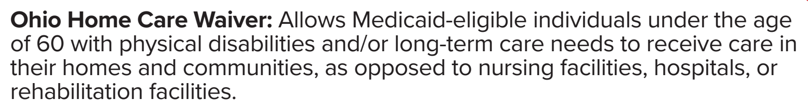
WAIVER PROVIDER REFERENCE GUIDE

Keep this document handy! It contains important information to help new and current Ohio Home Care Waiver providers be successful in delivering quality care.



Ohio Home Care Waiver: Allows Medicaid-eligible individuals under the age of 60 with physical disabilities and/or long-term care needs to receive care in their homes and communities, as opposed to nursing facilities, hospitals, or rehabilitation facilities.

Person centered services plan (PCSP): Outlines the person-centered goals, objectives, and interventions selected by the case manager, individual, and their interdisciplinary team.

The PCSP includes the individual's approved, medically-necessary services and supports, and will inform providers of their tasks and schedule, as well as the billing codes and the amount of payment they are authorized to receive. Providers must be authorized to provide services on the PCSP prior to service delivery.

Plan of care (POC): Is the medical treatment plan that is established, approved, and signed by the primary care or treating physician. The plan of care specifies the type, frequency, scope, and duration of the services being provided. The plan of care is not the same as the person-centered services plan.

PROVIDER BILLING CONVERSION TABLE

Duration	Billing
1 - 15 minutes	1 unit
6 - 34 minutes	2 units
35 - 60 minutes	1 base unit
1 hour and 15 minutes	1 base unit + 1 unit
1 hour and 30 minutes	1 base unit + 2 units

Include on all claims submissions:

- Ordering, referring, and prescribing (ORP) number or legal name of the ORP provider who ordered the services for the individual
- The ORP provider's National Provider Number

INCIDENT MANAGEMENT AND REPORTING

- **Incident:** An alleged, suspected, or actual event that is not consistent with routine care of, and/or service to an individual. Ohio Medicaid, its designees and all providers are required to report incidents.
- Upon learning of an incident, providers must notify the proper authorities and the individual's case manager.
- Incidents which should be reported immediately include: abuse, neglect, exploitation, misappropriation, and death. All other incidents are to be reported with 24 hours unless bound by federal, state or local law or professional licensure or certificates require sooner.
- Providers are required to cooperate with incident investigations.
- As a Medicaid provider, you are required to review OAC 5160-45-05 regarding incident management on an annual basis and submit written notification signifying your completion of this activity.

Pick up the Phone!

Know when to notify a case manager

- The individual declines services/is non-compliant with physician's orders.
- The individual plans to move or has moved to another residential address.
- There are changes in the physical, mental, or emotional status of the individual.
- The individual's primary caregiver's status has changed.
- The provider feels threatened in the individual's environment.
- The individual no longer requires medically necessary services.
- The provider misses a visit, planned or unplanned.

RESOURCES

Ohio Medicaid Provider Hotline
(800) 686-1516

Public Consultant Group (PCG)
Provider Relations and MyOhioHCP login issues
(877) 908-1746
ohioHCBS.pcgus.com/index.html

Ohio Medicaid Ombudsman Unit
medicaid.ohio.gov/PROVIDERS/Training/BasicBilling.aspx

Waiver Provider Inquiries
ohioHCBS@pcgus.com

MyCare Ohio
bmhc@medicaid.ohio.gov

OAC requirements
codes.ohio.gov/oac

Electronic Web Check Locations
ohioattorneygeneral.gov/Business/Services-for-Business/WebCheck/Webcheck-CommunityListing

Hang on to these documents!

- Identifying information.
- Date and location of service delivery.
- Service start and end times.
- Tasks performed / not performed.
- Progress notes.
- The signatures of the provider and the individual or authorized representative.
- Appropriate ICD-10 codes.
- Clinical records, maintained in a confidential manner and kept for six years.
    - » Agency providers who work for a Medicare-certified, or otherwise-accredited agencies, must maintain the clinical records at their place of business.
    - » Non-agency providers must maintain clinical records at their place of business and in the individual's residence.
- Both agency and non-agency RNs and LPNs are responsible for keeping all copies of an individual's POC, which must align with the services authorized in the PCSP.
- Discharge summaries, which the provider must produce at the termination of waiver services. These must include documentation citing the individual's progress towards their PCSP goals while receiving services and list any recommended follow-up activities or referrals.

Keep your Provider Agreement in good standing!

Criminal Record Background Checks

Non-Agency
- Must undergo criminal record background check annually.
- Ohio Medicaid will notify providers based on their Medicaid anniversary date.
- If Ohio Medicaid does not receive the results of a criminal background check by the mandated date, steps will be taken to terminate your Medicaid Provider Agreement or deny your application.

Agency Employees
- Must undergo criminal record background checks per their agency's certification requirements.
- Notification will come from the employer regarding when and how to complete their criminal record background checks.

Both agency employees and non-agency providers are required to complete a criminal record background check upon enrolling in the Ohio Home Care Waiver Program.

Structural Review Expectations and Preparations

Unless the review is unannounced, Public Consulting Group (PCG) will call to schedule a review the 2-3 weeks in advance and indicate the timeframe for the clinical records being reviewed. Notification will be sent to providers documenting the details of their structural review.

- Have all necessary documents collected prior to your review.
- The review will determine whether waiver services are provided and billed for appropriately.
- Non-agency waiver providers will have structural reviews annually for the first 3 years. After this time, providers will continue to have annual reviews unless approved by Ohio Medicaid for biennial structural reviews.
- Agency employees are subject to reviews in accordance with their agency's certification and accreditation bodies.
- Should a structural review result in findings of non-compliance, providers are required to submit a plan of correction to PCG within 45 calendar days from the date the written report is issued.
- Failure to submit a plan of correction will result in a Notice of Operational Deficiency (NOD) from Ohio Medicaid.

Provider-Type Requirements

Agency and Non-Agency Registered Nurse (RN)
- Must coodinate with the case manager at least once every 60 days to update the POC and to ensure it aligns with the PCSP.

Non-Agency Licensed Practical Nurse (LPN)
- Must have an RN supervisor and undergo a face-to-face visit with the RN supervisor every 60 days.
- Must undergo a face-to-face visit with the RN supervisor and the individual/guardian every 120 days to assess the level of satisfaction of the individual receiving services.

Non-Agency Patient Care Assistant (PCA)
- Trained by the individual and must perform a return demonstration of PCA services upon request.

Agency Patient Care Assistant (PCA)
- Must undergo an in-person visit from their supervising RN every 60 days.

Provider Conditions of Participation

- Providers must abide by all conditions of participation outlined in OAC 5160-45-10.
- Providers may only deliver and bill for services outlined in the PCSP.
- In order to be reimbursed for any services, providers must receive prior authorization from the case manager and have authorization on the PCSP prior to billing.
- Providers have 7 calendar days to notify Ohio Medicaid of any changes in contact information, through MITS and PCG.
- Providers must accept all correspondence sent by Ohio Medicaid and PCG, including but not limited to, certified mail.