



HCBS Provider Training MyCare

Agency Providers

Home Health & Home Care

Training Module Summary

Home Health Provider

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- Requirements
- Responsibilities

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- Home Care Agency or Non-Medical Home Care Agency

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- Submitting Claims
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Home Health Provider Overview

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- Requirements
- Responsibilities

Description, Agency Provider

Buckeye's 3-way agreement with CMS and ODM guides us the same as it does our providers.

According to the Ohio Administrative Code regulations:

“Agency provider” means an entity employing one or more persons..... with a **designated person** directly and actively responsible for the day-to-day operations and administration of the agency**supervise and manage** the conduct of **agency employees** adherence to employment laws including rules and regulations set forth in the Ohio Administrative Code.

5123:2-2-01 Provider certification.

Home Health, Agency Waiver Provider

- Provided to members who are:
 - ✦ **Fully eligible** for both Medicare and Medicaid
 - ✦ Enrolled in a **MyCare Ohio** Plan
 - ✦ Meet an intermediate or skilled **level of care**
- Services include waiver nursing, home care attendant, personal care aide, homemaker and chore service.
- Services **must be authorized** by the Waiver Service Coordinator/Care Manager based on member waiver eligibility.

Home Health, Agency Non-Waiver

- Provided to members:
 - 🌿 **Fully eligible** for both Medicare and Medicaid
 - 🌿 Enrolled in a **MyCare Ohio** Plan
- Services include home health nursing, home health aide, and skilled therapies (physical therapy, occupational therapy, and speech-language pathology).
- The medical necessity for home health services must be certified by the member's qualifying treating physician.
- Providers of home health services are Medicare Certified Home Health Agency (MCRHHA).

Requirements, Home Health Agency

Providers are required to have a **Medicaid Provider agreement** with ODM.

- The Ohio Department of Medicaid sends BHP daily updates as new providers are activated and others are terminated.

Provider waiver-certification is required. Certification is approved, administered, awarded and managed by:

- PCG (Public Consulting Group)
- ODA (Ohio Department of Aging)
- Updates from ODM will include type(s) of waiver-certification
- The timeline to become ODM & Waiver-certified **can be lengthy** as there are several steps in the process.

5123:2-2-01 Provider certification.

Responsibilities, Home Health Agency

The Home Health Agency shall:

- **Understand what specific services** they are approved and certified to provide
- Be able to **readily supply the TIN and NPI** when accepting referrals
- Provide services **only to eligible individuals** whose needs he or she can meet
- **Be knowledgeable in the individual service plan** for each individual served prior to providing services to the individual

5123:2-2-01 Provider certification.

Responsibilities, Home Health Agency

The Home Health Agency shall accept responsibility for:

- Deliver services in accordance with the individual service plan
- **Service documentation** – scheduling and time reporting
- **Billing for services** – manage claims submissions

5123:2-2-01 Provider certification.

Home Health Provider Overview

Agency Types

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- Home Care Agency or Non-Medical
- Home Care Agency

Skilled Home Health Agency

The main and distinctive purpose of this type of agency is to provide **skilled care for treatment or rehabilitation services to homebound patients.**

Skilled home health professionals must strictly adhere to a physician approved **plan of care** that is deemed medically necessary and updated every 60 days in order for Medicare benefits to continue.

- Home health agency is licensed and usually Medicare certified
- Medicare certification means that the agency has met specific federal guidelines and criteria regarding patient care

Non-Skilled Home Care Agency

- home care agency services which are **non-skilled supportive custodial care**
- supplied by home health aides, certified nursing assistants (CNAs) and also non-certified nurse aides, and homemakers

Services range from meal preparation and light housekeeping to assistance with personal care such as bathing, dressing, toileting, and eating:

- not reimbursable under Medicare
- may be paid for by waiver for eligible participants
- physician's order is not required
- patient homebound status not required
- professionally authorized and monitored care plan is unnecessary

Home Health Agency, Waiver

Personal Care Aide	Homemaker	Home Health Aide
T1019	S5130	G0156
ODM-certified for services based on Home Health Aide training from ODH or ODM		

Home Health Agency, Waiver Skilled

Waiver Nursing	Private Duty Nurse (PDN)
RN: T1002 LPN: T1003	T1000
intermittent or continuous skilled nursing - these are nursing needs not being met through state plan	continuous skilled nursing

Types of Nursing Service

- Home Health Nursing (state plan) is “intermittent” skilled nursing care with a visit limit of 4 hours (16 units) or less.
- PDN (state plan) (Private Duty Nursing) is “continuous” skilled nursing care with a visit limit of more than 4 hours (17 units) but less than or equal to 12 hours (48 units).
- Waiver Nursing (waiver) is nursing care that requires the skills of an RN or LPN at the direction of an RN. It can be intermittent or continuous.

Home Health Agency, Waiver Skilled

Waiver Nursing	Private Duty Nurse (PDN)
RN: T1002 LPN: T1003	T1000
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Home Health Provider Overview

Member Information

- Eligibility & Services
- Transition of Care & Coordination of Care
- Service Plans & Authorizations

Member Eligibility & Services

Eligibility

- 1) Confirm that the member is waiver eligible
- 2) By contacting Provider Services at 866-296-8731 to verify member type, status and eligibility for waiver services, or
- 3) Search Member on Buckeye Web Portal

Services

- 1) Review the Service Plan (SP) that you are correctly listed
- 2) You must be eligible, certified and able to provide services as listed
- 3) Obtain Authorization confirmation

Transition of Care/Continuity of Care

The 3-Way Contract requires compliance with program requirements:

Care Management

- Manage **assessments** and **evaluate** for changes

Coordination and Continuity of Care

- Our goal is to **transition individuals** with as little disruption as possible
- Copies of member's previous Service Plan and Assessments are helpful to this process

Service Plan & Authorization Knowledge

- **Prior Authorization is required** for coverage of services coordinated for beneficiaries of the MyCare Ohio Waiver Program.
- The **Service Plan** (SP) identifies the services and all will vary
- The IP is responsible to **review each Service Plan** to assure that you are correctly listed as a provider for an eligible service identified on the SP.
- Being listed on the SP will validate approval and is the **basis for rendering services**.
- The **Authorization Confirmation** will further validate **approval to bill for services**.

Waiver Home Health Authorization

- Waiver Home Health Services
- Services will be based on the member's Services Plan (SP).
- The Waiver Service Coordinator (WSC) will be in contact with both the member and provider.
- Once services are added to the All Services Plan (ASP), an authorization will be entered into the system by an HCBS Program Coordinator.
- ➤ The All Services Plan (ASP) is authorization to begin and/or continue services – please do not delay services while awaiting an authorization number from Buckeye .
- The HCBS Program Coordinator will fax service providers with an authorization number to submit claims for payment.

Home Health Authorization

- Medicaid (state plan) services follow a separate authorization process from waiver services.
- Buckeye understands that an efficient prior authorization (PA) process is important to our providers. The following information for requesting a home health prior authorization will help make sure that we receive all of the information needed to process your requests as quickly as possible so that you can focus on what's most important – providing care to your patients.

The Buckeye Basics

- This basic information is required for all PA requests for home health (state plan) services.
- Verify member eligibility with Buckeye.
- Complete the appropriate authorization form (Medicare, Medicaid, MyCare).
- Attach supporting documentation required for home health services when submitting.

*****Remember, authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.**

Documentation

Start of Care Only

- Documentation of a face to face encounter with the treating physician within 90 days prior to the start of care date, or within 30 days following the start of care date.

Start of Care and Continuing Care Requests

- Supporting documentation of the patients need for home health services.
- Date of last face to face encounter with physician.
- Written physician's order for continuing home health services from the attending physician actively treating the patient.
- All Home Health requests require ongoing supervision of the treating physician. The treating physician must order recertification and document the clinical need for continuation of services.

Clinical Information

- Current diagnosis and co-morbidities
- Current medical status
- Medication list and compliance
- Recent hospitalization information
- DME currently utilized
- If requesting home health nurse visits, indicate the specific skilled nursing need to support the request.
- Latest 485 form, when available
- Provide a complete description of any wounds: size, depth, type and frequency of dressings.
- Daily home health notes for the last 2 weeks for continuing care.

Helpful Hints

These hints will help ensure that your PA requests contain all of the necessary information for review the first time they are submitted.

- Contact us. Buckeye is able to answer any questions you may have prior to submitting your request.
- Fax your PA requests, including all clinical documentation and signed CMN to the appropriate fax number.
- Maximum time requested is 60 days for start of care and continuing care per request.
- No more than a combined total of 14 hours (56 units) per week of home health nursing and home health aide services.
- The main purpose of home health services cannot be to provide incidental services. Incidental services include light chores , light house cleaning, preparing of meals and/or taking out the trash. These incidental services cannot increase the total number of hours requested.

Most Common Errors

Avoid the most common reasons for delay or denial of PA requests.

- Insufficient or missing clinical information necessary for review of the home health services.
- Lack of progress notes.
- Illegible documentation.

Home Health Provider Overview

Submitting Claims

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Billing for Services, Submit Claims

- Login into the Provider Portal at <https://provider.buckeyehealthplan.com>
- Refer to the **HCBS Quick Billing Guide** training module for complete step-by-step instructions

Specific to claims submissions:

- Diagnosis code: **R6889** (or you may use existing diagnosis code)
- Place of Service*: **Home (12)**
- Procedure codes: **T1019, G0156, T1002, T1003, T1000** reference the member's Service Plan for accuracy)
- Modifiers: **U2, U3** for same-day 2nd and 3rd visits, **TE, TD** for RN and LPN with T1000 and G0154 , **HQ** for groups
- Dates of Service: **same date in both date fields, enter each service date on separate line**
- Units/Minutes/Days*: enter total units for each visit (15 minutes/unit)
- Charges: enter **total charges** (this is not calculated for you)

Home Health Provider Overview

Provider Network

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Provider Network Status



- Providers **must be loaded** as an approved and certified waiver provider in the Buckeye system in order to **provide and bill** for services to waiver eligible members.
- Contact your Provider Network Specialist for more information.

Buckeye and the Area Agency on Aging

Buckeye **partners with the Area Agency on Aging** offices in each of the Buckeye MyCare areas.

- AAA Waiver Services Coordinators work alongside Buckeye to **manage and coordinate the care planning and services for individuals ages 60 and over.**
- On Buckeye's behalf, AAA administers the bi-annual **Provider Unit Service Utilization Review**, an ODM requirement that compares the service documentation with billing information for a random selection of providers.
- AAA and Buckeye collaborate on various projects and share objectives that focus on **consumer and provider** satisfaction and engagement.

Contacts, Care Management Teams



Member's Care Manager Identification (866) 549-8289 option 3
(Leave a message that will be returned within 2 business days)



Service Plan & Waiver Authorization Requests
Contact Member's AAA Waiver Service Coordinator or
Buckeye Care Manager, or
Christina Brim (866) 246-4356 ext 24365 CBRIM@CENTENE.COM

FAQs



Must I be on the Members service Plan in order to provide services? Yes that is correct. All providers have to be listed as a certified provider for that member to be able to provide and render services to that member.

As an independent provider will I be able to provide services to multiple members that have coverage through Buckeye? Yes, You are able to provider services to multiple members as long as you are listed on the Service Plan.

Is the members Service Plan my form of authorization for Buckeye? Being on the members SP is your approval and you will receive faxed Authorization confirmations from the Buckeye Centralized HCBS waiver Auth Dept.

Contacts



For questions related to claims or billing, please contact:

Provider Services 866-296-8731

or your Provider Network Specialist:

866-246-4356 Ext. 24291



Thank You!