization or nursing facility care; and increasing the continuity of care across sites of care.

The service differs from the Medicaid state plan benefits, specifically private duty nursing and home health aide, in these areas:

- The waiver service provides interventions that focus on the prevention of deteriorating or worsening medical conditions and the management of stabilized chronic conditions; and

- The waiver service does not provide continuous (more than four hours) blocks of service to individuals.

The mechanisms to prevent duplicate billing for similar services include:

- Prior authorization requirement by the state Medicaid agency for the private duty nursing; and
- Requirement for the waiver service plan to include home health aide service in order for the service to be reimbursable.
- Multi-family housing is defined as a housing site that uses a landlord-tenant rental agreement, provides a minimum of six units of housing under one roof; and receives assistance through a federally-assisted housing program (as defined under 24 C.F.R.5.100), a project-based voucher program (as defined in 24 C.F.R. 983) or a low-income housing tax credit program (that is based on Section 42 of the Internal Revenue Code). This waiver service is not furnished in facilities that are subject to Section 1616(e) of the Social Security Act.
- On-site access to the service produces increased service flexibilities for the individual by delivering the elements of the service in smaller blocks of time and more frequently throughout the day; and the scope/duration/and frequency of the service delivery can be quickly modified in response to the individual's intermittent and/or unplanned needs.
- The integration of the delivery of direct service interventions and health status monitoring activities is intended to support the transition of individuals from institutional settings and to reduce the risk for permanent institutionalization by: expanding access to services and supports delivered on an intermittent basis; empowering the individual to be an active participant in achieving his/her health care goals and reducing modifiable health risks; increasing the likelihood of timely identification of changes in health status; reducing the risks for acute exacerbations of chronic health conditions that result in hospitalization or nursing facility care; and increasing the continuity of care across sites of care.

The service differs from the Medicaid state plan benefits, specifically private duty nursing and home health aide, in these areas:

- The waiver service provides interventions which focus on the prevention of deteriorating or worsening medical conditions and the management of stabilized chronic conditions; and
- The waiver service does not provide continuous (more than four hours) blocks of service to the individual.

Provider Type: Medicare-certified Home Health Agency, Home health Agencies, Human Service Agencies, Social Service Agencies, Senior Centers Must be an ODA certified provider.

Home Care Attendant Services:

Home care attendant services include all of the following tasks when provided by an unlicensed home care attendant, and authorized by a licensed physician or an RN (hereafter referred to as the authorizing health care professional):

- Assistance with the self-administration of medications in accordance with OAC rule 5101:3-46-04.1;
- The performance of certain nursing tasks in accordance with OAC rule 5101:3-46-04.1; and
- Personal care aide tasks as set forth in OAC rule 5101:3-46-04.

While this service includes personal care aide tasks, it is more involved because of the provision of assistance with self-administration of medication and the performance of certain nursing tasks - tasks that have, until the passage of RC 5111.88-5111.8811 (Am. Sub. H.B. 1, 128th General Assembly), and the addition of this service, had to be performed by an RN, or licensed practical nurse at the direction of an RN, as waiver nursing, private duty nursing or home health nursing services.

Home care attendants are non-agency providers (i.e., independent contractors) who bill OMA directly for reimbursement for services provided. The service doesn't require a financial management service (FMS) provider, and OMA issues the 1099 directly to the home care attendant. Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.

A home care attendant shall assist an individual with the self-administration of only the following medication: oral medications; topical medications; subcutaneous injections of routine doses of insulin; programming of a pump used to deliver routine doses of insulin; medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and doses of schedule II, III, IV and V drugs only when administered orally or topically.

A home care attendant shall not assist an individual with the performance of any of the following nursing tasks: intravenous (IV) insertion, removal or discontinuation; intramuscular injections; IV medication administration; subcutaneous injections (except for routine doses of insulin as described in the previous paragraph); programming of pumps used to deliver medications, including but not limited to epidural, subcutaneous and IV (and except for routine doses of insulin as described in the previous paragraph); insertion and initiation of infusion therapies; and central line dressing changes.

Limits:

- The home care attendant must be identified as the provider, and have specified on the All Services Plan, the number of hours for which the provider is authorized to furnish home care attendant services to the individual.
- Home care attendant services do not include services performed in excess of what is approved pursuant to the waiver service plan.

- Individuals who receive home care attendant services do not have employer authority or budget authority, nor do they bear any liability for home care attendant services.
- Individuals cannot receive, and providers cannot bill separately for personal care aide services when personal care aide tasks are performed during a home care attendant service visit.
- A home care attendant who provides home care attendant services to an individual in accordance with the limitations set forth in Sections 5111.88 through 5111.8811 of the Revised Code, and Rule 5101:3-46-04.1 of the Administrative Code, including activities in accordance with the authorizing health care professional's authorization, is not considered to be engaging in the practice of nursing as an RN or an LPN in violation of section 4723.03 of the Revised Code (the Ohio Nurse Practice Act).
- Home Care Attendant Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Provider Type: Non-agency Home Care Attendant. Must be an ODA certified provider

Home Delivered Meals:

Home delivered meals (HDM) service provides individuals with safe and nutritious meals (either regular or therapeutic) that meet one-third of the dietary reference intake (DRI) and meet the current dietary guidelines for Americans and the recommended daily allowances (RDA). HDM service does not constitute a full nutritional regimen.

Eligible participants include those who have an assessed need for a home delivered meal due to one or more of the following:

- An ADL and/or IADL deficit results in the inability to safely prepare a meal and/or
- A cognitive impairment results in the inability to safely prepare a meal;
- The individual is at risk for malnutrition;
- The individual requires meals that are prepared to meet specialized dietary or therapeutic needs.

The service includes the preparation, packaging and delivery of a safe and nutritious meal(s) to an individual at his or her home. The meal may be hot, frozen, vacuum packaged, or shelf stable.

Specialized meals include, but are not limited to, specialized diets due medical conditions (i.e. reduced sodium, diabetic diet), or specialized textures.

Limits:

Home delivered meals shall not:

- Include services or activities performed in excess of what is approved on the individual's waiver service plan.

- Supplement or replace meal preparation activities that occur during the provision of waiver nursing, personal care aide, adult day health center, home care attendant or any other similar services.
- Supplement or replace the purchase of food or groceries.
- Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include, but are not limited to: food that must be portioned out and prepared, or any food that must be cooked or prepared.
- Be provided while the individual is hospitalized or is residing in an institutional setting.
- Duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Provider Type: Non-agency employed provider

Food preparation agency, Home Health Agency, Senior Centers, Social Service Agency, Churches, Hospitals, and Caterers, e.g., Meals on Wheels, a food vendor, etc.

License: OMA approved provider: Current, valid license or certificate from the local health department. Must be an ODA certified provider

Providers must meet all Federal, State and local regulations for preparation, handling and transport of food; must meet Ohio Uniform Food Safety Code; must pass all local health department inspections; and must pass all Ohio Department of Agriculture meat and poultry inspections.

Homemaker Services:

Homemaker services consist of general household tasks (e.g., meal preparation and routine household care) provided by a qualified homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemaker service providers shall meet such standards of education and training as are established by the State for the provision of these activities.

Homemaker service providers may also help the individual manage personal appointments, day-to-day household activities, and to ensure that the individual maintains his/her current living arrangement by acting as a travel attendant.

Provider Type: Home Health Agency, Social Service Agency, Hospitals
Must be an ODA certified provider

Home Medical Equipment and Supplemental Adaptive and Assistive Device Services

Home Medical Equipment and Supplemental Adaptive and Assistive Device Services are medical equipment, devices and supplies, and vehicle modifications to a vehicle owned by the individual, or a family member, or someone who resides in the same household as the individual, that promote accessibility, enabling the individual to

function with greater independence, avoid institutionalization, and reduce the need for human assistance. Adaptive and Assistive Devices, in particular, are contingent upon completion of and recommendations resulting from an evaluation. Some adaptive/assistive devices including, but not limited to, vehicle modifications may be provided prior to the individual's discharge from an institution into the community. In such instances, the adaptive/assistive device can be initiated up to 180 days prior to discharge, and the date of service for allowable expenses shall be the date on which the individual leaves the institution and enrolls on the waiver.

Adaptive and Assistive Devices and Medical Supplies do not include:

- Items considered by the federal Food and Drug Administration as experimental or investigational.
- Funding of down payments toward the purchase or lease of any adaptive and assistive devices.
- New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence. New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence.
- Payment toward the purchase or lease of a vehicle except as set forth in the service definition above.
- Routine care and maintenance of vehicle modifications and devices.
- Permanent modification of leased vehicles.
- Vehicle inspection costs.
- Vehicle insurance costs

Limits:

- Reimbursement for Home Medical Equipment and Supplemental Adaptive and Assistive Device Services shall not exceed a combined total of \$10,000 within a calendar year per individual.
- The service prohibits the same type of medical equipment, supplies and devices being purchased for the same individual during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the individual's medical and/or physical condition requiring the replacement.
- The service prohibits the same type of vehicle modification for the same individual within a three-year period, unless there is a documented change in the individual's medical and/or physical condition requiring the replacement.
- Home Medical Equipment and Supplemental Adaptive and Assistive Device Services do not include:
 - Items considered by the federal Food and Drug Administration as experimental or investigational.
 - Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services.

- Equipment, supplies or services furnished in excess of what is approved pursuant to, and as specified on the individual's All Services Plan.
- New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence.
- New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence.
- Payment toward the purchase or lease of a vehicle except as set forth in the service definition above.
- Routine care and maintenance of vehicle modifications and devices.
- Permanent modification of leased vehicles.
- Vehicle inspection costs.
- Vehicle insurance costs.
- Services performed in excess of what is approved pursuant to, and specified on, the individual's service plan.
- Supplemental Adaptive and Assistive Device Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Provider Type: Pharmacies/drug stores, Medical Equipment & Supplies Company, Durable Medical Equipment Suppliers, and other applicable agencies
Must be an ODA certified provider

Home Modification, Maintenance and Repair

This service includes physical adaptations to the individual's place of residence for accessibility purposes that permit an individual to live safely and independently. Environmental modifications must include a one-year warranty from the date of completion of the work against defective workmanship, and providers must guarantee that all materials/ products/appliances installed or furnished perform their advertised function. Some environmental modifications can be initiated up to 180 days prior to discharge, and the date of service for allowable expenses shall be the date on which the individual leaves the institution and enrolls on the waiver.

Limits: Home modifications do not include:

- Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the individual (i.e., carpeting, roof repair, central air conditioning, etc.).
- Adaptations that add to the total square footage of the home.
- Services performed in excess of what is approved pursuant to, and specified on, the individual's All Services Plan.
- The same type of home modification for the same individual during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the individual's medical and/or physical condition that requires the replacement.
- New home modifications or repair of previously approved home modifications that have been damaged as a result of confirmed misuse, abuse or negligence.

- The home modification and the provider of the service must be identified on the individual's waiver service plan.
- Home modification services are limited to \$10,000 per twelve-month calendar year.
- Home modification services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Provider Type: Independent Contractors and Independent General Contractors Home Improvement Companies; Builders; Neighborhood Organizations; Community Action Agencies. Must be an ODA certified provider

Independent Living Assistance

This service provides individuals with a range of information and educational training and supports they need to increase their ability to live more independently. Training focuses on financial, health and home management skill-building, as well as the development of social, personal care (such as self-administering medications) and community living skills.

The service also provides one-on-one coaching that gives the individual the tools and confidence to make informed/independent choices, set/achieve short and long-term goals, manage multiple tasks, identify options and solve problems, identify/link to community resources and connect to potential job opportunities. The service can be provided one-on-one, in a group or in a classroom setting, or over the phone, and may include travel attendant activities. The independent living skills training provider is not the individual's care manager.

Provider Type: Home Health Agency, Social Service Agency
Social Workers; Nurses; Homemakers; Individual workers. Must be an ODA certified provider.

Nutritional Consultation

Nutritional consultation services are services that provide personalized guidance to an individual who has special dietary needs. Nutritional consultation takes into consideration the individual's health, cultural, religious, ethnic and socio-economic background and dietary preferences and/or restrictions.

Nutritional consultation services shall not:

- Duplicate similar HCBS waiver services an individual is receiving; or
- Include services provided in excess of what is approved on the individual's waiver service plan.

Provider Type: Home Health Agency, Social Service Agency. Licensed Dietitian
Must be an ODA certified provider.

License: Licensure by Ohio Board of Dietetics and/or Licensure as appropriate per provider type.

Out-of-Home Respite

Out-of-Home Respite Services are services delivered to individuals in an out-of-home setting to provide respite for caregivers normally providing care. The service must include an overnight stay. The services the out-of-home respite provider must make available are:

- Waiver nursing
- Personal care aide services
- Three meals per day that meet the consumer's dietary requirements.

Limits:

- The services delivered by an Out-of-Home Respite service provider cannot be reimbursed separately.
- Out-of-Home Respite Services and the provider of such services must be identified on the waiver services plan.
- Out-of-Home Respite Services do not include services performed in excess of what is approved pursuant to the waiver services plan.
- Out-of-Home Respite Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.
-

Provider Type: Nursing Facility (NF) and other institutional providers (e.g., hospitals, etc.)

License: NF Licensure per OAC rule 5126-3-02

Personal Care Services:

The service furnishes hands-on assistance with activities of daily living (ADLs) in the home and in the community. Tasks include: Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output.

The service also furnishes hands-on assistance with instrumental activities of daily living (IADLs) in the home and in the community that are incidental to the provision of the hands-on assistance with ADLs, but may not comprise the entirety of the service. Tasks include: general homemaking activities including, but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming and waste disposal; Household chores including, but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and exit.

The service does not include: tasks performed by a licensed health professional, including skilled or nursing care.

Limits:

The service is intended to complement, not replace, similar services available under the Medicaid state plan.

The waiver service shall not be used in lieu of the Medicaid state plan home health benefit when it has been determined the individual meets the eligibility criteria, as defined in OAC 5101:3-12-01, to receive the service.

The waiver service shall not be authorized as an alternative when the individual refuses to utilize Medicaid home health benefits they have been determined eligible to receive. In these instances, the waiver service coordinator is responsible for assisting the individual in assessing the risks associated with their decisions and exploring options for meeting the identified needs.

The following services are not furnished at the same time the personal care assistance service is provided: home delivered meals, home care attendant service; Choices home care attendant services, assisted living, enhanced community living, and independent living assistance

Provider Type: Medicare-certified Home Health Agency or Joint Commission accredited agency; Home Health Agency; Social Service Agency; Hospitals; Non-agency employed personal care aide and; a Qualified consumer-employed provider. Must be an OMA certified provider.

Pest Control

Pest Control services are designed to prevent, suppress, or eradicate anything that competes with humans for food and water, injures humans, spreads disease to humans and/or annoys humans and causes or is expected to cause more harm than is reasonable to accept. Pests include insects such as roaches, mosquitoes, and fleas; insect-like organisms, such as mites and ticks; and vertebrates, such as rats and mice.

Services to control pests are services that prevent, suppress, or eradicate pest infestation.

Provider Type: Exterminator, Extermination Company. Must be an ODA certified provider.

Social Work Counseling

Social work/counseling services are transitional services provided to the individual, authorized representative, caregiver and/or family member on a short-term basis to promote the individual's physical, social and emotional well-being. Social work/counseling services promote the development and maintenance of a stable and supportive environment for the individual.

Social work/counseling services can include crisis interventions, grief counseling and/or other social service interventions that support the individual's health and welfare.

Social work/counseling services shall not:

- Take the place of case management services; or

- Include services provided in excess of what is approved on the individual's services plan.

Provider Type: Licensed professional clinical counselor, licensed professional counselor, licensed psychologist (MA or PhD), marriage and family therapist, licensed independent social worker, licensed social worker

License: Licensed by the Ohio Board of Counselors, Social Workers and Marital Family Therapist (LISW, LPCC, LPC, or MSSA); or licensed by the Ohio Board of Psychology as a Psychologist (MA or PhD)

Waiver Nursing Service

Waiver nursing services are defined as services provided to individuals that 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 individuals on the ICDS waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code (Ohio's Nurse Practice Act) and Administrative Code rules adopted there under, and shall possess a current, valid and unrestricted license with the Ohio Board of Nursing.

Waiver nursing provides part-time, intermittent and/or continuous nursing services. It is different than state plan home health nursing because its approved provider pool is not limited to Medicare-certified home health agencies and it can be provided in the community.

Limits: Waiver Nursing Services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Provider Type: Non-agency employed RN; non-agency employed LPN; Medicare-certified Home Health Agency and Joint Commission accredited agency

License: RN/LPN

Waiver Transportation

Waiver transportation services promote an individual's full participation in the community through access to waiver services, community activities, and medical appointments as specified by the individual's service plan when not otherwise available or funded by state plan or any other source.

The service is offered in addition to transportation service under the State Plan as defined at 42 CFR\$440.170(a) (if applicable), and does not replace it. Whenever possible family, neighbors, friends or community agencies that can provide this service without charge are utilized.

Limits:

Waiver transportation services and the provider of such services must be identified on the waiver service plan. Waiver transportation services do not include services performed in excess of what is approved pursuant to, and specified on, the individual's waiver service plan.

- ❖ Waiver transportation services do not duplicate coverage provided under the State plan and EPSDT services are not duplicated.

Getting Care, Getting Started

Waiver Service Coordinator

Plans are required to contract for Waiver Service Coordination with the AAA's as an option for individuals over the age of 60 who are on the MyCare Ohio community-based services waiver but may also offer other options. Members may select their Waiver Service Coordinator entity.

Plans may contract with AAA's, other entities, or provide waiver service coordination themselves for individuals under the age of 60 (The Care Manager and Waiver Services Coordinator may be the same individual).

If the member is under the age of 60, Molina Healthcare will automatically be the waiver service coordinator. Below are the services that a waiver service coordinator would engage:

- Waiver Service Coordination/Care Management
- Care and Service Plan Review
- Crisis Intervention
- Event Based Visits
- Institution-based Visits
- Service Management
- Medicaid Resolution
- Assessment of LTSS Need
- Member Education

The Area Agency on Aging (AAA) is the entity that is currently responsible for responding to the needs of the LTSS population who are 60 years of age and older by serving as advocates and planners. The AAA provides education, information and referral services to clients who are eligible under the Ohio Medicaid Waiver Program.

The AAA is the first stop for the member. Once the member is assessed and approved for one of the waivers by ODM the AAA's responsibilities are as follows:

- To determine the need for service, with special attention given to the needs of the low income and isolated elderly.

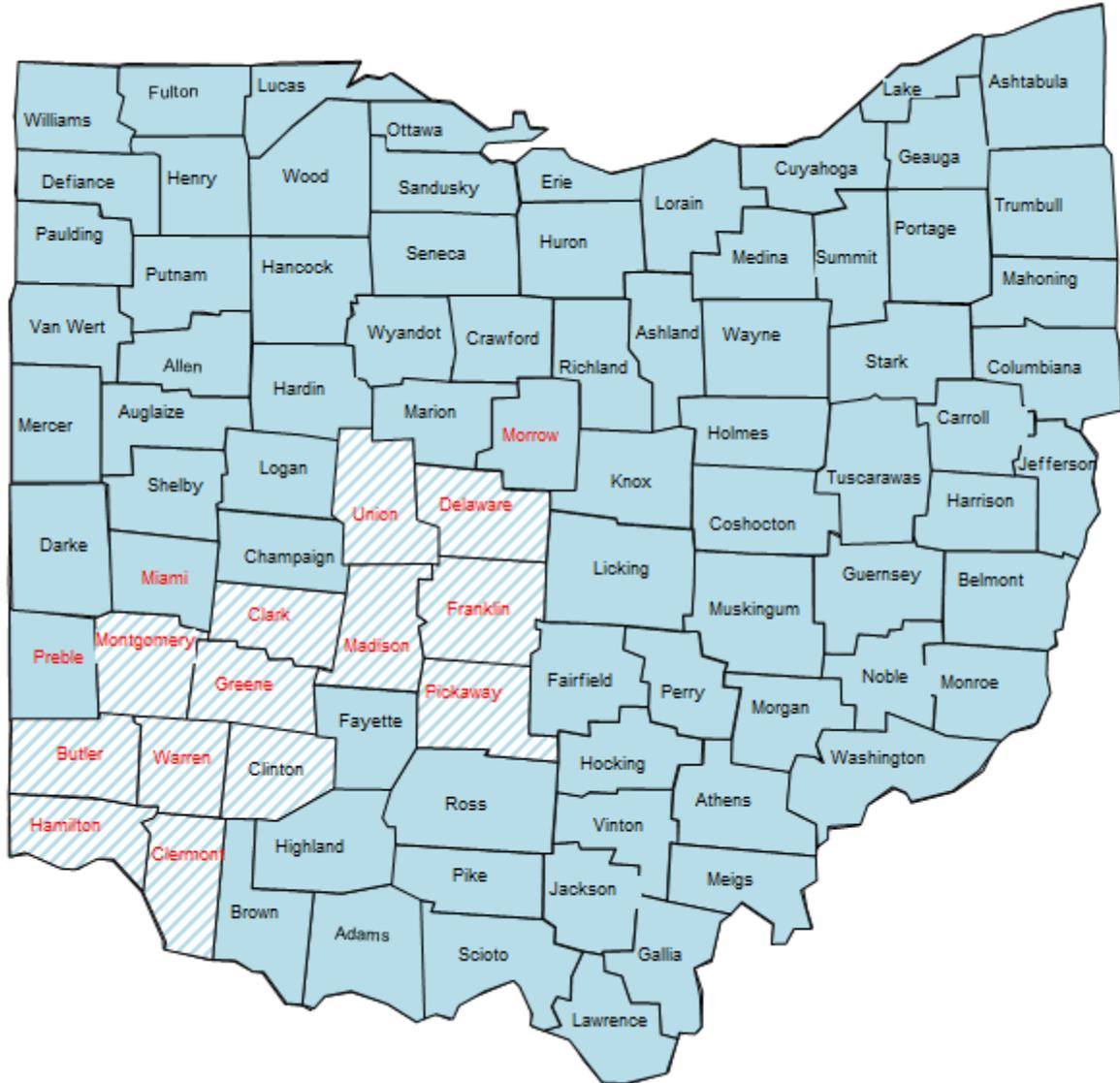
- To ensure availability of a variety of services and provide technical assistance, monitoring and evaluation of services provided.
- To assist in securing and maintaining maximum independence and dignity in a home environment for the older individual.
- To provide advocacy on behalf of the older individual.

When a client contacts the AAA, an intake coordinator will assess the need and provide the resources the client is requesting and is eligible to receive.

Molina Healthcare will work closely with the AAA to ensure that the member is getting the care that they need. Molina's Case Management Team will have a vital role in transitioning the member from Ohio Medicaid's Waiver to the Managed Care LTSS Program.

Once a provider of service has been located, billing for services will be the responsibility of the provider. Please see the billing section of this manual for additional information.

*****Ohio has 12 AAAs that cumulatively represent all 88 counties. Ohio AAAs are designated by the Ohio Department of Aging**



- ❖ The following counties are represented by Molina Healthcare of Ohio in the MyCare Ohio Program: Franklin, Delaware, Union, Madison, Pickaway, Clark, Greene, Montgomery, Warren, Butler, Hamilton and Clermont.

The AAA office that is designated for each of the counties represented in the Molina Dual Options Program is below:

Central Ohio Area Agency on Aging, AAA6
 174 East Long Street
 Columbus, OH 43215

Serving: Delaware, Franklin, Licking, Madison, Pickaway & Union Counties

Phone: 614-645-7250
Fax: 614-645-3884

Council on Aging of Southwestern Ohio, AAA1

175 Tri County Parkway
Cincinnati, OH 45246

Serving: Butler, Clermont, Hamilton and Warren Counties
Phone: 513-721-1025
Fax: 513-721-0090

Area Agency on Aging, AAA2

40 W. Second Street, Suite 400
Dayton, OH 45402

Serving: Clark, Greene and Montgomery Counties
Phone: 937-341-3000
Fax: 937-341-3005

Obtaining Referrals and Prior Authorizations

The referral is obtained while the member is enrolled on an HCBS waiver during their fee-for-service (FFS) period before they are enrolled on an ICDS plan. Molina will honor services authorized when the member was enrolled on an HCBS waiver during the transition period. Thereafter services will need to be authorized by Molina Healthcare. All waiver services will require prior authorization.

Can an Authorization be changed?

The member can request additional services or through the assessment, it can be determined by WCS and Molina Case Management that additional services or increments are needed. Once an additional need is established, the care plan will be updated and additional services authorized.

Care Management

Care Management is coordinated between the AAA's and Molina HealthCare Care Management Team.

Care Manager

- All individuals enrolled in MyCare Ohio will receive care management and be assigned a Care Manager from the Plan.

Care Management Team

The team may consist of the individual, the primary care provider, the care manager, the waiver service coordinator, as appropriate, the individual's family/caregiver/supports, and other providers based on the individual's needs and request.

What if abuse of member is suspected – who to contact?

Members and/or their authorized representative or legal guardian should report incidents to the member's MyCare Ohio care manager or waiver service coordinator along with the appropriate authorities.

Ombudsman

Long-term Care Ombudsmen safeguard consumers of care services in their areas, advocating for quality care, investigating complaints and giving them a voice. About half of these regional programs are part of the [Area Agency on Aging](#), while the other half are housed within other community service and advocacy agencies.

Ombudsmen field complaints about long-term care services, voice clients' needs and concerns to nursing homes, home health agencies, and other providers of long-term care. While they do not "police" nursing homes and home health agencies, they work with the long-term care provider and you, your family, or other representatives to resolve problems and concerns you may have about the quality of services you receive.

Ombudsmen link you with the services or agencies you need to live a more productive, fulfilling life, advise you on selecting long-term care in Ohio inform you about the rights of consumers and provide information and assistance with benefits and insurance.

To contact the Ombudsman for your region, please contact

Region 1 - Cincinnati Area

Serving Butler, Clermont, Clinton, Hamilton & Warren counties

Mary Day, Managing Ombudsman, Pro-Seniors LTCOP

7162 Reading Road, Suite 1150

Cincinnati, OH 45237

1-800-488-6070

www.proseniors.org

Region 2 - Dayton Area

Serving Champaign, Clark, Darke, Greene, Logan, Miami, Montgomery, Preble & Shelby counties

Monica Wynn

11 W. Monument, Suite 606

Dayton, OH 45402

1-800-395-8267

www.dayton-ombudsman.org

Region 6 - Columbus Area

Serving Delaware, Fairfield, Franklin, Fayette, Licking, Madison, Pickaway & Union counties

Rebecca Cooper

3820 Trueman Court
Hilliard, OH 43026
1-800-536-5891

www.centralohio.easterseals.com

Transition of Care (TOC) Policy and Requirements

Molina is committed to implementing the ICDS Waiver in a manner that allows for the safe transition of individuals while adhering to minimal service disruption. The State has developed the following requirements to aid the transition process:

In order to minimize service disruption, the MCP will honor the individual's existing service levels and providers for a pre-determined amount of time, depending upon the type of service

- The Plans will receive files of all existing authorized waiver services
- Providers can use the MITS provider portal to see if a consumer is enrolled in MyCare Ohio

Direct Care Waiver Services:

- Services will be maintained at current level and with current providers at the current Medicaid reimbursement rates for 365 days.
 - (Personal care, Waiver Nursing, Home Care Attendant, Choices Home Care Attendant, Out- of-Home Respite, Enhanced Community Living, Adult Day Health Services, Social Work Counseling, Independent Living Assistance.)

Assisted Living Waiver:

- Provider will be retained at current rate for the life of Demonstration.

All other Waiver Services:

- Services will be maintained at current level for 365 days, and existing
 - provider at existing rate for 90 days. Home Medical Equip & Adaptive and Assistive Device, Transportation, Chore, Emergency Response System, Home Modification, Homemaker, Meals, Alternative Meals, Pest Control, Nutrition Consultation, and Community Transition.

Below is a chart that summarizes the service and duration of the Transition of Care Period.

ICDS Plan Transition Requirements at Enrollment

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Physician	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
DME	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
Scheduled Surgeries	Must honor specified provider			
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider			
Dialysis Treatment	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.	90 days with same provider and level of service; and Comprehensive Plan of Care documents successful transition planning for new provider.
Vision and Dental	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Medicaid Home Health and PDN	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5160-45-01; or</p> <p>Individuals expresses a desire to self-direct services; or after 365 days.</p>	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
Assisted Living Waiver Service			Provider maintained at current rate for the life of Demonstration.	
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate for the life of Demonstration.	
Waiver Services- Direct Care Personal Care Waiver Nursing Home Care Attendant	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Plan initiated changes may not occur unless:</p>	N/A	N/A	N/A

Transition Requirements	HCBS Waiver Beneficiaries	Non-Waiver Beneficiaries with LTC Needs (HH and PDN use)	NF Beneficiaries AL Beneficiaries	Beneficiaries not identified for LTC Services
Choice Home Care Attendant Out of Home Respite Enhanced Community Living Adult Day Health Services Social Work Counseling Independent Living Assistance	A significant change occurs as defined in OAC 5160-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.			
Waiver Services- All other	Maintain service at current level for 365 days and existing service provider at existing rate for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the BH plan of care at the time of enrollment for 365 days. Medicaid rate applies during transition.

With the Exceptions:

During the transition period, change from the existing services or provider can occur in any of the following circumstances:

- Consumer requests a change
- Significant change in consumer's status
- Provider gives appropriate notice of intent to discontinue services to a consumer
- Provider performance issues are identified that affect an individual's health & welfare

Plan-initiated change in service provider can only occur after an in-home assessment and development of a plan for the transition to a new provider

During the Transition Period:

Existing providers can continue to serve current consumers who transition to MyCare Ohio. You will be working directly with participating Managed Care Plans.

- At the time of enrollment, any additional services needed by the enrollee that are not already on the enrollee's waiver service plan will need to be authorized by the Managed Care Plan.
- Plans will have their own processes for the approval of waiver services.
- A contract with the Plan is not necessary during the Transition period. Plans will reach out to providers.
- Existing providers **must make authorization and payment arrangements directly with the MyCare Ohio Plan.** Contact the Plan to make arrangements.

Self-Directed Care Services

Self-directed services means that participating individuals or their representatives have decision-making authority over certain services and manage their services with supports such as those provided by Morning Star. Self-directed services give individuals and their families more flexibility, control and responsibility for managing all aspects of the individual's care. Under Self-Directed Care, an individual is the "boss" and can hire and/or fire a provider for violations of their contract.

A waiver case manager will provide oversight to assist the consumer with self-directed personal care. The consumer also may choose an authorized representative to help with the day-to-day supervision of their service provider and to assist with employer-related tasks. A financial management agency, also known as a fiscal intermediary, will work with consumers to handle the taxes, payroll and worker's compensation responsibilities of being an employer.

All consumer-directed personal care providers are required to meet established training requirements, at the individual's expense, and to undergo criminal background checks prior to working for a PASSPORT consumer. The pay rate for consumer-directed care will be less than the current rate paid to agency providers and will be paid at a set rate

statewide. Federal law prohibits spouses, parents or legal guardians from being paid caregivers.

When a consumer is already participating in self-directed care through a Medicaid waiver prior to enrolling in the MyCare Ohio Waiver, the current provider for up to one year with the same services, frequency and rates will remain for up to one year unless any of the following happens:

- There is no longer an assessed need for one of the services;
- The authorized representative is no longer able to fulfill the responsibilities of employer;
- There is no longer an authorized representative, if required;
- The health and well-being of the consumer as determined by the Waiver Service Coordinator.

Morning Star Financial Services- Morning Star provides self-directed services for those with disabilities and the elderly in Ohio. Here are the descriptions of the primary models of service Morning Star currently supports:

Fiscal Conduit Model – The Fiscal Conduit model provides great flexibility and self-guidance. With this model, the responsibility falls on the Common Law Employer to manage business in the household such as directly paying support workers, vendors and managing or purchasing the management of your own payroll-related tasks. It is the responsibility of Morning Star as the fiscal support entity (FSE), to reimburse documented payments made after the services are rendered.

Vendor Fiscal/Employer Agent Model (Payroll Agent) – In the Vendor Fiscal/Employer Agent model the consumer or the consumer’s representative is the Common Law Employer. Morning Star is the agent providing administrative support. This support includes payment to employees, payment of payroll taxes, processing of employment related information and record-keeping.

Agency with Choice – The Agency with Choice model offers the most support to consumers or families who want to direct their own services. Under this model, Morning Star is the Common Law Employer and the consumer is the managing employer. This is a “dual employer” arrangement that empowers families to recruit, screen, hire, train, supervise and evaluate their own employees.

Contracting and Credentialing

****Currently credentialing is made through the AAA and contracting is through Molina Healthcare. Molina is required to contract only with waivers approved providers thru State of Ohio)

The Central Ohio Area Agency on Aging (COAAA) is the agency in central Ohio that must determine that any organization wanting to provide Waiver services has the

capacity to meet all of the Conditions of Participation (Ohio Administrative Code Rule 173-39-02) and relevant Service Specifications (Ohio Administrative Code Rule 173-39-02.1 through 173-39-02.17). To determine capacity, COAAA Quality Improvement (QI) coordinators examine the provider applicant's policies and procedures, documentation system, charting processes, and delivery of direct consumer services. The Provider Relations Division of the COAAA, the division charged with certifying and monitoring providers, operates with a quality improvement approach.

Who can apply to become an Ohio Department of Aging (ODA)-certified provider?

Applicants must be legal businesses (not-for-profit or for-profit) within the State of Ohio. All applicants must have provided, at the time of application, services to at least two consumers age 60 years and over in the central Ohio area for a minimum of three months. The applicant must employ qualified staff, and have written policies and procedures that support the Conditions of Participation and Service Specifications.

What are the Conditions of Participation and Service Specifications?

The Ohio Department of Aging (ODA), in consultation with the Ohio Department of Medicaid (ODM), the regional Area Agencies on Aging, and service providers, established the Conditions of Participation and Service Specifications as the standards by which all services must be delivered. They were designed to ensure the health, safety and welfare of each consumer.

The Conditions of Participation (OAC 173-39-02) apply to all service providers. The Service Specifications (OAC 173-39-02.1 through 173-39-2.17) define and set the standards for individual PASSPORT services and apply only to providers of those services.

There are no exceptions or waivers to the Conditions of Participation or Service Specifications, regardless of the size or the mission of the organization.

What does it mean to be a Contracted Provider?

- Allows you to be published as a Contracted provider with the Plan (Provider Directory, Plan Website, Medicaid Consumer Hotline)
- Established rate (s) of payment for your services, and facilitates Plans payment of claims.

As a condition of participation with Molina Healthcare, a provider must acquire and maintain ODM certification. Should a provider lose said certification, immediate termination of the contract will result.

Terminating your contract or authorization for approved services:

If a provider no longer is able or can provide for the approved services, the provider must contact the waiver service coordinator.

If the provider no longer wishes to be an LTSS provider and only wishes to be active on the other lines of business, the provider should contact Molina Healthcare immediately.

The Bidding Process:

The bidding process occurs when there is a service with no set fee. Molina Healthcare has set reimbursement fees for most of the commonly known services. Should a service not have a reimbursement, Molina will reach out to all appropriate providers to negotiate case rates.

Services that may require bids: Chore Services, Transportation, Home Modification Maintenance & Repair, Home Medical Equipment & Supplemental Adaptive and Assistive Devices, and Pest Control

Note: For ramp installation, bid is based on square footage of ramp and will include all the cost associated with the installation of the ramp for temp or permanent dwellings.

Appeals & Grievances

Appeals, Grievances, and State Hearings

Molina Healthcare maintains an organized and thorough grievance and appeal process to ensure timely, fair, unbiased and appropriate resolutions. Molina Healthcare members, or their authorized representatives, have the right to voice a grievance or submit an appeal through a formal process.

Molina Healthcare ensures that members have access to the appeal process, by providing assistance throughout the whole procedure in a culturally and linguistically appropriate manner; including oral, written, and language assistance if needed. Grievance information is also included in the Member Handbook.

This section addresses the identification, review and resolution of member grievances and appeals.

Member Appeals and Grievances

The Ohio Administrative Code (OAC) defines a grievance as an expression of dissatisfaction with any aspect of Molina Healthcare or participating providers' operations, provision of health care services, activities or behaviors.

Members may file a grievance by calling Molina Healthcare's Member Services Department at 1-855-665-4623 (TTY for the hearing impaired: 1-800-750-0750).

Members may also submit a grievance in writing to:

Molina Healthcare of Ohio, Inc.
Attn: Appeals and Grievance Department/MIRR

PO Box 349020
Columbus, Ohio 43234-9020

Members may authorize a designated representative to act on their behalf (hereafter referred to as “representative”). The representative can be a friend, a family member, health care provider, or an attorney. An authorized Representative Form can be found on Molina’s member website.

Molina Healthcare will investigate, resolve and notify the member or representative of the findings. Every attempt will be made to resolve a grievance at the time of a call. However, if a grievance is unable to be resolved immediately, it will be resolved as expeditiously as possible, but no later than the following timeframes:

- Within twenty-four (24) hours if Grievance must be expedited for the following reasons:
 - The complaint involves Molina Healthcare’s decision to invoke an extension relating to an organizational determination or reconsideration.
 - The complaint involves Molina Healthcare’s refusal to grant and a member’s request for an expedited organization determination or reconsideration.
- Two (2) working days of receipt of a grievance related to accessing medically necessary Medicaid covered services.
- Thirty (30) calendar days of receipt for grievances that are not regarding access to services.

If the grievance resolution affirms the denial, reduction, suspension, or termination of a Medicaid-covered service, or if the resolution permits the billing of a member due to Molina Healthcare’s denial of payment for that service, Molina Healthcare will notify the member of their right to request a state hearing.

All grievances received will be kept confidential except as needed to resolve the issue and respond to the member or representative.

Appeals are the request for a review of an action. The member or their representative acting on their behalf has the right to appeal Molina Healthcare’s decision to deny a service. For member appeals, Molina Healthcare must have written consent from the member authorizing someone else to represent them. A determination will not be made if written consent is not received within 15 calendar days from the date the appeal was received. An authorized Representative Form can be found on Molina’s member website. An appeal can be filed verbally or in writing within 90 days from the date of the Notice of Action. Molina Healthcare will send a written acknowledgement in response to written appeal requests received. Molina Healthcare will respond to the

member or representative in writing with a decision within 15 calendar days (unless an extension is granted to Molina Healthcare by ODM).

While lack of written consent does not pose any barrier to the commencement of the appeal process; if it is not received within the time frame, the appeal request will be closed and no determination will be made.

The member or their representative should state the reason they feel the service should be approved and be prepared to provide any additional information for review. For a copy of the Grievance and Appeal Form, see the “Forms” section of this manual.

Molina Healthcare has an expedited process for reviewing member appeals when the standard resolution timeframe could seriously jeopardize the member’s life, health or ability to attain, maintain or regain maximum function.

Expedited member appeals may be requested by the member or representative orally or in writing. Molina Healthcare will promptly inform the member or representative of the decision whether to expedite the appeal within 24 hours of receipt. With few exceptions, an expedited member appeal will be resolved as expeditiously as the member’s health condition requires but will not 72 hours from receipt. If Molina Healthcare denies the request for an expedited resolution of an appeal, the appeal will be transferred to the standard resolution timeframe of 15 calendar days from the date the appeal was received. The member or representative will be notified of an expedited resolution within 72 hours of Molina Healthcare’s receipt.

No punitive action will be taken against a member or representative for filing an expedited member appeal.

A member has the right to request a state hearing from the Bureau of State Hearings anytime there is dissatisfaction with Molina Healthcare’s decision related to Medicaid services. It is not necessary for a member or representative to file an appeal prior to requesting a state hearing.

Members are notified of their right to a state hearing in all of the following situations:

- A service denial (in whole or in part)
- Reduction, suspension or termination of a previously authorized service
- A member is being billed by a provider due to a denial of payment and Molina Healthcare upholds the decision to deny payment to the provider

A health care provider may act as the member’s authorized representative or as a witness for the member at the hearing.

Appeal decisions not wholly resolved in the member's favor will include information on how to request a state hearing and instructions on how to continue receiving benefits if benefits were denied until the time the state hearing is scheduled. If the state hearing upholds Molina Healthcare's decision and continued benefits were requested in the interim, the member may be responsible for payment.

Incident Reporting and Investigation

It is important that our providers report any activities that seem out of the norm. It is imperative that we ensure our members are protected and safe from harm. The following lists of "incidents" are required to be reported in a timely manner:

- Abuse: The infliction (by one's self or others) of injury, unreasonable confinement, intimidation or cruel punishment with resulting physical harm, pain or mental anguish.
 - Physical abuse is the intentional use of physical force resulting in injury, pain or impairment. It includes pushing, hitting, slapping, pinching and other ways of physically harming a person. It can also mean placing you in incorrect positions, force feeding, restraining or giving medication without your knowledge.
 - Emotional abuse occurs when a person is threatened, humiliated, intimidated or otherwise psychologically hurt. It includes the violation of your right to make decisions and/or the loss of your privacy.
 - Sexual abuse includes rape or other unwanted, nonconsensual sexual contact, but it can also mean forced or coerced nudity, exhibitionism and other non-touching sexual situations, regardless of the age of the perpetrator
- Neglect: When someone has a duty to do so, but fails to provide goods, services, or treatment necessary to assure your health and welfare.
- Exploitation: the unlawful or improper act of using a member or a member's resources for monetary or personal benefit, profit, or gain.
- Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) belonging to you by any means prohibited by law.
- Death of a member.

If you suspect any of the above to be true, please contact the Waiver Service Coordinator and/or the appropriate authority dependent upon the nature of the incident. For example: Molina Healthcare Fraud and Abuse Hotline (866) 606-3889 and Emergency 911

Provider Compliant Oversight

Structural Compliance Reviews (SCR) will be conducted by either Public Consulting Group (PCG) or the PASSPORT Administrative Agency (PAA).

Providers must follow the current Conditions of Participation and Service Specification requirements of the Medicaid Waiver (s) for which they are certified/approved

Each entity that pays claims will review provider's documentation to verify that services authorized and paid for are actually provided (MCP is a payor as well)

Provider Complaints:

- Work directly with the Plan first
- If not resolved, may submit complaint with ODM on-line at <https://pitd.hshapps.com/external/epc.a.spx>
- Certification issues work with AAA or ODM

Fighting Fraud, Waste and Abuse

Proper member identification is vital to reduce fraud, waste and abuse (FWA) in government health care programs. The best way to verify a member's identity is to obtain a copy of the member's ID card and a form of picture ID. Do you have suspicions of member or provider fraud? The Molina Healthcare AlertLine is available to you 24 hours a day, seven days a week, even on holidays at (866) 606-3889. Reports are confidential, but you may choose to report anonymously.

Claims and Encounter Data

Providers are required to bill Molina Healthcare of Ohio for all LTSS waiver services through mail using paper claims, EDI submission, or through the Web Portal. After registering on the Molina Web Portal a provider will be able to check eligibility, claim status and create/submit claims to Molina Healthcare. To register please visit: [Provider Self Services Web Portal](#)

Billing Molina

When billing Molina for services rendered, the following information must be captured during the billing process:

Member name, date of birth and ID number

- Date(s) of service for each service rendered
- Other insurance information, as applicable
- ICD-9 diagnosis and procedure codes
 - When an ICD-9 Diagnosis Code (Dx) is not available the default Dx Code shall be 780.99 ("other general symptoms")
 - When an ICD-10 Code is not available the default is ICD-10 R68.89

- ICD-9 diagnosis code reference
A single encounter may frequently correlate with multiple procedures and/or diagnosis codes. Diagnosis code reference indicators are required if at least one diagnosis code appears on the claim and must be present with the line item it is associated with in the claim line details section of the web portal. This is a single digit field used to “point” to the most appropriate ICD-9 codes by linking the corresponding diagnosis reference number (1, 2, 3, and/or 4) from the diagnosis indicated in the Diagnosis Code section
- When default ICD-9 diagnosis code 780.99 is the only diagnosis code billed, the diagnosis code reference is 1.
- HIPAA-compliant CPT, HCPCS and modifier code sets
(see below for additional information)
- Billed charges for each service line
- Total billed charges for the claim
- Place and type of service code
 - Examples: 01-Medical Care; 09-Other Medical; 97-Room and Board; 99-Ancillaries
- Units, as applicable (refer to the coding guide appendix)
- Provider federal tax identification number
- National Provider Identifier (NPI) or Ohio Medicaid identification Number (for Atypical Providers only) for rendering and billing/pay-to provider in the appropriate fields
- Rendering Provider Name
- Service Facility location information
- Pay-To Provider Name

Atypical Providers

Atypical providers are service providers that do not meet the definition of health care provider. Examples include taxi drivers, carpenters, personal care providers, etc. Although, they are not eligible to receive an NPI, these providers perform services that are reimbursed by Molina Healthcare of Ohio.

Atypical providers are required to use their Medicaid Identification Number given to them by the state of Ohio to take the place of the NPI. As long as the provider submits with the Medicaid ID number the claims will NOT be rejected back to the provider for missing information.

***When billing Molina Healthcare for Waiver Services, the HCPC Code and Modifier Description Guide can be used to locate the proper billable codes. This guide can be accessed by clicking on the following link: [LTSS Waiver Coding Guide](#). A numerical version of the guide is located in Appendix section of this manual.

Claim Submission

All claims (medical and behavioral health services) should be submitted to Molina Healthcare with appropriate supporting documentation.

- Molina Healthcare accepts the following claim forms:
 - CMS 1500 - AMA universal claim form also known as the National Standard Format (NSF) CMS Forms List - Centers for Medicare & Medicaid Services
<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html>
 - CMS 1450 - UB-04 (for hospitals)
<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-List.html>
- Claims for services that require prior authorization, but were not prior approved by Molina Healthcare, will be denied for no authorization.
- Providers must bill Molina Healthcare for services with the most current coding available, using HIPAA-compliant transaction and code sets.

Claims Submission: Web-Portal

It is preferred that all LTSS claims submission be made through the Molina Web-Portal when available.

- Web-Portal (www.MolinaHealthcare.com) Provider Self-Services
 - Register today to access our on-line services. A video will guide you through the easy on-line registration process.
 - Submit claims
 - Status claims
 - Print claims reports
 - If you experience any problems with the Provider Self-Services website, please contact Molina Healthcare's Help Desk at 1-866-449-6848 for technical assistance or call your Provider Services Representative directly.
- Emdeon - Electronic Data Interchange (EDI) Gateway Partner
 - Emdeon accepts all electronic claims (837P/837I) on behalf of Molina Healthcare. As a provider, you may continue to submit claims to your existing EDI clearinghouse: they will forward your files to Emdeon.
 - Providers billing Molina Healthcare electronically should use **payer number 20149**.
 - If you experience any problems with your transmission, please contact your local clearinghouse representative.

For additional information, go to Molina Healthcare's EDI website - www.MolinaHealthcare.com.

Molina Healthcare encourages electronic claim submission as it provides your office with the following benefits:

- Reduces operational costs associated with paper claims
- Reduces time for Molina Healthcare to receive a claim by eliminating mailing time
- Increases accuracy of data
- Ensures HIPAA compliance

Track your electronic transmissions using acknowledgement reports to ensure that claims are received for processing in a timely manner. When your claims are filed electronically you will:

- Receive an acknowledgement from the clearinghouse.
- Receive an acknowledgement from Emdeon within 5-7 business days of your transmission.

Creating a Claim in Web-Portal

There are three (3) sections in creating professional claims; **Member**, **Provider** and **Summary**.

Member	
Member Information	Enter insured member's information and patient information will automatically populate based on input. If patient is not same as insured subscriber, enter patient information. (e.g. newborn covered under mother)
Patient Condition	Enter dates that apply to patient condition as well as referring information and EPSDT claims. Include ambulance claims information, if applicable.
Verify Required Information	Requires that you enter place of service, patient account number, other health benefit plan (if known) and authorization to release patient information.
Other Insurance	Enter information for other insurance, if applicable.
Other Information	Enter other information such as Auto Accident, Employment, Other Party Responsible, etc., if known.
Provider	
Submitter Contact Information	Enter all required fields for submitter's contact information.
Billing Provider Information	The required information will automatically populate based on your account or the Billing Provider you selected from the drop down menu.
Rendering Provider Information	The required information will automatically populate based on your account or the Renderings Provider you selected from the drop down menu. If the rendering provider information is not available, call the Provider Services department for your state.
Facility Information	The required information will automatically populate based on your account or the Facility you selected from the drop down menu.
Diagnosis Code	Enter or search for a diagnosis code(s). You must enter at least one (1) diagnosis code.
Claim Line Details	Service From Date, Service To Date, Place of Service, Procedure Code,

	Units of Measurement, Quantity and Charges are required to add Claim Line Details. At least one Diagnosis Code reference is required for each claim line entered to submit your claim.
Supporting Information	This section is available for comments and remarks or brief explanatory statements. Comments are limited to 256 characters.
Summary Section	Summary section shows all input from the member and provider forms. You may review your inputs in this section before submitting the claim.

Open Incomplete Claim

Providers have the option to save an incomplete claim. To retrieve a claim take note of the Tracking Number found on top of the claim and open unsaved claim through **Claims Inquiry** page.

Export Claims Report Excel

The export claims report module allows you to download a report of claims submitted. Enter Service Dates From and Service Dates To, then click **Submit**. Click **Search** and an Excel file will be generated and placed in the Download Exported Claims module.

Download Exported Claims File

After you have exported a claim file, click **Save** to download the file and open file in Excel.

TIMELY CLAIM PROCESSING

In accordance with 42 C.F.R. § 447.46, the ICDS Plan must pay ninety percent (90%) of all submitted Clean Claims within thirty (30) days of the date of receipt and ninety-nine percent (99%) of such claims within ninety (90) days of the date of receipt.

The clean pharmacy and non-pharmacy claims will be separately measured against the thirty (30) and ninety (90) day prompt pay standards. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the ICDS Plan and delegated claims processing entities.

A clean claim is a claim that has no defect or impropriety, contains all required substantiating documentation and does not involve circumstances that require special treatment that could prevent timely payment. The receipt date of a claim is the date that Molina Healthcare receives either written or electronic notice of the claim. All hard copy claims received by Molina Healthcare will be stamped with the date of receipt.

ERA/EFT

Molina Healthcare offers Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) with our contracted vendor Change Healthcare. There is no fee related to the accessibility of your payment data as well as the EFT payment processing. This is a FREE service for you to take advantage of. Registration for the EFT/ERA is available on the Change Healthcare website.

Registration for the EFT/ERA is available on the Change Healthcare website. Once your registration is complete the following will occur:

- It takes normally 10 calendar days for pre-note approval
- An initial payment to at least one Tax ID + NP association is necessary to become eligible for EFT through Change Healthcare
- Monies can be transferred into your bank account within 24 hours of Molina Healthcare's payment process.

Explanation of Payment (EOP)

- EOP's are available to view and download on the Change Healthcare website.
- The EOP PDF will remain online for up to 12 months after the original payment

If you have any questions regarding the process, please contact:

wco.provider.registration@changehealthcare.com

Registration can be made by logging onto

<https://providernet.adminisource.com/Terms.aspx>

Timely Filing

Original Claims: Claims for covered services rendered to Molina Healthcare members must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 120 days from the date of service(s). Claims submitted after the filing limit will be denied.

Corrected Claims: Claims received with a correction of a previously adjudicated claim must be received by Molina Healthcare no later than the filing limitation stated in the provider contract or within 180 days of the original remittance advice. Claims submitted after the filing limit will be denied.

Claim Reconsiderations

Providers seeking an adjustment of a previously adjudicated claim must request such action within 180 days of the original remittance advice unless otherwise stated in the provider contract. Requests for claim adjustments submitted after the 180 day period or the timeframe specified in the provider contract cannot be considered.

In the event Molina Healthcare identifies the primary insurance information on file is incorrect, leaving Molina Healthcare as the primary carrier, the member's information will be updated and claims previously denied within 120 days of the COB update will be reprocessed. Claims denied prior to 120 days of the COB update will not be reprocessed.

The request for a claim adjustment must include the following documentation to allow for a thorough review of the request:

- A completed Molina Healthcare Claim Reconsideration Request Form marked as MyCare Ohio or a cover letter that includes the claim number and clearly explains the reason for the adjustment request.

- Additional documentation related to the claim, including the previous claim and remittance advice, a copy of the referral/authorization form (if applicable) and any other documentation to support the adjustment.
- The item(s) being resubmitted should be clearly marked as a request for an adjustment.

Forms are available at <http://www.MolinaHealthcare.com>. Select Providers, Ohio, Forms.

Requests for claim adjustments can be faxed to:
Fax: (800) 499-3406

90% of requests will be processed within 30 days of receipt. Molina Healthcare will return a response to the provider on the decision of the reconsideration request via fax, whenever this number is provided. All other responses will be sent via mail to the billing address on file.

Overpayment Requests

In the event Molina MyCare Ohio Dual Options determines that a claim has been overpaid; is a duplicate payment; or that funds were paid which were not provided for under the provider's contract, the overpayment amount will be automatically recovered by way of offset or recoupment unless the provider contract states otherwise. All recovery activity will appear on your Remittance Advice. The provider has sixty (60) days to refund Molina Healthcare by check or an accounts receivable will be established and the amount of the overpayment will be deducted from the provider's next check(s). All recovery activity will appear on your Remittance Advice. Use the Return of Overpayment Form to submit unsolicited refunds or check returns. Go to <http://www.MolinaHealthcare.com>. Select Providers, Ohio, Forms.

If you have any questions regarding a refund request letter, please call the Claims Recovery Unit at 1-866-642-8999 and follow the prompts to Ohio or Molina Healthcare Provider Services at 1-855-322-4079

In the event the provider receives a check that is not theirs or finds an overpayment, please send the refund with a copy of the Remittance Advice and claim information to:

Please direct payment and any correspondence to:

Molina Healthcare of Ohio
P.O. Box 715257
Columbus, Ohio 43271-5257

If returning a Molina Healthcare check, please send to:

Molina Healthcare of Ohio
P.O. Box 349020
Columbus, Ohio 43234-9020

Claims Coding

Billable codes are based on Current Procedural Terminology (CPT), Medicaid Purchasing Administration (MPA) guidelines, industry standard National Correct Code Initiative (NCCI) policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

The National Correct Coding Initiative (NCCI) developed by CMS helps promote national correct coding methodologies for ensuring that claims are coded appropriately according to State and Federal coding guidelines. The coding policies developed are based on:

- Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual;
- National and local policies and edits;
- Coding guidelines developed by national societies;
- Analysis of standard medical and surgical practice; and
- Review of current coding practice.

Billing Molina Healthcare Members

In accordance with OAC 5160-26-05 Managed Health Care Programs: Provider Panel and Subcontracting Requirements, a provider may bill a Molina Healthcare member only for *non-covered* services OR those services determined not to be medically necessary by Molina Healthcare's Utilization Management Department if both the member and the provider sign a payment agreement prior to the services being rendered. The agreement must be specific to the services being rendered and clearly state:

- The service is not covered by ODM or Molina Healthcare OR services determined not to be medically necessary by Molina Healthcare's Utilization Management Department.
- The member is choosing to receive the service and agrees to pay for it, even though the service may have been determined by Molina Healthcare to be not medically necessary.
- The member is under no obligation to pay the provider if the service is later found to be a covered benefit, even if the provider is not paid because of non-compliance with Molina Healthcare's billing and/or prior authorization requirements.
- For members with limited English proficiency, the agreement must be translated or interpreted into the member's primary language to be valid and enforceable. This interpretation/translation service is the responsibility of the provider to supply.

Patient Liability

Patient Liability is the portion of health care costs that a patient is required to pay. Patient Liability is paid directly to a long-term care provider. Examples of services subject to Patient Liability are as follows:

- Medical Institution
- Long-Term Care Facility
- Intermediate Care Facility for Mentally Retarded (ICF-MR)
- Home and Community Based Waiver Service (HCBCS)

Patient Liability remains the same each month unless there is a change in the clients income or deductions. The amount that a patient pays is set by ODM standards and guidelines.

*******Please note billing members for missed appointments is prohibited.**

OAC References for LTSS Services and Covered Benefits

[5101:3-46-04](#) Ohio home care waiver: definitions of the covered services and provider requirements and specifications.

[5101:3-1-06.1](#) Home and community-based service waivers: PASSPORT.

[173-39-02.6](#) Emergency Response Service

[5101:3-46-04](#) Ohio Home Care Waiver: Definitions of Covered Services and Provider Requirements and Specifications, paragraph H

[5101:3-1-06.1](#) [HCBS Waivers: Passport, Appendix A](#)

[5101:3-31-02](#) , entitled Passport program definitions.

[5101:3-1-06.4](#) [Home and Community-Based Waivers: Choices](#)

[5101:3-1-06.4](#) [HCBS Waivers: Choices, Appendix A](#)

[5101:3-46-06](#) Ohio Home Care Waiver Program: Reimbursement Rates and Billing Procedures

[173-39-02.13](#)- Non-emergency medical transportation service

[173-39-02.18](#) Non-medical/supplemental transportation service

[173-39-02.2](#) Alternative Meal Service

[173-39-02.14](#) Home Delivered Meal Service

[173-39-02.10](#) Nutritional Consultation Service

[173-39-02.16](#): Assisted Living Service

[5101:3-1-06.5](#): Home and Community Based Services (HCBS)

[173-39-02.9](#) Minor home modification, maintenance, and repair services

[5101:3-46-04](#) Ohio home care waiver: definitions of the covered services and provider requirements and specifications

[173-39-02.3](#) Pest Control Services

[5101:3-46-04](#) Ohio Home Care Waiver: Definitions of Covered Services and Provider Requirements and Specifications, paragraph G

[5101:3-46-06](#) Ohio Home Care Waiver Program: Reimbursement Rates and Billing Procedures

[5101:3-50-04](#) Transitions Carve-Out Waiver: Definitions of Covered Services and Provider Requirements and Specifications, paragraph G

[5101:3-50-06](#) Transitions Carve-Out Waiver: Reimbursement Rates and Billing Procedures

Appendix

HCPC Code and Modifier Description Guide

HCPC Code	Modifier	Description	Unit Increment
S5101		Adult Day Health Center Svcs	half day
S5102		Adult Day Health Center Svcs	full day
T1019		Personal Care Aide Svcs	15 minutes
T2029		Supp Adaptive & Assistive Devices	per service
S5165		Home Modifications	per service
S5160		Emergency Response Services	installation
S5161		Emergency Response Services	monthly fee
S5170		Home Delivered Meals	per meal
S0215		Supplemental Transportation	per mile
T1002	RN	Waiver Nursing	15 minutes
T1003	LPN	Waiver Nursing	15 minutes
S5125		Home Care Attendant - Nursing	15 minutes
S5125	U8	Home Care Attendant - Personal Care	15 minutes
H0045		Out of Home Respite	per day
		Passport Waiver	
S5102	UA	Adult Day Service - Enhanced	1 day
S5101	UA	Adult Day Service - Enhanced	1/2 day
S5100	UA	Adult Day Service - Enhanced	15 minutes
S5102	UAU3	Adult Day Service - Intensive	1 day
S5101	UAU2	Adult Day Service - Intensive	1/2 day

S5100	UAU1	Adult Day Service - Intensive	15 minutes
A0080	UA	Adult Day Service - Transportation	1 mile
A0080	UAU2	Adult Day Service - Transportation (2nd)	1 mile
T2003	UA	Adult Day Service - Transportation	1 one-way trip
T2003	UAU2	Adult Day Service - Transportation (2nd)	1 one-way trip
T2025	UAU5	Adult Day Service - Transportation	1 round trip
T2025	UAU2	Adult Day Service - Transportation (2nd)	1 round trip
S5170	UA	Home Delivered Meals	1 meal
S5170	UAU6	Home Delivered Meals - Therapeutic	1 meal
S5170	UAU7	Home Delivered Meals - Kosher	1 meal
S5130	UA	Homemaker Service	1/4 hour
S5121	UA	Chore Service	1 job
G0155	UA	Social Work Counseling Service	1/4 hour
S9470	UA	Nutritional Consultation Service	1/4 hour
T1019	UA	PCS by Cert Long Term Care Agency Prov	1/4 hour
T1019	UAU2	PCS by Cert Long Term Care Agency Prov (2nd)	1/4 hour
T1019	UAU1	PCS by Consumer Directed Personal Care	1/4 hour
T1019	UAU3	PCS by Consumer Directed Personal Care (2nd)	1/4 hour
T1019	UAU4	PCS by Consumer Directed PC (OT)	1/4 hour
T1999	UAU1	Home Medical Equip/Supplies - Ambulatory	1 item
T1999	UAU2	Home Medical Equip/Supplies - Ambulatory (2nd)	1 item
T1999	UAU3	Home Medical Equip/Supplies - Ambulatory (3rd)	1 item
T1999	UAU4	Home Med Equip/Supplies - non-ambulatory	1 item
T1999	UAU5	Home Med Equip/Supplies - non-ambulatory (2nd)	1 item
T1999	UAU6	Home Med Equip/Supplies - non ambulatory (3rd)	1 item
T1999	UAU7	Home Med Equip/Supplies - Hygiene/disposables	1 item
T1999	UAU8	Home Med Equip/Supplies - Hygiene/disposables (2nd)	1 item
T1999	UAU9	Home Med Equip/Supplies - Hygeine/disposables (3rd)	1 item
T1999	UA	Home Med Equip/Supplies - Equipment and Repair	1 item
T1999	UAUC	Home Med Equip/Supplies - Nutrition Supplement	1 item
S5161	UAU1	Personal Emergency Response System	1 month rental
S5161	UAU2	Personal Emergency Response System	1 partial month
S5160	UA	Personal Emergency Response System	installation
S5161	UAU3	Personal Emergency Response System	2nd pendant rental
S5162	UA	Personal Emergency Response System	Alternative ERS Device
S5165	UA	Environmental Accessibility Adaptations	1 completed work order
S5135	UA	Independent Living Assist - In Person Activities	1/4 hour
S5135	UAU5	Independent Living Assist - Travel Attendant	1/4 hour
S2025	UA	Independent Living Assist - Telephone Assistance	1 completed call
T2025	UAU6	Transportation	1 round trip

T2025	UAU3	Transportation (2nd)	1 round trip
T2003	UAU5	Transportation	1 one-way trip
T2003	UAU4	Transportation (2nd)	1 one-way trip
T2038	UA	Community Transition Service	1 completed job order
A0200	UA	Non Medical Transportation	1 round trip
A0200	UAU2	Non Medical Transportation (2nd)	1 round trip
A0100	UA	Non Medical Transportation	1 one-way trip
A0100	UAU2	Non Medical Transportation (2nd)	1 one-way trip
T2025	UAU1	Enhanced Community Living Service	1/4 hour
		Choices Waiver	
S5102	UB	Adult Day Service - Enhanced	1 day
S5101	UB	Adult Day Service - Enhanced	1/2 day
S5100	UB	Adult Day Service - Enhanced	15 minutes
S5102	UBU3	Adult Day Service - Intensive	1 day
S5101	UBU2	Adult Day Service - Intensive	1/2 day
S5100	UBU1	Adult Day Service - Intensive	15 minutes
A0090	UB	Adult Day Service - Transportation	1 mile
A0090	UBU2	Adult Day Service - Transportation (2nd)	1 mile
T2003	UBU4	Adult Day Service - Transportation	1 one-way trip
T2003	UBU2	Adult Day Service - Transportation (2nd)	1 one-way trip
T2025	UBU5	Adult Day Service - Transportation	1 round trip
T2025	UBU4	Adult Day Service - Transportation (2nd)	1 round trip
T2029	UBU1	Home Medical Equip/Supplies - Ambulatory	1 item
T2029	UBU4	Home Med Equip/Supplies - non-ambulatory	1 item
T2029	UBU7	Home Med Equip/Supplies - Hygiene/disposables	1 item
T2029	UB	Home Med Equip/Supplies - Equipment and Repair	1 item
T2029	UBBC	Home Med Equip/Supplies - Nutrition Supplement	1 item
S5161	UBU1	Personal Emergency Response System	1 month rental
S5161	UBU2	Personal Emergency Response System	1 partial month
S5160	UB	Personal Emergency Response System	installation
S5161	UBU3	Personal Emergency Response System	2nd pendant rental
S5162	UB	Personal Emergency Response System	Alternative ERS Device
S5165	UB	Environmental Accessibility Adaptations	1 completed work order
S5170	UB	Home Delivered Meals	1 meal
S5170	UBU2	Home Delivered Meals - Therapeutic	1 meal
S5170	UBU7	Home Delivered Meals - Kosher	1 meal
S5170	UBU3	Alternative Meal Service	1 meal
S5121	UB	Pest Control	1 job
		Assisted Living Waiver	
T2031	U1	Tier 1	per day

T2013	U2	Tier 2	per day
T2031	U3	Tier 3	per day
T2038	U4	Community Transition Svc (for NH residents enrolling in the waiver)	1 completed job order
		ICDS Waiver	
T2031	U1	Assisted Living Service - Tier 1	per day
T2031	U2	Assisted Living Service - Tier 2	per day
T2031	U3	Assisted Living Service - Tier 3	per day
S5101		Adult Day Health	half day
S5102		Adult Day Health	full day
A0080		Adult Day Health - Transportation	per mile
T1019		Personal Care - Employer Authority	15 minutes
T1019	HQ	Personal Care - Employer Authority - group visit	15 minutes
S5130		Homemaker	15 minutes
S5121		Chore Service	per job
T2029		Home Med Equip and Supp Adaptive and Assist Devices - Budget	per service
S5165		Home Modifications maintenance and repair - Budget Authority	per service
S5160		Personal Emergency Response	installation
S5161		Personal Emergency Response	monthly rental
S5170		Home Delivered Meals	1 meal
S5170	UBU3	Alternative Meals - Budget Authority	1 meal
S0215		Waiver Transportation	per mile
T2001	RN	Waiver Nursing	15 minutes
T2003	LPN	Waiver Nursing	15 minutes
T2001	RNHQ	Waiver Nursing - group visit	15 minutes
T2003	LPNHQ	Waiver Nursing - group visit	15 minutes
S5125		Home Care Attendant - Nursing	15 minutes
S5125	U8	Home Care Attendant - Personal Care	15 minutes
H0045		Out of Home Respite	per day
T2025		Enhanced Community Living	15 minutes
G0155		Social Work Counseling	15 minutes
S9470		Nutritional Consultation	15 minutes
S5135		Independent Living Assistance	15 minutes
T2038		Community Transition	1 completed job
T2025	UB	Choices Home Care Attendant - Employer/Budget Authority	15 minutes
S5121	UB	Pest Control - Budget Authority	1 job

