

Ohio Home Care

Bob Taft, Governor

Barbara E. Riley, Director

Ohio Department of Job and Family Services

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Medical Assistance Letters

MAL 469

Medical Assistance Letter (MAL) # 469

Community Services Transmittal Letter (CSTL) # 04-03

June 8, 2004

TO: Providers of ODJFS-Administered HCBS Waiver Services
Home Services Facilitation Agencies
Directors, County Departments of Job and Family Services
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Superintendents, County Boards of MR/DD
Director, Ohio Department of Aging
Directors, Area Agencies on Aging

FROM: Thomas J. Hayes, Director

SUBJECT: ADOPTION OF RULES 5101:3-12-25, 5101:3-12-26, 5101:3-28, 5101:3-29 AND 5101:3-12-30
OF THE ADMINISTRATIVE CODE GOVERNING THE OHIO HOME CARE PROGRAM

The Ohio Department of Job and Family Services (ODJFS) has promulgated new rules related to Chapter 5101:3-12 of the Ohio Administrative Code (OAC). They will become effective on July 1, 2004. and are identified as follows:

OAC 5101:3-12-25 **Criminal Records Checks Involving Agency-employed Providers of ODJFS-administered Waiver Services** sets forth the process and requirements for the criminal records checks of persons under final consideration for employment with a waiver agency, and existing employees with a waiver agency in a full-time, part-time or temporary position, and who are providing HCBS in an ODJFS-administered waiver.

OAC 5101:3-12-26 **Criminal Records Checks Involving Independent Providers of ODJFS-Administered Waiver Services** sets forth the process and requirements for the criminal records checks of independent providers of HCBS in an ODJFS-administered waiver.

OAC 5101:3-12-28 **Enrollment Process for ODJFS-Administered Waiver Service Providers** sets forth the enrollment process for ODJFS-administered waiver service providers.

OAC 5101:3-12-29 **Consumer Incident Reporting** sets forth the standards and procedures for operating ODJFS' incident management, investigation and response systems (IMIRS). The rule applies to ODJFS and providers of waiver services for ODJFS-administered waivers. ODJFS may contract with other agencies or entities to perform one or more investigatory functions under this rule.

OAC 5101:3-12-30 **Monitoring Under ODJFS-Administered Home and Community-Based Service Waivers** sets forth the monitoring requirements and procedures under ODJFS-administered waivers.

To locate a copy of this MAL/CSTL or the rules referenced herein, please go to URL: <http://emanuals.odjfs.state.oh.us/emanuals>. If you do not have internet access, you may request a copy of the rules by calling (614) 466-6742.

Related questions should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 27th Floor

Columbus, Ohio 43215-3414

BHCS@odjfs.state.oh.us

MAL 468

Medical Assistance Letter (MAL) #468

Community Services Transmittal Letter (CSTL) #04-02

June 8, 2004

TO: Providers of Home and Community-Based Services
Home Services Facilitation Agencies
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators
Director, Ohio Department of Aging
Directors, Area Agencies on Aging

FROM: Thomas J. Hayes, Director

SUBJECT: Ohio Access Success Project Rule

The Ohio Department of Job and Family Services (ODJFS) has adopted a rule to Chapter 5101:3-12 of the Ohio Administrative Code (OAC). The following rule became effective on July 1, 2004:

Rule 5101:3-12-35 Non-Medicaid Ohio Access Success Project is being adopted to clarify the eligibility requirements and benefit limitations for the non-Medicaid funded Ohio Access Success Project. The rule clarifies the non-Medicaid Ohio Access Success Project process and requirements for individuals seeking to make the transition from residing in a Medicaid participating nursing facility to residing in a community setting and to make use of the project's funds to make possible the transition.

To locate a copy of this MAL/CSTL or the rule, please go to the URL:

<http://emanuals.odjfs.state.oh.us/emanuals/medicaid>.

Questions pertaining to the MAL/CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 27th Floor

Columbus, Ohio 43215-3414

(614) 466-6742

BHCS@odjfs.state.oh.us

MAL 467

Medical Assistance Letter (MAL) # 467

Community Services Transmittal Letter (CSTL) # 04-01

June 8, 2004

TO: Providers of Home and Community-Based Services
Home Services Facilitation Agencies
Directors, County Departments of Job and Family Services
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Superintendents, County Boards of MR/DD
Director, Ohio Department of Aging
Directors, Area Agencies on Aging

FROM: Thomas J. Hayes, Director

SUBJECT: NO CHANGE RULE FILING IN COMPLIANCE WITH SECTION 119.032 OF THE REVISED CODE FOR RULES 5101:3-12-07, 5101:3-12-08, 5101:3-12-09, 5101:3-12-11 AND 5101:3-12-12 OF THE ADMINISTRATIVE CODE (EFFECTIVE APRIL 8, 2004)

The above-captioned rules have been reviewed in accordance with Section 119.032 of the Revised Code, which requires the review of all state agency rules within a five-year period. This review determined whether the rules should continue without amendment, be amended, or be rescinded taking into consideration their purpose and scope. The rules were reviewed to ensure that they are clear and concise as written, program requirements are accurate and up-to-date, unnecessary paperwork is eliminated, and when possible, local agencies are given more flexibility. Pursuant to this review, and in light of the redesign of the Ohio Home Care Program that will result in forthcoming policy and rule changes later this year, no changes were made to the rules at this time.

5101:3-12-07 ODHS-administered HCBS Waiver Services

5101:3-12-08 Quality Assurance and Monitoring of the Ohio Home Care Program

5101:3-12-09 Individual Cost Cap for Consumers in the Core-Plus and ODHS Waiver Benefit Packages

5101:3-12-11 Home Services Facilitation

5101:3-12-12 Consumer Options under the Ohio Home Care Program

To locate a copy of this MAL/CSTL or the rules referenced herein, please go to URL:
<http://emanuals.odjfs.state.oh.us/emanuals/medicaid>.

Questions pertaining to this MAL/CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 27th Floor

Columbus, Ohio 43215-3414

(614) 466-6742

BHCS@odjfs.state.oh.us

Community Services Transmittal Letters

CSTL 06-02

Community Services Transmittal Letter (CSTL) No. 06-02

July 25, 2006

TO: Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
ODJFS Medical Assistance Coordinators
Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Director, Ohio Board of Nursing
Director, Ohio Nurses Association
Director, Ohio Licensed Practical Nurses' Association of Ohio
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care

FROM: Barbara E. Riley, Director

SUBJECT: ADOPTION OF NEW OAC RULES 5101:3-46-06, 5101:3-47-06 AND 5101:3-50-06 SETTING FORTH REIMBURSEMENT RATES AND BILLING PROCEDURES FOR THE OHIO HOME CARE WAIVER, THE TRANSITIONS MR/DD WAIVER AND THE TRANSITIONS CARVE-OUT WAIVER, AMENDMENT OF OAC RULE 5101:3-1-06 AND RESCISSION OF OAC RULE 5101:3-1-06.3

The Ohio Department of Job and Family Services (ODJFS) is amending rule [5101:3-1-06](#) and adopting new rules [5101:3-46-06](#), [5101:3-47-06](#) and [5101:3-50-06](#) of the Ohio Administrative Code (OAC). These rules set forth the reimbursement rates and billing procedures for the Ohio Home Care Waiver, the Transitions MR/DD Waiver and the Transitions Carve-Out Waiver, respectively, and are effective July 1, 2006. ODJFS is also amending OAC rule 5101:3-1-06 and rescinding OAC rule 5101:3-1-06.3.

OAC rules 5101:3-46-06, 5101:3-47-06 and 5101:3-50-06 replace OAC rule 5101:3-1-06.3. Reimbursement rates for the Ohio Home Care Waiver, the original Transitions MR/DD Waiver, and the new Transitions Carve-Out Waiver will be contained within individual OAC chapters along with other rules specifically related to those waivers. OAC rule 5101:3-1-06, also governing reimbursement of Medicaid home and community-based service waivers, is being amended to make reference to the new ODJFS-administered waiver rule cites, as well as to make changes related to ODMR/DD and ODA-administered waiver reimbursement rule cites.

Instructions:

Remove OAC rule 5101:3-1-06 and replace with amended OAC rule 5101:3-1-06.

Remove and file as obsolete OAC rule 5101:3-1-06.3.

Insert new OAC rules 5101:3-46-06, 5101:3-47-06 and 5101:3-50-06.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

<http://emanuals.odjfs.state.oh.us/emanuals/>

This CSTL and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider."
- (2) Select "Ohio Home Care."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired CSTL number.
- (4) Scroll through the CSTL to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 33rd Floor

Columbus, Ohio 43215-3414

BHCS@odjfs.state.oh.us

CSTL 06-01

Community Services Transmittal Letter (CSTL) No. 06-01

July 25, 2006

TO: Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators
Director, Ohio Department of Aging
Directors, Area Agencies on Aging
Director, Ohio Statewide Independent Living Council
Chairperson, Ohio Olmstead Task Force

FROM: Barbara E. Riley, Director

SUBJECT: RESCISSION OF OAC RULES 5101:3-12-07, 5101:3-12-13 AND 5101:3-12-15 GOVERNING THE OHIO HOME CARE PROGRAM AND ADOPTION OF NEW OAC RULES 5101:3-45-01, 5101:3-46-02, 5101:3-46-04, 5101:3-46-07, 5101:3-47-02, 5101:3-47-04, 5101:3-50-02 AND 5101:3-50-04 GOVERNING THE OHIO HOME CARE, TRANSITIONS MR/DD AND TRANSITIONS CARVE-OUT WAIVERS

In conjunction with the redesign of the Ohio Home Care Program, the Ohio Department of Job and Family Services (ODJFS) is rescinding rules 5101:3-12-07, 5101:3-12-13 and 5101:3-12-15 of the Ohio Administrative Code (OAC) governing the Ohio Home Care Program. ODJFS is also adopting OAC rules 5101:3-45-01, 5101:3-46-02, 5101:3-46-04, 5101:3-46-07, 5101:3-47-02, 5101:3-47-04, 5101:3-50-02 and 5101:3-50-04 governing the Ohio Home Care Waiver, the Transitions MR/DD Waiver and the new Transitions Carve-Out Waiver. The Transitions Carve-Out Waiver is being created to serve those Ohio Home Care Waiver Consumers who will be adversely affected by the changes in the eligibility criteria for the redesigned Ohio Home Care Waiver. These rule changes are effective July 1, 2006.

Rule 5101:3-12-07, entitled ODHS-administered HCBS Waiver Services, sets forth the current provider specifications for ODJFS-administered waiver service providers. It is being rescinded and replaced by new rules 5101:3-46-04, 5101:3-47-04 and 5101:3-50-04.

Rule 5101:3-12-13, entitled Ohio Home Care Waiver Enrollment and Waiting List Process, sets forth the current policies associated with enrollment on the Ohio Home Care Waiver, and the placement and processing of applicants on the Ohio Home Care Waiver waiting list. It is being rescinded and replaced by new rule 5101:3-46-07.

Rule 5101:3-12-15, entitled Transitions HCBS Waiver, sets forth the policies governing the Transitions (MR/DD) Waiver. It is being rescinded and replaced by various rules found in OAC Chapters 5101:3-45 and 5101:3-47.

Rule [5101:3-45-01](#), entitled ODJFS-administered Waiver Program: Definitions, contains the key definitions associated with the ODJFS-administered waiver program. It replaces rule 5101:3-12-01, in part.

Rule [5101:3-46-02](#), entitled Ohio Home Care Waiver: Consumer Eligibility for Enrollment, sets forth the requirements associated with consumer eligibility for enrollment in the Ohio Home Care Waiver. It replaces rule 5101:3-12-04, in part.

[5101:3-46-04](#), entitled Ohio Home Care Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Ohio Home Care

Waiver. This rule also sets forth the provider requirements and specifications for the delivery of Ohio Home Care Waiver services. It replaces rule 5101:3-12-07.

[5101:3-46-07](#), entitled Ohio Home Care Waiver: Enrollment and Waiting List Process, sets forth the policies associated with enrollment on the Ohio Home Care Waiver, and the placement and processing of applicants on the Ohio Home Care Waiver waiting list. It replaces rule 5101:3-12-13.

[5101:3-47-02](#), entitled Transitions MR/DD Waiver: Consumer Eligibility for Enrollment, sets forth the requirements associated with consumer eligibility for enrollment in the Transitions MR/DD Waiver. It replaces rule 5101:3-12-04, in part.

[5101:3-47-04](#), entitled Transitions MR/DD Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions MR/DD Waiver. This rule also sets forth the provider requirements and specifications for the delivery of Transitions MR/DD Waiver services. It replaces rule 5101:3-12-07.

[5101:3-50-02](#), entitled Transitions Carve-Out Waiver: Consumer Eligibility for Enrollment, sets forth the requirements associated with consumer eligibility for enrollment in the Transitions Carve-Out Waiver. It replaces rule 5101:3-12-04, in part.

[5101:3-50-04](#), entitled Transitions Carve-Out Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions Carve-Out Waiver. This rule also sets forth the provider requirements and specifications for the delivery of Transitions Carve-Out Waiver services. It replaces rule 5101:3-12-07.

Instructions:

Remove rules 5101:3-12-07, 5101:3-12-13 and 5101:3-12-15, and file as obsolete.

Insert new rules 5101:3-45-01, 5101:3-46-02, 5101:3-46-04, 5101:3-46-07, 5101:3-47-02, 5101:3-47-04, 5101:3-50-02 and 5101:3-50-04.

Web Page:

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- (2) Select "Ohio Home Care."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired CSTL number.
- (4) Scroll through the CSTL to the desired rule number highlighted in blue and select the rule number.

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 33rd Floor

Columbus, Ohio 43215-3414

BHCS@odjfs.state.oh.us

CSTL 05-03

Community Services Transmittal Letter (CSTL) 05-03

September 28, 2005

TO: Providers, ODJFS-administered Home and Community-Based Services
Case Managers and Administrators,
CareStar Directors,
County Department of Job and Family Services
Medical Assistance Coordinators
Director, Ohio Department of Aging
Directors, Area Agencies on Aging
Director, Ohio Statewide Independent Living Council
Chairperson, Ohio Olmstead Task Force

FROM: Barbara E. Riley, Director

SUBJECT: RESCISSION OF OAC RULE 5101:3-12-35 AND ADOPTION OF NEW OAC RULE 5101:3-49-01 GOVERNING THE NON-MEDICAID FUNDED OHIO ACCESS SUCCESS PROJECT

The Ohio Department of Job and Family Services (ODJFS) recently rescinded rule 5101:3-12-35 and adopted new rule [5101:3-49-01](#) of the Ohio Administrative Code (OAC), governing the nonmedicaid funded Ohio Access Success Project. These rule changes will become effective October 1, 2005.

OAC rule 5101:3-49-01 replaces OAC rule 5101:3-12-35, and per the enactment of the SFY 06/07 biennial budget, it also removes the requirement that individuals continuously reside in a nursing facility for not less than eighteen consecutive months prior to making application for nonmedicaid Ohio Access Success Project benefits.

To locate a copy of this CSTL or the rule, please go to URL:
<http://emanuals.odjfs.state.oh.us/emanuals/medicaid>.

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 33rd Floor

Columbus, Ohio 43215-3414

BHCS@odjfs.state.oh.us

CSTL 05-02

Community Services Transmittal Letter (CSTL) No.05-02

August 30, 2005

TO: Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators
Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Directors, Area Agencies on Aging

FROM: Barbara E. Riley, Director

SUBJECT: AMENDED OAC RULES 5101:3-12-03, 5101:3-12-05 AND 5101:3-12-06 GOVERNING THE OHIO HOME CARE PROGRAM

As a result of the five-year rule review required by Revised Code Section 119.032, the Ohio Department of Job and Family Services (ODJFS) recently amended Ohio Administrative Code (OAC) rules [5101:3-12-03](#), "ODJFS-Administered Home Care Benefit Packages," [5101:3-12-05](#), "Eligible Providers of Ohio Home Care Services," and [5101:3-12-06](#), "Core Home Care Services." These rules are effective September 1, 2005.

The changes in these rules are not substantive. However, OAC rule 5101:3-12-05 was amended to add reference to OAC rules regarding criminal record checks for agency-employed and independent providers of ODJFS-administered waiver services.

To locate a copy of this CSTL or the rules, please go to URL:

<http://emanuals.odjfs.state.oh.us/emanuals/medicaid>. Click links "Ohio Health Plans-Provider (left column), "Ohio Home Care" (right column), "Community Services Transmittal Letters" (left column).

If you do not have access to the Internet, you may obtain hard copies of the rules mentioned in this CSTL by completing and returning the enclosed [JFS 03400](#) "Service Provider Update Request Form."

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 33rd Floor

Columbus, Ohio 43215-3414

BHCS@odjfs.state.oh.us

Attachment

[Click to view the JFS 03400, Service Provider Update Request Form for CSTL 05-02.](#)

CSTL 05-01

Community Services Transmittal Letter (CSTL) #05-01

August 11, 2005

TO: Providers, ODJFS-administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Department of Job and Family Services
Medical Assistance Coordinators
Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Directors, Area Agencies on Aging

FROM: Barbara Riley, Director

SUBJECT: NEW OAC RULE 5101:3-45-10 SETTING FORTH THE CONDITIONS OF PARTICIPATION FOR ODJFS-ADMINISTERED WAIVER SERVICE PROVIDERS

The Ohio Department of Job and Family Services (ODJFS) recently adopted Administrative Code rule [5101:3-45-10](#), setting forth the conditions of participation for ODJFS-administered waiver service providers. This rule will become effective August 1, 2005.

Rule 5101:3-45-10 is being created as part of the state's redesign of the Ohio Home Care Program. Specifically, it clearly delineates what a provider can and cannot do while providing services to consumers enrolled on an ODJFS-administered waiver. It also strengthens ODJFS' program monitoring capabilities.

To locate a copy of this CSTL or the rule, please go to URL:
<http://emanuals.odjfs.state.oh.us/emanuals/medicaid>.

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

30 East Broad Street, 33rd Floor

Columbus, Ohio 43215-3414

BHCS@odjfs.state.oh.us

CSTL 04-03

Medical Assistance Letter #469 / [Community Services Transmittal Letter #04-03](#)

June 8, 2004

CSTL 04-02

Medical Assistance Letter #468 / [Community Services Transmittal Letter #04-02](#)

June 8, 2004

CSTL 04-01

Medical Assistance Letter #467 / [Community Services Transmittal Letter #04-01](#)

June 8, 2004

CSTL 02-01

Medical Assistance Letter #434 / Community Services Transmittal Letter #02-01

June 21, 2002

CSTL 00-02

Community Services Transmittal Letter # 00-02

July 7, 2000

TO: Home and Community-Based Services (HCBS) Waiver Program Providers
Home Services Facilitation Agencies
County Department of Human Services Directors
District Office Directors

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: PERMANENT AMENDMENT OF OHIO ADMINISTRATIVE CODE (OAC) RULE 5101:3-1-06
HCBS WAIVER REIMBURSEMENT

In accordance with Ohio Revised Code Section 119.032, each state agency is required to review its rules a minimum of once every five years. The intent of the law is to ensure that rules are clearly written and that program requirements are accurate, up-to-date, and clearly expressed. To the extent possible, unnecessary paperwork will be eliminated, and local agencies will be given increased flexibility. The purpose of a rule review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration each rule's scope and purpose.

The Ohio Department of Human Services (ODHS) has amended rules 5101:3-1-06 on a permanent basis. This updated version of the rules replaces the rule contained in Community Services Transmittal Letter # 00-01.

The attached rule and appendix list each service available under each Home and Community-Based Services (HCBS) Waiver program, the service code, reimbursement rate, and unit of service. Services are reimbursed at the provider's usual and customary rates or the Medicaid maximum rate, whichever is lower.

Nine service codes reimbursements are being increased for the PASSPORT waiver, including adult day care service transportation per mile, a one way trip and round trip; home delivered meals and special meals; homemaker services; social work counseling service; nutritional consultation service; and personal care service.

Three service codes are being deleted from the PASSPORT waiver, including second meal; second homemaker service; and second personal care service.

OAC Rule 5101:3-1-06 is effective July 1, 2000. If you have questions regarding this rule, please contact the Bureau of Community Long Term Care Services Policy Section, at (614) 466-6742.

Community Services Transmittal Letter # 00-01

March 3, 2000

TO: Home and Community-Based Services (HCBS) Waiver Program Providers
Home Services Facilitation Agencies
County Department of Human Services Directors
District Office Directors

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: PERMANENT AMENDMENT OF OHIO ADMINISTRATIVE CODE (OAC) RULES 5101:3-31-02 PASSPORT HOME AND COMMUNITY-BASED SERVICES (HCBS) PROGRAM DEFINITIONS, 5101:3-31-09 PASSPORT HCBS WAIVER PROGRAM SERVICES SPECIFICATIONS, 5101:3-31-11 PASSPORT HCBS WAIVER RATE SETTING AND 5101:3-1-06 HCBS WAIVER REIMBURSEMENT

In accordance with Ohio Revised Code Section 119.032, each state agency is required to review its rules a minimum of once every five years. The intent of the law is to ensure that rules are clearly written and that program requirements are accurate, up-to-date, and clearly expressed. To the extent possible, unnecessary paperwork will be eliminated, and local agencies will be given increased flexibility. The purpose of a rule review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration each rule's scope and purpose.

The Ohio Department of Human Services (ODHS) has amended rules 5101:3-31-02 , 5101:3-31-09 and 5101:3-31-11 on a permanent basis. These rules address definitions, service requirements and the reimbursement rate setting process respectively, for the PASSPORT waiver program.

These rules add the following information to the PASSPORT waiver program: nine new definitions, service specifications for enhanced and intensive adult day service, and reimbursement rate information for enhanced and intensive levels of adult day services.

The Ohio Department of Human Services (ODHS) has amended rules 5101:3-1-06 on a permanent basis. This updated version of the rules replaces the rule contained in Community Services Transmittal Letter # 99-1.

The attached rule and appendix list each service available under each Home and Community-Based Services (HCBS) Waiver program, the service code, reimbursement rate, and unit of service. Services are reimbursed at the provider's usual and customary rates or the Medicaid maximum rate, whichever is lower.

Six new service codes are being added to the PASSPORT waiver, including enhanced adult day care service, enhanced adult day care service half day, enhanced adult day care service 15 minutes, intensive adult day care service, intensive adult day care service half day, intensive adult day care service 15 minutes. Service codes are being deleted for adult day service and adult day service half day.

OAC Rules 5101:3-31-02 , 5101:3-31-09 , 5101:3-31-11 and 5101:3-1-06 are effective March 1, 2000. If you have questions regarding this rule, please contact the Bureau of Community Long Term Care Services Policy Section, at (614) 466-6742.

CSTL #99-1

Community Services Transmittal Letter # 99-1

November 23, 1999

TO: Home and Community-Based Services (HCBS) Waiver Program Providers
Home Services Facilitation Agencies
County Department of Human Services Directors
District Office Directors

FROM: Jacqueline Romer-Sensky, Director

SUBJECT: PERMANENT ADMENDMENT OF OHIO ADMINISTRATIVE CODE (OAC) RULE 5101:3-1-06
HCBS WAIVER REIMBURSEMENT

In accordance with Ohio Revised Code Section 119.032, each state agency is required to review its rules a minimum of once every five years. The intent of the law is to ensure that rules are clearly written and that program requirements are accurate, up-to-date, and clearly expressed. To the extent possible, unnecessary paperwork will be eliminated, and local agencies will be given increased flexibility. The purpose of a rule review is to determine whether a rule should be continued without amendment, be amended, or be rescinded, taking into consideration each rule's scope and purpose.

The Ohio Department of Human Services (ODHS) has amended rule 5101:3-1-06 on a permanent basis. This update version of the rule replaces the rule contained in Community Services Transmittal Letter #98-1.

The attached rule and appendix list each service available under each Home and Community-Based Services (HCBS) waiver program, the service code, reimbursement rate, and unit of service. Services are reimbursed at the provider's usual and customary rates or the Medicaid maximum rate, whichever is lower.

Six new service codes are being added to the PASSPORT waiver, including home medical equipment and supplies, and independent living assistance. Service codes are being deleted for occupational therapy and respite. In addition, service codes for surcharges are being deleted for adult day care, meals, homemaker, social work, nutrition counseling, occupational therapy, personal care, and respite.

OAC Rule 5101:3-1-06 is effective November 1, 1999. If you have any questions regarding this rule, please contact the Bureau of Community Long Term Care Services Policy Section, at (614) 466-6742.

CSTL 98-1

Medical Assistance Letter 370 / Community Services Transmittal Letter 98-1

July 29, 1998

Ohio Home Care Rules

5101:3-1-06 Home and community-based service waivers: general description.

Effective Date: July 1, 2006.

Most current prior effective date: [January 1, 2004](#).

- (A) Section 2176 of Public Law 97-35, the Omnibus Budget Reconciliation Act of 1981, established a waiver program under which states can be reimbursed for providing home and community-based services (HCBS). Under the HCBS waivers, states can designate specific target populations who can receive a wider range of HCBS than normally covered under the state plan. Waiver requests submitted by the states to the secretary of the department of health and human services may be approved for a three-year period; each waiver may be renewed for five-year periods.
- (B) Eligibility for HCBS waiver programs is limited to medicaid recipients who, in the absence of home and community services, would require long-term care in a nursing facility (NF), intermediate care facility for the mentally retarded (ICF-MR) or hospital as designated by the specific waiver.
- (C) **Regular** HCBS waivers must be limited to one of the following target groups or any subgroup thereof that the state may define:
- (1) Aged or disabled, or both; or
 - (2) Mentally retarded or developmentally disabled, or both; or
 - (3) Mentally ill.
- (D) At no time during the term of a HCBS waiver may the number of individuals approved to receive waiver services exceed the specific number annually allocated in the waiver.
- (E) Descriptions, approval information and reimbursement rates for each of the HCBS waivers can be found as follows:
- (1) PASSPORT HCBS waiver information can be found in rule [5101:3-1-06.1](#) of the Administrative Code.
 - (2) ~~Individual options and residential facility HCBS waiver service maximum payment standards can be found in rule 5101:3-1-06.2 of the Administrative Code.~~ The payment standards governing reimbursement for HCBS waiver programs administered by the Ohio department of mental retardation and developmental disabilities (ODMR/DD) can be found in rule 5101:3-41-11 of the Administrative Code.
 - ~~(3) — ODJFS-administered HCBS waiver information can be found in rule 5101:3-1-06.3 of the Administrative Code.~~
 - (3) Ohio home care waiver reimbursement rates and billing procedures are set forth in rule [5101:3-46-06](#) of the Administrative Code.
 - (4) Transitions MR/DD waiver reimbursement rates and billing procedures are set forth in rule [5101:3-47-06](#) of the Administrative Code.
 - (5) Transitions carve-out waiver reimbursement rates and billing procedures are set forth in rule [5101:3-50-06](#) of the Administrative Code.
 - ~~(4)~~(6) Choices HCBS waiver information can be found in rule [5101:3-1-06.4](#) of the Administrative Code.
 - (7) Assisted living HCBS waiver information can be found in rule [5101:3-1-06.5](#) of the Administrative Code.

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[CSTL 06-02](#)

5101:3-1-06.3 Home and community-based service waivers: ODJFS-administered (Ohio home care and transitions).

Effective Date: January 1, 2004.

- (A) There are two ODJFS-administered HCBS waiver(s), Ohio home care, approved July 1, 1998 and transitions, approved on January 1, 2002. Both are administered in accordance with Chapter 5101:3-12 of the Administrative Code.
- (B) Ohio home care is targeted toward persons who:
 - (1) Regardless of age, must have a skilled level of care as specified in rule 5101:3-3-05 of the Administrative Code, have a chronic, unstable medical condition that requires the skills of a registered nurse to detect and evaluate the consumer's need for possible treatment or for instituting nursing procedures, and in the absence of the ODJFS-administered HCBS waivers, would require long term hospitalization or NF placement or;
 - (2) If under the age of sixty, must have an intermediate level of care in accordance with rule 5101:3-3-06 of the Administrative Code, and in the absence of the ODJFS-administered HCBS waiver would require NF placement.
- (C) Transitions is targeted toward individuals who were enrolled in the Ohio home care waiver, and were determined to have an ICF-MR level of care in accordance with rule 5101:3-3-07 of the Administrative Code.
- (D) The ODJFS-administered HCBS waiver services and program eligibility in accordance with Chapter 5101:3-12 of the Administrative Code.
- (E) Financial eligibility for the ODJFS-administered HCBS waiver shall be determined in accordance with Chapter 5101: 1-39 of the Administrative Code.
- (F) Maximum allowable reimbursement rates for the ODJFS-administered HCBS waiver services are listed in appendix A of this rule. HCBS reimbursement must be provided in accordance with paragraphs (A) to (D) of rule 5101:3-1-60 of the Administrative Code.
- (G) For consumers enrolled on or after July 1, 1998 on the ODJFS-administered HCBS waiver(s), providers must bill for the codes listed for the ODJFS-administered HCBS waiver codes listed in appendix A of this rule and the appropriate services in accordance with rule 5101:3-1-07 of the Administrative Code.

[Click here to view Appendix A of OAC 5101:3-1-06.3.](#)

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Statutory Authority: 173.40, 5111.02

Rule Amplifies: 173.40, 5111.01, 5111.02

5101:3-12-08 Quality Assurance And Monitoring Of The Ohio Home Care Program.

Effective Date: July 1, 1998 (No Change)

- (A) ODHS shall operate an oversight program of providers of the Ohio home care program. The purpose of the oversight program shall be to:
 - (1) Monitor compliance with the requirements of the Ohio home care program as enumerated in Chapter 5101:3-12 of the administrative Code; and
 - (2) Identify negative outcome of consumers resulting from actions or inactions on the part of providers.
- (B) The review process may include, but not be limited to, outcomes-based interviews with consumers, on-site visits to the provider's location for the examination or collection of records and/or desk reviews of documentation submitted by providers.
- (C) The review team shall confirm that consumer outcomes, including but not limited to the following, are being met:
 - (1) Consumer is free from infections and communicable diseases caused by the provider's actions or inactions;
 - (2) Consumer's environment is free from hazards that threaten the health and safety of the consumer;
 - (3) Consumer receives only medically necessary care or care based on the consumer's functional abilities that justify the need for services;
 - (4) Consumer's care and services are monitored on a basis consistent with needs;
 - (5) Consumer's status is monitored in order to identify changes which could lead to harm or deterioration; and
 - (6) Consumer's rights are upheld.
- (D) ODHS actions based on the findings of the reviews may include, but not be limited to, any of the following:
 - (1) Contact the provider and ODHS or its designee when it is reported that a consumer's care is suspect, and/or there is a serious and immediate threat to the consumer's health and safety;
 - (2) Notification of the provider in writing of the review findings;
 - (3) A request that the provider prepare and submit to ODHS a corrective action plan within ten working days of the receipt of the findings/deficiencies, unless otherwise indicated by ODHS. The plan shall:
 - (a) Describe the action that will correct each deficiency and set a target date by which the correction shall be completed and be approved by ODHS.
 - (b) In the case where ODHS does not approve the plan, a new corrective action plan may be requested.
 - (4) The provision of technical assistance to the provider in the correction of the deficiency(ies); and
 - (5) As necessary, the imposition of sanctions on providers in accordance with paragraph (F) of this rule.
- (E) Referrals may be made at any time during the review process, as deemed appropriate by ODHS. Referrals shall include, but are not limited to:
 - (1) Referral to appropriate ODHS staff for further provider reviews or audits;

- (2) Referral to the Ohio attorney general for investigation of possible fraud;
 - (3) Referral to the Ohio department of health, or appropriate licensure, certification, or credentialing entity, for review;
- (F) In the event that ODHS determines the provider has not followed the corrective action plan or successfully achieved its desired results, and/or has created a serious and immediate threat to the health and safety of the consumer, sanctions may be imposed upon the provider. Such sanctions, include but are not limited to:
- (1) Placing an enrollment freeze on the provider;
 - (2) Transferring consumers to another provider;
 - (3) Suspension of the medicaid provider agreement until the corrective action plan has been completed to ODHS' satisfaction; and
 - (4) Termination of the medicaid provider agreement.
- (G) Proposals contained in paragraphs (D), (E) and (F) of this rule are subject to appeal or reconsideration, as appropriate, pursuant to rule 5101:3-1-57 of the Administrative Code.
- (H) ODHS may conduct satisfaction surveys of consumers as part of its quality assurance oversight and monitoring of the Ohio home care program, and may make all or part of the results available to consumers.
- (I) As part of the quality assurance and monitoring activities referred to in this rule the provider shall:
- (1) Provide space for ODHS employees to conduct on-site reviews of consumer records;
 - (2) Make all requested information available at the time of the reviews; and
 - (3) Have staff available to answer questions ODHS staff may have.

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[MAL 467/CSTL 04-01](#)

5101:3-12-09 Individual Cost Cap For Consumers In The Core-Plus And ODHS Waiver Benefit Packages.

Effective Date: July 1, 1998 (No Change)

- (A) The individual cost cap shall be assigned for consumers receiving services under the core-plus or ODHS-administered waiver benefit packages. The individual cost cap shall be reassigned annually and at the time of any change in the consumer's medical condition and/or functional ability which results in a change in the need for core services and/or ODHS-administered HCBS waiver services.
- (B) Individual cost cap has the same definition as set forth in rule 5101:3-12-01 of the Administrative Code. It is based on the information from the data collection that is related to the consumer's functional ability, need for skilled and unskilled services, cognitive ability and need for services in the absence of a caregiver.
- (C) The individual cost cap shall be assigned to each consumer for a period of twelve months unless there is a change requested as described in paragraph (H) of this rule.
- (D) All ODHS-administered HCBS waiver services and core services that are needed by the consumer and which are reimbursed by medicaid must be provided at or below the individual cost cap.
- (E) Before services begin, and at the time of any change in the individual cost cap, the consumer shall be informed by ODHS or its designee of the individual cost cap assigned. The consumer is entitled to hearing rights in accordance with Chapters 5101:6-1 to 5101:6-9 of the Administrative Code.
- (F) For consumers who were enrolled in an ODHS-administered HCBS waiver or who were receiving ODHS prior authorized private duty nursing services prior to July 1, 1998 and who have not experienced a change in medical condition:
 - (1) Data collection will occur at the time of the annual redetermination;
 - (2) The individual cost cap assigned for the twelve-month period following the annual redetermination will be based on the consumer's level of services currently approved on his or her ODHS approved prior authorization form; and
 - (3) During the twelve month period, ODHS or its designee will work with the consumer and the interdisciplinary team to assure that the cost of needed services will fall within the individual cost cap as it is determined by the data collection described in paragraph (F)(1) of this rule.
- (G) For consumers who were enrolled in an ODHS-administered HCBS waiver or who were receiving ODHS prior authorized private duty nursing services prior to July 1, 1998 and have experienced a change in medical condition:
 - (1) Data collection will occur at the time of the annual redetermination or at the time when the change in condition occurs, whichever comes first;
 - (2) The individual cost cap assigned for the twelve-month period following the data collection will be based on the elements listed in paragraph (B) of this rule;
 - (3) ODHS or its designee shall work with the consumer and the interdisciplinary team to assure that the cost of needed services will fall within the individual cost cap.
- (H) Changes in the individual cost cap:

Changes in the amount of core services and ODHS-administered HCBS waiver services that will result in a change in the assigned individual cost cap shall require the approval of the consumer's treating physician, recommendation to ODHS or its designee and approval by ODHS.
- (I) The maximum individual cost cap that may be assigned to a consumer shall equal the amount of the annual per capita cost for institutional care for those individuals who meet the HCBS eligibility criteria identified in rule 5101:3-12-04 of the Administrative Code but who are not enrolled in the HCBS waiver

program, divided by twelve. Individual cost caps are determined at the beginning of each state fiscal year and use the values on the most recent approved HCFA 372 annual report on home and community-based services waiver, or the waiver itself, if no HCFA 372 is available.

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[MAL 467/CSTL 04-01](#)

5101:3-12-11 Home Services Facilitation.

Effective Date: July 1, 1998 (No Change)

- (A) "Home services facilitation" consists of administrative services which:
- (1) Facilitate the process for the consumer accessing and receiving home care services;
 - (2) Facilitate the preapproval process for the coverage and the reimbursement of home care services and durable medical equipment (DME) and supply services for consumers eligible for core-plus benefits and ODHS-administered waiver benefits;
 - (3) Enhance the capability of the department to monitor and control program utilization while giving consumers and providers increased flexibility in determining how to best utilize covered services and other resources;
 - (4) Facilitate the process for determining eligibility for the ODHS-administered waiver benefit;
 - (5) Facilitate the process for determining if consumers are eligible for core-plus benefits when the consumer is eligible for medicaid services, the consumer needs more than fourteen hours of any combination of nursing and/or daily living services per week, and the consumer is not enrolled in any of the waiver programs (ODHS-administered, ODA-administered waiver program, or ODMR-administered waiver program);
- (B) Home services facilitation shall be performed by ODHS or an entity (entities) designated by and under contract with ODHS. The entity (entities) designated by and under contract with ODHS to provide home services facilitation shall be referred to as the designee or contractor in Chapter 5101:3-12 of the Administrative Code. Different entities may be designated by and under contract with ODHS to provide home service facilitation to consumers who reside in specified regions of the state.
- (C) In order to facilitate the process for accessing and receiving home care services for consumers eligible to receive core-plus benefits and ODHS-administered waiver benefits, the designee must perform the following duties, except as provided for in paragraph (H) of this rule:
- (1) Assign a personal home services facilitator, hereafter referred to as facilitator, to each consumer eligible to receive core-plus benefits or ODHS-administered waiver benefits.
 - (2) Allow the consumer to specify the relationship and the amount of personal contact they would like to have with their facilitator for the provision of home services facilitation (e.g. check-in telephone calls once per month, face-to-face visits once per quarter, available by phone only as needed, available for meetings only as needed, etc.). In accordance with the terms and conditions mutually agreed upon by the consumer and the facilitator, the facilitator must develop a written plan for the provision of home services facilitation and incorporate the plan into the all services plan. If it is predetermined that the facilitator will make periodic contact with the consumer, the written plan must specify the schedule for face-to-face contact or non face-to-face contact (e.g. by telephone, e-mail, etc.).
- At a minimum, the following relationship must be maintained:
- (a) The facilitator or designated back-up (when off-duty, on vacation or sick leave) must be available to the consumer by telephone twenty-four hours per day.
 - (b) The facilitator or designated back-up must schedule face-to-face meetings with consumers, as they are requested by the consumer.
 - (c) When incidents have occurred which place the consumer's health and safety at significant risk, ODHS or its designee may require the consumer to have, for a specified time, periodic face-to-face visits by their facilitator or a register nurse employed by the designee or home care provider as a requirement for remaining eligible for core-plus or ODHS-administered waiver benefits.

(d) The designee or the facilitator must be responsive to requests made by consumers and/or providers for changes in the consumer's all services plan or for specialized services, including but not limited to, adaptive and assistive devices not normally covered under medicaid, and home modifications.

(3) The facilitator must assist consumers with the development of an all services plan that is customized to optimally meet the consumer's medical and/or functional needs and the consumer's personal and lifestyle preferences in terms of the types of services, the frequency of visits, the length of the visits where the consumer wants the services rendered (e.g. in the home or in a community setting) and their desired level of independence.

(4) The facilitator must assure that consumers understand their rights as utilizers of services under the Ohio home care program and must assist consumers in exercising their rights to select their home care providers from a pool of eligible medicaid providers and in exercising the patient rights specified in 42 CFR 484.

(5) At the request of consumers, the facilitator must arrange for the provision of services by direct home care providers.

(6) At the request of consumers, the facilitator must assist consumers with the development and presentation of grievances, and/or solution of grievances, against direct home care providers and act as an ombudsman for resolving problems or between the direct care provider and the consumer.

(7) At the request of consumers or their providers, expedite the process for the department to review special requests for (DME) items, supplemental DME items, home modifications and other specialized services.

(8) If the service is needed, the facilitator must provide social work counseling services and nutritional counseling services to any consumer eligible to receive ODHS-administered waiver benefits.

(D) The process for receiving preapproval for the provision of home care services, requests for changes in home care services and requests for changes to the assigned cost cap.

(1) Home care services provided to consumers eligible for core-plus benefits or ODHS-administered waiver benefits must be preapproved by the designee to be covered and reimbursable under medicaid.

(2) The designee is responsible for contacting all individuals, home care providers and other associated entities or organizations who are, or will be, participating in meeting the consumer's needs in order to begin the process of developing the all services plan in an interdisciplinary team.

(a) The most basic interdisciplinary team membership would consist of the consumer and/or the consumer's legal guardian or representative, the primary medicaid provider and the facilitator assigned to the case. The specific format within which the team's collaboration occurs will be determined by the team under the direction of the designee, but the designee must ensure that the consumer and all providers, paid (by medicaid or another payment source) and unpaid, have an opportunity to participate in the process. For example, the interdisciplinary team process may require face-to-face meetings. In other situations the collaboration may occur by reports or phone contact.

(b) The method used by the designee and the team must result in the development of an all services plan which will meet the physical, mental, emotional and developmental needs of the consumer.

(c) The designee shall consider the recommendations of the interdisciplinary team and finalize the all services plan.

- (i) The all services plan as approved by the designee shall specify the services or range of services that each provider may render and receive reimbursement for under the Ohio home care program.
- (ii) The all services plan shall also specify any limitations or specific requirements that must be met for the services to be covered or reimbursed.
- (iii) A copy of the all services plan shall be provided to the consumer and each provider. The provider's copy of the all services plan shall serve as the provider's official record of the services for which they are prior authorized to perform.

- (3) When any member of the interdisciplinary team identifies a need to revise the all service plan, a request must be made to the consumer's facilitator. After the interdisciplinary team agrees on a revised all service plan and before the facilitator approves the revised all services plan, the facilitator must ensure and maintain documentation to support that the services contained in the revised all services plan are medically necessary and/or appropriate based on the consumer's functional ability, the services contribute to the overall goal of preventing institutionalization and the services can be rendered within the individual cost cap assigned to the consumer.
- (4) If changes are proposed to the all services plan which would place the cost of services above or below the cost cap assigned to the consumer, the designee will be responsible for collecting data supporting the need for a change in the individual cost cap by updating the data collection instrument and submitting it to ODHS. If ODHS approves a different individual cost cap, the designee may approve the revised all services plan. If ODHS does not approve a different individual cost cap, the interdisciplinary team must develop an all services plan that does not exceed the individual cost cap assigned to the consumer. The consumer retains the right to a hearing in accordance with Chapters 5101:6-1 to 5101:6-9 of the Administrative Code if he or she disagrees with the ODHS approved individual cost cap.
- (5) To expedite the prior authorization of DME services for consumers receiving home services facilitation, ODHS is delegating the approval function of the DME prior authorization process to the designee. Providers of durable medical equipment and supplies must contact the designee if they would like to have the prior authorization process expedited by the designee.

(E) Utilization monitoring and management

- (1) The designee is responsible for monitoring and managing utilization of home care services for consumers eligible for core-plus benefits and consumers eligible for ODHS-administered waiver benefits.
- (2) The individual cost cap assigned to a consumer is not an automatic entitlement amount available to a consumer to spend on home care services. The individual cost cap is the upper limit spending authority for a consumer. The designee will be responsible for determining the appropriate amount, type, scope and duration of services, up to the individual cost cap, based on the consumer's condition and living arrangement.

(F) Eligibility determination for ODHS-administered HCBS waiver services.

There are two components to the eligibility determination of applicants for the HCBS waiver programs: Medicaid financial eligibility, which is determined by a CDHS in accordance with rules 5101:1-39-94 and 5101:1-39-95 of the Administrative Code; and ODHS-administered HCBS waiver program eligibility which is determined by ODHS and/or its designee in accordance with paragraph (C)(1) and paragraphs (C)(3) to (C)(7) of rule 5101:3-12-04 of the Administrative Code.

The eligibility determination process for the ODHS-administered HCBS waiver program is as follows:

- (1) When a waiver applicant or authorized representative of a waiver applicant (e.g., family member, home health agency, hospital discharge planner, nursing facility social worker,

physician, etc.) wants to apply for the ODHS-administered HCBS waiver program, the individual must begin the application process at the county department of human services (CDHS).

- (a) If the waiver applicant is not currently enrolled in the medicaid program the applicant must complete both the ODHS 2399 HCBS waiver referral form and the ODHS 7100 the common application form. The CDHS will determine, presumptively, if the waiver applicant meets the income eligibility for enrollment on the waiver program, and notify the designee that the waiver applicant appears to meet the income eligibility for the waiver program. The CDHS will proceed to determine and verify that the waiver applicant meets the income eligibility for enrollment in the ODHS-administered HCBS waiver program. Notification by a CDHS shall be done in accordance with paragraph (D) of rule 5101:1-39-94 of the Administrative Code.
 - (b) At the option of the CDHS, if the waiver applicant is currently enrolled on the medicaid program and his/her medicaid eligibility has been determined within the last ninety days, the waiver applicant automatically meets the income eligibility for enrollment on the waiver and must only complete the ODHS 2399 HCBS waiver referral form. The CDHS will notify the designee that the waiver applicant meets the income eligibility for the waiver program and submit an application for enrollment on the waiver.
 - (c) If the waiver applicant is currently enrolled on the medicaid program and his/her medicaid eligibility has not been determined within the last ninety days, the procedure set forth in paragraph (C)(1)(a) of this rule applies.
- (2) Upon notification from the CDHS by CRIS-E alert 678, the designee will contact the individual by telephone (or an alternative arrangement if so indicated on the application) to collect preliminary information and to set up an appointment for the face-to-face visit to collect the data necessary to determine waiver program eligibility.
 - (a) The preliminary information collected by telephone will assist the designee in determining if the waiver applicant is a likely candidate for the ODHS-administered HCBS waiver program and/or if the waiver applicant's home care needs can be met through the medicaid program (without the waiver), through one of the waiver programs administered by ODA or ODMR/DD, or through other programs available in the applicant's community. The designee is responsible for referring the waiver applicant to the most appropriate resources for accessing and receiving home care services at the earliest possible date of service.
 - (b) If the preliminary information collected by the designee over the telephone indicates that the waiver applicant will not be eligible for the waiver or the designee is able to successfully arrange for appropriate services without the need for the waiver, the designee may request that the waiver applicant voluntarily withdraw their waiver application. If the waiver applicant withdraws the application the designee notifies ODHS to deny the waiver application. If the waiver applicant chooses not to withdraw the application, the designee will perform the face-to-face visit for data collection and will complete the ODHS-administered HCBS waiver program eligibility determination process. The applicant will be notified at a later date of their denial or approval of eligibility.
 - (c) If the preliminary information collected by the designee over the telephone indicates that the individual meets the eligibility criteria for the waiver, the designee will perform the face-to-face visit for data collection and will complete the ODHS-administered HCBS waiver program eligibility process.
 - (3) The designee must perform the face-to-face visit, at the convenience of the waiver applicant, within five days from the receipt of notification from the CDHS. The face-to-face may be scheduled later than five days at the request of the waiver applicant.

- (4) The designee/ODHS must complete the waiver program eligibility portion within ten days from the notification of presumptive eligibility by the county of human services.
 - (5) Since the financial eligibility performed by the county may take longer than ten days, waiver applicants should contact the designee for information on the status of their application. It is the responsibility of the designee to facilitate the application process with the county department of human services.
 - (6) All waiver applicants will be notified in writing of their enrollment in the ODHS-administered HCBS waiver program or their denial from enrollment in the ODHS-administered HCBS waiver program. Enrollment in the ODHS-administered HCBS waiver program entitles the consumer to receive ODHS-administered waiver benefits under the Ohio home care program.
 - (7) Upon meeting the eligibility requirements for the ODHS-administered waiver benefits, an individual cost cap will be assigned to the consumer and the designee will proceed to provide home services facilitation set forth in paragraphs (C) to (E) of this rule.
- (G) Eligibility determination for core-plus benefits.
- (1) When a consumer, who is already eligible for medicaid benefits, or authorized representative of a consumer (e.g. family member, home health agency, hospital discharge planner, nursing facility social worker, physician, etc.) wants to apply for core-plus benefits (i.e, wants to receive more than fourteen hours per week of any combination of nursing and/or daily living services), the designee for the region where the recipient resides must be contacted.
 - (2) The designee will arrange for a face-to-face visit to collect the data needed to determine if the consumer is eligible for core-plus benefits. The visit must be scheduled within five days from the date of the receipt of the notification and the final determination must be made within ten days from the receipt of the notification.
 - (3) If the consumer is not currently admitted to and receiving services from an inpatient hospital or long term care facility and the designee is provided with documentation to support that the additional nursing and/or daily living services are medically necessary and that the a five to ten day delay in the provision of services of the additional nursing and/or daily living services could be detrimental to the health of the consumer, the designee may approve the provision of the additional services for ten days or until the final eligibility determination is made. In such cases the designee will develop a ten day all services plan which would specify the amount, scope and duration of core home care services to be covered during the ten day period.
 - (4) Upon meeting the eligibility criteria set forth in paragraph (B) of rule 5101:3-12-04 of the Administrative Code, an individual cost cap will be assigned to the consumer and the designee will proceed to provide the home services facilitation identified in paragraphs (C) to (E) of this rule.
- (H) The designee is not obligated to render the services itemized in paragraph (C) of this rule to consumers enrolled in the ODHS-administered HCBS waiver program who have selected the consumer option set forth in paragraph (A)(6) of rule 5101:3-12-12 of the Administrative Code. The designee shall be responsible for performing the other duties specified in this rule and the applicable responsibilities set forth in rule 5101:3-12-12 of the Administrative Code.

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[MAL 467/CSTL 04-01](#)

5101:3-12-12 Consumer Options Under The Ohio Home Care Program.

Effective Date: July 1, 1998 (No Change)

- (A) "Consumer options" under the Ohio home care program are designed to allow consumers greater flexibility and autonomy over the arrangement and provision of required core home care services. They include:
- (1) Allowing the provision of nursing and therapy services by family members of consumers in the core-plus or ODHS-administered HCBS waiver benefit if they are employed by a medicare-certified home health agency, or in the case of the ODHS-administered HCBS waiver benefit package, by a JCAHO-accredited home health agency.
 - (2) Allowing the provision of daily living services to adult consumers in the core-plus or ODHS-administered HCBS waiver benefit by family members (excluding spouses of consumers and parents, stepparents and legal guardians of minor children) as defined in paragraph (L) of rule 5101:3-12-01 of the Administrative Code who are employed by a medicare-certified home health agency, or in the case of the ODHS-administered HCBS waiver benefit package, by a JCAHO-accredited home health agency.
 - (3) Allowing the provision of nursing services under the core-plus and ODHS-administered HCBS waiver benefits by independent home care nurses, as defined in paragraph (H) of rule 5101:3-12-05 of the Administrative Code.
 - (4) Allowing the provision of daily living services under the ODHS-administered HCBS waiver benefit by ODMR/DD and ODA HCBS waiver providers of personal care, homemaker or chore services. Such providers must be ODHS-administered HCBS waiver independent daily living non-aides as defined in paragraph (F) of rule 5101:3-12-05 of the Administrative Code.
 - (5) Allowing the provision of daily living services by ODHS-administered HCBS waiver independent daily living aides as defined in paragraph (E) of rule 5101:3-12-05 of the Administrative Code, and ODHS-administered HCBS waiver independent daily living non-aides as defined in paragraph (F) of rule 5101:3-12-05 of the Administrative Code.
 - (6) Allowing consumers enrolled in the ODHS-administered HCBS waiver benefit to forego ongoing care coordination by ODHS or its designee, and receive care through a medicare-certified or JCAHO-accredited home health agency of their choice.
- (B) Under the consumer options identified in paragraphs (A)(1) to (A)(3) of this rule:
- (1) Consumers shall:
 - (a) Participate in the development of the all services plan.
 - (b) Participate in the development of the plan of care.
 - (c) Approve time sheets which the provider submits to ODHS or its designee, as requested by ODHS.
 - (2) ODHS or its designee shall perform all of those responsibilities enumerated in rule 5101:3-12-11 of the Administrative Code.
- (C) Under the consumer options identified in paragraphs (A)(4) and (A)(5) of this rule:
- (1) Consumers shall:
 - (a) Participate in the development of the plan of care and/or all services plan.
 - (b) Select and dismiss the provider.
 - (c) Train the provider to meet the consumer's specific health care needs.

- (d) Establish a workable back-up plan for situations when the primary provider is unable to render the service at the scheduled time.
- (e) Approve time sheets which the provider submits to ODHS or its designee, as requested by ODHS.
- (f) Have demonstrated to ODHS or its designee the necessary skills to direct their own services, or who if trained, could develop the necessary skills.
- (g) Agree that ongoing enrollment is contingent upon a determination by ODHS or its designee that they can adequately continue to direct their own care.

(2) ODHS or its designee shall:

- (a) Perform all of those responsibilities enumerated in rule 5101:3-12-11 of the Administrative Code.
- (b) If requested, assist the consumer in developing strategies to manage their own health care (e.g., recruitment of providers, screening of applicants, selecting and dismissing providers, and management of ODHS-administered HCBS waiver independent daily living aides and non-aides employed under these respective options).
- (c) Monitor consumer outcomes and report negative outcomes to ODHS for quality assurance oversight in accordance with rule 5101:3-12-08 of the Administrative Code.
- (d) Maintain a formal grievance process whereby consumers can appeal decisions denying them participation in either of these options.
- (e) Compile, maintain and make available to interested parties a database of nursing and daily living service providers in the predetermined region.

(3) ODHS may provide technical assistance regarding provider enrollment, billing processes and explanations of consumer responsibilities to providers who are providing services under either of these options. This requires distribution, explanation, assistance/review in completion of the provider application and submission of the application to ODHS.

(4) Providers shall be considered independent contractors and shall be responsible for paying their own federal, state and local taxes and for any other required deductions.

(D) Under the consumer option identified in paragraph (A)(6) of this rule:

(1) Consumers or their legal guardian shall:

- (a) Participate in the development of the all services plan.
- (b) Participate in the development of the plan of care.
- (c) Select and dismiss the provider.
- (d) Train the provider to meet the consumer's specific health care needs.
- (e) Establish a workable back-up plan for situations when the primary provider is unable to render the service at the scheduled time.
- (f) Approve time sheets which the provider submits to ODHS or its designee, as requested by ODHS.
- (g) Monitor the provider to determine if care was provided as mutually agreed upon by the treating physician, consumer and the provider in accordance with the plan of care.

(2) ODHS or its designee shall:

- (a) Finalize and approve the all services plan.

- (b) Monitor consumer outcomes and report negative outcomes to ODHS for quality assurance oversight in accordance with rule 5101:3-12-08 of the Administrative Code.

R.C. 119.032 review dates: 01/09/2004 and 02/01/2007

Certification: CERTIFIED ELECTRONICALLY

Date: 01/09/2004

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: Eff 7-1-98

[**MAL 467/CSTL 04-01**](#)

5101:3-12-25 Criminal Records Checks Involving Agency-Employed Providers Of Odjfs-Administered Waiver Services.

Effective Date: July 1, 2004

- (A) This rule sets forth the process and requirements for the criminal records checks of persons under final consideration for employment with a waiver agency, and existing employees with a waiver agency in a full-time, part-time or temporary position, and who are providing home and community-based services (HCBS) in an ODJFS-administered waiver.
- (B) For the purposes of this rule,
- (1) "Applicant" means a person who is under final consideration for employment or, after the effective date of section 5111.95 of the Revised Code, an existing employee, with a waiver agency in a full-time, part-time or temporary position, that involves providing HCBS to a person with disabilities.
 - (2) "Chief Administrator" means the head of a waiver agency, or his or her designee.
 - (3) "Criminal Records Check" means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation (BCII) in accordance with section 109.572 of the Revised Code.
 - (4) "Disqualifying Offense" means any of the following:
 - (a) A violation of sections 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23 or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised Code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; or
 - (b) An existing or former law of the state of Ohio, any other state, or the United States that is substantially equivalent to any of the disqualifying offenses listed in subparagraph (B)(4)(a).
 - (5) "Home and Community-Based Services" (HCBS) refers to the services defined in division (A) (4) of section 5111.95 of the Revised Code.
 - (6) "Superintendent" means superintendent of BCII.
 - (7) "Waiver Agency" means a person or government entity that is not certified under the medicare program and is accredited by the community health accreditation program (CHAP) or the joint commission on accreditation of health care organizations (JCAHO), or a company that provides HCBS to persons with disabilities through ODJFS-administered waiver programs.
- (C) Process for conducting criminal records checks
- (1) The chief administrator of a waiver agency shall require each person, at the time of initial application for a position that involves providing HCBS to a person with a disability, that the applicant must provide a set of fingerprint impressions and that a criminal records check must be conducted if the person comes under final consideration for employment.

- (2) An employee of a waiver agency in a full-time, part-time, or temporary position that involves providing HCBS to a person with disabilities shall comply with this rule within sixty days after the effective date of this rule unless he or she:
- (a) Previously was the subject of a criminal records check relating to that position; and
 - (b) Has been continuously employed in that position since that criminal records check was conducted.
- (3) Except as otherwise noted in paragraph (C) (2) of this rule, the chief administrator of a waiver agency shall request that the BCII superintendent conduct a criminal records check with respect to each ODJFS-waiver agency provider applicant, and pursuant to sections 5111.95, 5111.96 and 109.572 of the Revised Code.
- (a) If an applicant does not present proof of having been a resident of the state of Ohio for the five-year period immediately prior to the date the criminal records check is requested, or provide evidence that within that five-year period the superintendent has requested information about the applicant from the federal bureau of investigation (FBI), the chief administrator shall request that the superintendent obtain a criminal records check from the FBI.
 - (b) Even if an applicant presents proof of having been a resident of the state of Ohio for the five-year period, the chief administrator may request that the superintendent obtain information from the FBI in the criminal records check.
- (4) The chief administrator of a waiver agency shall:
- (a) Provide information to each applicant about requesting a copy of the form prescribed pursuant to division (C) (1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet presented pursuant to division (C) (2) of that section, and obtain the completed form and impression sheet from the applicant; and
 - (b) Forward the completed form and impression sheet to the BCII superintendent.
- (5) If an applicant fails to complete the form or provide the fingerprint impressions, then he or she shall not be employed in any position in a waiver agency for which a criminal records check is required by this rule.
- (6) A waiver agency may conditionally employ an applicant for whom a criminal records check is required by this rule prior to obtaining the results of that check, provided that the request is made no later than five business days after he or she begins conditional employment.
- (7) The waiver agency shall terminate employment if the results of the criminal records check, other than the results of any request for information from the FBI, are not obtained within the period ending sixty days after the date the request is made.
- (8) Regardless of when they are obtained, if the results indicate that the employee has been convicted of or pleaded guilty to any of the offenses listed in paragraph (B) (4) of this rule, then the waiver agency:
- (a) Shall terminate his or her employment, or
 - (b) May choose to employ him or her because he or she meets personal character standards set by the department and enumerated in paragraph (D) of this rule.
- (9) Termination of employment shall be considered just cause for discharge for the purposes of division (D) (2) of section 4141.29 of the Revised Code if the individual makes any attempt to deceive the waiver agency about his or her criminal record.

- (10) Waiver agencies shall pay to BCII the fee prescribed pursuant to division (C) (3) of section 109.572 of the Revised Code for each criminal records check conducted pursuant to their request. Waiver agencies may:
- (a) Charge an applicant a fee not to exceed the amount the waiver agency pays in accordance with this paragraph;
 - (b) Only collect fees if the waiver agency notifies the person at the time of the initial application for employment of the amount of the fee and that, unless the fee is paid, he or she will not be considered for employment.
- (11) Reports of any criminal records checks conducted by BCII in accordance with this rule are not public records for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:
- (a) The person who is the subject of the criminal records check or the individual's representative;
 - (b) The chief administrator of the waiver agency requesting the criminal records check or the administrator's representative;
 - (c) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial of employment of the applicant, or dealing with employment or unemployment benefits of the applicant.

(D) Personal character standards

- (1) A waiver agency may employ an applicant who has been convicted of or pleaded guilty to an offense listed in paragraph (B) (4) of this rule in a position that involves providing HCBS to disabled consumers if all of the following personal character standards are met for each offense:
- (a) The applicant is not a repeat violent offender;
 - (b) The offense is not sexually-oriented;
 - (c) The offense is not one of abuse or neglect as described in section 2903.34 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.34 of the Revised Code;
 - (d) The offense is not a repeat theft-related offense or a violation of any two, or a combination of any two existing or former laws of the state of Ohio, any other state, or the United States, if the theft-related offenses are substantially equivalent to any of the offenses described in paragraph (B) (4) of this rule;
 - (e) The offense is not one of aggravated murder as described in section 2903.01 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.01 of the Revised Code;
 - (f) The offense is not one of murder as described in section 2903.02 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.02 of the Revised Code;
 - (g) The offense is not one of voluntary manslaughter as described in section 2903.03 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.03 of the Revised Code;

- (h) The offense is not a disqualifying offense as defined in paragraph (B) (4) of this rule; and the applicant is discharged from imprisonment, sentenced to probation in lieu of imprisonment, or is on parole and is meeting all conditions subject to that conviction;
 - (i) A waiver agency may employ an applicant who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if, and only if, at least five years have elapsed since the applicant was fully discharged from imprisonment, probation and parole; and
 - (j) A waiver agency may not employ an applicant who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if the victim was a child.
- (2) When the conditions enumerated in paragraph (D) (1) of this rule are met, the waiver agency shall consider each of the following factors in determining whether it is not likely that the applicant will commit another disqualifying offense:
- (a) The duties and responsibilities of the position;
 - (b) The nature and seriousness of the offense;
 - (c) Whether or not the applicant had committed a disqualifying offense as described in paragraph (B) (4) of this rule
 - (d) The circumstances under which the offense was committed, including but not limited to:
 - (i) The applicant's age at the time of the offense;
 - (ii) The degree to which the applicant participated in the offense;
 - (iii) The age and ability of the victim, including whether the victim was an individual with a disability;
 - (e) The extent to which the position being filled provides an opportunity for the commission of the same or similar offenses;
 - (f) The time elapsed since the applicant was fully discharged from imprisonment, probation and parole;
 - (g) The applicant's efforts at rehabilitation and the results of those efforts;
 - (h) Whether any criminal proceedings are pending against the applicant;
 - (i) A conviction listed on the report of the criminal records check which identifies any offenses contained in the Revised Code that are not listed in paragraph (B) (4) of this rule, if the crime bears a direct and substantial relationship to the duties and responsibilities of the position being filled; and
 - (j) Any other factors which are relevant to the performance of the job duties.
- (3) It is the duty of the applicant to provide proof that the standards in regard to personal character specified in paragraphs (D) (1) and (D) (2) of this rule are met. If the applicant fails to provide such proof or if the waiver agency determines that the proof offered by the applicant is inconclusive, the applicant shall not be placed in a position that requires direct care to ODJFS-administered waiver consumers with disabilities.

(E) Pardons

A conviction of, or a plea of guilty to, an offense listed or described in paragraph (B) (4) of this rule shall not prevent an applicant's employment under any of the following circumstances:

- (1) The applicant has been granted an unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;

- (2) The applicant has been granted an unconditional pardon for the offense pursuant to an existing or former law of the state of Ohio, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code;
- (3) The applicant has been granted a conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the condition(s) under which the pardon was granted have been satisfied; or
- (4) The conviction or guilty plea has been set aside pursuant to law.

(F) Documentation - applicant log

The chief administrator of a waiver agency shall maintain an applicant log separate from the personnel record. It shall contain the following information:

- (1) Names of all applicants;
- (2) The date of application;
- (3) The date the applicant started work;
- (4) The date the criminal records check request was submitted to BCII;
- (5) The type(s) of criminal records checks requested (BCII, FBI or both);
- (6) The date the BCII and FBI checks were received;
- (7) Whether or not the results of the check revealed that the applicant committed a disqualifying offense(s), and the specific offense(s) and date(s) committed;
- (8) The number of references received on behalf of the applicant, the dates that the references were received, and how the references were verified;
- (9) Whether the personal character standards were applied as a condition for employment;
- (10) Whether or not the applicant was conditionally hired, hired and/or terminated;
- (11) The date of the fingerprint check by BCII, the FBI or both;
- (12) The chief administrator of a waiver agency shall certify in the applicant log that it has used each and every personal character standard as described in paragraph (D) of this rule when hiring an applicant whose background check results revealed the commission of a disqualifying offense as described in paragraph (B) of this rule.

Effective: July 1, 2004

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.95

Rule Amplifies: 5111.95, 109.572

[MAL 469/CSTL 04-03](#)

5101:3-12-26 Criminal Records Checks Involving Independent Providers Of ODJFS-Administered Waiver Services.

Effective Date: July 1, 2004

- (A) This rule sets forth the process and requirements for the criminal records checks of independent providers of home and community-based waiver services (HCBS) in an ODJFS-administered waiver.
- (B) For the purposes of this rule,
- (1) "Anniversary Date" means the later of the effective date of the provider agreement relating to the independent provider or sixty days after the effective date of section 5111.96 of the Revised Code.
 - (2) "Criminal records check" means any criminal records check conducted by the superintendent of the bureau of criminal identification and investigation (BCII) in accordance with section 109.572 of the Revised Code.
 - (3) "Department" means the Ohio department of job and family services.
 - (4) "Disqualifying Offense" means any of the following:
 - (a) A violation of Sections 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.16, 2903.21, 2903.34, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.11, 2913.21, 2913.31, 2913.40, 2913.43, 2913.47, 2913.51, 2919.12, 2919.24, 2919.25, 2921.36, 2923.12, 2923.13, 2923.161, 2925.02, 2925.03, 2925.04, 2925.05, 2925.06, 2925.11, 2925.13, 2925.22, 2925.23, or 3716.11 of the Revised Code, felonious sexual penetration in violation of former section 2907.12 of the Revised code, a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, a violation of section 2919.23 of the Revised Code that would have been a violation of section 2905.04 of the Revised Code as it existed prior to July 1, 1996, had the violation been committed prior to that date; or
 - (b) An existing or former law of the state of Ohio, any other state, or the United States that is substantially equivalent to any of the disqualifying offenses listed in subparagraph (B)(4)(a) of this rule.
 - (5) "Effective Date of Provider Agreement" means the next occurrence of the month in which the initial provider agreement was entered into between the department and the provider. If, in the first year of application of the requirement contained in this rule, the effective date of the provider agreement is less than sixty days after the effective date of this rule, the effective date of the provider agreement is extended by seventy-five days from the date otherwise determined in this sentence.
 - (6) "Home and Community-Based Services" (HCBS) means services as defined in division (A) (4) of section 5111.95 of the Revised Code.
 - (7) "Independent Provider" means a person who is submitting an application for a provider agreement or who has a provider agreement as an independent provider of HCBS services in an ODJFS-administered waiver.
 - (8) "Superintendent" means superintendent of BCII.
- (C) Process for Conducting Criminal Records Checks
- (1) ODJFS shall inform:

- (a) Each prospective independent provider, at the time of initial application for a medicaid provider agreement that involves providing HCBS to persons with disabilities, that he or she must provide a set of fingerprint impressions, and a criminal record check must be conducted.
 - (b) Each currently-enrolled independent provider, on or before the time of the anniversary date of their medicaid provider agreement that involves providing HCBS to consumers with disabilities, that he or she must provide a set of fingerprint impressions and that a criminal records check must be conducted.
- (2) ODJFS shall require the independent provider to complete a criminal records check prior to entering into a medicaid provider agreement with the independent provider, and at least annually thereafter.
 - (a) If the independent provider does not present proof of having been a resident of the state of Ohio for the five-year period immediately prior to the date the criminal records check is requested, or provide evidence that within that five-year period the superintendent has requested information about the independent provider from the Federal Bureau of Investigation (FBI), ODJFS shall request the independent provider obtain through the superintendent a criminal records check from the FBI.
 - (b) Even if an independent provider presents proof of having been a resident of the state of Ohio for the five-year period, ODJFS may request that he or she obtain information through the superintendent from the FBI in the criminal records check.
- (3) ODJFS shall provide information to each independent provider about requesting a copy of the form prescribed pursuant to division (C) (1) of section 109.572 of the Revised Code and a standard fingerprint impression sheet prescribed pursuant to division (C) (2) of that section, and instructions regarding submission procedures to BCII.
- (4) Each independent provider shall forward the completed form, impression sheet, and fee to the BCII superintendent. The BCII fee shall be the fee prescribed pursuant to division (C) (3) of section 109.572 of the Revised Code for each criminal records check conducted on his or her behalf pursuant to this rule.
- (5) An independent provider who fails to complete the form or provide fingerprint impressions shall not be approved as an independent provider.
- (6) Except as provided by paragraph (D) of this rule, ODJFS shall not issue a new provider agreement to, and shall terminate an existing provider agreement of an independent provider if he or she has been convicted of or pleaded guilty to any of the disqualifying offenses enumerated in paragraph (B) (4) of this rule.
- (7) Reports of any criminal records checks conducted by BCII in accordance with section 109.572 of the Revised Code and this rule are not public records for the purposes of section 149.43 of the Revised Code and shall not be made available to any person other than the following:
 - (a) The person who is the subject of the criminal records check, or the person's representative;
 - (b) The consumer seeking the services of the independent provider;
 - (c) The administrator at ODFJS who is requesting the criminal records check or the administrator's representative;
 - (d) Any court, hearing officer, or other necessary individual involved in a case dealing with a denial or termination of a Medicaid provider agreement related to the criminal records check.

- (8) Failure on the part of the independent provider to submit to a criminal records check within ninety days of notification by ODJFS of his or her need to do so shall render the independent provider immediately ineligible to provide services to all ODJFS-administered waiver consumers. ODJFS or its designated contracted case management entity shall take immediate steps to remove the independent provider from all all services plans until such time as the independent provider has satisfactorily completed all requirements of this rule.
- (9) If the independent provider continues to be noncompliant with the provisions of this rule, ODJFS shall initiate termination of the medicaid provider agreement.

(D) Personal character standards

- (1) A consumer may choose to enter into a provider agreement with an independent provider who has been convicted of or pleaded guilty to an offense listed in paragraph (B) (4) of this rule in a position that involves providing HCBS to disabled consumers if all of the following personal character standards are met for each offense:
- (a) The independent provider is not a repeat violent offender;
 - (b) The offense is not sexually-oriented;
 - (c) The offense is not one of abuse or neglect as described in section 2903.34 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.34 of the Revised Code;
 - (d) The offense is not a repeat theft-related offense or a violation of any two, or a combination of any two existing or former laws of the state of Ohio, any other state, or the United States, if the theft-related offenses are substantially equivalent to any of the offenses described in paragraph (B) (4) of this rule;
 - (e) The offense is not one of aggravated murder as described in section 2903.01 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.01 of the Revised Code;
 - (f) The offense is not one of murder as described in section 2903.02 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.02 of the Revised Code;
 - (g) The offense is not one of voluntary manslaughter as described in section 2903.03 of the Revised Code or a violation of an existing or former law of the state of Ohio, any other state, or the United States, if the offense is substantially equivalent to any offense described in section 2903.03 of the Revised Code;
 - (h) The offense is not a disqualifying offense as defined in paragraph (B) (4) of this rule; and the independent provider is discharged from imprisonment, sentenced to probation in lieu of imprisonment, or is on parole and is meeting all conditions subject to that conviction;
 - (i) A consumer may employ an independent provider who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if, and only if, at least five years have elapsed since the independent provider was fully discharged from imprisonment, probation and parole; and
 - (j) A consumer may not employ an independent provider who has been convicted of or pleaded guilty to a disqualifying offense as defined in paragraph (B) (4) of this rule if the victim was a child.

- (2) When the conditions enumerated in paragraph (D) (1) of this rule are met, the consumer shall consider each of the following factors in determining whether or not it is likely that the independent provider will commit another disqualifying offense:
- (a) The duties and responsibilities of the position;
 - (b) The nature and seriousness of the offense;
 - (c) Whether or not the independent provider had committed a disqualifying offense as described in paragraph (B) (4) of this rule;
 - (d) The circumstances under which the offense was committed, including but not limited to:
 - (i) The independent provider's age at the time of the offense;
 - (ii) The degree to which the independent provider participated in the offense;
 - (iii) The age and ability of the victim, including whether the victim was an individual with a disability;
 - (e) The extent to which the position being filled provides an opportunity for the commission of the same or similar offenses
 - (f) The time elapsed since the independent provider was fully discharged from imprisonment, probation and parole;
 - (g) The independent provider's efforts at rehabilitation and the results of those efforts;
 - (h) Whether any criminal proceedings are pending against the independent provider;
 - (i) A conviction listed on the report of the criminal records check which identifies any offenses contained in the Revised Code that are not listed in paragraph (B) (4) of this rule, if the crime bears a direct and substantial relationship to the duties and responsibilities of the position being filled; and
 - (j) Any other factors which are relevant to the performance of the job duties.
- (3) It is the duty of the independent provider to provide proof that the standards in regard to personal character specified in paragraphs (D) (1) and (D) (2) of this rule are met. If the independent provider fails to provide such proof or if the consumer determines that the proof offered by the independent provider is inconclusive, the independent provider shall not be placed in a position that requires directed care to ODJFS-administered waiver consumers with disabilities.

(E) Pardons

A conviction of, or a plea of guilty to, an offense listed or described in paragraph (B) (4) of this rule shall not prevent an independent provider's employment under any of the following circumstances:

- (1) The independent provider has been granted an unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;
- (2) The independent provider has been granted an unconditional pardon for the offense pursuant to an existing or former law of the state of Ohio, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code;
- (3) The independent provider has been granted a conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the condition(s) under which the pardon was granted have been satisfied; or
- (4) The conviction or guilty plea has been set aside pursuant to law.

Effective: July 1, 2004

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.96

Rule Amplifies: 5111.96 and 109.572

[MAL 469/CSTL 04-03](#)

5101:3-12-28 Enrollment Process For ODJFS-Administered Waiver Service Providers.

Effective Date: July 1, 2004

- (A) All ODJFS-administered waiver service providers must meet the eligibility requirements set forth in rule 5101:3-12-05 of the Administrative Code. Any person who wants to provide waiver services in an ODJFS-administered waiver must complete the service provider application process set forth in this rule and receive enrollment approval from ODJFS.
- (B) All applicants must submit a complete and accurate service provider application packet to ODJFS or to the entity designated by ODJFS to receive and process such packets. Each applicant must submit with their service provider application packet a signed statement affirming that the applicant received and read all Administrative Code provisions governing the Ohio home care program.
- (C) ODJFS will review the service provider application packet to verify the following information for each provider type.
 - (1) For each medicare-certified home health agency, ODJFS will verify the agency's current medicare certification status, and that the agency and/or the agency's primary officer, director, or owner is not on the U.S. department of health and human services' exclusionary participant list.
 - (2) For each other accredited home health agency, ODJFS will verify the agency's current accreditation status, and that the agency and/or the agency's primary officer, director, or owner is not on the U.S. department of health and human services' exclusionary participant list.
 - (3) For each waiver independent daily living aide, ODJFS will verify the following:
 - (a) The aide has successfully completed the nurse aide competency evaluation conducted by the Ohio department of health under section 3721.31 of the Revised Code, or has successfully completed and passed the home health aide competency evaluation as specified in 42 CFR Part 484 (as effective on July 1, 2004);
 - (b) The aide is not listed on the U.S. department of health and human services' exclusionary participant list;
 - (c) The aide has successfully completed a criminal records check as enumerated in rule 5101:3-12-26 of the Administrative Code and, if applicable, the consumer has implemented the personal character standards enumerated in paragraph (D) of rule 5101:3-12-26 of the Administrative Code; and
 - (d) The aide is not listed on the Ohio department of mental retardation and developmental disabilities' (ODMR/DD) abuser registry.
 - (4) For each waiver independent daily living non-aide, ODJFS will verify the following:
 - (a) The non-aide has successfully completed a criminal records check as enumerated in rule 5101:3-12-26 of the Administrative Code, and if applicable, the consumer has implemented the personal character standards enumerated in paragraph (D) of rule 5101:3-12-26 of the Administrative Code;
 - (b) The non-aide is not listed on the U.S. department of health and human services' exclusionary participant list; and
 - (c) The non-aide is not listed on the ODMR/DD abuser registry.
 - (5) For each independent home care nurse, ODJFS will verify the following:
 - (a) The nurse has a valid and active RN or LPN license in the state of Ohio;

- (b) An appropriate license is held by an LPN supervisor;
- (c) There are no pending actions or sanctions against the nurse by the Ohio board of nursing;
- (d) The nurse has successfully completed a criminal records check as enumerated in rule [5101:3-12-26](#) of the Administrative Code and, if applicable, the consumer has implemented the personal character standards enumerated in paragraph (D) of rule 5101:3-12-26 of the Administrative Code;
- (e) The nurse is not listed on the U.S. department of health and human services' exclusionary participant list; and
- (f) The nurse is not listed on the ODMR/DD abuser registry.
- (6) For each ODJFS-administered HCBS waiver provider of other waiver services, ODJFS will verify that the entity or organization meets the requirements specified in paragraphs (I) (2) and (I) (3) or (J) of rule [5101:3-12-05](#) of the Administrative Code.
- (D) ODJFS will not process a service provider application packet if the packet does not contain information necessary to complete the required verifications. ODJFS will not process a service provider application packet if the applicant does not submit the signed statement as required by section (B) of this rule. ODJFS will notify the applicant in writing of any missing information, and will provide the applicant thirty calendar days to provide the required documentation. If the applicant does not submit the required documentation within thirty calendar days, the service provider application process will be terminated.
- (E) ODJFS will review all information and make a determination regarding the applicant's eligibility for enrollment. If ODJFS determines the applicant is ineligible for enrollment, the applicant is entitled to appeal rights in accordance with rule [5101:3-1-17.6](#) of the Administrative Code.

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[MAL 469/CSTL 04-03](#)

5101:3-12-29 Consumer Incident Reporting.

Effective Date: July 1, 2004

- (A) ODJFS will operate an incident management, investigation and response system (IMIRS). This rule sets forth the standards and procedures for operating the IMIRS. This rule applies to ODJFS and providers of waiver services for ODJFS-administered waivers. ODJFS may contract with other agencies or entities to perform one or more investigatory functions under this rule.
- (B) ODJFS will maintain the secure and confidential storage of ODJFS-approved occurrence reporting forms, and ODJFS-approved incident narrative forms, and any associated investigation reports and related documents. All such documents will be filed according to the name of the consumer, and in an area separate from the involved consumer's clinical record.
- (C) "Level 1" incidents will include, but not be limited to:
- (1) Physical, emotional, mental and/or sexual abuse of a consumer;
 - (2) Neglect of a consumer;
 - (3) Abandonment of a consumer;
 - (4) Exploitation of a consumer;
 - (5) Death of a consumer;
 - (6) Accident or injury of a consumer which may or may not result in hospitalization or emergency room visit;
 - (7) Inappropriate delivery of services to a consumer, with health and safety implications;
 - (8) Services provided to a consumer that are beyond the provider's scope of practice, with health and safety implications;
 - (9) Services delivered to a consumer without physician's orders, that may have health and safety implications;
 - (10) Errors in the administration of medication to the consumer, with health and safety implications;
 - (11) Alleged illegal activity by the consumer resulting in documented police intervention;
 - (12) Consumer's inappropriate use or abuse of substances which may result in health and safety implications;
 - (13) Theft of consumer's money;
 - (14) Theft of consumer's personal property; and
 - (15) Theft of consumer's medication.
- (D) Reporting, notification and response requirements of "Level 1" incidents
- (1) If an ODJFS-administered waiver provider learns of a "Level 1" incident, the provider must report the incident to ODJFS within twenty-four hours.
 - (2) If ODJFS receives a report of an incident, ODJFS will contact the appropriate investigatory or law enforcement authority which may include one or more of the following:
 - (a) The law enforcement agency having jurisdiction over the location at which the incident occurred, if the "Level 1" incident includes conduct that would constitute a possible criminal act, including abuse or neglect.
 - (b) The public children services agency (PCSA) and/or the public adult protective services units having jurisdiction over the location where the consumer resides, if applicable.

- (c) The county board of mental retardation and developmental disabilities (CBMR/DD) for all allegations of abuse, neglect and other major unusual incidents as specified in section 5123.61 of the Revised Code. This notification must be made following all reporting mandates as outlined by ODMR/DD.
- (d) The consumer's local mental health case manager, if such services are identified on the all services plan. This notification must be made following reporting mandates as outlined by the Ohio department of mental health.
- (e) The Ohio department of health or Ohio board of nursing, if appropriate.

(E) Investigation requirements for "Level 1" incidents

ODJFS will conduct investigations of "Level 1" incidents as follows:

- (1) ODJFS will review all available information to determine if there are adequate safeguards to protect the consumer's health and welfare.
- (2) ODJFS will not delegate the investigation of the following types of incidents to a contractor:
 - (a) "Level 1" incidents that include an allegation that an employee of the contractor is responsible for the death, or abuse, or neglect of a consumer; or
 - (b) "Level 1" incidents of a consumer's death where the circumstances of the death are suspicious in nature.
- (3) ODJFS will review the information gathered in the investigation, and may consider the recommendations of any contractor, to determine if the reported incident is substantiated.

(F) Substantiated "Level 1" incidents involving ODJFS-administered waiver service providers

- (1) Upon substantiation of "Level 1" incident(s), the ODJFS-administered waiver service provider will be notified by ODJFS via certified mail with a cease and desist letter. The letter will:
 - (a) Outline the alleged behavior or practice to be stopped;
 - (b) Specify the Administrative Code rule that supports the noncompliance finding(s);
 - (c) Specify what the provider must do to correct the finding(s); and
 - (d) Specify the date a plan of correction must be submitted to ODJFS, not to exceed fifteen calendar days after the date the letter was mailed.
- (2) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider in writing that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.
- (3) ODJFS will impose sanctions upon the provider in accordance with rule [5101:3-12-08](#) of the Administrative Code if the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not submitted a plan of correction or has not had a plan of correction approved;
 - (c) Has not complied with the time frames outlined in this rule;
 - (d) Has failed to protect consumers from repeated and substantiated "Level 1" incidents; and/or
 - (e) Has created a serious and immediate threat to the health and/or safety of the consumer.

(G) At its discretion, for technical assistance or oversight, ODJFS will conduct a separate, independent review or investigation of a "Level 1" incident investigated by a contractor.

(H) "Level 2" incidents will include, but not be limited to:

- (1) Errors in the administration of medication to the consumer, without health and safety implications;
- (2) Alleged illegal activity occurring in the consumer's environment without law enforcement intervention;
- (3) A consumer's exposure to or diagnosis of communicable disease;
- (4) A consumer's family or environmental crisis;
- (5) Loss of a consumer's informal (unpaid) caregiver or family member; and/or
- (6) A consumer's unplanned hospital or nursing home stay.

(I) Reporting, notification and response requirements for "Level 2" incidents.

- (1) If an ODJFS-administered waiver provider learns of a "Level 2" incident, the provider must report the incident to ODJFS within twenty-four hours.
- (2) If ODJFS receives a report of an incident, ODJFS will contact the appropriate investigatory or law enforcement authority which may include one or more of the following:
 - (a) The law enforcement agency having jurisdiction over the location at which the incident occurred, if the "Level 2" incident includes conduct that would constitute a possible criminal act, including abuse or neglect.
 - (b) The PCSA and/or the public adult protective services units having jurisdiction over the location where the consumer resides, if applicable.
 - (c) Contact the CBMR/DD for all allegations of major unusual incidents as specified in section 5123.61 of the Revised Code. This notification must be made in accordance with all reporting mandates as outlined by ODMR/DD.
 - (d) The consumer's local mental health case manager, if such services are identified on the all services plan. This notification must be made following reporting mandates as outlined by the Ohio department of mental health.
 - (e) The Ohio department of health or Ohio board of nursing, as appropriate.

(J) Investigatory requirements for "Level 2" incidents

ODJFS will conduct investigations of "Level 2" incidents as follows:

- (1) ODJFS will review all available information to determine if there are adequate safeguards for the consumers health and welfare.
- (2) ODJFS will review the information gathered in the investigation, and may consider recommendations of any contractor, to determine if the "Level 2" incident is substantiated.

(K) Substantiated "Level 2" incidents involving ODJFS-administered waiver service providers

- (1) Upon substantiation of a "Level 2" incident, the ODJFS-administered waiver service provider will be notified by ODJFS via certified mail with a cease and desist letter. The letter will:
 - (a) Outline the alleged behavior or practice to be stopped;
 - (b) Specify the Administrative Code rule that supports the noncompliance finding;
 - (c) Specify what the provider must do to correct the finding; and
 - (d) The date a plan of correction must be submitted to ODJFS, not to exceed thirty calendar days after the date the letter was mailed.

- (2) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider in writing that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.
- (3) ODJFS will impose sanctions upon the provider in accordance with rule [5101:3-12-08](#) of the Administrative Code if the provider:
- (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not submitted a plan of correction or has not had a plan of correction approved;
 - (c) Has not complied with the time frames outlined in this rule;
 - (d) Has failed to protect consumers from repeated and substantiated "Level 2" incidents; and/or
 - (e) Has created a serious and immediate threat to the health and/or safety of the consumer.
- (L) At its discretion, and for technical assistance or oversight, ODJFS will conduct a separate, independent review or investigation of a "Level 2" incident investigated by a contractor.
- (M) ODJFS will provide a written summary of the investigative findings to the reporter of a "Level 1" or "Level 2" incident, unless it may jeopardize the health and safety of the consumer. Adherence to all consumer confidentiality and HIPAA regulations shall be assured.
- (N) ODJFS will determine when to close cases of suspected abuse, neglect, death and exploitation as well as any other "Level 1" incident investigated by the department.
- (O) ODJFS will be responsible for ensuring that all cases have been properly closed and may request further review if necessary.

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[MAL 469/CSTL 04-03](#)

5101:3-12-30 Monitoring Under ODJFS-Administered Home And Community-Based Service Waivers.

Effective Date: July 1, 2004

- (A) Every ODJFS-administered waiver provider will submit to regularly scheduled monitoring. The monitoring will include:
- (1) Structural review of compliance with rules [5101:3-12-05](#), [5101:3-12-06](#), [5101:3-12-07](#), [5101:3-1-172](#), [5101:3-1-173](#), and [5101:3-12-25](#) or [5101:3-12-26](#) of the Administrative Code, as determined by the appropriate provider type; and
 - (2) Continuous monitoring of provider compliance and performance through the provider occurrence process enumerated in paragraph (D) of this rule.
- (B) ODJFS may contract with other agencies or entities to perform one or more functions enumerated in this rule.
- (C) Structural reviews
- (1) ODJFS will conduct an annual face-to-face structural review of all ODJFS-administered waiver providers using the ODJFS structural compliance review tool, beginning from the first date of service delivery, with the exception of the following:
 - (a) For medicare certified home health agencies and JCAHO or CHAP accredited agencies, the results of the respective certifying or accrediting body will serve as the required structural review.
 - (b) For home modifications, vehicle modifications, equipment and supplies and emergency response system providers, the structural review will occur annually through the second year of service delivery, and biennially thereafter.
 - (2) ODJFS may conduct a structural review as a result of reported provider occurrences as defined in paragraph (D) of this rule.
 - (3) The structural review will include no less than the following:
 - (a) A telephone call or a written announcement establishing the date, time and location of the review.
 - (b) An evaluation of compliance in accordance with paragraph (A) of this rule.
 - (c) A unit of service verification audit assuring that services authorized and delivered are billed for correctly.
 - (d) An evaluation of the ODJFS-administered waiver provider's implementation of any/all plans of correction.
 - (e) An exit conference with agency/provider staff or with the independent provider.
 - (4) For the structural review, ODJFS will gather unit of service verification samples. These will consist of:
 - (a) Ten per cent of the agency-based provider's current ODJFS-administered waiver service delivery records for each service, with a minimum of three and a maximum of thirty records per service/per provider.
 - (b) Three months of clinical records and supporting documentation per consumer for all independent providers. In cases where the independent provider services more than one ODJFS-administered waiver consumer, the structural review will examine three months of clinical records and supporting documentation up to a maximum of six consumers. The findings of this limited review may result in an expanded review of records.

- (5) The unit of service verification audit described in paragraph (C) (3) (c) of this rule will include a comparison of services authorized, delivered and billed as it relates to the consumer's all services plan. ODJFS will report any/all provider overpayments to the department's surveillance and utilization review section. Providers will return any overpayment of funds to ODJFS.
- (6) ODJFS will conduct a combined structural review for all agency-based ODFJS-administered waiver providers that provide both daily living and nursing services. The total sample will equal the required sample as set forth in paragraphs (C) (4) (a) and (C) (4) (b) of this rule.
- (7) ODJFS reserves the right to conduct unannounced structural reviews at any time to evaluate alleged health and/or safety issues, provider occurrences and/or performance concerns. The provider will cooperate by accommodating ODJFS, meeting, making available appropriate meeting space, records and/or other documents requested as part of the review.
- (8) ODJFS will complete one structural review tool per service for each consumer record contained in the review sample, as described in paragraphs (C) (4) (a) and (C) (4) (b) of his rule.
- (9) After the structural review has been conducted, ODJFS will issue a written report to the provider. The report will summarize the overall outcome of the compliance review, list specific rule citations where noncompliance has been determined, and outline specific requirements or actions that must be addressed in a plan of correction. ODJFS may issue an abbreviated written report when identifying consumer health and/or safety issues.
- (10) No later than forty-five calendar days after ODJFS mails the written report described in paragraph (C) (9) of this rule, the provider must submit to ODJFS a plan of correction for all identified noncompliance findings. If ODJFS issues an abbreviated written report identifying consumer health and/or safety issues, the provider's plan of correction must be submitted to ODJFS within five working days after it was mailed.
- (11) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider that the plan addresses the issues of noncompliance outlined in ODJFS' written report. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS.
- (12) ODJFS may impose sanctions upon the provider in accordance with rule [5101:3-12-08](#) of the Administrative Code in the event the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results.
 - (b) Has not complied with the timeframes enumerated in this rule.
 - (c) Has created a serious and immediate threat to the health and/or safety of any ODJFS-administered waiver consumer.
 - (d) Did not cooperate in meeting face-to-face for the structural review.
 - (e) Did not make service delivery and/or clinical records available.
 - (f) Did not submit a satisfactory plan of correction, or upon request, resubmit a satisfactory plan of correction.

(D) Provider occurrence process

- (1) Provider occurrence means:
 - (a) Consumer care violations;
 - (b) Provider billing violations;
 - (c) Medicaid fraud; and/or

- (d) Substandard provider performance.
- (2) ODJFS will investigate provider occurrences and gather supporting documentation upon discovery of any such occurrence.
- (3) ODJFS may gather any of the following information as part of the investigation:
 - (a) Clinical and/or progress notes from the provider;
 - (b) Case management documentation from the consumer's file;
 - (c) Assessment information;
 - (d) The all services plan;
 - (e) MMIS billing information;
 - (f) Doctor's orders;
 - (g) Prior occurrence reports;
 - (h) Consumer/family documentation;
 - (i) Any other relevant supporting documentation.
- (4) If ODJFS decides to substantiate the occurrence, it will notify the provider via certified mail with a cease and desist letter. The letter will:
 - (a) Outline the alleged behavior or practice which must be stopped by the provider;
 - (b) Specify the Administrative Code rule cites that support the noncompliance finding;
 - (c) Specify what the provider must do to correct the finding; and
 - (d) Specify the date on which the provider must submit a plan of correction to ODJFS, not to exceed thirty calendar days after the date the letter was mailed.
- (5) If ODJFS finds the provider's plan of correction acceptable, it shall approve the plan and confirm to the provider that the plan addresses the issues of noncompliance outlined in the cease and desist order. If ODJFS determines that it cannot approve the provider's plan of correction, it will inform the provider of this determination in writing, require the provider to submit a new plan of correction, and specify the required actions that must be included in the new plan of correction. The provider must submit the new plan of correction by the date specified by ODJFS..
- (6) The provider may request technical assistance from ODJFS to correct deficiencies or findings of noncompliance at any time.
- (7) ODJFS may conduct a structural review as outlined in paragraph (C) of this rule to evaluate the provider's implementation of the plan of correction.
- (8) ODJFS reserves the right to conduct unannounced provider structural reviews at any time to evaluate provider occurrences. The provider will cooperate by accommodating ODJFS, meeting, making available appropriate meeting space, records, and/or other documents that may be requested as a part of the review.
- (9) ODJFS may impose sanctions upon the provider in accordance with rule [5101:3-12-08](#) of the Administrative Code in the event the provider:
 - (a) Has not followed the plan of correction and/or successfully achieved the plan's desired results;
 - (b) Has not complied with the time frames outlined in paragraph (D) of this rule;
 - (c) Has repeated substantiated occurrences;
 - (d) Has created a serious and immediate threat to the health and/or safety of the consumer.

- (10) All allegations of medicaid fraud will be processed by ODJFS using supporting documentation enumerated in subparagraph (D) (3) of this rule, and shall be immediately referred to the medicaid fraud control unit (MFCU) of the Ohio attorney general's office.
- (11) All allegations of provider overpayment will be processed by ODJFS. The occurrence reporting form, along with the supporting documentation as enumerated in subparagraph (D) (3) of this rule will be forwarded to the surveillance and utilization review section. Overpayments will be returned to ODJFS.
- (12) ODJFS will review a provider's occurrence reports prior to conducting a structural compliance review. Documented noncompliance will be addressed during the review.

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[MAL 469/CSTL 04-03](#)

5101:3-12-35 Non-Medicaid Ohio Access Success Project.

Effective Date: July 1, 2004

- (A) This rule sets forth the eligibility requirements and benefit limitations for the non-medicaid funded Ohio access success project.
- (B) Definitions:
- (1) "Fiscal Year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.
 - (2) "Individual" means a NF resident who is seeking non-medicaid Ohio access success project benefits.
 - (3) "Nursing Facility (NF)" means a facility or a distinct part of a facility as defined in division (M) of section 5111.20 of the Revised Code.
 - (4) "Ohio access success project non-medicaid funded project" means the portion of the Ohio access success project that is authorized to be paid for with non-medicaid program funds. The benefits provided under the Ohio access success project non-medicaid project shall not exceed a once in a lifetime two thousand dollar benefit.
 - (5) "ODJFS" means the Ohio department of job and family services.
 - (6) "ODA" means the Ohio department of aging.
 - (7) "Resided continuously" means all consecutive days during which an individual, regardless of payment source, occupies a bed in a NF that is included in a facility's certified capacity under medicaid. Coverage of bed-hold days for medically necessary and other limited absences in a NF covered under the provisions of rule [5101:3-3-59](#) of the Administrative Code are considered days during which an individual occupies a bed in a NF.
 - (8) "Transition" means the same as relocation to the community from the NF.
- (C) The application process for the Ohio success project non-medicaid project benefit includes:
- (1) Completion by ODJFS or its designee of the "non-medicaid Ohio access success project referral"; and
 - (2) A face-to-face interview with the individual and ODJFS or its designee.
- (D) An individual must meet all of the following to qualify for the Ohio access success project non-medicaid project benefits:
- (1) The individual must be a recipient of medicaid-funded NF services at the time of application;
 - (2) The individual must have resided continuously in a NF for not less than eighteen months immediately preceding the individual's application for the Ohio access success project non-medicaid project;
 - (3) The individual must need the level of care provided by the NF;
 - (4) The individual must not meet ICF-MR level of care as defined in rule [5101:3-3-07](#) of the Administrative Code;
 - (5) The individual must have a determination by ODJFS or its designee that the projected monthly cost of services for the individual in the community as defined in paragraph (E) of this rule will not exceed eighty per cent of the average monthly medicaid costs of a medicaid recipient residing in the NF as described in paragraph (F) of this rule; and
 - (6) The individual does not qualify for benefits funded by medicaid Ohio access success project.

- (E) The calculation of the projected monthly costs of services for the individual in the community shall include:
- (1) The average medicaid per member per month costs for hospital and physician services as determined by ODJFS;
 - (2) The average medicaid per member per month costs for pharmacy services as determined by ODJFS; and
 - (3) The individual's assessed monthly need for medicaid covered services including, but not limited to:
 - (a) Home health services;
 - (b) Transportation;
 - (c) Adaptive equipment;
 - (d) Durable medical equipment.
- (F) The calculation of the average monthly cost of an individual residing in a NF shall be the sum of:
- (1) The average medicaid per diem paid to all NFs as of July 1 of the fiscal year in which eligibility is being determined under this section; and
 - (2) The average per member per month medicaid costs for medicaid services not covered in paragraph (F)(1) of this rule for a NF resident.
- (G) Non-medicaid Ohio access success project benefit funds shall be used to purchase goods and services to assist in the transition of the consumer from the NF to a community setting. Goods and services include, but are not limited to:
- (1) Rental deposits;
 - (2) Utility deposits;
 - (3) Moving expenses;
 - (4) Home modifications; and/or
 - (5) Debts to facilitate securing a community setting.
- (H) An individual applying for or receiving benefits under the non-medicaid success project shall retain the right to appropriate notice for a hearing in accordance with division-level [5101:6](#) of the Administrative Code.
- (I) ODJFS has the authority to limit the number of individuals for the non-medicaid Ohio access success project to the extent funds are available.

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5101:3-45-01 ODJFS-administered waiver program: definitions.

Effective Date: July 1, 2006.

- (A) "Activities of daily living" are personal or self-care skills performed on a regular basis, with or without the use of adaptive and assistive devices that enable a consumer to meet basic life needs for food, hygiene and appearance as defined in rule 5101:3-3-06 of the Administrative Code.
- (B) "Agency-consumer agreement" and "JFS 02379 Agency-Consumer Agreement" mean the agreements signed by the consumer and/or authorized representative and the case manager (CM) that assure that the consumer is voluntarily enrolling in an ODJFS-administered waiver as an alternative to receiving services in a facility or hospital. They identify the conditions and responsibilities a waiver consumer must agree to as a condition of enrollment.
- (C) "Agency-employed waiver service provider" is a provider who is employed by an agency that is eligible to participate in the medicaid program upon execution of a medicaid provider agreement.
- (D) "All services plan" is the service coordination and payment authorization document that identifies specific goals, objectives and measurable outcomes for consumer health and functioning expected as a result of services provided by both formal and informal caregivers, and that addresses the physical and medical conditions of the consumer.
- (1) At a minimum, the all services plan shall include:
- (a) Essential information needed to provide care to the consumer that assures the consumer's health and welfare;
- (b) Billing authorization; and
- (c) Signatures indicating the consumer's acceptance or rejection of the all services plan.
- (2) The all services plan is not the same as the physician's plan of care.
- (E) "Applicant" is a person who completes a JFS 02399 "Request for Medicaid Home and Community-Based Services" and submits it to the county department of job and family services (CDJFS) requesting an eligibility determination for an ODJFS-administered waiver.
- (F) "Assessment" is a comprehensive face-to-face evaluation conducted as part of the ODJFS-administered waiver program eligibility determination/redetermination process. It is an evaluation of a person's living arrangements/ household composition, medical and acute/long term care history, medical interventions and treatment regimens, medication profile, functional ability, psycho-social status, safety and cognition status, environmental situation, usage of adaptive and assistive equipment, informal supports and caregiver involvement, and formal supports, and results in a level of care recommendation.
- (G) "Assurance of health and welfare agreement" is the document created between the designated case management agency (CMA) and the consumer identifying and setting forth the interventions mutually agreed upon by the consumer and CM to promote the health and welfare of the ODJFS-administered waiver consumer.
- (H) "Authorized representative" is a person the waiver applicant or consumer identifies in writing to the designated CMA as a person who will act on his or her behalf for specifically identified purposes.
- (I) "Case management agency (CMA)" is the entity under contract with ODJFS that provides case management services to consumers enrolled on an ODJFS-administered waiver.
- (J) "Case management services" are the administrative activities that link, coordinate and monitor the services and resources provided to a consumer enrolled on an ODJFS-administered waiver. ODJFS may contract with other entities to perform one or more of these functions.

- (K) "Case manager" is a registered nurse (RN), licensed social worker (LSW) or licensed independent social worker (LISW) employed by the CMA who provides case management services to consumers enrolled on an ODJFS-administered waiver.
- (L) "CDJFS" is a county department of job and family services.
- (M) "Clinical record" is a record containing written documentation that must be maintained by each ODJFS-administered waiver service provider.
- (N) "CMS" is the federal centers for medicare and medicaid services.
- (O) "Community health accreditations program (CHAP)" is an organization that evaluates and accredits home health agencies. For the purpose of providing services to ODJFS-administered waiver consumers, CHAP-accredited agencies are "otherwise accredited agencies" that may provide the same ODJFS-administered waiver services that JCAHO-accredited agencies provide.
- (P) "Consumer" is an applicant determined financially eligible for medicaid and program-eligible for an ODJFS-administered waiver who is enrolled on an ODJFS-administered waiver.
- (Q) "Event-based assessment" is a face-to-face comprehensive evaluation of an ODJFS-administered waiver consumer as warranted by a significant change experienced by that consumer.
- (R) "Family member" as that term is used in the transitions MR/DD waiver set forth in Chapter [5101:3-47](#) of the Administrative Code, is a consumer's or provider's immediate relative or member of the family, including:
- (1) Husband or wife;
 - (2) Birth or adoptive parent, child or sibling;
 - (3) Stepparent, stepchild, stepbrother, stepsister, half-brother, or half-sister;
 - (4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;
 - (5) Grandparent or grandchild; or
 - (6) Spouse of grandparent or grandchild.
- (S) "Formal services" are paid services provided to a consumer regardless of funding source. Formal services include, but are not limited to, medicare, private insurance, third party insurance, and community-funded services such as those funded by county boards of mental retardation and developmental disabilities (CBMR/DD).
- (T) "Group rate" is the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting. When providing services in a group setting, the provider must bill using the HQ modifier as described in rule [5101:3-46-06](#), [5101:3-47-06](#) or [5101:3-50-06](#) of the Administrative Code, as applicable.
- (U) "Group setting" is a situation where a waiver nursing and/or personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ODJFS-administered waiver service, or a combination of ODJFS-administered waiver services and similar non-ODJFS-administered waiver services.
- (V) "Health and welfare" is a requirement imposed by CMS whereby ODJFS must assure that necessary safeguards are taken to protect the health and welfare of ODJFS-administered waiver consumers. CMS will not grant an ODJFS-administered waiver, and may terminate an existing ODJFS-administered waiver, if ODJFS fails to assure compliance with this requirement. ODJFS meets this requirement, at a minimum, by implementing policies and procedures regarding the following:
- (1) Consumer risk and safety planning and evaluations;
 - (2) Consumer critical incident management;

- (3) Housing and environmental safety evaluations;
- (4) Consumer behavioral interventions;
- (5) Consumer medication management; and
- (6) Natural disaster and public emergency response planning.
- (W) "ICF-MR level of care" is the institutional level of care set forth in rule [5101:3-3-07](#) of the Administrative Code.
- (X) "Individual cost cap" is the monthly cost of services that is approved by ODJFS for a consumer enrolled in the Transitions MR/DD Waiver. ODJFS, or at its direction, the CMA, oversees that the cost of medicaid covered services does not exceed the individual cost cap, determines when an increase or decrease in the cap is required, and makes a recommendation with justification to ODJFS for approval for increasing or decreasing the individual cost cap.
- (Y) "Informal services" are unpaid services provided to a consumer.
- (Z) "Institutional level of care" is any of the levels of care set forth in rules [5101:3-3-05](#), [5101:3-3-06](#) and [5101:3-3-07](#) of the Administrative Code.
- (AA) "Institutional setting" is any nursing facility (NF), intermediate care facility for the mentally retarded/developmentally disabled (ICF-MR) or hospital.
- (BB) "Instrumental activity of daily living" is a community living skill performed on a regular basis, with or without the use of adaptive and assistive devices, that enables a consumer to independently manage his or her living arrangement as defined in rule [5101:3-3-08](#) of the Administrative Code.
- (CC) "Intermediate level of care (ILOC)" is the institutional level of care set forth in rule [5101:3-3-06](#) of the Administrative Code.
- (DD) "Joint commission on accreditation of healthcare organizations (JCAHO)" is an organization that evaluates and accredits home health agencies. For the purpose of providing services to ODJFS-administered waiver consumers, JCAHO-accredited agencies are "otherwise accredited agencies" that may provide the same ODJFS-administered waiver services that CHAP-accredited agencies provide.
- (EE) "Legally responsible family member," as that term is used in the Ohio home care waiver set forth in Chapter [5101:3-46](#) of the Administrative Code and the transitions carve-out waiver set forth in Chapter [5101:3-50](#) of the Administrative Code, is a consumer's spouse, or in the case of a minor, the consumer's birth or adoptive parent, or foster caregiver.
- (FF) "Medical necessity" and "medically necessary" have the same meaning as set forth in rule [5101:3-1-01](#) of the Administrative Code.
- (GG) "Medicare-certified home health agency" is any entity, agency or organization that has and maintains medicare certification as a home health agency, and is eligible to participate in the medicaid program upon execution of a medicaid provider agreement.
- (HH) "Non-agency waiver service provider" is an independent provider who is not employed by an agency, and who is eligible to participate in the medicaid program upon execution of a medicaid provider agreement.
- (II) "Noninstitutional setting" is any setting that is not a NF, ICF-MR or hospital.
- (JJ) "Non-legally responsible family member," as that term is used in the Ohio home care waiver set forth in Chapter [5101:3-46](#) of the Administrative Code and the transitions carve-out waiver set forth in Chapter [5101:3-50](#) of the Administrative Code, is a member of the consumer's family, excluding the consumer's spouse, or in the case of a minor, the consumer's birth or adoptive parent, or foster caregiver.
- (KK) "ODJFS" is the Ohio department of job and family services.

- (LL) "ODJFS-administered waiver program" is the Ohio home care program benefit package that consists of home and community-based service waivers administered by ODJFS in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#), and Chapters [5101:3-45](#), [5101:3-46](#), [5101:3-47](#) and [5101:3-50](#) of the Administrative Code.
- (MM) "ODJFS-administered waiver provider" is an agency or non-agency provider eligible to provide ODJFS-administered waiver services upon execution of a medicaid provider agreement.
- (NN) "Ohio Home Care Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#) of the Administrative Code, and Chapters [5101:3-45](#) and [5101:3-46](#) of the Administrative Code.
- (OO) "Otherwise-accredited agency" is any agency or organization that has and maintains JCAHO- or CHAP-accreditation for the provision of both home health services, personal care services and support services upon execution of a medicaid provider agreement.
- (PP) "Program eligibility assessment tool (PEAT)" is the ODJFS-developed tool used during a face-to-face interview with an applicant or consumer as part of the ODJFS-administered waiver program eligibility determination/redetermination process.
- (QQ) "Personal character standards" are character standards that must be taken into consideration when determining eligibility for enrollment of an agency or non-agency employed waiver service provider or applicant who has been convicted or pleaded guilty to an offense listed in rule [5101:3-12-25](#) or [5101:3-12-26](#) of the Administrative Code, and seeks employment in a position that involves providing home and community based services to disabled consumers.
- (RR) "Plan of care" is the medical treatment plan that is established, approved and signed by the treating physician. The plan of care must be signed by the treating physician prior to requesting reimbursement for a service. The plan of care is not the same as the all services plan.
- (SS) "Request for Medicaid Home and Community-Based Services" and "JFS 02399 Request for Medicaid Home and Community-Based Services" mean the form an applicant must complete and submit to the CDJFS requesting an eligibility determination for enrollment in an ODJFS-administered waiver.
- (TT) "Residential address" is any physical dwelling with a unique mailing address where an ODJFS-administered waiver consumer lives. A residential address may include, but is not limited to an apartment within an apartment complex. It would not include the entire apartment building or complex.
- (UU) "Significant change" is a change experienced by a consumer that warrants an event-based assessment. Significant changes include, but are not limited to, a change in health status, caregiver status, and location/residence; referral to or active involvement on the part of a protective service agency; institutionalization; and when the consumer has not received waiver services for ninety calendar days.
- (VV) "Skilled level of care (SLOC)" is the institutional level of care set forth in rule [5101:3-3-05](#) of the Administrative Code.
- (WW) "Transitions Carve-Out Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#) of the Administrative Code, and Chapters [5101:3-45](#) and [5101:3-50](#) of the Administrative Code.
- (XX) "Transitions MR/DD Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#) of the Administrative Code, and Chapters [5101:3-45](#) and [5101:3-47](#) of the Administrative Code.

Replaces: Part of 5101:3-12-01

Effective Date: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification:

Promulgated Under: 119.03

Statutory Authority: 5111.85 Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 5/1/98, 9/29/00, 3/1/02 (Emer), 5/30/02

[CSTL 06-01](#)

5101:3-45-10 Conditions of participation for Ohio department of job and family services (ODJFS) administered waiver service providers.

Effective: August 1, 2005

(A) ODJFS-administered waiver service providers shall:

- (1) Maintain an active, valid medicaid agreement as set forth in rule [5101:3-1-17.3](#) of the Administrative Code.
- (2) Meet all requirements in the applicable provider service specifications set forth in rules [5101:3-12-06](#) and [5101:3-12-07](#) of the Administrative Code.
- (3) Comply with, and maintain documentation of compliance with, the patient rights standards set forth in the home health agency medicare conditions of participation in 42 CFR 484.
- (4) Comply with the consumer incident reporting requirements set forth in rule [5101:3-12-29](#) of the Administrative Code.
- (5) Comply with the criminal records check requirements set forth in rules [5101:3-12-25](#) and [5101:3-12-26](#) of the Administrative Code.
- (6) Attend ODJFS and case management agency (CMA) sponsored provider training sessions.
- (7) Assure consumers receive ODJFS-administered waiver services in accordance with the all services plan.
 - (a) Medicare-certified home health agencies and other accredited home health agencies shall assure that back-up staff will be available to provide services when the provider's regularly scheduled staff cannot or do not meet their obligation to provide services to the consumer.
 - (b) Independent nurses, independent daily living aides and independent daily living non-aides shall assist the consumer, upon initiation of services, in developing a back-up plan in the event the regularly scheduled independent provider cannot or does not meet their obligation to provide services to the consumer.
- (8) Immediately provide all requested information to ODJFS, the centers for medicare and medicaid services (CMS) and the CMA.
- (9) Not use or disclose any information concerning a consumer for any purpose without the documented consent of the consumer. Even with the consumer's consent, the information may not be used or disclosed for any purpose not directly associated with the provision of services.
- (10) Comply with all federal and state privacy laws, including the Health Insurance Portability and Accountability Act (HIPAA) regulations as set forth in 45 CFR parts 160, 162 and 164, and the medicaid confidentiality regulations as set forth in 42 CFR 421.300 through 306.
- (11) Maintain and retain all required documentation. For each unit of service provided, the provider shall clearly document what service was provided and obtain the signature of the consumer on the dated document.
- (12) Retain all records of service delivery and billing for a period of six years after the date of receipt of the payment based upon those records or until any initiated audit is completed, whichever is longer.
- (13) Cooperate with ODJFS and the CMA during any quality assurance activities to monitor the provider's performance, including providing space for and being available to answer questions for onsite reviews and making all requested information available promptly.

- (14) Notify the CMA within twenty-four hours and provide written documentation within five calendar days when the provider is aware of significant changes that may affect the service needs of the consumer. Significant changes that may affect service needs of the consumer include, but are not limited to:
- (a) The consumer refuses services.
 - (b) The consumer moves to another residential address.
 - (c) There are documented changes in the physical, mental, and/or emotional status of the consumer, documented changes in environmental conditions, and/or other health and safety issues.
 - (d) The consumer no longer needs medically necessary services as defined in rule [5101:3-1-01](#) of the Administrative Code.
 - (e) Abuse or neglect of the consumer is suspected.
- (15) Submit written notification to the consumer and the CMA at least thirty calendar days prior to the anticipated last date of service if the provider is terminating the provision of ODJFS-administered waiver services to the consumer. Exceptions to this requirement include:
- (a) Thirty-day advanced notification is not required when the consumer has been hospitalized, placed in a long term care facility, or has expired.
 - (b) The thirty-day advanced notification may be waived for the provider by the CMA on a case-by-case basis.
 - (c) The thirty-day advanced notification of service termination is not required if the consumer is terminating the services of the provider.
- (B) Independent providers are independent contractors and must pay applicable federal, state and local income and employment taxes in compliance with federal, state and local requirements. Federal employment taxes include medicare and social security. On an annual basis, independent providers must submit the ODJFS-approved affidavit stating they paid the applicable federal, state and local income and employment taxes.
- (C) ODJFS-administered waiver service providers shall deliver services professionally, respectfully, and legally, and during the provision of authorized services, shall not engage in unprofessional, disrespectful or illegal behavior that includes, but is not limited to the following:
- (1) Consuming the consumer's food and/or drink, or using the consumer's personal property without the consumer's offer and consent.
 - (2) Bringing children, pets, friends, relatives, or anyone else to the consumer's place of residence.
 - (3) Taking the consumer to the provider's place of residence.
 - (4) Consuming alcohol, medicine, drugs, or other chemical substances not in accordance with the legal, valid, prescribed use and/or in any way that impairs the provider in the delivery of services to the consumer.
 - (5) Discussing religion or politics with the consumer and others present in the care setting.
 - (6) Discussing providers' personal issues with the consumer and others in the care setting.
 - (7) Accepting, obtaining or attempting to obtain money or anything of value, including gifts or tips from the consumer, household members and family members of the consumer.
 - (8) Engaging with the consumer in sexual conduct, or in conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not the contact is consensual.

- (9) Leaving the home for a purpose not related to the provision of services without notifying the agency supervisor, the consumer's emergency contact person, identified caregiver and/or case manager (CM).
- (10) Using the consumer's motor vehicle, unless used solely for the benefit of the consumer.
- (11) Engaging in activities that may distract from service delivery including, but not limited to:
 - (a) Watching television or playing computer or video games.
 - (b) Making or receiving personal calls.
 - (c) Engaging in non-care-related socialization with individuals other than the consumer.
 - (d) Providing care to individuals other than the consumer.
 - (e) Smoking without the consent of the consumer.
 - (f) Sleeping.

(D) ODJFS-administered waiver service providers shall not:

- (1) Engage in behavior that causes or may cause physical, verbal, mental or emotional distress or abuse to the consumer.
- (2) Engage in behavior that may reasonably be interpreted as inappropriate involvement in the consumer's personal relationships.
- (3) Be designated to serve or make decisions for the consumer in any capacity involving a declaration for mental health treatment, durable power of attorney, financial power of attorney, or guardianship pursuant to court order unless one or more of the following exceptions applies:
 - (a) The consumer and the provider relationship existed and the provider had been appointed and was already serving as the consumer's designee pursuant to a declaration for mental health treatment, durable power of attorney, financial power of attorney, or guardianship pursuant to court order prior to September 1, 2005.
 - (b) The consumer and the provider relationship existed and the provider was subsequently, but prior to September 1, 2005, appointed the consumer's designee pursuant to a declaration for mental health treatment, durable power of attorney, financial power of attorney, or guardianship pursuant to court order.
 - (c) The consumer's designee pursuant to a declaration for mental health treatment, durable power of attorney, or financial power of attorney is the consumer's parent or spouse.
 - (d) A family member is appointed by the court as a legal guardian for the consumer.
- (4) Sell to or purchase from the consumer products or personal items. The only exception to this would be family members when not delivering services.
- (5) Engage in behavior that constitutes a conflict of interest or takes advantage of or manipulates ODJFS-administered waiver program rules resulting in an unintended advantage for personal gain; or that has detrimental results for the consumer, their family, caregiver and/or another provider.

(E) Failure to meet the required conditions of participation as set forth in this rule may result in sanctions in accordance with rule [5101:3-12-08](#) of the Administrative Code and/or termination of the medicaid provider agreement in accordance with rule [5101:3-1-17.6](#) of the Administrative Code.

Effective: 08/01/2005

R.C. 119.032 review dates: 08/01/2010

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.01, 5111.02

[CSTL 05-01](#)

5101:3-46-02 Ohio home care waiver: consumer eligibility for enrollment.

Effective Date: July 1, 2006.

(A) For the purposes of this rule,

- (1) "Applicant" has the same meaning as set forth in rule 5101:3-45-01 of the Administrative Code; and
- (2) "Consumer" has the same meaning as set forth in rule 5101:3-45-01 of the Administrative Code.

(B) To be eligible for Ohio home care waiver enrollment, an applicant must:

- (1) Be determined eligible for Ohio medicaid in accordance with rules 5101:1-38-01.6 and 5101:1-39-95 of the Administrative Code; and
- (2) Be determined program eligible for the Ohio home care waiver by meeting the following requirements:
 - (a) Participate in the assessment process as defined in rule 5101:3-45-01 of the Administrative Code;
 - (b) Be age zero through fifty-nine with either an intermediate level of care in accordance with rule 5101:3-3-06 of the Administrative Code or a skilled level of care in accordance with rule 5101:3-3-05 of the Administrative Code;
 - (c) Need services that are not available through other sources in amounts sufficient to meet the applicant's needs;
 - (d) Not reside in an institution, residential care facility, adult foster home or other group living arrangement subject to state licensure or certification;
 - (e) In the absence of the Ohio home care waiver, require nursing facility (NF) placement or long term hospitalization;
 - (f) Elect to receive Ohio home care waiver services instead of institutional services and sign a JFS 02379 agency-consumer agreement prior to enrollment;
 - (g) Be assigned a potential slot for enrollment in the Ohio home care waiver;
 - (h) Participate in the development of an all services plan;
 - (i) Be able to have the services identified in the all services plan met within the funding range established in accordance with rule 5101:3-46-08 of the Administrative Code; and
 - (j) Accept the all services plan by signing and dating the plan.

(C) An applicant meeting the eligibility requirements set forth in paragraph (B) of this rule shall be enrolled in the Ohio home care waiver in accordance with the enrollment process set forth in paragraph (A) of rule 5101:3-46-07 of the Administrative Code if the Ohio home care waiver has not reached the CMS-authorized participation limit for the applicable program year. If the CMS-authorized participation limit has been reached, the waiting list process set forth in paragraphs (B), (C) and (D) of rule 5101:3-46-07 of the Administrative Code shall be followed.

(D) If an applicant fails to meet any of the eligibility criteria set forth in paragraph (B) of this rule, the applicant shall be denied enrollment on the Ohio home care waiver.

(E) Reassessments and requirements for maintaining ongoing eligibility.

- (1) An Ohio home care waiver consumer shall be reassessed at least annually, and more frequently if there is a significant change in the consumer's situation that may impact the consumer's health and welfare. If the annual reassessment determines that the consumer no longer meets the eligibility criteria set forth in paragraph (B) of this rule, the consumer shall be disenrolled

from the Ohio home care waiver. In such instances, the consumer shall be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.

- (2) If an Ohio home care waiver consumer does not receive any waiver services for ninety consecutive days, ODJFS shall, within ten days of the ninetieth day, reassess the consumer's need for waiver services. If it is determined that waiver services are no longer needed, the consumer shall be disenrolled from the Ohio home care waiver. The consumer shall be afforded notice and hearing rights in accordance with division-level 5101:6 of the Administrative Code.
- (3) If, at any time, a consumer ceases to meet any of the eligibility criteria set forth in paragraph (B) of this rule, the consumer shall be disenrolled from the Ohio home care waiver. In such instances, the applicant or consumer shall be afforded notice and hearing rights in accordance with division-level 5101:6 of the Administrative Code.

Replaces: Part of 5101:3-12-04

Effective Date: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

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[CSTL 06-01](#)

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

Effective date: July 1, 2006.

This rule sets forth the definitions of the services covered by the Ohio home care waiver. This rule also sets forth the provider requirements and specifications for the delivery of Ohio home care waiver services. The services are reimbursed in accordance with rule [5101:3-46-06](#) of the Administrative Code.(A) Waiver nursing services.

- (1) "Waiver nursing services" are defined as services provided to Ohio home care waiver consumers 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 consumers on the Ohio home care waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and shall possess a current and valid license in good standing with the Ohio board of nursing.
- (2) "Personal care aide services" as defined in paragraph (B) of this rule may be reimbursed as waiver nursing services when provided incidental to waiver nursing services as defined in paragraph (A)(1) of this rule and performed during the authorized waiver nursing visit.
- (3) Waiver nursing services do not include:
 - (a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules adopted there under and to be performed by individuals who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;
 - (b) Services that require the skills of a psychiatric nurse;
 - (c) Visits performed for the sole purpose of meeting the supervisory requirements as set forth in paragraphs (B)(6)(c) and (B)(6)(d) of this rule; or
 - (d) Services performed in excess of the number of hours approved pursuant to the all services plan.
- (4) In order to submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must:
 - (a) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider;
 - (b) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code, unless the legally responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency;
 - (c) Not be the foster caregiver of the consumer;
 - (d) Be identified as the provider on the all services plan that is prior-approved by the designated case management agency (CMA);
 - (e) Be performing nursing services pursuant to signed and dated written orders from the treating physician; and
 - (f) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.
- (5) Non-agency LPNs, at the direction of an RN, must:
 - (a) Conduct a face-to-face visit with the directing RN at least every sixty days after the initial visit to evaluate the provision of waiver nursing services and LPN performance, and to

assure that waiver nursing services are being provided in accordance with the approved plan of care; and

(b) Conduct a face-to-face visit with the consumer and the directing RN no less than every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the consumer's satisfaction with care delivery, and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care

(6) All waiver nursing service providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency waiver nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (k) of this paragraph.

(a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record shall include documentation that the RN has reviewed the plans of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the consumer's condition.

(f) In all instances when the treating physician gives verbal orders to the nurse, the nurse must document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse must subsequently secure documentation of the verbal orders, signed and dated by the treating physician.

(g) In all instances when a non-agency LPN is providing waiver nursing services, the LPN must provide clinical notes, signed and dated by the LPN, documenting the face-to-face visits between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer and the directing RN. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A copy of the "do not resuscitate" (DNR) order, if one exists.

(i) Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(j) Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team.

(k) A discharge summary, signed and dated by the departing nurse, at the point the nurse is no longer going to provide services to the consumer, or when the consumer no longer needs nursing services.

(B) Personal care aide services.

- (1) "Personal care aide services" are defined as services provided pursuant to the Ohio home care waiver's all services plan that assist the consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) impairments. If the all services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. Personal care aide services consist of the services listed in subparagraphs (a) to (e) of this paragraph. Personal care aide service providers may elect not to furnish one or more of the listed services. If the provider so elects, the provider must notify the designated CMA, in writing, of the services the provider elects not to furnish.

 - (a) 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;
 - (b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, and waste disposal;
 - (c) 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;
 - (d) Paying bills and assisting with personal correspondence as directed by the consumer; and
 - (e) Accompanying or transporting the consumer to Ohio home care waiver services, medical appointments, other community services, or running errands on behalf of the consumer.
- (2) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the all services plan.
- (3) Personal care aides shall not administer prescribed or over-the-counter medications to the consumer, but may, pursuant to paragraph (B) of rule 4723-13-04 of the Administrative Code, help the consumer self-administer medications by:

 - (a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;
 - (b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;
 - (c) Opening the container for a consumer who is physically unable to open the container;
 - (d) Assisting a consumer who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and
 - (e) Assisting a consumer who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the consumer.
- (4) Personal care aide services shall be delivered by one of the following:

 - (a) An employee of a medicare-certified, or otherwise-accredited home health agency; or
 - (b) A non-agency personal care aide.
- (5) In order to submit a claim for reimbursement, all individuals providing personal care aide services must meet the following:

 - (a) Be at least eighteen years of age;
 - (b) Be identified as the provider on the all services plan that is prior-approved by the designated CMA;
 - (c) Have a valid social security number, and one of the following forms of identification:

- (i) Alien identification,
 - (ii) State of Ohio identification,
 - (iii) A valid driver's license, or
 - (iv) Other government-issued photo identification;
 - (d) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code;
 - (e) Not be the foster caregiver of the consumer;
 - (f) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit; and
 - (g) Comply with the additional applicable provider-specific requirements as specified in paragraph (B)(6) or (B)(7) of this rule.
 - (6) Medicare-certified and otherwise-accredited home health agencies must assure that personal care aides meet the following requirements:
 - (a) Prior to commencing service delivery, the personal care aide must:
 - (i) Obtain a certificate of completion of either the nurse aide competency evaluation program conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005), and
 - (ii) Obtain and maintain first aid certification.
 - (b) Maintain evidence of the completion of eight hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately after the personal care aide's first anniversary of employment with the agency, and must be completed annually thereafter.
 - (c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, must:
 - (i) Conduct a face-to-face consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.
 - (ii) Conduct a face-to-face consumer home visit at least every sixty days after the initial visit to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, personal care aide performance.
 - (iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.
 - (iv) Discuss the evaluation of personal care aide services with the case manager.
 - (d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.
 - (e) Be able to effectively communicate with the consumer.
 - (7) Non-agency personal care aides must meet the following requirements:
 - (a) Prior to commencing service delivery personal care aides must have:

- (i) Obtained a certificate of completion within the last twenty-four months for either the nurse aide competency evaluation program conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005); or other equivalent training program. The program must include training in the following areas:
 - (a) Personal care aide services as defined in paragraph (B)(1) of this rule;
 - (b) Basic home safety; and
 - (c) Universal precautions for infection control, including hand-washing and proper disposal of bodily waste.
 - (ii) Obtained and maintain first aid certification.
 - (b) Complete eight hours of in-service continuing education annually that must occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to consumer health and welfare, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.
 - (c) Comply with the consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.
 - (d) Comply with ODJFS monitoring requirements in accordance with rule [5101:3-12-30](#) of the Administrative Code.
 - (e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the Ohio home care waiver.
 - (f) Be able to effectively communicate with the consumer.
- (8) All personal care aide providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency personal care aides must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.
- (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.
 - (b) Consumer medical history.
 - (c) Name of consumer's treating physician.
 - (d) A copy of the initial and all subsequent all services plans.
 - (e) Documentation of drug allergies and dietary restrictions.
 - (f) A copy of the "do not resuscitate" (DNR) order, if one exists.
 - (g) Documentation that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon

completion of service delivery. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

- (h) Progress notes signed and dated by the personal care aide, documenting all communications with the CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.
- (i) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the consumer, or when the consumer no longer needs personal care aide services.

(C) Adult day health center services.

- (1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that is used solely for the provision of ADHCS.
 - (a) The services the adult day health center must make available are the following:
 - (i) Waiver nursing services as set forth in paragraph (A) of this rule, or personal care aide services as set forth in paragraph (B)(1) of this rule;
 - (ii) Recreational and educational activities; and
 - (iii) No more than two meals per day that meet the consumer's dietary requirements.
 - (b) The services the adult day health center may also make available include the following:
 - (i) Skilled therapy services as set forth in rule [5101:3-12-01](#) of the Administrative Code;
 - (ii) Transportation of the consumer to and from ADHCS.
 - (c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on a day.
 - (d) All of the services set forth in paragraphs (C)(1)(a) and (C)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.
- (2) ADHCS do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, providers of ADHCS must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA; and
 - (b) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.
- (4) All providers of ADHCS must:
 - (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
 - (b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.

- (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.
 - (d) Assure that any waiver nursing services provided are within the nurse's scope of practice as limited in paragraph (A)(1) of this rule.
 - (e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.
 - (f) Maintain, at all times, a paid staff to consumer ratio of 1:6.
- (5) Providers of ADHCS must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.
- (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
 - (b) Consumer medical history.
 - (c) Name of consumer's treating physician.
 - (d) A copy of the initial and all subsequent all services plans.
 - (e) A copy of the "do not resuscitate" (DNR) order, if one exists.
 - (f) Documentation of drug allergies and dietary restrictions.
 - (g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the paragraph.
 - (h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ADHCS provider is no longer going to provide services to the consumer, or when the consumer no longer needs ADHCS.
 - (i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meal services.

- (1) "Home delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician, taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.
- (2) Home delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, all providers of home delivered meal services must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;

- (b) Possess a valid food vendor's license;
- (c) Assure that all meals are prepared and delivered as identified on the all services plan; and
- (d) Only submit a claim for up to two meals per day per consumer.

(4) Home delivered meal service providers must maintain the documentation identified in subparagraphs (a) to (d) of this paragraph.

- (a) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).
- (b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.
- (c) All appropriate food vendor's licenses.
- (d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.

(5) Upon request, home delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.

(6) Home delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.

(7) Home delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer to function with greater independence in the home and remain in the community. Home modification services shall not exceed ten thousand dollars within a twelve-month period per consumer.

- (a) The property owner must give written consent for the home modification that indicates an understanding that the Ohio home care waiver will not pay to have the property returned to its prior condition.
- (b) The need for home modification services must be identified in an evaluation completed by an occupational therapist or physical therapist as licensed pursuant to sections 4755.07 and 4755.44 of the Revised Code.

(2) Home modification services do not include:

- (a) Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the consumer (i.e., carpeting, roof repair, central air conditioning, etc.);
- (b) Adaptations that add to the total square footage of the home; and
- (c) Services performed in excess of what is approved pursuant to the all services plan.

(3) Home modification service providers shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the bid specification. The reimbursement may

only be adjusted if the job specifications are modified in writing by the designated CMA and the adjustment is warranted. Family members and volunteers will only be reimbursed for the cost of materials.

(4) In order to submit a claim for reimbursement, providers of home modification services must:

- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Assure that the home modification was completed in accordance with the agreed upon specifications using all of the materials and equipment cited in the bid;
- (c) Assure that the home modification was tested and in proper working order;
- (d) Assure that the home modification met all applicable state and local building codes and complies with the Americans with Disabilities Act (ADA);
- (e) Maintain insurance and bonding for general contracting services and provide proof to the designated CMA upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the consumer; and
- (f) Obtain a final written approval from the consumer and the designated CMA after completion of the home modification service.

(5) Selection of home modification service providers.

- (a) The designated CMA shall develop job specifications in consultation with the consumer, authorized representative, and/or caregiver(s) to meet the consumer's environmental accessibility needs with the lowest cost alternative.
- (b) The designated CMA shall send the home modification specifications to every home modification service provider in the consumer's region and invite the submission of competitive bids. The following must be submitted with all bids:
 - (i) A drawing or diagram of the home modification;
 - (ii) An itemized list of all materials needed for the home modification;
 - (iii) An itemized list of the cost of the materials needed for the home modification;
 - (iv) An itemized list of the labor costs;
 - (v) A written statement of all warranties provided; and
 - (vi) A written attestation that the provider, all employees and/or all subcontractors to be used to perform the job specifications have the necessary experience and skills.
- (c) The designated CMA shall review all submitted bids and the home modification service will be awarded to the lowest responsive and most responsible bidder, with price and other relevant factors being considered in the selection process.

(F) Supplemental transportation services.

- (1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point.
- (2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to the all services plan.

- (3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.
- (4) Agency supplemental transportation service providers must:
- (a) Maintain a current list of drivers;
 - (b) Assure that all drivers providing supplemental transportation services are age eighteen or older;
 - (c) Maintain a copy of the valid driver's license for each driver;
 - (d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services;
 - (e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;
 - (f) Assure that drivers are not the consumers' legally responsible family members as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code; and
 - (g) Assure that drivers are not the consumers' foster caregivers.
- (5) Non-agency supplemental transportation service providers must:
- (a) Be age eighteen or older;
 - (b) Possess a valid driver's license;
 - (c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services;
 - (d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;
 - (e) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code; and
 - (f) Not be the consumer's foster caregiver.
- (6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.

(G) Supplemental adaptive and assistive device services.

- (1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the consumer, or the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code, that are not otherwise available through any other funding source and that are suitable to enable the consumer to function with greater independence, avoid institutionalization, and reduce the need for human assistance. The designated CMA shall only approve the lowest cost alternative that meets the consumer's needs.
- (a) Reimbursement for medical equipment and supplies shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one-year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical condition requiring the replacement.

- (b) Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of vehicle modification for the consumer for a three-year period unless there is a documented change in the consumer's medical and/or physical condition requiring the replacement.
- (2) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same consumer. Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide the designated CMA with documentation of:
- (a) Evidence of a valid driver's license, with appropriate restrictions;
- (b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;
- (c) Evidence of the vehicle owner's collision and liability insurance for the vehicle being modified; and
- (d) A written statement from a certified mechanic stating the vehicle is in good operating condition.
- (3) Supplemental adaptive and assistive device services do not include:
- (a) Items considered by the federal food and drug administration as experimental or investigational;
- (b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;
- (c) Payment toward the purchase or lease of a vehicle;
- (d) Routine care and maintenance of vehicle modifications and devices;
- (e) Permanent modification of leased vehicles;
- (f) Vehicle inspection costs;
- (g) Vehicle insurance costs; and
- (h) Services performed in excess of what is approved pursuant to the all services plan.
- (4) In order to submit a claim for supplemental adaptive and assistive device services, the provider must:
- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services; and
- (c) Assure that the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.
- (5) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (d) of this paragraph.

- (a) Consumer identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
- (b) Name of consumer's treating physician.
- (c) A copy of the initial and all subsequent all services plans.
- (d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(H) Out-of-home respite services.

- (1) "Out-of-home respite services" are services delivered to a consumer in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.
 - (a) The services the out-of-home respite provider must make available are:
 - (i) Waiver nursing services as set forth in paragraph (A) of this rule;
 - (ii) Personal care aide services as set forth in paragraph (B)(1) of this rule; and
 - (iii) Three meals per day that meet the consumer's dietary requirements.
 - (b) All services set forth in paragraph (H)(1)(a) of this rule and delivered during the provision of out-of-home respite services shall not be reimbursed as separate services.
- (2) Out-of-home respite services do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, providers of out-of-home respite services must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.
 - (b) Be either:
 - (i) An intermediate care facility (i) for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in accordance with rules [5101:3-3-02](#) and [5101:3-3-02.3](#) of the Administrative Code; or
 - (ii) A nursing facility (NF) licensed and certified in accordance with rules [5101:3-3-02](#) and [5101:3-3-02.3](#) of the Administrative Code; or
 - (iii) Another institutional setting approved by the designated CMA.
 - (c) Be providing out-of-home respite services for one individual, or for up to three individuals in a group setting on the same date.
- (4) All providers of out-of-home respite services must:
 - (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
 - (b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.
 - (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.

(5) Providers of out-of-home respite services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

(a) Consumer's identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the "do not resuscitate" (DNR) order, if one exists.

(f) Documentation of drug allergies and dietary restrictions.

(g) Documentation that clearly shows the date of out-of-home respite service delivery, including tasks performed or not performed. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing out-of-home respite service provider, at the point the service provider is no longer going to provide services to the consumer, or when the consumer no longer needs out-of-home respite services.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing.

(l) Emergency response services.

(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers 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 are considered to be high risk for the purposes of this service.

(2) ERS do not include:

(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and

(b) Services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.

(4) Providers of ERS must:

(a) Permit consumers to select from a variety of remote activation devices;

(b) Assure that consumers have systems that meet their specific needs;

(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;

(d) Conduct monthly testing of emergency response systems to assure proper operation;

- (e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;
 - (f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;
 - (g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;
 - (h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;
 - (i) Assure that emergency response center staff respond to alarm messages within sixty seconds of receipt; and
 - (j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.
- (5) Providers of ERS must maintain the following documentation:
- (a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;
 - (b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;
 - (c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and
 - (d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.

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[CSTL 06-01](#)

5101:3-46-06 Ohio home care waiver: reimbursement rates and billing procedures.

Effective Date: July 1, 2006.

(A) Definitions of terms used for billing and calculating rates.

- (1) "Base rate," as used in table A, column 3 of paragraph (B) of this rule, means the amount paid for up to the first four units of service delivered.
- (2) "Billing unit," as used in table B, column 3 of paragraph (B) of this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).
- (3) "Group rate," as used in paragraph (E)(1) of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.
- (4) "Group setting" is a situation where a waiver nursing and/or personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ODJFS-administered waiver service, or a combination of ODJFS-administered waiver services and similar non-ODJFS-administered waiver services.
- (5) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.
 - (a) For the billing codes in table B of paragraph (B) of this rule, the medicaid maximum rate is set forth in column 4.
 - (b) For the billing codes in table A of paragraph (B) of this rule, the medicaid maximum rate is:
 - (i) The base rate as defined in paragraph (A) (1) of this rule, or
 - (ii) The base rate as defined in paragraph (A) (1) of this rule plus the unit rate as defined in paragraph (A) (7) of this rule for each additional unit of service delivered.
- (6) "Modifier," as used in paragraph (E) of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.
- (7) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service provided.

(B) Billing code tables.

- Table A -

<u>Column 1</u>	<u>Column 2</u>	<u>Column 3</u>	<u>Column 4</u>
<u>Billing code</u>	<u>Service</u>	<u>Base rate</u>	<u>Unit rate</u>
<u>T1002</u>	<u>Waiver nursing services provided by an RN</u>	<u>\$50.60</u>	<u>\$5.42</u>
<u>T1003</u>	<u>Waiver nursing services provided by an LPN</u>	<u>\$50.60</u>	<u>\$5.42</u>
<u>T1019</u>	<u>Personal care aide services</u>	<u>\$24.00</u>	<u>\$3.00</u>

- Table B -

<u>Column 1</u>	<u>Column 2</u>	<u>Column 3</u>	<u>Column 4</u>
<u>Billing code</u>	<u>Service</u>	<u>Billing unit</u>	<u>Medicaid maximum rate</u>
H0045	<u>Out-of-home respite services</u>	<u>Per day</u>	<u>\$200.00</u>
S0215	<u>Supplemental transportation services</u>	<u>Per mile</u>	<u>\$0.38</u>
S5101	<u>Adult day health center services</u>	<u>Per half day</u>	<u>\$32.50</u>
S5102	<u>Adult day health center services</u>	<u>Per day</u>	<u>\$65.00</u>
S5160	<u>Emergency response services</u>	<u>Per installation and testing</u>	<u>\$45.00</u>
S5161	<u>Emergency response services</u>	<u>Per monthly fee</u>	<u>\$45.00</u>
S5165	<u>Home modification services</u>	<u>Per item</u>	<u>Amount prior-authorized on the all services plan</u>
T2029	<u>Supplemental adaptive and assistive device services</u>	<u>Per item</u>	<u>Amount prior-authorized on the all services plan</u>
S5170	<u>Home delivered meal services</u>	<u>Per meal</u>	<u>\$7.00</u>

(C) In order for a provider to submit a claim for Ohio home care waiver services, the services must be provided in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#) of the Administrative Code, and Chapters [5101:3-45](#) and [5101:3-46](#) of the Administrative Code.

(D) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.

(E) Required modifiers.

- (1) The "HQ" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement as a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.
- (2) The "U1" modifier must be used when a provider submits a claim for billing code T1002 and the consumer is receiving infusion therapy.
- (3) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to a consumer for the same date of service.
- (4) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to a consumer for the same date of service.
- (5) The "U4" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

(F) Reimbursement will be provided in accordance with paragraphs (A) to (D) of rule [5101:3-1-60](#) of the Administrative Code.

Replaces: Part of 5101:3-1-06.3

Effective Date: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 06/19/2006

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 1/1/04

[CSTL 06-02](#)

5101:3-46-07 Ohio home care waiver: enrollment and waiting list process.

Effective Date: July 1, 2006.

- (A) When the Ohio department of job and family services (ODJFS) receives notification of an application for enrollment in the Ohio home care waiver from the county department of job and family services (CDJFS) as outlined in rule [5101:3-38-01.6](#) of the Administrative Code, ODJFS shall first determine if there is a potential slot available for the applicant.
- (1) If a potential slot is available, the slot is reserved for the applicant while eligibility determinations are made for medicaid and the Ohio home care waiver as set forth in rules [5101:3-46-02](#), [5101:3-38-01.6](#) and [5101:1-39-95](#) of the Administrative Code.
 - (a) An applicant who meets the required medicaid and the required Ohio home care waiver eligibility criteria is enrolled on the Ohio home care waiver in accordance with rules [5101:3-12-08](#) to 5101:3-12-30[5101:3-12-30](#), Chapter [5101:3-45](#), and Chapter [5101:3-46](#) of the Administrative Code.
 - (b) If the applicant is not eligible for the Ohio home care waiver, the application is denied and the applicant retains full hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.
 - (2) If a potential slot is not available on the Ohio home care waiver, the applicant is denied and retains full hearing rights in accordance with division-level [5101:6](#) of the Administrative Code. The applicant is placed on the Ohio home care waiver waiting list in accordance with the procedures set forth in paragraph (B) of this rule.
- (B) ODJFS shall maintain a statewide waiting list for the Ohio home care waiver consisting of applicants denied enrollment for the reason that all slots on the waiver are reserved. An applicant is placed on the Ohio home care waiver waiting list according to the applicant's signature date on the JFS 02399 "Request for Medicaid Home and Community-Based Services (HCBS)" as described in rule [5101:3-38-01.6](#) of the Administrative Code. When multiple applicants for the Ohio home care waiver have the same JFS 02399 signature date, the position on that waiver's waiting list shall be determined by the last four digits of each applicant's social security number, with the lowest number appearing first on the list. When a potential slot becomes available, ODJFS shall notify the next applicant on the waiting list in writing to reapply for the Ohio home care waiver within thirty days of receiving notification.
- (1) If ODJFS or its designated case management agency (CMA) is not notified by a CDJFS that the applicant has reapplied within thirty days, the applicant shall be removed from the waiting list and ODJFS shall notify the next person on the waiting list in writing about the potential slot.
 - (2) If ODJFS or the CMA is notified that the applicant has reapplied for the Ohio home care waiver within thirty days, ODJFS shall initiate the process set forth in paragraph (A)(1) of this rule.
- (C) If an applicant for a home and community-based services waiver administered by the Ohio department of mental retardation and developmental disabilities (ODMR/DD) is found ineligible for that waiver in accordance with Chapter [5101:3-40](#) or [5101:3-43](#) of the Administrative Code, as appropriate, and applies for the Ohio home care waiver, the earliest known JFS 02399 signature date filed determines the applicant's placement on the Ohio home care waiver waiting list.
- (D) Applicants on the waiting list shall be given priority for accessing Ohio home care waiver slots as described in paragraph (A)(1) of this rule when they meet any of the criteria set forth in paragraphs (D)(1) and (D)(2) of this rule. Applicants will be considered according to the signature date on the JFS 02399. When multiple applicants for the Ohio home care waiver have the same JFS 02399 signature date, the position on the waiver's waiting list shall be determined by the last four digits of each applicant's social security number, with the lowest number appearing first on the list. When a potential slot becomes available, the next applicant on the waiting list who meets the criteria set forth in

paragraphs (D)(1) and (D)(2) of this rule shall be notified in writing to reapply for the Ohio home care waiver within thirty days of receiving notification.

(1) Children who:

(a) Are from birth up to, but not including, their sixth birthday; and

(b) Have been residing in an inpatient hospital setting at the time of, and at least thirty days prior to, application for the Ohio home care waiver.

(2) Applicants who are residents of a medicaid-funded nursing facility (NF) at the time of application and have a projected monthly cost of services in the community that will not exceed eighty per cent of the average monthly medicaid costs of a medicaid recipient residing in a NF.

Replaces: 5101:3-12-13

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Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 8/1/01, 3/1/02 (Emer), 5/30/02

[CSTL 06-01](#)

5101:3-47-02 Transitions MR/DD waiver: consumer eligibility for enrollment.

Effective Date: July 1, 2006.

- (A) Enrollment on the transitions MR/DD waiver is only available to consumers who were enrolled on the Ohio home care waiver as of January 1, 2002, or on the effective date of this rule were either enrolled on the core-plus benefit or enrolled on an ODMR/DD-administered waiver and receiving core services. Transfer will occur after ODJFS or its designated case management agency (CMA) determines the criteria set forth in paragraph (B) of this rule are met.
- (B) To be eligible and maintain eligibility, a transitions MR/DD waiver consumer must:
- (1) Be eligible for Ohio medicaid in accordance with rules [5101:3-38-01.6](#) and [5101:1-39-95](#) of the Administrative Code; and
 - (2) Be determined program eligible for the transitions MR/DD waiver by meeting the following requirements:
 - (a) Participate in the assessment process as defined in rule [5101:3-45-01](#) of the Administrative Code;
 - (b) Have an ICF-MR level of care in accordance with rule [5101:3-3-07](#) of the Administrative Code;
 - (c) Need services that are not available through other sources in amounts sufficient to meet the consumer's needs;
 - (d) Be able to have service needs met within his or her assigned individual cost cap as set forth in rule [5101:3-46-05](#) of the Administrative Code using a combination of waiver, medicaid state plan and/or other available formal and informal services;
 - (e) Not reside in an institution, ICF-MR, residential care facility, adult foster home or other group living arrangement subject to state licensure or certification;
 - (f) In the absence of the transitions MR/DD waiver, require placement in an ICF-MR;
 - (g) Continue to elect to receive transitions MR/DD waiver services instead of institutional services by signing a JFS 02379 agency-consumer agreement; and
 - (h) Participate in the development of an all services plan; and
 - (i) Accept the all services plan by signing and dating the plan.
- (C) A transitions MR/DD waiver consumer shall be reassessed at least annually, and more frequently if there is a significant change in the consumer's situation that may impact the consumer's health and welfare. If the annual reassessment determines that the consumer no longer meets the eligibility criteria set forth in paragraph (B) of this rule, then the consumer shall be disenrolled from the transitions MR/DD waiver. In such instances, the consumer shall be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.
- (D) If a transitions MR/DD waiver consumer does not receive any waiver services for ninety consecutive days, ODJFS shall, within ten days of the ninetieth day, reassess the consumer's need for waiver services. If it is determined that waiver services are no longer needed, the consumer shall be disenrolled from the transitions MR/DD waiver. The consumer shall be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.
- (E) If, at any time, a consumer ceases to meet any of the eligibility criteria set forth in paragraph (B) of this rule, the consumer shall be disenrolled from the transitions MR/DD waiver. In such instances, the consumer shall be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.

Replaces: Part of 5101:3-12-04

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Certification:

Promulgated Under: 119.03

Statutory Authority: 5111.85 Rule Amplifies: 5111.01, 5111.02, 5111.85, 5111.856

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[CSTL 06-01](#)

5101:3-47-04 Transitions MR/DD waiver: definitions of the covered services and provider requirements and specifications.

Effective Date: July 1, 2006.

This rule sets forth the definitions of the services covered by the transitions MR/DD waiver. This rule also sets forth the provider requirements and specifications for the delivery of transitions MR/DD waiver services. The services are reimbursed in accordance with rule [5101:3-47-06](#) of the Administrative Code.

(A) Waiver nursing services.

- (1) "Waiver nursing services" are defined as services provided to transitions MR/DD waiver consumers 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 to consumers on the transitions MR/DD waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and they shall possess a current and valid license in good standing with the Ohio board of nursing.
- (2) "Personal care aide services" as defined in paragraph (B) of this rule may be reimbursed as waiver nursing services when provided incidental to waiver nursing services as defined in paragraph (A)(1) of this rule and performed during the authorized waiver nursing visit.
- (3) Waiver nursing services do not include:
 - (a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules to be adopted there under, and to be performed by individuals who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;
 - (b) Services that require the skills of a psychiatric nurse;
 - (c) Visits performed for the sole purpose of meeting the supervisory requirements as set forth in paragraphs (B)(6)(c) and (B)(6)(d) of this rule; and
 - (d) Services performed in excess of the number of hours approved pursuant to the all services plan.
- (4) In order to submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must:
 - (a) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider;
 - (b) Not be the consumer's family member as that term is defined in paragraph (R) of rule [5101:3-45-01](#) of the Administrative Code, unless the family member is employed by a medicare-certified, or otherwise-accredited home health agency;
 - (c) Not be the foster caregiver of the consumer;
 - (d) Be identified as the provider on the all services plan that is prior-approved by the designated case management agency (CMA);
 - (e) Be performing nursing services pursuant to signed and dated written orders from the treating physician; and
 - (f) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.
- (5) Non-agency LPNs, at the direction of an RN, must:
 - (a) Conduct a face-to-face visit with the directing RN at least every sixty days after the initial visit to evaluate the provision of waiver nursing services and LPN performance, and to

assure that waiver nursing services are being provided in accordance with the approved plan of care; and

(b) Conduct a face-to-face visit with the consumer and the directing RN no less than every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the consumer's satisfaction with care delivery, and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care.

(6) All waiver nursing service providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency waiver nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (k) of this paragraph.

(a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record shall include documentation that the RN has reviewed the plans of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the consumer's condition.

(f) In all instances when the treating physician gives verbal orders to the nurse, the nurse must document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse must subsequently secure documentation of the verbal orders, signed and dated by the treating physician.

(g) In all instances when a non-agency LPN is providing waiver nursing services, the LPN must provide clinical notes, signed and dated by the LPN, documenting the face-to-face visit between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer and the directing RN. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A copy of the "do not resuscitate" (DNR) order, if one exists.

(i) Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(j) Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team.

(k) A discharge summary, signed and dated by the departing nurse, at the point the nurse is no longer going to provide services to the consumer, or when the consumer no longer needs nursing services.

(B) Personal care aide services.

- (1) "Personal care aide services" are defined as services provided pursuant to the transitions MR/DD waiver's all services plan that assist the consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) impairments. If the all services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. Personal care aide services consists of services listed in subparagraphs (a) to (e) of this paragraph. Personal care aide service providers may elect not to furnish one or more of the listed services. If the provider so elects, the provider must notify the designated CMA, in writing, of the services the provider elects not to furnish.

 - (a) 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;
 - (b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, and waste disposal;
 - (c) 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;
 - (d) Paying bills and assisting with personal correspondence as directed by the consumer; and
 - (e) Accompanying or transporting the consumer to transitions MR/DD waiver services, medical appointments, other community services, or running errands on behalf of the consumer.
- (2) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the all services plan.
- (3) Personal care aides shall not administer prescribed or over-the-counter medications to the consumer, but may, pursuant to paragraph (B) of rule 4723-13-04 of the Administrative Code, help the consumer self-administer medications by:

 - (a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;
 - (b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;
 - (c) Opening the container for a consumer who is physically unable to open the container;
 - (d) Assisting a consumer who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and
 - (e) Assisting a consumer who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the consumer.
- (4) Personal care aide services shall be delivered by one of the following:

 - (a) An employee of a medicare-certified, or otherwise-accredited home health agency; or
 - (b) A non-agency personal care aide.
- (5) In order to submit a claim for reimbursement, all individuals providing personal care aide services must meet the following:

 - (a) Be at least eighteen years of age;
 - (b) Be identified as the provider on the all services plan that is prior-approved by the designated CMA;

- (c) Have a valid social security number, and one of the following forms of identification:
 - (i) Alien identification,
 - (ii) State of Ohio identification,
 - (iii) A valid driver's license, or
 - (iv) Other government-issued photo identification;
- (d) Not be the consumer's family member as that term family is defined in paragraph (R) of rule [5101:3-45-01](#) of the Administrative Code, unless the family member is employed by a medicare-certified or otherwise accredited home health agency, and the consumer is the provider's adult child;
- (e) Not be the foster caregiver of the consumer;
- (f) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit; and
- (g) Comply with the additional applicable provider-specific requirements as specified in paragraph (B)(6) or (B)(7) of this rule.
- (6) Medicare-certified and otherwise-accredited home health agencies must assure that personal care aides meet the following requirements:
 - (a) Prior to commencing service delivery, the personal care aide must:
 - (i) Obtain a certificate of completion of either the nurse aide competency evaluation program conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005), and
 - (ii) Obtain and maintain first aid certification.
 - (b) Maintain evidence of the completion of eight hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately after the personal care aide's first anniversary of employment with the agency, and must be completed annually thereafter.
 - (c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, must:
 - (i) Conduct a face-to-face consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.
 - (ii) Conduct a face-to-face consumer home visit at least every sixty days after the initial visit to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, personal care aide performance.
 - (iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.
 - (iv) Discuss the evaluation of personal care aide services with the case manager.
 - (d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the transitions MR/DD waiver.
 - (e) Be able to effectively communicate with the consumer.

- (7) Non-agency personal care aides must meet the following requirements:
- (a) Prior to commencing service delivery personal care aides must have:
 - (i) Obtained a certificate of completion within the last twenty-four months for either the nurse aide competency evaluation program conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005); or other equivalent training program. The program must include training in the following areas:
 - (a) Personal care aide services as defined in paragraph (B)(1) of this rule;
 - (b) Basic home safety; and
 - (c) Universal precautions for infection control, including hand-washing and proper disposal of bodily waste.
 - (ii) Obtained and maintain first aid certification.
 - (b) Complete eight hours of in-service continuing education annually that must occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to consumer health and safety, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.
 - (c) Comply with the consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.
 - (d) Comply with ODJFS monitoring requirements in accordance with rule [5101:3-12-30](#) of the Administrative Code.
 - (e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the transitions MR/DD waiver.
 - (f) Be able to effectively communicate with the consumer.
- (8) All personal care aide providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency personal care aides must maintain the clinical records at their place of business in a manner that protects the confidentiality of these records, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.
- (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.
 - (b) Consumer medical history.
 - (c) Name of consumer's treating physician.
 - (d) A copy of the initial and all subsequent all services plans.
 - (e) Documentation of drug allergies and dietary restrictions.
 - (f) A copy of the "do not resuscitate" (DNR) order, if one exists.

- (g) Documentation that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon completion of service delivery. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- (h) Progress notes signed and dated by the personal care aide, documenting all communications with the CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.
- (i) A discharge summary, signed and dated by the departing non-agency personal care aide or RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the consumer, or when the consumer no longer needs personal care aide services.

(C) Adult day health center services.

- (1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that is used solely for the provision of ADHCS.
 - (a) The services the adult day health center must make available are the following:
 - (i) Waiver nursing services as set forth in paragraph (A) of this rule, or personal care aide services as set forth in paragraph (B)(1) of this rule;
 - (ii) Recreational and educational activities; and
 - (iii) No more than two meals per day that meet the consumer's dietary requirements.
 - (b) The services the adult day health center may also make available include the following:
 - (i) Skilled therapy services as set forth in rule [5101:3-12-01](#) of the Administrative Code;
 - (ii) Transportation of the consumer to and from ADHCS.
 - (c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on a day.
 - (d) All of the services set forth in paragraphs (C)(1)(a) and (C)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.
- (2) ADHCS do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, providers of ADHCS must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA; and
 - (b) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.
- (4) All providers of ADHCS must:
 - (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
 - (b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer

takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.

- (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.
- (d) Assure that any waiver nursing services provided are within the nurse's scope of practice as limited in paragraph (A)(1) of this rule.
- (e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.
- (f) Maintain, at all times, a paid staff to consumer ratio of 1:6.

(5) Providers of ADHCS must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

- a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
- (b) Consumer medical history.
- (c) Name of consumer's treating physician.
- (d) A copy of the initial and all subsequent all services plans.
- (e) A copy of the "do not resuscitate" (DNR) order, if one exists.
- (f) Documentation of drug allergies and dietary restrictions.
- (g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the paragraph.
- (h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ADHCS provider is no longer going to provide services to the consumer, or when the consumer no longer needs ADHCS.
- (i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meal services.

- (1) "Home delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician, taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.
- (2) Home delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, all providers of home delivered meal services must:

- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Possess a valid food vendor's license;
- (c) Assure that all meals are prepared and delivered as identified on the all services plan; and
- (d) Only submit a claim for up to two meals per day per consumer.

(4) Home delivered meal service providers must maintain the documentation identified in subparagraphs (a) to (d) of this paragraph.

- (a) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).
- (b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.
- (c) All appropriate food vendor's licenses.
- (d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.

(5) Upon request, home delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.

(6) Home delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.

(7) Home delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer to function with greater independence in the home and remain in the community. Home modification services shall not exceed ten thousand dollars within a twelve-month period per consumer.

- (a) The property owner must give written consent for the home modification that indicates an understanding that the transitions MR/DD waiver will not pay to have the property returned to its prior condition.
- (b) The need for home modification services must be identified in an evaluation completed by an occupational therapist or physical therapist as licensed pursuant to sections 4755.07 and 4755.44 of the Revised Code.

(2) Home modification services do not include:

- (a) Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the consumer (i.e., carpeting, roof repair, central air conditioning, etc.);
- (b) Adaptations that add to the total square footage of the home; and
- (c) Services performed in excess of what is approved pursuant to the all services plan.

(3) Home modification service providers shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the bid specification. The reimbursement may only be adjusted if the job specifications are modified in writing by the designated CMA and the adjustment is warranted. Family members and volunteers will only be reimbursed for the cost of materials.

(4) In order to submit a claim for reimbursement, providers of home modification services must:

- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Assure that the home modification was completed in accordance with the agreed upon specifications using all of the materials and equipment cited in the bid;
- (c) Assure that the home modification was tested and in proper working order;
- (d) Assure that the home modification met all applicable state and local building codes and complies with the Americans with Disabilities Act (ADA);
- (e) Maintain insurance and bonding for general contracting services and provide proof to the designated CMA upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the consumer; and
- (f) Obtain a final written approval from the consumer and the designated CMA after completion of the home modification service.

(5) Selection of home modification service providers.

- (a) The designated CMA shall develop job specifications in consultation with the consumer, authorized representative, and/or caregiver(s) to meet the consumer's environmental accessibility needs with the lowest cost alternative.
- (b) The designated CMA shall send the home modification specifications to every home modification service provider in the consumer's region and invite the submission of competitive bids. The following must be submitted with all bids:
 - (i) A drawing or diagram of the home modification;
 - (ii) An itemized list of all materials needed for the home modification;
 - (iii) An itemized list of the cost of the materials needed for the home modification;
 - (iv) An itemized list of the labor costs;
 - (v) A written statement of all warranties provided; and
 - (vi) A written attestation that the provider, all employees and/or all subcontractors to be used to perform the job specifications have the necessary experience and skills.
- (c) The designated CMA shall review all submitted bids and the home modification service will be awarded to the lowest responsive and most responsible bidder, with price and other relevant factors being considered in the selection process.

(F) Supplemental transportation services.

- (1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point.
- (2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to the all services plan.

- (3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.
- (4) Agency supplemental transportation service providers must:
- (a) Maintain a current list of drivers;
 - (b) Assure that all drivers providing supplemental transportation services are age eighteen or older;
 - (c) Maintain a copy of the valid driver's license for each driver;
 - (d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services;
 - (e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;
 - (f) Assure that drivers are not the consumers' family members as that term is defined in paragraph (R) of rule [5101:3-45-01](#) of the Administrative Code; and
 - (g) Assure that drivers are not the consumers' foster caregivers.
- (5) Non-agency supplemental transportation service providers must:
- (a) Be age eighteen or older;
 - (b) Possess a valid driver's license;
 - (c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services;
 - (d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;
 - (e) Not be the consumer's family member as that term is defined in paragraph (R) of rule [5101:3-45-01](#) of the Administrative Code; and
 - (f) Not be the consumer's foster caregiver.
- (6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.

(G) Supplemental adaptive and assistive device services.

- (1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the consumer, or the consumer's family member as that term is defined in paragraph (R) of rule [5101:3-45-01](#) of the Administrative Code, that are not otherwise available through any other funding source and that are suitable to enable the consumer to function with greater independence, avoid institutionalization, and reduce the need for human assistance. The designated CMA shall only approve the lowest cost alternative that meets the consumer's needs.
- (a) Reimbursement for medical equipment and supplies shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one-year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical condition requiring the replacement.

- (b) Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of vehicle modification for the consumer for a three-year period unless there is a documented change in the consumer's medical and/or physical condition requiring the replacement.
- (2) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same consumer. Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide the designated CMA with documentation of:
- (a) Evidence of a valid driver's license, with appropriate restrictions;
- (b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;
- (c) Evidence of the vehicle owner's collision and liability insurance for the vehicle being modified; and
- (d) A written statement from a certified mechanic stating the vehicle is in good operating condition.
- (3) Supplemental adaptive and assistive device services do not include:
- (a) Items considered by the federal food and drug administration as experimental or investigational;
- (b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;
- (c) Payment toward the purchase or lease of a vehicle;
- (d) Routine care and maintenance of vehicle modifications and devices;
- (e) Permanent modification of leased vehicles;
- (f) Vehicle inspection costs;
- (g) Vehicle insurance costs; and
- (h) Services performed in excess of what is approved pursuant to the all services plan.
- (4) In order to submit a claim for supplemental adaptive and assistive device services, the provider must:
- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services; and
- (c) Assure that the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.
- (5) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (d) of this paragraph.

- (a) Consumer identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
- (b) Name of consumer's treating physician.
- (c) A copy of the initial and all subsequent all services plans.
- (d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(H) Out-of-home respite services.

- (1) "Out-of-home respite services" are services delivered to a consumer in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.
 - (a) The services the out-of-home respite provider must make available are:
 - (i) Waiver nursing services as set forth in paragraph (A) of this rule;
 - (ii) Personal care aide services as set forth in paragraph (B)(1) of this rule; and
 - (iii) Three meals per day that meet the consumer's dietary requirements.
 - (b) All services set forth in paragraph (H)(1)(a) of this rule and delivered during the provision of out-of-home respite services shall not be reimbursed as separate services.
- (2) Out-of-home respite services do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, providers of out-of-home respite services must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.
 - (b) Be either:
 - (i) An intermediate care facility (i) for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in accordance with rules [5101:3-3-02](#) and [5101:3-3-02.3](#) of the Administrative Code; or
 - (ii) A nursing facility (NF) licensed and certified in accordance with rules [5101:3-3-02](#) and [5101:3-3-02.3](#) of the Administrative Code; or
 - (iii) Another institutional setting approved by the designated CMA.
 - (c) Be providing out-of-home respite services for one individual, or for up to three individuals in a group setting on the same date.
- (4) All providers of out-of-home respite services must:
 - (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
 - (b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.
 - (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.

(5) Providers of out-of-home respite services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

(a) Consumer's identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the "do not resuscitate" (DNR) order, if one exists.

(f) Documentation of drug allergies and dietary restrictions.

(g) Documentation that clearly shows the date of out-of-home respite service delivery, including tasks performed or not performed. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing out-of-home respite service provider, at the point the service provider is no longer going to provide services to the consumer, or when the consumer no longer needs out-of-home respite services.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing.

(l) Emergency response services.

(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers 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 are considered to be high risk for the purposes of this service.

(2) ERS do not include:

(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and

(b) Services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.

(4) Providers of ERS must:

(a) Permit consumers to select from a variety of remote activation devices;

(b) Assure that consumers have systems that meet their specific needs;

(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;

(d) Conduct monthly testing of emergency response systems to assure proper operation;

- (e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;
 - (f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;
 - (g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;
 - (h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;
 - (i) Assure that emergency response center staff respond to alarm messages within sixty seconds of receipt; and
 - (j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.
- (5) Providers of ERS must maintain the following documentation:
- (a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;
 - (b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;
 - (c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and
 - (d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.

Replaces: Part of 5101:3-12-07

Effective Date: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification:

Promulgated Under: 119.03

Statutory Authority: 5111.85Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 3/30/90 (Emer), 6/29/90, 7/1/90, 3/12/92 (Emer), 6/1/92, 7/31/92 (Emer), 10/30/92, 7/1/93 (Emer), 7/30/93, 9/1/93, 1/1/96, 7/1/98

[CSTL 06-01](#)

5101:3-47-06 Transitions MR/DD waiver program: reimbursement rates and billing procedures.

Effective Date: July 1, 2006.

(A) Definitions of terms used for billing and calculating rates.

- (1) "Base rate," as used in table A, column 3 of paragraph (B) of this rule, means the amount paid for up to the first four units of service delivered.
- (2) "Billing unit," as used in table B, column 3 of paragraph (B) of this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).
- (3) "Group rate," as used in paragraph (E)(1) of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.
- (4) "Group setting" means a situation where a waiver nursing and/or personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ODJFS-administered waiver service, or a combination of ODJFS-administered waiver services and similar non-ODJFS-administered waiver services.
- (5) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.
 - (a) For the billing codes in table B of paragraph (B) of this rule, the medicaid maximum rate is set forth in column 4.
 - (b) For the billing codes in table A of paragraph (B) of this rule, the medicaid maximum rate is:
 - (i) The base rate as defined in paragraph (A) (1) of this rule, or
 - (ii) The base rate as defined in paragraph (A) (1) of this rule plus the unit rate as defined in paragraph (A) (7) of this rule for each additional unit of service delivered.
- (6) "Modifier," as used in paragraph (E) of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.
- (7) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service provided.

(B) Billing code tables.

- Table A -

<u>Column 1</u>	<u>Column 2</u>	<u>Column 3</u>	<u>Column 4</u>
<u>Billing code</u>	<u>Service</u>	<u>Base rate</u>	<u>Unit rate</u>
<u>T1002</u>	<u>Waiver nursing services provided by an RN</u>	<u>\$50.60</u>	<u>\$5.42</u>
<u>T1003</u>	<u>Waiver nursing services provided by an LPN</u>	<u>\$50.60</u>	<u>\$5.42</u>
<u>T1019</u>	<u>Personal care aide services</u>	<u>\$24.00</u>	<u>\$3.00</u>

- Table B -

<u>Column 1</u>	<u>Column 2</u>	<u>Column 3</u>	<u>Column 4</u>
<u>Billing code</u>	<u>Service</u>	<u>Billing unit</u>	<u>Medicaid maximum rate</u>
<u>H0045</u>	<u>Out-of-home respite services</u>	<u>Per day</u>	<u>\$200.00</u>
<u>S0215</u>	<u>Supplemental transportation services</u>	<u>Per mile</u>	<u>\$0.38</u>
<u>S5101</u>	<u>Adult day health center services</u>	<u>Per half day</u>	<u>\$32.50</u>
<u>S5102</u>	<u>Adult day health center services</u>	<u>Per day</u>	<u>\$65.00</u>
<u>S5160</u>	<u>Emergency response services</u>	<u>Per installation and testing</u>	<u>\$45.00</u>
<u>S5161</u>	<u>Emergency response services</u>	<u>Per monthly fee</u>	<u>\$45.00</u>
<u>S5165</u>	<u>Home modification services</u>	<u>Per item</u>	<u>Amount prior-authorized on the all services plan</u>
<u>T2029</u>	<u>Supplemental adaptive and assistive device services</u>	<u>Per item</u>	<u>Amount prior-authorized on the all services plan</u>
<u>S5170</u>	<u>Home delivered meal services</u>	<u>Per meal</u>	<u>\$7.00</u>

(C) In order for a provider to submit a claim for transitions MR/DD waiver services, the services must be provided in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#) of the Administrative Code, and Chapters [5101:3-45](#) and [5101:3-47](#) of the Administrative Code.

(D) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.

(E) Required modifiers.

- (1) The "HQ" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement at a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.
- (2) The "U1" modifier must be used when a provider submits a claim for billing code T1002 and the consumer is receiving infusion therapy.
- (3) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to a consumer for the same date of service.
- (4) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to a consumer for the same date of service.
- (5) The "U4" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

(F) Reimbursement will be provided in accordance with paragraphs (A) to (D) of rule [5101:3-1-06](#) of the Administrative Code.

Replaces: Part of 5101:3-1-06.3

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Prior Effective Dates: 1/1/04

[CSTL 06-02](#)

5101:3-49-01 Non-medicaid-funded Ohio access success project.

Effective date: October 1, 2005

- (A) This rule sets forth the eligibility requirements and benefit limitations for the non-medicaid-funded Ohio access success project.
- (B) Definitions:
- (1) "Fiscal year" is defined as the fiscal year of this state, as specified in section 9.34 of the Revised Code.
 - (2) "Individual" is defined as a nursing facility (NF) resident who is seeking non-medicaid Ohio access success project benefits.
 - (3) "Nursing Facility" and "NF" are defined as a facility or a distinct part of a facility as defined in division (M) of section 5111.20 of the Revised Code.
 - (4) "Non-medicaid-funded Ohio access success project" is defined as the portion of the Ohio access success project that is authorized to pay for relocation expenses with non-medicaid program funds.
 - (5) "ODJFS" is defined as the Ohio department of job and family services.
 - (6) "ODA" is defined as the Ohio department of aging.
 - (7) "Relocation" is defined as transition from a NF into the community as set forth in section 5111.97 of the Revised Code.
- (C) The non-medicaid-funded Ohio access success project benefit shall be used to purchase goods and services to assist in the relocation of the individual from a NF to a community setting. Goods and services include, but are not limited to rental deposits, utility deposits, moving expenses, home modifications and debts to facilitate the securing of residence in a community setting. A maximum, one-time benefit of two thousand dollars can be spent at the time of relocation.
- (D) The application process for the non-medicaid-funded Ohio access success project requires:
- (1) Completion by ODJFS or its designee of the "non-medicaid Ohio access success project referral"; and
 - (2) A face-to-face interview with the individual and ODJFS or its designee.
- (E) In order to qualify for non-medicaid-funded Ohio access success project benefits an individual must:
- (1) Be a recipient of medicaid-funded NF services at the time of application;
 - (2) Need the level of care provided by the NF;
 - (3) Not meet the ICF-MR level of care as set forth in rule [5101:3-3-07](#) of the Administrative Code;
 - (4) Have a determination by ODJFS or its designee that the projected monthly cost of services for the individual in the community as set forth in paragraph (F) of this rule shall not exceed eighty per cent of the average monthly medicaid costs of a medicaid recipient residing in a NF as described in paragraph (G) of this rule; and
 - (5) Not qualify for Ohio access success project benefits that are reimbursable by medicaid.
- (F) The calculation of projected monthly service costs for the individual in the community shall include all of the following:
- (1) The average medicaid per member per month costs for hospital and physician services as determined by ODJFS;
 - (2) The average medicaid per member per month costs for pharmacy services as determined by ODJFS; and

- (3) The individual's assessed monthly need for medicaid-covered services including, but not limited to home health services, transportation, adaptive equipment and durable medical equipment.
- (G) The calculation of average monthly costs for an individual residing in a NF shall be the sum of:
- (1) The average medicaid per diem paid to all NFs as of July first of the state fiscal year in which eligibility is being determined under this rule; and
- (2) The average per member per month medicaid costs for medicaid services not covered in paragraph (G)(1) of this rule for a NF resident.
- (H) An individual applying for or receiving benefits under the non-medicaid Ohio access success project shall retain the right to appropriate notice for a hearing in accordance with division-level designation [5101:6](#) of the Administrative Code.
- (I) ODJFS has the authority to limit the number of individuals participating in the non-medicaid Ohio access success project to the extent funds are available. ODJFS may direct the available funds toward the relocation of individuals at the greatest risk of remaining in the NF.

Replaces: 5101:3-12-35

Effective Date: 10/01/2005

R.C. 119.032 review dates:

Certification

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Statutory Authority: 5111.97

Rule Amplifies: 5111.97

Prior Effective Dates: 7/1/04

[CSTL 05-03](#)

5101:3-50-02 Transitions carve-out waiver: consumer eligibility for enrollment.

Effective Date: July 1, 2006.

- (A) Enrollment on the transitions carve-out waiver is only available to consumers who on the effective date of this rule were either enrolled on the Ohio home care waiver, receiving services through the core-plus benefit, or enrolled on an ODA-administered waiver and receiving core services. Transfer will occur after ODJFS or its designated case management agency (CMA) determines the criteria set forth in paragraph (B) of this rule are met.
- (B) To be eligible and maintain eligibility, a transitions carve-out waiver consumer must:
- (1) Be eligible for Ohio medicaid in accordance with rule [5101:1-38-01.6](#) of the Administrative Code; and
 - (2) Be determined program eligible for the transitions carve-out waiver by meeting the following requirements:
 - (a) Participate in the assessment process as defined in rule [5101:3-45-01](#) of the Administrative Code;
 - (b) Be either age sixty or older;
 - (c) Have either an intermediate level of care in accordance with rule [5101:3-3-06](#) of the Administrative Code or a skilled level of care in accordance with rule [5101:3-3-05](#) of the Administrative Code;
 - (d) Need services that are not available through other sources in amounts sufficient to meet the consumer's needs;
 - (e) Not reside in an institution, residential care facility, adult foster home or other group living arrangement subject to state licensure or certification;
 - (f) In the absence of the transitions carve-out waiver, require NF placement or long term hospitalization;
 - (g) Continue to elect to receive transitions carve-out waiver services instead of institutional services by signing a JFS 02379 agency-consumer agreement;
 - (h) Participate in the development of a all services plan;
 - (i) Be able to have the services identified in the all services plan met within the funding range established in accordance with rule [5101:3-50-05](#) of the Administrative Code; and
 - (j) Accept the all services plan by signing and dating the plan.
- (C) A transitions carve-out waiver consumer shall be reassessed at least annually, and more frequently if there is a significant change in the consumer's situation that may impact the consumer's health and welfare. If the annual reassessment determines that the consumer no longer meets the eligibility criteria set forth in paragraph (B) of this rule, then the consumer shall be disenrolled from the transitions carve-out waiver. In such instances, the consumer shall be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.
- (D) If a transitions carve-out waiver consumer does not receive any waiver services for ninety consecutive days, ODJFS shall, within ten days of the ninetieth day, reassess the consumer's need for waiver services. If it is determined that waiver services are no longer needed, the consumer shall be disenrolled from the transitions carve-out waiver. The consumer will be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.
- (E) If, at any time, a consumer ceases to meet any of the eligibility criteria set forth in paragraph (B) of this rule, the consumer shall be disenrolled from the transitions carve-out waiver. In such instances, the

consumer shall be afforded notice and hearing rights in accordance with division-level [5101:6](#) of the Administrative Code.

Replaces: Part of 5101:3-12-04

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[CSTL 06-01](#)

5101:3-50-04 Transitions carve-out waiver: definitions of the covered services and provider requirements and specifications.

Effective Date: July 1, 2006.

This rule sets forth the definitions of the services covered by the transitions carve-out waiver. This rule also sets forth the provider requirements and specifications for the delivery of transitions carve-out waiver services. The services are reimbursed in accordance with rule [5101:3-50-06](#) of the Administrative Code.

(A) Waiver nursing services.

- (1) "Waiver nursing services" are defined as services provided to transitions carve-out waiver consumers 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 consumers on the transitions carve-out waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and shall possess a current and valid license in good standing with the Ohio board of nursing.
- (2) "Personal care aide services" as defined in paragraph (B) of this rule may be reimbursed as waiver nursing services when provided incidental to waiver nursing services as defined in paragraph (A)(1) of this rule and performed during the authorized waiver nursing visit.
- (3) Waiver nursing services do not include:
 - (a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules to be adopted there under, and to be performed by individuals who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;
 - (b) Services that require the skills of a psychiatric nurse;
 - (c) Visits performed for the sole purpose of meeting the supervisory requirements as set forth in paragraphs (B)(6)(c) and (B)(6)(d) of this rule; or
 - (d) Services performed in excess of the number of hours approved pursuant to the all services plan.
- (4) In order to submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must:
 - (a) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider;
 - (b) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code, unless the legally responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency;
 - (c) Not be the foster caregiver of the consumer;
 - (d) Be identified as the provider on the all services plan that is prior-approved by the designated case management agency (CMA);
 - (e) Be performing nursing services pursuant to signed and dated written orders from the treating physician; and
 - (f) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.
- (5) Non-agency LPNs, at the direction of an RN, must:
 - (a) Conduct a face-to-face visit with the directing RN at least every sixty days after the initial visit to evaluate the provision of waiver nursing services and LPN performance, and to

assure that waiver nursing services are being provided in accordance with the approved plan of care; and

(b) Conduct a face-to-face visit with the consumer and the directing RN no less than every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the consumer's satisfaction with care delivery, and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care.

(6) All waiver nursing service providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency waiver nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (k) of this paragraph.

(a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record shall include documentation that the RN has reviewed the plans of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the consumer's condition.

(f) In all instances when the treating physician gives verbal orders to the nurse, the nurse must document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse must subsequently secure documentation of the verbal orders, signed and dated by the treating physician.

(g) In all instances when a non-agency LPN is providing waiver nursing services, the LPN must provide clinical notes, signed and dated by the LPN, documenting the face-to-face visits between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer and the directing RN. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A copy of the "do not resuscitate" (DNR) order, if one exists.

(i) Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(j) Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team.

(k) A discharge summary, signed and dated by the departing nurse, at the point the nurse is no longer going to provide services to the consumer, or when the consumer no longer needs nursing services.

(B) Personal care aide services.

- (1) "Personal care aide services" are defined as services provided pursuant to the transitions carve-out waiver's all services plan that assist the consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) impairments. If the all services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. Personal care aide services consists of the services listed in subparagraphs (a) to (e) of this paragraph. Personal care aide service providers may elect not to furnish one or more of the listed services. If the provider so elects, the provider must notify the designated CMA, in writing, of the services the provider elects not to furnish.

 - (a) 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;
 - (b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, and waste disposal;
 - (c) 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;
 - (d) Paying bills and assisting with personal correspondence as directed by the consumer; and
 - (e) Accompanying or transporting the consumer to transitions carve-out waiver services, medical appointments, other community services, or running errands on behalf of the consumer.
- (2) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the all services plan.
- (3) Personal care aides shall not administer prescribed or over-the-counter medications to the consumer, but may, pursuant to paragraph (B) of rule 4723-13-04 of the Administrative Code, help the consumer self-administer medications by:

 - (a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;
 - (b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;
 - (c) Opening the container for a consumer who is physically unable to open the container;
 - (d) Assisting a consumer who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and
 - (e) Assisting a consumer who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by placing the dose in another container and placing that container to the mouth of the consumer.
- (4) Personal care aide services shall be delivered by one of the following:

 - (a) An employee of a medicare-certified, or otherwise-accredited home health agency; or
 - (b) A non-agency personal care aide.
- (5) In order to submit a claim for reimbursement, all individuals providing personal care aide services must meet the following:

 - (a) Be at least eighteen years of age;
 - (b) Be identified as the provider on the all services plan that is prior-approved by the designated CMA;

- (c) Have a valid social security number, and one of the following forms of identification:
 - (i) Alien identification,
 - (ii) State of Ohio identification,
 - (iii) A valid driver's license, or
 - (iv) Other government-issued photo identification;
 - (d) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code;
 - (e) Not be the foster caregiver of the consumer;
 - (f) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit; and
 - (g) Comply with the additional applicable provider-specific requirements as specified in paragraph (B)(6) or (B)(7) of this rule.
- (6) Medicare-certified and otherwise-accredited home health agencies must assure that personal care aides meet the following requirements:
- (a) Prior to commencing service delivery, the personal care aide must:
 - (i) Obtain a certificate of completion of either the nurse aide competency evaluation program conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005), and
 - (ii) Obtain and maintain first aid certification.
 - (b) Maintain evidence of the completion of eight hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately after the personal care aide's first anniversary of employment with the agency, and must be completed annually thereafter.
 - (c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN at the direction of an RN, in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, must:
 - (i) Conduct a face-to-face consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.
 - (ii) Conduct a face-to-face consumer home visit at least every sixty days after the initial visit to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, personal care aide performance.
 - (iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.
 - (iv) Discuss the evaluation of personal care aide services with the case manager.
 - (d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the transitions carve-out waiver.
 - (e) Be able to effectively communicate with the consumer.
- (7) Non-agency personal care aides must meet the following requirements:
- (a) Prior to commencing service delivery personal care aides must have:

- (i) Obtained a certificate of completion within the last twenty-four months for either the nurse aide competency evaluation program conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005); or other equivalent training program. The program must include training in the following areas:
 - (a) Personal care aide services as defined in paragraph (B)(1) of this rule;
 - (b) Basic home safety; and
 - (c) Universal precautions for infection control, including hand-washing and proper disposal of bodily waste.
 - (ii) Obtained and maintain first aid certification.
 - (b) Complete eight hours of in-service continuing education annually that must occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to consumer health and welfare, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.
 - (c) Comply with the consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.
 - (d) Comply with ODJFS monitoring requirements in accordance with rule [5101:3-12-30](#) of the Administrative Code.
 - (e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the transitions carve-out waiver.
 - (f) Be able to effectively communicate with the consumer.
- (8) All personal care aide providers must maintain a clinical record for each consumer served. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business in a manner that protects the confidentiality of these records. Non-agency personal care aides must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.
- (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.
 - (b) Consumer medical history.
 - (c) Name of consumer's treating physician.
 - (d) A copy of the initial and all subsequent all services plans.
 - (e) Documentation of drug allergies and dietary restrictions.
 - (f) A copy of the "do not resuscitate" (DNR) order, if one exists.
 - (g) Documentation that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon

completion of service delivery. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

- (h) Progress notes signed and dated by the personal care aide, documenting all communications with the CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.
- (i) A discharge summary, signed and dated by the departing non-agency personal care aide or the RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the consumer, or when the consumer no longer needs personal care aide services.

(C) Adult day health center services.

(1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that is used solely for the provision of ADHCS.

- (a) The services the adult day health center must make available are the following:
 - (i) Waiver nursing services as set forth in paragraph (A) of this rule, or personal care aide services as set forth in paragraph (B)(1) of this rule;
 - (ii) Recreational and educational activities; and
 - (iii) No more than two meals per day that meet the consumer's dietary requirements.
- (b) The services the adult day health center may also make available include the following:
 - (i) Skilled therapy services as set forth in rule [5101:3-12-01](#) of the Administrative Code;
 - (ii) Transportation of the consumer to and from ADHCS.
- (c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on a day.
- (d) All of the services set forth in paragraphs (C)(1)(a) and (C)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.

(2) ADHCS do not include services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for reimbursement, providers of ADHCS must:

- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA; and
- (b) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.

(4) All providers of ADHCS must:

- (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
- (b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.

- (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.
- (d) Assure that any waiver nursing services provided are within the nurse's scope of practice as limited in paragraph (A)(1) of this rule.
- (e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.
- (f) Maintain, at all times, a paid staff to consumer ratio of 1:6.
- (5) Providers of ADHCS must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.
 - (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
 - (b) Consumer medical history.
 - (c) Name of consumer's treating physician.
 - (d) A copy of the initial and all subsequent all services plans.
 - (e) A copy of the "do not resuscitate" (DNR) order, if one exists.
 - (f) Documentation of drug allergies and dietary restrictions.
 - (g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the paragraph.
 - (h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ADHCS provider is no longer going to provide services to the consumer, or when the consumer no longer needs ADHCS.
 - (i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meal services.

- (1) "Home delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician, taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.
- (2) Home delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, all providers of home delivered meal services must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;

- (b) Possess a valid food vendor's license;
- (c) Assure that all meals are prepared and delivered as identified on the all services plan; and
- (d) Only submit a claim for up to two meals per day per consumer.

(4) Home delivered meal service providers must maintain the documentation identified in subparagraphs (a) to (d) of this paragraph.

- (a) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).
- (b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.
- (c) All appropriate food vendor's licenses.
- (d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.

(5) Upon request, home delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.

(6) Home delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.

(7) Home delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.

(E) Home modification services.

(1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer to function with greater independence in the home and remain in the community. Home modification services shall not exceed ten thousand dollars within a twelve-month period per consumer.

- (a) The property owner must give written consent for the home modification that indicates an understanding that the transitions carve-out waiver will not pay to have the property returned to its prior condition.
- (b) The need for home modification services must be identified in an evaluation completed by an occupational therapist or physical therapist as licensed pursuant to sections 4755.07 and 4755.44 of the Revised Code.

(2) Home modification services do not include:

- (a) Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the consumer (i.e., carpeting, roof repair, central air conditioning, etc.);
- (b) Adaptations that add to the total square footage of the home; and
- (c) Services performed in excess of what is approved pursuant to the all services plan.

(3) Home modification service providers shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the bid specification. The reimbursement may

only be adjusted if the job specifications are modified in writing by the designated CMA and the adjustment is warranted. Family members and volunteers will only be reimbursed for the cost of materials.

(4) In order to submit a claim for reimbursement, providers of home modification services must:

- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Assure that the home modification was completed in accordance with the agreed upon specifications using all of the materials and equipment cited in the bid;
- (c) Assure that the home modification was tested and in proper working order;
- (d) Assure that the home modification met all applicable state and local building codes and complies with the Americans with Disabilities Act (ADA);
- (e) Maintain insurance and bonding for general contracting services and provide proof to the designated CMA upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the consumer; and
- (f) Obtain a final written approval from the consumer and the designated CMA after completion of the home modification service.

(5) Selection of home modification service providers.

- (a) The designated CMA shall develop job specifications in consultation with the consumer, authorized representative, and/or caregiver(s) to meet the consumer's environmental accessibility needs with the lowest cost alternative.
- (b) The designated CMA shall send the home modification specifications to every home modification service provider in the consumer's region and invite the submission of competitive bids. The following must be submitted with all bids:
 - (i) A drawing or diagram of the home modification;
 - (ii) An itemized list of all materials needed for the home modification;
 - (iii) An itemized list of the cost of the materials needed for the home modification;
 - (iv) An itemized list of the labor costs;
 - (v) A written statement of all warranties provided; and
 - (vi) A written attestation that the provider, all employees and/or all subcontractors to be used to perform the job specifications have the necessary experience and skills.
- (c) The designated CMA shall review all submitted bids and the home modification service will be awarded to the lowest responsive and most responsible bidder, with price and other relevant factors being considered in the selection process.

(F) Supplemental transportation services.

- (1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point.
- (2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to the all services plan.

- (3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.
- (4) Agency supplemental transportation service providers must:
- (a) Maintain a current list of drivers;
 - (b) Assure that all drivers providing supplemental transportation services are age eighteen or older;
 - (c) Maintain a copy of the valid driver's license for each driver;
 - (d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services;
 - (e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;
 - (f) Assure that drivers are not the consumers' legally responsible family members as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code; and
 - (g) Assure that drivers are not the consumers' foster caregivers.
- (5) Non-agency supplemental transportation service providers must:
- (a) Be age eighteen or older;
 - (b) Possess a valid driver's license;
 - (c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services;
 - (d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;
 - (e) Not be the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code; and
 - (f) Not be the consumer's foster caregiver.
- (6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.

(G) Supplemental adaptive and assistive device services.

- (1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the consumer, or the consumer's legally responsible family member as that term is defined in paragraph (EE) of rule [5101:3-45-01](#) of the Administrative Code, that are not otherwise available through any other funding source and that are suitable to enable the consumer to function with greater independence, avoid institutionalization, and reduce the need for human assistance. The designated CMA shall only approve the lowest cost alternative that meets the consumer's needs.
- (a) Reimbursement for medical equipment and supplies shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one-year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical condition requiring the replacement.

- (b) Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of vehicle modification for the consumer for a three-year period unless there is a documented change in the consumer's medical and/or physical condition requiring the replacement.
- (2) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same consumer. Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide the designated CMA with documentation of:
- (a) Evidence of a valid driver's license, with appropriate restrictions;
- (b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;
- (c) Evidence of the vehicle owner's collision and liability insurance for the vehicle being modified; and
- (d) A written statement from a certified mechanic stating the vehicle is in good operating condition.
- (3) Supplemental adaptive and assistive device services do not include:
- (a) Items considered by the federal food and drug administration as experimental or investigational;
- (b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;
- (c) Payment toward the purchase or lease of a vehicle;
- (d) Routine care and maintenance of vehicle modifications and devices;
- (e) Permanent modification of leased vehicles;
- (f) Vehicle inspection costs;
- (g) Vehicle insurance costs; and
- (h) Services performed in excess of what is approved pursuant to the all services plan.
- (4) In order to submit a claim for supplemental adaptive and assistive device services, the provider must:
- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
- (b) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services; and
- (c) Assure that the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.
- (5) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (d) of this paragraph.

- (a) Consumer identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
- (b) Name of consumer's treating physician.
- (c) A copy of the initial and all subsequent all services plans.
- (d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(H) Out-of-home respite services.

- (1) "Out-of-home respite services" are services delivered to a consumer in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.
 - (a) The services the out-of-home respite provider must make available are:
 - (i) Waiver nursing services as set forth in paragraph (A) of this rule;
 - (ii) Personal care aide services as set forth in paragraph (B)(1) of this rule; and
 - (iii) Three meals per day that meet the consumer's dietary requirements.
 - (b) All services set forth in paragraph (H)(1)(a) of this rule and delivered during the provision of out-of-home respite services shall not be reimbursed as separate services.
- (2) Out-of-home respite services do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, providers of out-of-home respite services must:
 - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.
 - (b) Be either:
 - (i) An intermediate care facility (i) for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in accordance with rules [5101:3-3-02](#) and [5101:3-3-02.3](#) of the Administrative Code; or
 - (ii) A nursing facility (NF) licensed and certified in accordance with rules [5101:3-3-02](#) and [5101:3-3-02.3](#) of the Administrative Code; or
 - (iii) Another institutional setting approved by the designated CMA.
 - (c) Be providing out-of-home respite services for one individual, or for up to three individuals in a group setting on the same date.
- (4) All providers of out-of-home respite services must:
 - (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
 - (b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.
 - (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.

(5) Providers of out-of-home respite services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

(a) Consumer's identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

(d) A copy of the initial and all subsequent all services plans.

(e) A copy of the "do not resuscitate" (DNR) order, if one exists.

(f) Documentation of drug allergies and dietary restrictions.

(g) Documentation that clearly shows the date of out-of-home respite service delivery, including tasks performed or not performed. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing out-of-home respite service provider, at the point the service provider is no longer going to provide services to the consumer, or when the consumer no longer needs out-of-home respite services.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing.

(l) Emergency response services.

(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers 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 are considered to be high risk for the purposes of this service.

(2) ERS do not include:

(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and

(b) Services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.

(4) Providers of ERS must:

(a) Permit consumers to select from a variety of remote activation devices;

(b) Assure that consumers have systems that meet their specific needs;

(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;

(d) Conduct monthly testing of emergency response systems to assure proper operation;

- (e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;
 - (f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;
 - (g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;
 - (h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;
 - (i) Assure that emergency response center staff respond to alarm messages within sixty seconds of receipt; and
 - (j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.
- (5) Providers of ERS must maintain the following documentation:
- (a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;
 - (b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;
 - (c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and
 - (d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.

Replaces: Part of 5101:3-12-07

Effective Date: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification:

Promulgated Under: 119.03

Statutory Authority: 5111.85

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Prior Effective Dates: 3/30/90 (Emer), 6/29/90, 7/1/90, 3/12/92 (Emer), 6/1/92, 7/31/92 (Emer), 10/30/92, 7/1/93 (Emer), 7/30/93, 9/1/93, 1/1/96, 7/1/98

[CSTL 06-01](#)

5101:3-50-06 Transitions carve-out waiver program: reimbursement rates and billing procedures.

Effective Date: July 1, 2006.

(A) Definitions of terms used for billing and calculating rates.

- (1) "Base rate," as used in table A, column 3 of paragraph (B) of this rule, means the amount paid for up to the first four units of service delivered.
- (2) "Billing unit," as used in table B, column 3 of paragraph (B) of this rule, means a single fixed item, amount of time or measurement (e.g., a meal, a day, or mile, etc.).
- (3) "Group rate," as used in paragraph (E)(1) of this rule, means the amount that waiver nursing and personal care aide service providers are reimbursed when the service is provided in a group setting.
- (4) "Group setting" means a situation where a waiver nursing and/or personal care aide service provider furnishes the same type of services to two or three individuals at the same address. The services provided in the group setting can be either the same type of ODJFS-administered waiver service, or a combination of ODJFS-administered waiver services and similar non-ODJFS-administered waiver services.
- (5) "Medicaid maximum rate" means the maximum amount that will be paid by medicaid for the service rendered.
 - (a) For the billing codes in table B of paragraph (B) of this rule, the medicaid maximum rate is set forth in column 4.
 - (b) For the billing codes in table A of paragraph (B) of this rule, the medicaid maximum rate is:
 - (i) The base rate as defined in paragraph (A) (1) of this rule, or
 - (ii) The base rate as defined in paragraph (A) (1) of this rule plus the unit rate as defined in paragraph (A) (7) of this rule for each additional unit of service delivered.
- (6) "Modifier," as used in paragraph (E) of this rule, means the additional two-alpha-numeric-digit billing codes that providers are required to use to provide additional information regarding service delivery.
- (7) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service provided.

(B) Billing code tables.

- Table A -

<u>Column 1</u>	<u>Column 2</u>	<u>Column 3</u>	<u>Column 4</u>
<u>Billing code</u>	<u>Service</u>	<u>Base rate</u>	<u>Unit rate</u>
<u>T1002</u>	<u>Waiver nursing services provided by an RN</u>	<u>\$50.60</u>	<u>\$5.42</u>
<u>T100</u>	<u>Waiver nursing services provided by an LPN</u>	<u>\$50.60</u>	<u>\$5.42</u>
<u>T101</u>	<u>Personal care aide services</u>	<u>\$24.00</u>	<u>\$3.00</u>

- Table B -

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Billing unit	Medicaid maximum rate
H0045	Out-of-home respite services	Per day	\$200.00
S0215	Supplemental transportation services	Per mile	\$0.38
S5101	Adult day health center services	Per half day	\$32.50
S5102	Adult day health center services	Per Day	\$65.00
S5160	Emergency response services	Per installation and testing	\$45.00
S5161	Emergency response services	Per monthly fee	\$45.00
S5165	Home modification services	Per item	Amount prior-authorized on the all services plan
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the all services pla
S5170	Home delivered meal services	Per meal	\$7.0

- (C) In order for a provider to submit a claim for transitions carve-out waiver services, the services must be provided in accordance with rules [5101:3-12-08](#) to [5101:3-12-30](#) of the Administrative Code, and Chapters [5101:3-45](#) and [5101:3-50](#) of the Administrative Code.
- (D) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.
- (E) Required modifiers.
- (1) The "HQ" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement at a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.
 - (2) The "U1" modifier must be used when a provider submits a claim for billing code T1002 and the consumer is receiving infusion therapy.
 - (3) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to a consumer for the same date of service.
 - (4) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to a consumer for the same date of service.
 - (5) The "U4" modifier must be used when a provider submits a claim for billing code T1002, T1003 or T1019 for a single visit that was more than twelve hours in length but did not exceed sixteen hours.
- (F) Reimbursement will be provided in accordance with paragraphs (A) to (D) of rule [5101:3-1-60](#) of the Administrative Code.

Replaces: Part of 5101:3-1-06.3

Effective Date: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

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Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 1/1/04

[CSTL 06-02](#)

Billing Instructions

BIN.1000. General Billing Instructions

BIN.1001. Introduction

This section of the Medicaid Handbook contains specific information on how to complete an ODHS claim form for an initial claim submission, claim adjustment and claim resubmission. It also provides information on how to interpret the remittance advice issued by the department. Providers should review this information carefully so that timely and accurate reimbursement can be made. These instructions are for home care providers who are billing the department for services rendered to consumers who are not enrolled in a managed care plan. Providers must only submit claims to the department for fee-for-service, non-HMO, consumers with a valid Ohio Medicaid Card.

Chapter 3334, General Information, should be used in conjunction with this section and referenced for information on the Medical Cards (Section III) and Reimbursement (Section V). All Medicaid claims submitted to the Ohio Department of Human Services for payment are entered into the Medicaid payment system by one of two processes: direct entry tapes or hard copy claim forms.

The direct entry tape system is the quickest way of entering claims into the Medicaid payment system. Some large volume providers prepare their own tapes. There are also billing agents who will prepare tapes for low volume providers.

Although the department does not sponsor any of these billing agents, providers interested in this type of service should contact the Provider Relations Section. They will send providers a list of the billing agents approved by the department or the requirements and technical specifications necessary to qualify as a Direct Entry Biller.

All hard copy Medicaid invoices are entered into the system by Key Data Entry, where an operator keys each claim into the computer. Hard copy claim forms submitted for processing should not be folded or stapled. If there are questions about the billing instructions, please contact the Provider Relations Section at:

P.O. Box 1461

Columbus, Ohio 43266-0161

Toll Free dial 950-5627, wait for tone then dial 8-3288 or

(614) 728-3288

BIN.1001.2. Instructions for Completing the CMS 1500

[Click here to view the Instructions for Completing the CMS 1500.](#)

BIN.1003. Billing Instructions: Medicaid Claim Form 6780 for Medicare / Medicaid Crossover

[Click here to view the ODHS 6780 Medicaid Claim form.](#)

This section contains instructions specific to billing for Medicare/Medicaid crossovers only. Please see [BIN.1100.](#) for instructions on how to complete the ODHS 6780 form for transportation claims and dental claims.

Follow these instructions only if the recipient is eligible for both Medicare and Medicaid and:

- The provider does not normally accept assignment from Medicare;
- The provider accepts assignment from Medicare, billed and received reimbursement from Medicare, and has not received Medicaid payment for the coinsurance and deductible within 60 days to 90 days of the Medicare reimbursement date;
- The crossover claim has been denied for a 231 error code.

(A) Medicare/Medicaid Crossover:

Medicare must be billed first for all Medicare covered services provided to Medicare/Medicaid eligible patients. In most cases, Medicare will reimburse the provider the usual and customary fees less a coinsurance charge and a deductible. Medicare will then forward the provider's bill to Medicaid. Medicaid will automatically pay the coinsurance and deductible charges. This automatic payment process is called Medicare/Medicaid crossover. For more information see Chapter 3334, General Information, Sections I (C) and V(D).

(B) Provider Does Not Normally Accept Medicare Assignment

For all Medicaid covered services, including those provided to a Medicare/Medicaid eligible recipient, the provider may not bill the patient for any part of the covered service. Therefore if a provider has not accepted assignment from Medicare, Medicaid will not automatically reimburse the coinsurance and deductible for a Medicare/Medicaid eligible recipient.

When the provider does not accept assignment from Medicare, Medicare reimburses the recipient for the approved amount less the deductible and coinsurance charge and does not forward the bill to Medicaid. The provider may not bill the recipient for the coinsurance, the deductible, or any outstanding balance of the bill. If the provider wants to receive any coinsurance and/or deductible payments, the provider must bill Medicaid for the coinsurance and deductible following the Medicare/Medicaid crossover instructions in this section.

(C) Provider Accepts Medicare Assignment

With the exception of services subject to the Medicare payment limitation, when a Medicare assignment provider bills Medicare for services, supplies, or equipment provided to a patient who is eligible for both Medicare and Medicaid, Medicare reimburses the provider the approved amount minus any coinsurance and deductible. Medicare forwards the bill for the coinsurance and deductible to Medicaid. Medicaid automatically reimburses the provider the coinsurance and deductible within 60 to 90 days of the Medicare reimbursement.

If the Medicaid reimbursement for coinsurance and deductible has not been made within 60 to 90 days of the Medicare reimbursement, the provider can bill Medicaid for the coinsurance and deductible following the Medicare/ Medicaid Crossover Instructions in this section, if the provider bills the department on hard copy claims, or the provider may bill Medicare/Medicaid crossover claims on tape following the National Standard Format (NSF).

When billing the department hard copy, a separate ODHS 6780 form must be submitted for each Medicare/ Medicaid patient listed on the Summary Notice of Medicare Benefits. The provider is no longer required to attach the Medicare Summary Notice if the date of service for the claim is less than one year old. A Summary Notice is required when the date of service for the claim is older than one year.

(D) Claims with coinsurance amounts greater than 20% of the Medicare allowed amount

The Medicare coinsurance amount payable by Medicaid will always be equal to or less than 20% of the Medicare allowed amount. Any claim crossed over to ODHS showing a coinsurance amount greater than 20% will be denied by the department with a 231 error code and the provider will have to recalculate the coinsurance amount and submit a crossover claim to the department.

Psychotherapy services and certain other psychiatric services are subject to a Medicare payment limitation of 62.5% of the allowed amount determined by Medicare. To enable Medicare providers to collect the 37.5% reduced from the Medicare allowed amount from MediGap and other third party insurers, the Medicare carrier now adds the 37.5% amount to the coinsurance amount and reports it in the coinsurance column on the Medicare EOB. This causes all the claims with these services to exceed the 20% threshold and to be denied by the department.

Technically the 37.5% reduced from the Medicare allowed amount for psychiatric services is not considered coinsurance by HCFA. State Medicaid programs are only required to pay the actual coinsurance amount which is a maximum of 12.5% of the Medicare allowed amount for those claims (20% of 62.5% of the allowed amount is equal to 12.5% of the allowed amount). The Ohio Medicaid program does not pay providers the 37.5% reduced from the Medicare allowed amount for these services. To receive coinsurance and deductible payments for these services, the provider must recalculate the coinsurance amount and submit a new crossover claim using the instructions provided in this section. See instructions for Item 20 for calculation.

(E) Claims Completely Denied or Line Item Services Denied by Medicare

If the provider is submitting a claim that has been completely denied by Medicare, DO NOT follow the Medicare/Medicaid Crossover Instructions in this section. Prepare a HCFA 1500 claim form following the regular billing instructions, attaching the denial from Medicare (Summary Notice of Medicare Benefits), attach the ODHS 6653 Medicaid Claim Problem Form and mail to:

ODHS

The Provider Relations Section

P.O. Box 1461

Columbus, Ohio 43266-0161.

If there are a number of services for the same recipient, and only one is not covered by Medicare, fill out a separate claim form for the noncovered services. Remember, when billing for a service denied by Medicare, each claim form must be accompanied by a Summary Notice of Medicare Benefits. This is important because the computer program that pays the claim will reject a mixed claim form.

BIN.1003.1 Medicare/Medicaid Crossover Instructions

NOTE: *FOR MEDICARE/MEDICAID CROSSOVER CLAIMS, USE THE ODHS 6780 CLAIM FORM ONLY*

- Item 1. PROVIDER'S NAME AND ADDRESS: The provider's name, mailing address, city, state, and zip code must be typed on each invoice.
- Item 2. PROVIDER NUMBER: Enter the seven (7) digit Medicaid Provider Number assigned to the individual provider who performed the service.
- Item 3. GROUP NUMBER: If you are billing for a group practice, enter the seven (7) digit Medicaid Provider Number assigned to the group. Item 2 (Individual Provider number of the servicing provider) must also be completed when billing for a group practice. If Item 3 is completed, the Ohio Department of Human Services will send any payment for the billed services to the provider group.

- Item 4. PROVIDER SERVICE CODE: For Medicare Crossover services enter a CAPITAL "F" in Item 4. Also a large capital letter "F" must be handwritten or typed in the provider service code block located in the left hand corner.
- Item 5. MEDICAL RECORD NUMBER: (Optional) This is for provider's use in identifying patients and allows use of up to nine numbers or letters (no other characters are allowed). If used, this number will appear on the remittance advice under "Med Rec."
- Item 6. PATIENT'S LAST NAME: Enter the last name of the patient. USE CAPITAL LETTERS ONLY.
- Item 7. PATIENT'S FIRST NAME: Enter the first name of the patient. USE CAPITAL LETTERS ONLY.
- Item 8. PRIOR AUTHORIZATION NUMBER: Leave Blank
- Item 9. BILLING NUMBER: Enter the twelve (12) digit number found in the column marked "Billing Number" on the Ohio Medicaid Card for the individual who received services.
- Item 10. PRIMARY DIAGNOSIS CODE: Leave Blank
- Item 11. REFERRAL NUMBER: Leave Blank
- Item 12. EPSDT INDICATION: Leave Blank
- Item 13. FAMILY PLANNING: Leave Blank
- Item 14. ACCIDENT RELATED: Leave Blank
- Item 15. OTHER SOURCE: Only one number or alpha letter may be entered in this space. Your claim will deny if more than one source code is listed. when 1-6 is entered in this block the amount collected must be entered in block 22. When R, P, F, L, E, S, or X is entered in this block the provider must maintain documentation to support the use of these codes.

If you have received payment for the service from another source other than Medicare, please enter the appropriate one (1) character source code found below:

OTHER SOURCE CODES

- 1 = Self / Family/Spend down liability
- 2 = Blue Cross/Blue Shield
- 3 = Private Carrier
- 4 = Employer or Union
- 5 = Public Agency
- 6 = Other (enter the name and address of the source in the provider remarks section)

Bill all third-party insurers first. If you have not received payment from a third party insurer, but there are indications of private (non-Medicaid/non-Medicare) health insurance coverage in the case, please enter the appropriate one (1) character reason code found below:

- R- No Response From Carrier. Means no response from the insurance carrier for 90 days (see ODHS Medicaid Handbook 3334). A claim with this code may not be submitted until 91 days after the date of treatment.
- P- No Coverage for This Recipient Number. Means the provider has confirmed there is health insurance (other than Medicaid or Medicare) for some members of the Medicaid case, but the particular patient is not covered. If the medical card indicates that the recipient has third-party insurance but you have verified that the recipient does not have third-party insurance, complete the 6614 form following the instructions in this section.
- F- No Coverage for All Recipient Numbers. Means there is no health insurance (other than Medicaid or Medicare) for any member of the Medicaid case. If the medical card indicates that all the individuals listed on the card have third-party insurance and you have verified that is not the case, complete the 6614 form following the instructions provided in this section.
- L- Disputed or Contested Liability. Means the provider has confirmed there is health insurance (other than Medicaid or Medicare), but the coverage for the billed service is disputed or contested by the insurance carrier.
- S- Noncovered Services. Means the provider has confirmed there is health insurance (other than Medicaid and Medicare), but the policy does not cover the services being billed. This

code should also be used when the amount billed has been applied to the insurance deductible.

E- Insurance Benefits Exhausted. Means the provider has confirmed there is health insurance (other than Medicaid or Medicare), but the policy benefits for the billed services have been exhausted.

X- Noncooperative Recipient. Means the provider has confirmed there is health insurance (other than Medicaid or Medicare), but the patient refused to cooperate in collection effort. Providers are expected to take reasonable measures to ascertain any third-party resource available to the recipient and to file a claim with that third-party insurer.

Note: Documentation to justify use of codes R,P,F,L,S,E, and X must be retained for future audit purposes. The department will monitor the use of these codes by providers.

If you have not received payment from another source and there is no indication of private health insurance coverage (non-Medicaid/non-Medicare) for the case, leave this item blank.

Item 16. SECONDARY DIAGNOSIS CODE: Leave Blank

Note: The body of this invoice consists of twelve (12) numbered lines and eight (8) alphabetized columns. The following instructions are the same for all twelve lines.

Column A Service Date: Enter the six-digit dates of service (MMDDYY) in chronological order (first to last). Enter all six characters consecutively without dashes, slashes, or spaces; example: 070795 = July 7, 1995.

Column B Service Code: Enter the procedure code and applicable modifier as found on the Medicare Summary Notice.

Column C Place of Service Code: Enter the place of service code as found on the Medicare Summary Notice.

Column D Leave Blank

Column E Enter the units of service as shown on the Medicare Summary Notice.

Column F Leave Blank

Column G Leave Blank

Column H Charges: Enter your usual and customary fee for the service as submitted to Medicare.

Item 17. BILLING DATE: Enter the invoice preparation date. Use six (6) digit format. Example: 070795 = July 7, 1995.

Item 18. APPROVED AMOUNT: Enter the total dollar amount approved by Medicare indicated on the Summary Notice from Medicare.

Item 19. DEDUCTIBLE: Enter the dollar amount shown in the Deductible Column on the Summary Notice of Medicare Benefits. If there is no deductible, leave this item blank.

Item 20. CO-INSURANCE: 1) For all services except for psychiatric services subject to the Medicare payment limitation, enter the dollar amount shown in the coinsurance column on the Summary of Notice of Medicare Benefits received from Medicare; or 2) For all psychiatric services subject to the Medicare payment limitation (e.g., all psychotherapy services), calculate the correct coinsurance amount using the following formula and enter that calculated amount in this space: Reported coinsurance = [(Medicare allowed amount * .625) - (deductible)] * .20

Item 21 TOTAL CHARGE: Enter the sum of the line item charges listed in Column H.

Item 22 OTHER SOURCE AMOUNT: Enter the amount collected from all sources other than Medicare. If the amount collected from all sources other than Medicare exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment. (When an amount is entered in this Item, Item 15 must also be completed.) If the sum of the coinsurance and deductible is less than the third-party payment, no money amount will be paid by Medicaid.

Item 23 NET CHARGE: Leave Blank

Item 24. Leave Blank

Item 25. DATE PAID BY MEDICARE: Enter the payment date shown in the upper right hand corner of the Summary Notice of Medicare Benefits, using the six (6) digit format. (MMDDYY)

REMARKS -FOR PROVIDER USE: This section may be used to clarify information on this invoice.

PROVIDER CERTIFICATION: The signature of the provider rendering the service billed on this invoice is required.

MAILING INSTRUCTIONS: Remove perforated strips and separate invoices. Retain yellow copy of completed invoice for your files.

Mail the original (pink) invoice with Summary Notice of Medicare Benefits attached to the invoice to:

Ohio Department of Human Services

P.O. Box 2338

Columbus, Ohio 43266-0038

DO NOT FOLD INVOICE

BIN.1004. Description of the Elements of a Remittance Advice

[Click here to view a mock up of the ODHS Remittance Advice.](#)

The Ohio Department of Human Services' Medicaid Management Information System (MMIS) produces a remittance advice for all adjudicated claims. The remittance advice is sent to providers of Medicaid and/or Disability Assistance services to indicate the outcome of claims. All Medicaid claims and Disability Assistance (DA) claims that are adjudicated on the same date are reflected on the same remittance advice.

Sometimes a Remittance Advice (RA) Newsletter will appear as the first page of the remittance advice. The RA newsletter contains important information regarding billing and/or claims processing problems or announcements on the implementation of new or revised Medicaid policies.

The remittance advice is divided into three sections: claims paid, claims denied, and the summary. All paid Medicaid and DA claims are listed first. If a claim was partially paid (e.g., 3 of 4 line items were paid and the other denied) it would appear in the section of paid claims. If the entire claim is denied, it will appear in the section with the denied claims. A summary of the claim transactions follows the listing of denied claims.

After the Remittance Advice summary, there are two additional features that will assist a provider in determining the reason a claim was denied. First will be a listing and description of all error codes (EOBs) found in the Remittance Advice. Second, if the Remittance Advice contains the error code 101 which means that the claim has already been paid and appeared on a previously issued Remittance Advice, the final section of the Remittance Advice will give the provider information as to when the claim was paid.

The list below explains fields found on all remittance advices:

HEADER FIELDS (Items 1 - 4):

1. PROVIDER PAGE: The sequential page number of the Remittance Advice.
2. PROVIDER NUMBER: The provider number for the provider ODHS reimbursed.
3. PROVIDER NAME/PROVIDER ADDRESS: The provider name/address to which payment is issued.
4. CLAIM STATUS: Heading of section containing either paid or denied claims.

LAYOUT OF THE LISTING OF PAID OR DENIED CLAIMS (Items 5 -28):

5. DATE:
 - A. From Date: The date the service was provided or the first date of service if REMITTANCE ADVICE NUMBER: A unique internal control number.
6. VOUCHER NUMBER: Internal payment control number.
7. DATE: The date (month/day/year) the Remittance Advice was printed.
8. TRANSACTION CONTROL NUMBER (TCN): This is a unique, seventeen-digit number assigned to each claim. The TCN is assigned to the claim at the date of receipt. It is used to identify a claim for adjustments, resubmittals, and inquiry research.
9. SERVICE consecutive dates were billed.
 - B. To Date: The date the service was provided or the last date of service if consecutive dates were billed.
10. UNITS OF SERVICE:
 - A. Submitted: The number of consecutive dates of service, number of items, number of times performed, or time units entered on the claim.
 - B. Paid: The actual number of consecutive days of service, number of items, number of times performed, or time units paid by ODHS.

11. PROC-MOD/REVENUE-PROC/DRUG CODE: In accordance with the claim type, this item contains the code that identifies the services entered on the claim, i.e., procedure code, modifier, revenue code, or drug code.
12. TOTAL CHARGE: The total charge entered on the claim form for the service rendered by the provider.
13. ALLOWED CHARGE: Appears for paid claims only and is the amount reimbursed by the ODHS. Negative amounts indicate credits to previously paid claims.
14. ALLOWED CHARGE SOURCE CODE: Single character which indicates how the allowed charge was determined. See BIN.2002. for a list of allowed charge source codes.
15. PAID REFERENCE: The reference code which appears at the end of the Remittance Advice identifying the paid claim that caused the duplicate error code.
16. CLAIM TYPE: The listing of service types on the Remittance Advice, e.g., physician, clinic, etc.
17. RECIPIENT ID: The twelve (12) digit number that was entered on the claim by the provider. This number should coincide with the billing number of the patient's Medicaid card.
18. PATIENT'S NAME: Medicaid patient's name as it appears on the state's eligibility files as identified by the recipient ID, item 18, above.
19. COUNTY NUMBER/NAME: The two-digit number and name identifying the county in which the recipient now resides.
20. MEDICAL RECORD NUMBER: Medical record number submitted by the provider on the claim.
21. ADJUSTMENT CODE: Two-digit code identifying the reason for the recalculation and/or correction of the underpayment/overpayment to a previously paid claim. See BIN.2003. for a list of adjustment reason codes.
22. LESS THIRD PARTY: The amount paid by other health insurance, as reported by the provider, that has been deducted from the allowed charge. (Will only appear when third-party payment has been indicated.)
23. INTEREST PAID: The amount of accrued interest, by individual claim, paid to the provider as a late payment penalty. This amount will be added into the claim total.
24. DETAILED BREAKDOWN BY CLAIM TOTAL:
 - A. Total charge
 - B. Total allowed charges
25. OTHER INSURANCE COVERAGE FOR THIS RECIPIENT: Identifies health insurance carrier's name and address when claim is denied for other insurance coverage. This indicator will only appear when claim is denied for third-party coverage.
26. INSURANCE POLICY INFORMATION: Will only appear when claim is denied for third-party coverage.
 - A. Policy holder
 - B. Policy number
 - C. Group number
27. LIST OF LINE NUMBERS EOB CODES FOR THE DENIED CLAIM:

Line-(i.e. 01 thru 12)- identifies the line that denied
Line-00- identifies the entire claim as denied
EOB- identifies the code for which the claim line or entire claim denied

LAYOUT OF THE REMITTANCE ADVICE SUMMARY (Items 29 -32):

28. DETAILED BREAKDOWN BY (CLAIM TYPE):

- A. Number of claims
 - B. Total charge
 - C. Total allowed charges
29. TOTAL FOR CLAIMS DENIED:
- A. Number of denied claims
 - B. Total charges
 - C. Total allowed charge
30. TOTAL WARRANT AMOUNT PAID:
- A. Total number of paid claims on the Remittance Advice
 - B. Total of all charges considered for payment
 - C. Total allowed charges
31. TOTAL WARRANT AMOUNT DENIED:
- A. Total number of denied claims on the Remittance Advice
 - B. Total charges for denied claims
 - C. Total allowed amount

LAYOUT OF THE EOB CODE DEFINITIONS (Item 33):

32. DESCRIPTION OF ERROR (EOB) CODES APPEARING ON REMITTANCE ADVICE

LAYOUT OF PAID CLAIMS CAUSING DUPLICATE DENIALS (Items 34 - 42):

33. REFERENCE LINE (see item 16) OF PAID CLAIM: References the paid claim that caused the claim identified in item 16 to be denied as a duplicate claim.
34. LINE ITEM: Identifies the reference number line that caused the duplicate error code.
35. TRANSACTION CONTROL NUMBER: Identifies the transaction control number of the paid claim.
36. CLAIM TYPE: Identifies the claim type of the paid claim.
37. PROCEDURE CODE/MODIFIER: Identifies the procedure code and any modifiers for the paid claim.
38. FROM-TO-DATE: Identifies the service date for the paid claim.
39. UNITS: Identifies the units of service for the paid claim.
40. ALLOWED CHARGE: Identifies the allowed charge for the paid claim.
41. DATE PAID: Identifies the date of the remittance advice containing the paid claim which caused the "101" denial, exact duplicate claim.

BIN.1005. Adjustments to Paid Claims

[Click here to view the ODHS 6767 Adjustment Request form.](#)

If a provider believes that an improper payment of a claim for covered Medicaid services has occurred through either the omission of information, submittal of incorrect claims data, and/or systems error, an adjustment may be requested by submitting a copy of the applicable remittance advice along with a completed adjustment request form (Adjustment Request Form ODHS 6767).

Adjustments resulting in refunds to the department will be handled by crediting the refund against future payments to the provider. The department discourages refund payments by check but will accept checks in the event that the provider is terminating his/her Medicaid provider status or the provider believes that future payments from the department will be insufficient to cover the refund due.

Item 3, and items 7-12 (I) and (J) on the adjustment form should be completed only if the provider is making the refund by check.

In requesting the review of a claim by the Claims Adjustment Unit, it is essential that all relevant information, as it applies to payment of the original claim, be submitted with the Adjustment Request Form. All aspects of the payment that are in question should be highlighted on the submitted remittance advice page with appropriate comments. In addition, the remarks section of the ODHS 6767 form should be used to explain the concerns and identify the specific provider staff contact, in the event further clarification is essential. Should additional space be required please use a memorandum.

The Adjustment Request Form should be used for correcting overpayments or underpayments but not for resubmission of denied claims. (See BIN.1006. for instructions on the resubmission of denied claims.)

The adjustment form should not be used to request an increase in payment if the original claim was correctly submitted and the provider received the maximum payment allowed under Medicaid (denoted by an allowed charge Source "C" beside the allowed amount).

BIN.1005.1 Instructions: Adjustment Request Form ODHS 6767 (12/95)

- Item 1. Provider Name: Enter the name of the provider who actually received the Medicaid payment.
Provider Address -Enter the complete mailing address; including city, state and zip code, of the provider who received the Medicaid payment.
Provider Number -Enter the seven (7) digit Medicaid provider number assigned to the provider who received the Medicaid payment. This must be completed for an adjustment to occur.
- Item 2. Check One -All adjustment requests on each ODHS 6767 must be either an initial request or follow-up request.
An Initial Request -Check "initial request" if an ODHS 6767 has not previously been submitted for the payment(s) in question.
A Follow-Up Request -If a request has been previously submitted check the "follow-up request" block in red on a photostatic copy of the original ODHS 6767. Do not complete a second ODHS 6767.
- Item 3. One Check Enclosed -Complete this block when reimbursing ODHS with one check for one or more adjustments, provided all the adjustments are included in the same submission. If the check covers more than one service with different reasons for refunds, check neither block; instead complete the Reason for Refund block as explained under items 7-12 "H" below. If more than one check is enclosed, do not use this block; instead complete the Check Numbers and Check Amounts blocks as explained under items 7-12 "I" and "J" below.
Check No. -Enter the number of the check enclosed.
Check Amount -Enter the total dollar amount of the check enclosed.
Private Insurance -Check the "private insurance" block if the refund resulted from a third-party payment.
Other -Check the "other" block if the refund is from sources other than private insurance and provide a brief explanation in the remarks section.
- Item 4. Claim Type: Check the type of claim(s) originally submitted. If adjustments are to be requested for more than one type of claim, separate request forms must be submitted.
- Item 5. Total Number of Claims: Enter the total number of claims included in the request. If the total is more than six(6) claims, additional request forms must be submitted with the total number of claims involved entered on each form. Example: A request for 18 claims adjustments would require three (3) forms and the number 18 would be entered in this block of each form.
- Item 6. Check One: Check the appropriate block to indicate whether the request involves either Medicare Crossover or Medicaid Claims. Do not include both types on the same submission.

Items 7-12 A through M: Recipient Information

- A. Recipient Name -Enter the name of the recipient who actually received the service. Enter last name first.
- B. Dates of Service - Enter the six (6) digit dates of service (MMDDYY) in chronological order (first to last). Enter all six characters consecutively without dashes, slashes or spaces; example: 070795= July 7, 1995.
- C. Recipient ID# -Enter the twelve (12) digit billing as printed on the patient's Medicaid card. The billing number can be found in the block marked "billing number" on the Ohio Medicaid card.
- D. Transaction Control Number -Enter the transaction control number (TCN) in question as it appears on the Remittance Advice.
- E. Prior Authorization - Complete only if Prior Authorization was required for the services billed. Enter the six (6) digit number from the Prior Authorization form (ODHS 3142 or ODHS 3612) which authorized the procedure.

- F. Incorrect Code/Units/Modifier -Enter the incorrect code, unit(s), or modifier as they appear on the Remittance Advice. If the code, unit(s), or modifier is correct, leave this and the following space blank.
- G. Correct Code/Units/Modifier -If the original code, unit(s), or modifier of service was incorrect, enter the correct code, unit(s), or modifier.
- H. Reason for Refund - Complete this item if more than one check is enclosed with the request. Check either the "Private Insurance" or "Other" block, depending on the source of third party payment. Please see Item 3 above for exceptions. If checking the "Other" block, write an explanation in the Remarks section following the instructions in item 13 below.
- I. Check Number -If more than one check is enclosed, enter the number of the check applicable to the specific recipient identified in block A.
- J. Check Amount -If more than one check is enclosed, enter the total amount applicable to the specific recipient identified in block A.
- K. Amount Refunded for Recipient -Complete if a single check is enclosed. Enter the portion of the check amount which is being refunded for the specific recipient and service. Please see Item 3 above for exceptions.
- L. Medicaid Paid -Enter the amount paid by Medicaid for the specific recipient, as it appears on the Remittance Advice.
- M. Attachments - Check this block if document(s) relating to the request are included in the information sent, for example: Prior Authorization forms or a Remittance Advice with a different pay date showing duplication.

Item 13. Remarks: Complete this section if the block marked "Other" in items 7-12 "H" was checked or if further clarification of the error is necessary. Each explanation should include the appropriate recipient information item numbers 7-12, and the name and work phone of a contact person if different from the person signing the form. If it is necessary to use an additional page, write "see attached page" in this section.

Signature, Telephone Number, Date - Enter the signature of the provider representative responsible for completing the form, the telephone number (including area code) where they may be reached, and the date the form was completed.

If no check is enclosed, the request for review of a claim payment by the Claims Adjustment Unit is to be sent with supporting documentation to the following address:

Ohio Department of Human Services (or) O.D.H.S.

Claims Adjustment Unit

P.O. Box 309

Columbus, Ohio 43266-0309

If a check (or checks) are enclosed, the check(s) must be made payable to the "Treasurer, State of Ohio". Attach check to the adjustment form and mail with supporting documentation to the following address:

Ohio Department of Human Services (or) O.D.H.S.

Department # 341

Columbus, Ohio 43265-0341

BIN.1006. Resubmission of Denied Claims

Denied claims are determined through pre-screening or by computer program edits.

- Prescreening is the personal review of every hard copy claim received by the Claims Control Unit. No mechanized or electronic processing has yet occurred. The original (hard copy) claim is returned to the provider, if the claim is denied during prescreening. The department would not have a historical record of a claim denied during the prescreening process.
- Computer Program Edits are applied to claims that have been entered into the system. If a claim is denied during this process, a record of the denial is created for historical value, and notification of the denial will be sent to providers via remittance advice. Computer denials are either a total claim denial or a partial claim denial.

BIN.1006.1 Hard Copy Claims Denied During Prescreening:

- (A) Claims are denied because manual prescreening procedures have detected missing or incorrect data which makes the claim(s) unacceptable.
- (B) Claims denied in this process are mailed back to providers of origination with a brief explanation of the reason(s) for denial.
- (C) Claims denied during prescreening must be corrected and, if necessary, retyped before resubmitting them to the department. Use the billing date of the denied claim. Do not submit copies. Mail the corrected hard copy claim(s) to the Ohio Department of Human Services' address used for all first-time submittals.

BIN.1006.2 Hard Copy Claims Totally Denied During Computer Processing:

- (A) A totally denied claim is described as one with all charges denied; the paid amount is 0.00.
- (B) Totally denied claims are usually caused by an error or a problem in the header portion of the claim (e.g., invalid recipient billing number, missing diagnosis code, etc.). Totally denied claims are reflected at the end of the remittance advice. Error codes (EOBs), displayed with each claim, indicate the reason(s) for denial. Descriptions of the denial reason appear on the last page of the advice.
- (C) If the reason for the denial can be corrected by the provider, the totally denied claim can be resubmitted by completing a new claim with the necessary corrections and resubmitting it to the regular P.O. box used for original claim submissions.
- (D) If the reason for the denial cannot be corrected by the provider and the provider wishes to contest the reason for the denial, a contested, totally denied claim can be resubmitted by completing a new claim form, using the original billing date of the denied claim and including the transaction control number of the originally denied claim in the remarks block on the invoice and completing the an ODHS 6653 Medical Claim Problem Form. Attach a copy of the remittance advice along with the ODHS 6653 Medical Claim Problem Form and mail to:

Ohio Department of Human Services

Provider Relations Section

P.O. Box 1461

Columbus, Ohio 43266-0161

BIN.1006.3 Hard Copy Claims Partially Denied During Computer Processing:

- (A) A partially denied claim is one on which some line items have been paid and others denied. (A portion of the charges were denied.)
- (B) Claims that are partially denied will appear in the paid claims section of the remittance advice.
- (C) If the reason for the line item denial is something that the provider can correct and the claim is less than one year old, complete a new claim containing just the denied line items with the appropriate corrections and submit it to the department using the regular P.O. box used for submitting original claims. For example, the original claim omitted a required modifier so the provider just needs to complete a new claim form listing the code with the appropriate modifier and mail it with the regular claims.

If the claim is over 365 days from the date of service, the claim must be submitted in accordance with paragraph (D) below.

- (D) If the partially denied claim is over 365 days or the reason for the line item denial is something that cannot be corrected by the provider and the provider wishes to contest the reason for the denial of the line item, the provider must complete a new claim form including the transaction control number of the original claim and complete an ODHS 6653 Medical Claim Problem Form. A copy of the 6653, a copy of the original remittance advice, and any other attachments that may be relevant to the payment of the claim must be attached to the claim and the claim must be mailed to the address listed below. Some examples of a contested line item denial would be: 1) the line item was denied because the recipient was not eligible for the date of service listed for the line item but the provider has a copy of the patient's Medicaid card indicating that the patient was eligible; or 2) the provider uses a modifier as instructed in the handbook but the claim denied for an invalid modifier.

If the claim is over 365 days from the date of service, the provider must request on the ODHS 6653 that the 365 day edit be overridden and provide documentation that the claim was originally submitted to the department prior to the 365 day billing deadline.

Ohio Department of Human Services

Provider Relations Section

P.O. Box 1461

Columbus, Ohio 43266-0161

**BIN.1006.4 Direct Entry Claims Partially or Totally Denied During Computer Processing
(Claims submitted via magnetic tape):**

- (A) Resubmit a corrected claim through your direct-entry agent unless otherwise directed by the department billing instructions; e.g., a denial edit which states that the claim can be submitted only as hard copy.
- (B) If resubmittal is by hard copy, attach a copy of the remittance advice statement with the claim in question highlighted.

BIN.1007. Instructions for Medical Claim Problem Form, ODHS 6653

[Click here to view the ODHS 6653 Medicaid Claim Problem form.](#)

The ODHS 6653, Medical Claim Problem Form is to be used:

- (A) To inquire about the payment status of a claim when at least sixty days after the original claim has been submitted or notification that the claim was crossed over from Medicare;
- (B) To ask for clarification about a problem claim;
- (C) To request assistance in getting a totally denied claim paid, when the reason for the denial is not one that can be corrected by the provider and resubmitted through the regular claims processing system;
- (D) To request assistance in getting a partially denied claim paid, when the reason for the denial is not one that can be corrected by the provider and resubmitted through the regular claims processing system;
- (E) To request assistance in getting a claim paid, when the claim is over 365 days from the date of service and the claim was originally submitted to the department prior to the 365 day billing deadline.

The ODHS 6653 should not be used:

- (A) To request higher reimbursement for a service for which the provider received the maximum reimbursement allowed under Medicaid (as indicated by a allowed source code C) or the services were determined and manually paid by the department;
- (B) To request an adjustment on a paid claim (see instructions for Adjustment Request Form); or
- (C) To correct third-party liability information (see instructions for Health Insurance Fact Form).

Each claim inquiry requires a separate ODHS 6653 form.

Providers may obtain the ODHS 6653 by completing the ODHS 9510, Request For Forms, and mailing it to:

Forms Distribution

2098 Integrity Drive North

Columbus, Ohio 43209

Note: A separate ODHS 6653 form is required for each claim inquiry.

- (A) **PROVIDER INFORMATION DATA:** Please furnish complete information in blocks.
 - Provider's Name: Enter the complete name of the provider.
 - Provider's Address: Enter the complete address of the provider.
 - Contact Person: Enter the full name of the person from the practice who should be contacted if the department needs clarification or additional information.
 - Telephone Number: Enter the telephone number where the contact person may be reached.
- (B) **CLAIM INFORMATION DATA:** Please furnish complete information for all of the blocks.
 - Data Completed: Enter the date the ODHS 6653 form was completed.
 - Provider Number: Enter the seven (7) digit servicing provider number.
 - Group Practice #: Enter the seven digit provider group practice number.
 - Recipient Name: Enter the name of the recipient who received the service.
 - Billing Number: Enter the twelve (12) digit billing number for the recipient who received services.
 - Service/Discharge: Enter the first date of service of the line item in question or the date of discharge.
- (C) **CLAIMS HISTORY INFORMATION:** Enter the 17 digit transaction control number of the problem claim.
- (D) **EOB CODE:** Check the EOB code block(s) related to the denied claim. Note specific instructions.

(E) EXPLANATION: Describe the problem you wish resolved in the explanation section. Send attachments when appropriate (i.e., operative reports, Medicare summary notices, remittance advices, etc.).

When the department receives your ODHS 6653 form, it will be date stamped and forwarded to the Provider Relations Section. The reviewer will research the problem and return an answer to you.

All claims received by the department without the ODHS form will be placed directly into the claims processing system.

ODHS 6653 forms that are improperly completed and/or submitted prior to the sixty (60) day follow-up time frame will be returned to the provider.

BIN.1008. Instructions For Health Insurance Fact Form, ODHS 6614

[Click here to view the ODHS 6614 Health Insurance Fact form.](#)

Information pertaining to third-party insurance coverage on a recipient may be found in the upper right side on the recipient's Medical Assistance Card (i.e., Medicaid Card, Ohio Disability Medical Assistance Card, etc.). Translation of the most common TPL codes may be found in BIN.2001.

When the TPL information on the recipient's card does not match the information provided to you by the recipient and/or by the third party insurer listed on the card or the information you receive on the Medicaid remittance advice indicates that the information on the card does not match the information the department has on file for the recipient, a 6614 should be completed by following the instructions provided in this section and submitted to:

The Bureau of Claims Services

Medical Services Section

Cost Avoidance Unit

P.O. Box 182410

Columbus, Ohio 43218-2410

Below are some examples of a few situations in which the completion of this form would be necessary.

Example 1: The remittance advice indicates the claim has been denied because the recipient has third-party insurance, but you have received a claim denial or some other form of written documentation from the listed third-party insurer that the recipient is not covered by the plan.

Example 2: The Medicaid card shows all the recipient's on the card are covered by a third-party insurance plan, but the patient indicates that only one of the individuals is covered by the plan and you have written documentation from the insurer to support this information.

Example 3: The Medicaid card shows the recipient has third-party insurance, the provider bills the insurance company and received information back indicating that the recipient is not covered by the insurance plan.

Example 4: The Medicaid card does not show the recipient has any third-party insurance but the recipient indicates they do have private insurance coverage, or the provider has documentation private insurance exists.

Example 5: The patient has changed third-party insurance plans but the card still indicates the patient's previous insurance plan.

Providers may order the Health Insurance Fact Form, ODHS 6614, from:

The Ohio Department of Human Services

Inventory Management

2098 Integrity Drive North

Columbus, Ohio 43209

BIN.1008.1 Provider Information

PROVIDER NUMBER: Enter the provider's seven digit Medicaid provider number.

PROVIDER NAME: Enter the name of the provider number associated with the provider number listed above.

ADDRESS: Enter the mailing address where correspondence relating to this form should be mailed to the provider listed above.

CONTACT PERSON: Enter the name of the individual with whom the department should contact if any further information is needed.

PHONE NUMBER: Enter the phone number (including area code) where the contact person may be reached.

BIN.1008.2 Recipient Information

PATIENT'S NAME: Enter the name of the patient for whom the services were rendered.

MEDICAID BILLING #: Enter the twelve (12) digit billing number listed by the patient's name on the patient's medical card (Ohio Medicaid, General assistance, etc.)

NAME OF INSURANCE CARRIER: Enter the complete name of the third party insurance company or entity liable for payment, other than Medicaid or Medicare.

ADDRESS: Enter the complete mailing address of the third party insurance company or other liable entity named above.

PHONE NUMBER: Enter the phone number (including area code) for the third party insurance company or the liable entity named above.

POLICY HOLDER'S NAME: Enter the name of the individual whom the third party insurance company or liable entity deems as the holder of the policy. This will always be an individual person, not a company.

POLICY #: Enter the number assigned to the insurance policy by the carrier. This number may sometimes be the policyholder's social security number.

Note: Never enter the Medicaid or Medicare billing number in the space.

POLICYHOLDER'S SS#: Enter the social security number of the policy holder.

GROUP #: Enter the code number that identifies to the third party insurer or liable entity the group and/or employer through which the insurance policy was issued.

NAME ADDRESS, PHONE NUMBER OF EMPLOYER: If the insurance is offered as a benefit through work or a company plan, enter the name, address, phone number of that company or employer.

VERIFIED POLICY TERMINATION DATE: If the policy has been terminated, enter the date of termination. When you are declaring that a policy has been terminated you must supply supporting documentation from the third party insurer showing the actual termination date (e.g., EOB with a message indicating the specific termination date or a letter from the carrier specifying the termination date).

If new health insurance is being reported to the department please try to get a copy of the recipient's third party insurance card. If you are aware of any other family members being covered on this policy please indicate all the individuals who are covered by this plan on the front of the 6614 form.

BIN.1009. Instructions for Prior Authorization, Form ODHS 3142 (Rev.10/87)

[Click here to view the ODHS 3142 Prior Authorization form.](#)

Reimbursement for some items and/or services covered under the Medicaid program is available only upon prior authorization or payment authorization from the department. Prior authorization means that the department must authorize or approve the payment of an item or service before the provider may submit a bill and receive reimbursement for the item or service. In most situations, approval of items and/or services requiring prior authorization should be obtained from the department by the provider before the services are rendered or the items are delivered. Authorization for reimbursement may be sought after the services or items have been provided, but the provider runs the risk that coverage of the item or service will be denied by the department. Prior authorization or payment authorization must be requested in writing by completing the ODHS 3142 Prior Authorization form and submitting it to the department as explained below.

The provider is responsible for verifying patient eligibility at the date of service by viewing the patient's Medicaid card. Reimbursement of items or services prior authorized by the department is contingent upon the eligibility of the patient at the time of service, a change in coverage or the benefits by any other third-party payers or Medicare, and the department's claim filing time limitations.

OBTAINING THE PRIOR AUTHORIZATION FORM

To order the ODHS 3142, complete the Request For Forms ODHS 9510 and mail to:

Ohio Department of Human Services

Inventory Management

2098 Integrity Drive North

Columbus, Ohio 43209

Note: No phone orders will be accepted.

BIN.1009.1 Completing the Prior Authorization Form

(A) Type of Service: Check appropriate box for the service requiring prior authorization.

(B) Special Programs: Check appropriate box for special programs (if applicable).

(C) Provider Information

Group or Individual Provider Number: Enter 7-digit provider number. Show only one number. The approval, denial, or deferral letter will be sent to the address of the requesting provider.

Contact Person: Enter the name of person completing form.

Provider Name: Enter provider name.

Provider Address: Enter the current provider address.

Provider Telephone Number: Enter provider telephone number.

Date Form Completed: Enter date: MMDDYY.

(D) Recipient Information

Case Number: Enter the first ten (10) digits of the twelve (12) digit number found in the column marked "Billing Number" on the Medicaid card.

Recipient Number: Enter the last two (2) digits of the twelve (12) digit number found in the column marked "Billing Number" on the Medicaid card.

Recipient Age: Enter recipient's age in years.

Case Last Name: Enter the last name corresponding to the Medicaid billing number on Medicaid card.

First Name: Enter the first name corresponding to the Medicaid billing number on the Medicaid card.

Address: Enter the current case address. If the recipient resides in a Long Term Care Facility, enter name and address of facility.

Medicare/BCMH Number: If recipient has Medicare or BCMH coverage, enter corresponding number.

Patient Resides: Check appropriate box. If Long Term Care Facility is checked, give name and address of facility in current address block.

(E) Requested Services

Quantity: Enter two (2) digits indicating quantity of items/procedures (e.g., 01 for single procedure) being requested.

Code: Enter the five (5) character Health Care Financing Administration Common Procedure Coding System (HCPCS) code which corresponds to the service requested.

Usual and Customary Charge: Enter the provider's usual and customary fee for the service or item.

Dates of Previous Services: Enter dates of previous services applicable to this request.

Description: Enter complete description of service or item to be provided (additional information may be attached if necessary). The provider should describe: his/her findings, a detailed plan of treatment, known medical problems, and an itemized listing of usual and customary charges.

Dispensing/Service: If the service or item being requested was rendered or dispensed on an emergency basis prior to submission of this request, enter the date of service.

BIN.1009.2 Submitting the Prior Authorization Form

All requests must be made by submission of a completed ODHS 3142. No telephone requests can be honored. However, in situations where the provider considers a delay to be detrimental, the service may be rendered and approval sought after the fact.

Mail first copy of completed form to:

Ohio Department of Human Services

Medical Operations Section

P.O. Box 1002

Columbus, Ohio 43266-0002

Note: Retain second copy for your file.

BIN.1009.3 Expedited PA Process for HEALTHCHEK Children

The prior authorization process is expedited for HEALTHCHEK (EPSDT-eligible) children seeking medically necessary services that are not routinely covered by Medicaid. The provider should mark the HEALTHCHEK box in the "Check special program" section of the ODHS 3142 and attach documentation to this form. The ODHS 3142 and documentation can either be mailed to the address given above or sent by fax to (614) 752-8387.

BIN.1009.4 Explanation of Prior Authorization Deferral, Approval, and Denial

When a prior authorization request has been processed by the department, the department may request additional information through a notice of deferral. If adequate information has been submitted, the department will issue a letter indicating either approval or denial of the requested services.

A deferred request indicates that the department has not yet made a final decision on the request. A request will be deferred when the information submitted on the PA form is incorrect or incomplete. The deferral notice will indicate the problem and/or may request additional information.

Approval letters inform the provider that a requested service/item has been approved for coverage for an eligible Medicaid recipient. The assigned 6-digit prior authorization number must be used on the claim submitted for Medicaid payment (Item 23 of the HCFA 1500 or Item 8 on the ODHS 6780). The recipient name, case number, and recipient number are indicated along with the prior authorization number (PA number). This information should be used on the billing form HCFA 1500 or ODHS 6780. Additionally, specifications are made as to the extent of approval. This includes the date range within which the provider is authorized to provide service (contingent upon the eligibility of the recipient). Also indicated is the amount (AMT) the department has approved for the service, and the quantity (UNITS) of service approved.

All fields on the HCFA 1500 and ODHS 6780, other than the billed charge amount, must be completed as found in the prior authorization approval letter. Providers should enter their usual and customary fee in the billed charge field. Any discrepancy between information contained in the approval letter and information entered on the claim form (with the exception of billed charges) will cause rejection of the claim.

Denial of a service informs the provider that the department will not pay for the service as requested. This letter lists the recipient name, case number, and recipient number along with a PA number (for reference only). It informs the provider of the code, description of the service, and reason for denial. The recipient and the county department of human services will also receive notification.

BIN.1100. Transportation Services Billing Instructions

This section contains billing instructions that are specific to transportation and dental services. Transportation and dental services claims are billed on the ODHS 6780. Transportation providers should see section BIN.1003. for instructions on completing the ODHS 6780 for **Medicare / Medicaid Crossover** and refer to preceding sections for instructions on how to complete other ODHS forms.

*Note: Transportation and dental services are **never** billed on the HCFA 1500 billing form.*

BIN.1101. Medicaid Claim Form 6780 for Medical Transportation Services

[Click here to view the ODHS 6780 Claim Form.](#)

Complete the ODHS 6780 by following these instructions for services rendered to Medicaid patients. (To obtain Medicare co-insurance and deductible for services provided to a patient eligible for both Medicare and Medicaid, following the ODHS 6780 billing instructions for Medicaid/Medicare Crossover-Section BIN.1003.)

Item 1. PROVIDER'S NAME AND ADDRESS: The provider's name, mailing address, city, state, and zip code must be typed on each invoice.

Item 2. PROVIDER NUMBER: Enter the seven (7) digit Medicaid Provider Number assigned to the Medical Transportation Provider or individual dentist who performed the services. This must be completed for payment.

Item 3. GROUP NUMBER: Leave Blank.

Dental: If billing for a group practice, enter the seven (7) digit Medicaid Provider Number assigned to the group. Item 2 (Individual Provider number of the servicing provider) must also be completed when billing for a group practice.

Item 4. PROVIDER SERVICE CODE: Enter a CAPITAL LETTER "A" in Item 4. Also a large capital letter "A" must be handwritten or typed in the provider service code block located in the upper left hand corner.

Dental: Enter a CAPITAL LETTER "I" in Item 4. Also a large capital letter "I" must be handwritten or typed in the provider service code block located in the upper left hand corner.

Item 5. MEDICAL RECORD NUMBER: (optional) This is for provider's use in identifying patients and allows use of up to nine numbers or letters (no other characters are allowed). If used, this number will appear on the remittance advice under "Med Rec".

Item 6. PATIENT'S LAST NAME: Enter the last name of the patient. USE CAPITAL LETTERS ONLY.

Item 7. PATIENT'S FIRST NAME: Enter the first name of the patient. USE CAPITAL LETTERS ONLY.

Item 8. PRIOR AUTHORIZATION NUMBER: Complete only if Prior Authorization is required for the services billed. Use the ODHS assigned six (6) digit number from the approved Prior Authorization notification. Deleted sentence here.

Dental: (See Explanation of Prior (payment) Authorization Approval - Section III).

Item 9. BILLING NUMBER: Enter the 12 digit billing number from the patient's Medical Card (Ohio Medicaid, Disability Assistance, etc.). Do not use any number other than the one designated on the medical card as "Billing Number".

Item 10. PRIMARY DIAGNOSIS CODE: Leave blank.

Item 11. REFERRAL NUMBER: Physician Certification: Except in instance of Ambulance Transportation to a hospital emergency room in an emergency situation; e.g., as a result of accident, injury or acute illness, all ambulance and ambulette services must be certified by a physician as medically necessary. An explanation of the need for service must be entered in the remarks section and signed by the attending or ordering physician. Enter the Medicaid provider number of the attending or ordering physician.

Dental: If the patient was referred to you, enter the referring provider's number. If the referring provider's number is not available, enter 9111115 in this space and the referring provider's name and address in the "Remarks" section.

Item 12. EPSDT INDICATION: Leave blank.

Dental: Enter a CAPITAL LETTER "Y" if the service rendered is a follow-up EPSDT service. Enter a CAPITAL LETTER "N" if the service is not a follow-up EPSDT service.

Item 13. FAMILY PLANNING: Leave blank.

Item 14. ACCIDENT RELATED: Leave blank.

Dental: Enter a CAPITAL LETTER "Y" if the service rendered was a result of an accident.. Enter a CAPITAL LETTER "N" if the service rendered was not a result of an accident.

Item 15. OTHER SOURCE: If you have received payment for the service from a source other than Medicare, please enter the appropriate one (1) character code found below:

OTHER SOURCE CODES

- 1 = Self/Family
- 2 = Blue Cross/Blue Shield
- 3 = Private Carrier
- 4 = Employer or Union
- 5 = Public Agency
- 6 = Other (enter the name and address of source in provider remarks section)

If you have not received payment, but there are indications of health insurance coverage in the case or if you have received a denial for the entire claim, please enter the appropriate one (1) character reason code found below:

- R - No response from carrier. Means no response from the insurance carrier for 90 days. A claim with this code may not be submitted until 91 days after the date of treatment.
- P - No coverage for this recipient number. Means that the provider has confirmed that there is health insurance for some members of the Medicaid case, but the particular patient is not covered.
- F - No coverage for all recipient numbers. Means that there is no health insurance for any member of the Medicaid case.
- L - Disputed or contested liability. Means that the provider has confirmed that there is health insurance, but the coverage for the billed service is disputed or contested by the insurance carrier.
- S - Non-covered services. Means that the provider has confirmed that there is health insurance, but the policy does not cover the services being billed. This code should also be used when the amount billed has been applied to the insurance deductible.
- E - Insurance benefits exhausted. Means that the provider has confirmed that there is health insurance, but the policy benefits for the billed services have been exhausted.
- X - Non-cooperative Recipient. Means that the provider has confirmed that there is health insurance, but the patient refused to cooperate in collection effort.

Note: Documentation to justify use of codes R, P, F, L, S, E, and X must be retained for future audit purposes.

If you have not received payment from another source and there is no indication of health insurance coverage for the case, leave this item blank.

Item 16. SECONDARY DIAGNOSIS: Leave blank.

Note: The body of this invoice consists of twelve (12) numbered lines and eight (8) alphabetized columns. The following instructions are the same for all twelve lines.

Column A SERVICE DATE: Enter the six-digit dates of service (MMDDYY) in chronological order (first to last). Enter all six characters consecutively without dashes, slashes, or spaces; example: 060796 = June 7, 1996.

Note: All services must be billed to Medicaid within 365 days of the service date.

Note: The recipient must be eligible at the time of service.

Column B SERVICE CODE: Enter the 5 character Health Care Financing Administration Common Procedure Coding System (HCPCS) code which corresponds to the service rendered. **A 2 character (alpha/numeric) modifier will be required on all transportation service codes** (see AMB.1100.). **When entering a code with a modifier, enter all seven (7) characters consecutively without dashes or spaces.** Section II of this Chapter should be referenced for the appropriate use of modifiers.

Column C Leave blank.

Dental: Enter the appropriate code number for the location at which the service was provided. Refer to Section I for place of service guidelines.

- 01 - Office
- 02 - Home
- 03 - Inpatient Hospital
- 04 - Outpatient Hospital
- 05 - Emergency Room
- 06 - Clinic
- 07 - Mobile Unit
- 08 - Ambulatory Surgery Center
- 09 - Nursing Home ECF
- 10 - Other. If code is used, explain in the remarks section.

Column D

Leave blank.

Column E

UNITS OF SERVICES: For loaded mileage codes, enter the total number of loaded miles. For all other codes, enter a "1".

Dental: Leave Blank

Column F

Leave blank.

Dental: Tooth/Number/Letter: Enter the appropriate tooth number or letter found below. Use tooth numbers on permanent teeth and tooth letters on primary teeth. Use CAPITAL LETTERS on primary teeth. Use two (2) digits for the tooth number, example: 02. A supernumary tooth can be identified as "SN".

[Click here to view the tooth numbering guide.](#)

Column G

TIME: Enter the pick-up time in military style with no breaks between numbers. Example: 1500 = 3:00 p.m

Dental: Tooth Surface: Enter surface(s) involved for all restorations. Use the following CAPITAL LETTER(S) ONLY for the surface(s) involved:

- M - Mesial
- L - Lingual
- F - Facial
- O - Occlusal
- D - Distal
- I - Incisal
- B - Buccal

Column H

CHARGES: Enter your usual and customary fee for the service.

Item 17. **BILLING DATE:** Enter the invoice preparation date. Use six (6) digit format. Example: 060796 = June 7, 1996.

Item 18. **APPROVED AMOUNT:** Leave blank.

Item 19. **DEDUCTIBLE:** Leave blank.

Item 20. **CO-INSURANCE:** Leave blank.

Item 21. **TOTAL CHARGE:** Enter the total charge for all services on this invoice. This number should be the sum of all charges in Column H.

Item 22. **OTHER SOURCE AMOUNT:** Enter the amount collected from all sources **other than Medicare**. If the amount collected from all sources **other than Medicare** exceeds the maximum payment that Medicaid will make for the service, Medicaid will not make any additional payment. (When an amount is entered in this Item, Item 15 must also be completed.) For claims involving Medicare coverage, see Medicaid/Medicare Crossover ODHS 6780 billing instructions.

Item 23. **NET CHARGE:** Enter the difference between the total charge (Item 21) and the amount received from other sources (Item 22).

Item 24. **CONSENT DATE:** Leave blank.

Item 25. DATE PAID BY MEDICARE: Leave Blank

REMARKS - FOR PROVIDER USE: This section may be used to clarify information on this invoice.

PROVIDER CERTIFICATION: The signature of the provider rendering the services billed on this invoice is required.

MAILING INSTRUCTIONS: Remove perforated strips and separate invoices. Retain and file yellow copy of completed invoice for your files.

Mail the original (pink) invoice when completed to:

Ohio Department of Human Services

P.O. Box 2644

Columbus, OH 43266-0044

DO NOT FOLD INVOICE

BIN.1102. Instructions for Completing the ODHS 3452 Physician Certification Form

[\[OAC cite: Rule 5101:3-15-02 effective 10-1-97\]](#)

[Click here to view the ODHS 3452, Physician Certification Form.](#)

1. **Transport Company Name** - Enter the name of the company providing transportation.
2. **Date of Service** - Enter the date(s) of service.
3. **Transport Company Address** - Enter the address of the company providing transportation.
4. **Time of Pick-up** - Enter the time of the transport.
5. **Provider's Medicaid Number** - Enter 7-digit provider number for the transporting company.
6. **Telephone Number** - Enter the telephone number of the transporting company.
7. **Patient's Name** - Enter the name of the patient being transported.
8. **Date of Birth** - Enter the patient's date of birth.
9. **Medicaid Billing Number** - Enter the patient's Medicaid Billing Number as it appears on their Ohio Medicaid card.
10. **Patient's Address** - Enter the address of the patient being transported.
11. **Medicare Number** - Enter the patient's Medicare number. (if applicable)
12. **Pick up Location (Complete Address)** - Enter the location of the patient when picked up.
13. **Destination Location (Complete Address)** - Enter the location where the patient is to be taken.
14. **Justification if services provided is more than 50 miles from patient's residence.** - Enter the reason why the patient requires transportation more than 50 miles one way or 100 miles round trip.
15. **What medical service was performed at destination?** - Enter the type of service the patient is to receive at the destination location.
16. **Give Primary Diagnosis/Complaints and Description of Current Illness/Injury** - Enter a complete description of the current illness or injury that has rendered the patient nonambulatory. (Nonambulatory is defined in Rule 5101:3-15-03 of the Ohio Administrative Code and in section AMB.1104. of the Transportation Handbook)
17. **Check the Appropriate Items** - Check only the boxes that apply to patient at the time of transport. (More than one box can be checked.)
18. **Provide Further Information** - Provide detailed information as to why the patient cannot be transported by common carrier or wheelchair vehicle (ambulette), and if bed confined list diagnosis.
19. **Type of Transportation Needed** - Check one box only. (ie. Common carrier or ambulette or ambulance)
20. **Signature of Attending Physician** - The doctor ordering the treatment should sign here. If he/she is not available, a registered nurse, upon the doctor's verbal or telephone orders, can sign the doctor's name and initial the signature.
21. **Date** - Enter the date the form was signed.
22. **Physician's Name Printed** - Enter the printed name of the signing physician.
23. **Physician's Provider #** - Enter the attending physician's Ohio Medicaid provider number.

[BIN.1200. Vision Care Billing Instructions](#)

This chapter contains billing information specific to vision care services. Please see [BIN.1002.](#) for instructions for completing the HCFA 1500 billing form, [BIN.1003.](#) for instructions for completing the ODHS 6780 for Medicare / Medicaid Crossover and preceding sections for instructions on completing other ODHS forms.

BIN.1201. Billing for Professional Vision Care Services

Professional vision care services must be billed by the provider to the Ohio Department of Human Services on the HCFA 1500, using the appropriate CPT or HCFA level code.

Professional vision care services include:

- comprehensive and intermediate vision examinations
- special ophthalmological diagnostic and treatment services
- Evaluation and Management services
- eyeglass fitting services
- contact lense and ocular prosthetic fitting services

BIN.1202. Materials Not Covered Under the Vision Volume Purchase Contract

Refer to Section VIS.1113 for a list of materials not covered under the vision volume purchase contract. These materials must be billed by the provider to the Ohio Department of Human Services on the HCFA 1500, using the appropriate CPT or HCFA level code.

BIN.1203. Modifiers

A modifier is required when billing for certain vision care services provided in a hospital setting (i.e., inpatient, outpatient, or emergency room). These services include a "professional" component and a "technical" component. When the services are provided in a hospital setting, the professional component must be reported separately by adding the modifier "26" to the usual billing code when the provider (optometrist or ophthalmologist) submits a claim. The technical component of a service performed in a hospital setting can only be billed by the hospital.

The following ophthalmology service codes require modifiers:

92060	92065	92082	92081	92083
92235	92250	92270	92265	92275
92280	92283	92285	92284	92286

When these codes are provided in a non-hospital setting, providers (optometrists and ophthalmologists) may:

- bill the procedure code without a modifier when both the professional and technical components are performed by the provider, or
- if the professional component only, or the technical component only are performed, bill the procedure code with the "26" and "TC" modifier depending on which component, professional or technical, is provided.

BIN.2001. Third Party Carriers Information, Top Insurance Companies Listed in Code Number Order

THIRD PARTY CARRIERS INFORMATION

TOP INSURANCE COMPANIES LISTED IN CODE NUMBER ORDER

ABBREVIATIONS	CODE	COMPANY NAME	ADDRESS	CITY	ST	ZIP	
ARP	00570	AMERICAN ASSOCIATION OF RETIRED PERSONS	P.O.BOX 13999	PHILADELPHIA	PA	19103	
AMERICAN POSTAL WORKERS	00570	AMERICAN POSTAL WORKERS	P.O. BOX 967	SILVER SPRINGS	MD	20910	
AETNA	01260	AETNA LIFE INSURANCE COMPANY	P.O. BOX 16516	COLUMBUS	OH	43216	
BANKERS LIFE	01900	BANKERS LIFE AND CASUALTY	444 WEST LAWRENCE AVE	CHICAGO	IL	60630	
BENEFIT MGT	02312	BENEFITS MANAGEMENT	44 INDUSTRIAL WAY	NORWOOD	MA	2062	
BENEFIT PLANS	02340	BENEFITS PLANS INC	1474 GRANDVIEW, DRAWER 12477	COLUMBUS	OH	43212	
BENEPLAN TRAT	02360	BENEPLAN STRATEGIES	P.O. BOX 1391	DAYTON	OH	45401	-139
CENTRAL STATES	02980	CENTRAL STATES SE and SW	8550 BRYN MAWR AVE	CHICAGO	IL	60631	
CHAMPUS/BC/BS	03040	CHAMPUS-BC/BS OF INDIANA	P.O. BOX 3059	COLUMBUS	IN	47202	
CONNECTICUTT GENERAL LIFE	04050	CONNECTICUTT GENERAL LIFE	GROUP HEALTH CLAIMS	HARTFORD	CT	6152	
EMERALD HEALTH NETWORK	05036	EMERALD HEALTH NETWORK	P.O. BOX 6946	CLEVELAND	OH	43216	
EMPLOYEES BENEFIT MGMT CORP	05122	EMPLOYEES BENEFIT MANAGEMENT CORP	4789 RINGS ROAD	DUBLIN	OH	43017	-075
EQUITABLE LIFE ASSURANCE	05250	EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES	P.O. BOX 16782	COLUMBUS	OH	43216	
GENERAL AMERICAN LIFE INS CO	06850	GENERAL AMERICAN LIFE INSURANCE COMPANY	P.O. BOX 396	ST. LOUIS	MO	63166	
GOODYEAR TIRE and RUBBER	07422	GOODYEAR TIRE and RUBBER COMPANY	1144 EAST MARKET STREET	AKRON	OH	44316	
GOVERNMENT	07440	GOVERNMENT EMPLOYEES	P.O. BOX 10304	KANSAS CITY	MO	64111	

LIFE INSURANCE		HOSPITAL ASSOCIATION					
GREAT WEST LIFE ASSUR	07750	GREAT WEST LIFE ASSURANCE	135 SOUTH LASALLE ST, SUITE 1042	CHICAGO	IL	60603	
GUARDIAN LIFE INSURANCE	08050	GUARDIAN LIFE INSURANCE COMPANY OF AMERICA	P.O. BOX 8014	APPLETON	WI	54913	
HOSPITAL SERV ASSOC	08590	HOSPITAL SERVICE ASSOC. (HSA) MEDICAL BENEFITS MUTUAL	P.O. BOX 1009	NEWARK	OH	43055	
JOHN HANCOCK	09900	JOHN HANCOCK MUTUAL INSURANCE	P.O. BOX 111	BOSTON	MA	2177	
LIBERTY LIFE ASSO	10350	LIBERTY LIFE ASSURANCE COMPANY	175 BERKELEY STREET	BOSTON	MA	2117	
LINCOLN NAT'L LIFE INS CO	11000	LINCOLN NATIONAL LIFE INSURANCE COMPANY	P.O. BOX 2249	GREEN BAY	WI	54344	
MAIL HANDLERS BENEFIT PLAN	11290	MAIL HANDLERS BENEFIT PLAN	P.O. BOX 6222	ROCKVILLE	MD	20850	
METROPOLITAN LIFE INS CO	11290	METROPOLITAN LIFE INSURANCE COMPANY	1 MADISON AVENUE	NEW YORK	NY	10010	
MASS MUTUAL LIFE INS CO	11700	MASSACHUSETTES MUTUAL LIFE INSURANCE COMPANY	P.O. BOX 15628	SPRINGFIELD	MA	115	
MCELROY MINISTER CO	11740	MCELROY MINISTER COMPANY	141 EAST TOWN STREET	COLUMBUS	OH	43215	-5169
MUTUAL HEALTH SERVICE CO	12760	MUTUAL HEALTH SERVICES INC.	P.O. BOX 94601	CLEVELAND	OH	44101	-1902
MUTUAL OMAHA	12899	MUTUAL OF OMAHA INSURANCE COMPANY	MUTUAL OF OMAHA PLAZA	OMAHA	NE	38175	
NAT'L ASSOC LETTER CARR	13010	NATIONAL ASSOCIATION OF LETTER CARRIERS	11111 SUNSET HILLS ROAD	RESTION	VA	22093	
NATIONWIDE LIFE INS CO	13700	NATIONWIDE LIFE INSURANCE COMPANY	P.O. BOX 2399	COLUMBUS	OH	43216	
NEW YORK LIFE INSURANCE CO	13850	NEW YORK LIFE INSURANCE COMPANY	51 MADISON AVENUE	NEW YORK	NY	10010	
PHYSICIANS MUTUAL INS	15660	PHYSICIANS MUTUAL INSURANCE COMPANY	P.O. BOX 3313	OMAHA	NE	68103	
PROVIDENT LIFE and CASUALTY	16301	PROVIDENT LIFE and CASUALTY	25 MERCHANT STREET, SUITE 10	CINCINNATI	OH	45240	
PRUDENTIAL INS CO	16600	PRUDENTIAL INSURANCE COMPANY/AMER	P.O. BOX 44059	JACKSONVILLE	FL	32231	
STATE FARM INS CO	17918	STATE FARM INSURANCE COMPANY	1440 GRANVILLE ROAD	NEWARK	OH	43093	-000

RAVELERS	18900	TRAVELERS INS CO, RAILROAD EMPLOYEES	P.O. BOX 1200	LANSING	IL	60438	
RAVELERS	18900	TRAVELERS INSURANCE COMPANY	ONE TOWER SQUARE	HARTFORD	CT	6115	
UNION FIDEL	19150	UNION FIDELITY INSURANCE COMPANY	4850 STREET ROAD	TREVOSE	PA	19049	
LUECROSS/BLU SHIELD	22405	COMMUNITY MUTUAL INSURANCE CO	1351 WILLIAM TAFT ROAD	CINCINNATI	OH	45206	
LUECROSS/BLU SHIELD	32404	BLUE CROSS and BLUE SHIELD NORTHWEST	P.O. BOX 943	TOLEDO	OH	43656	
LUECROSS/BLU SHIELD	42403	COMMUNITY MUTUAL INSURANCE CO	6740 N. HIGH STREET	WORTHINGTON	OH	43085	
LUECROSS/BLU SHIELD	42404	BC/BS OF OH WESTERN DIV, WEST CENTRAL REGION	P.O. BOX 14646	DAYTON	OH	45414	
LUECROSS/BLU SHIELD	42405	CENTRAL BENEFITS MUTUAL and CASUAL INSURANCE CO	P.O. BOX 16526	COLUMBUS	OH	43216	
LUECROSS/BLU SHIELD	52405	BLUE CROSS and BLUE SHIELD	P.O. BOX 8590	CANTON	OH	44771	
MIC	62405	COMMUNITY MUTUAL INSURANCE CO	2400 MARKET STREET	YOUNGSTOWN	OH	44507	
MCDONOUGH CAPERTON	66263	MCDONOUGH/CAPERTON EMPLOYEE BENEFITS	P.O. BOX 3262	CHARLESTON	WV	25332	
LUECROSS/BLU SHIELD	82405	BLUE CROSS and BLUE SHIELD OF NORTHERN OH and NORTHEAST	2066 E. NINETH STREET	CLEVELAND	OH	44115	

NOTE: For codes not listed above, the provider must check with the recipient to determine insurance coverage information

BIN.2001.1 Third Party Carriers Information, Top Insurance Companies Listed in alphabetical Order by Company Name

THIRD PARTY CARRIERS INFORMATION

TOP INSURANCE COMPANIES LISTED IN CODE NUMBER ORDER

ABBREVIATIONS	CODE	COMPANY NAME	ADDRESS	CITY	ST	ZIP	
ARP	00570	AMERICAN ASSOCIATION OF RETIRED PERSONS	P.O.BOX 13999	PHILADELPHIA	PA	19103	
AMERICAN POSTAL WORKERS	00570	AMERICAN POSTAL WORKERS	P.O. BOX 967	SILVER SPRINGS	MD	20910	
AETNA	01260	AETNA LIFE INSURANCE COMPANY	P.O. BOX 16516	COLUMBUS	OH	43216	
BANKERS LIFE	01900	BANKERS LIFE AND CASUALTY	444 WEST LAWRENCE AVE	CHICAGO	IL	60630	
BENEFIT MGT	02312	BENEFITS MANAGEMENT	44 INDUSTRIAL WAY	NORWOOD	MA	2062	
BENEFIT PLANS	02340	BENEFITS PLANS INC	1474 GRANDVIEW, DRAWER 12477	COLUMBUS	OH	43212	
BENEPLAN TRAT	02360	BENEPLAN STRATEGIES	P.O. BOX 1391	DAYTON	OH	45401	-139
CENTRAL STATES	02980	CENTRAL STATES SE and SW	8550 BRYN MAWR AVE	CHICAGO	IL	60631	
CHAMPUS/BC/BS	03040	CHAMPUS-BC/BS OF INDIANA	P.O. BOX 3059	COLUMBUS	IN	47202	
CONNECTICUTT GENERAL LIFE	04050	CONNECTICUTT GENERAL LIFE	GROUP HEALTH CLAIMS	HARTFORD	CT	6152	
EMERALD HEALTH NETWORK	05036	EMERALD HEALTH NETWORK	P.O. BOX 6946	CLEVELAND	OH	43216	
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EQUITABLE LIFE ASSURANCE	05250	EQUITABLE LIFE ASSURANCE SOCIETY OF THE UNITED STATES	P.O. BOX 16782	COLUMBUS	OH	43216	
GENERAL AMERICAN LIFE INS CO	06850	GENERAL AMERICAN LIFE INSURANCE COMPANY	P.O. BOX 396	ST. LOUIS	MO	63166	
GOODYEAR TIRE and RUBBER	07422	GOODYEAR TIRE and RUBBER COMPANY	1144 EAST MARKET STREET	AKRON	OH	44316	

GOVERNMENT LIFE INSURANCE	07440	GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION	P.O. BOX 10304	KANSAS CITY	MO	64111	
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LIBERTY LIFE ASS CO	10350	LIBERTY LIFE ASSURANCE COMPANY	175 BERKELEY STREET	BOSTON	MA	2117	
LINCOLN NAT'L LIFE INS CO	11000	LINCOLN NATIONAL LIFE INSURANCE COMPANY	P.O. BOX 2249	GREEN BAY	WI	54344	
MAIL HANDLERS BENEFIT PLAN	11290	MAIL HANDLERS BENEFIT PLAN	P.O. BOX 6222	ROCKVILLE	MD	20850	
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RAVELERS	18900	TRAVELERS INSURANCE COMPANY	ONE TOWER SQUARE	HARTFORD	CT	6115	
UNION FIDEL	19150	UNION FIDELITY INSURANCE COMPANY	4850 STREET ROAD	TREVOSE	PA	19049	
BLUECROSS/BLU SHIELD	22405	COMMUNITY MUTUAL INSURANCE CO	1351 WILLIAM TAFT ROAD	CINCINNATI	OH	45206	
BLUECROSS/BLU SHIELD	32404	BLUE CROSS and BLUE SHIELD NORTHWEST	P.O. BOX 943	TOLEDO	OH	43656	
BLUECROSS/BLU SHIELD	42403	COMMUNITY MUTUAL INSURANCE CO	6740 N. HIGH STREET	WORTHINGTON	OH	43085	
BLUECROSS/BLU SHIELD	42404	BC/BS OF OH WESTERN DIV, WEST CENTRAL REGION	P.O. BOX 14646	DAYTON	OH	45414	
BLUECROSS/BLU SHIELD	42405	CENTRAL BENEFITS MUTUAL and CASUAL INSURANCE CO	P.O. BOX 16526	COLUMBUS	OH	43216	
BLUECROSS/BLU SHIELD	52405	BLUE CROSS and BLUE SHIELD	P.O. BOX 8590	CANTON	OH	44771	
MIC	62405	COMMUNITY MUTUAL INSURANCE CO	2400 MARKET STREET	YOUNGSTOWN	OH	44507	
MCDONOUGH CAPERTON	66263	MCDONOUGH/CAPERTON EMPLOYEE BENEFITS	P.O. BOX 3262	CHARLESTON	WV	25332	
BLUECROSS/BLU SHIELD	82405	BLUE CROSS and BLUE SHIELD OF NORTHERN OH and NORTHEAST	2066 E. NINETH STREET	CLEVELAND	OH	44115	

NOTE: For codes not listed above, the provider must check with the recipient to determine insurance coverage information

BIN.2002. Allowed Charge Source (Indicates how the allowed charge was determined)

ALLOWED CHARGE SOURCE	
(Indicates how the allowed charge was determined)	
CODE	DEFINITION
A	MANUALLY PRICED
B	BY REPORT
C	MAXIMUM FEE
D	INPATIENT PERCENT OF CHARGES
E	HOME HEALTH REVENUE CODE
F	DIAGNOSIS RELATED GROUP
G	BILLED CHARGE
H	OUTPATIENT PERCENT OF CHARGES
I	MEDICARE COINSURANCE AND DEDUCTIBLE
J	ENCOUNTER CODE
K	DENIED
L	CAPITATION RATE
M	OUTPATIENT LAB MAXIMUM FEE
N	NEGOTITATED RATE
O	DRG FILE
P	DRUG FILE
Q	NURSING HOME PER DIEM RATE
R	MENTAL HEALTH PER DIEM RATE
S	DRG PER DIEM DATE
T	NO PAY
U	DRG NORMAL
V	DRG HIGH DAY
W	DRG HIGH COST

X	DRG TRANSFER
Y	DRG CHECK NOT APPROVED
Z	PRIOR AUTHORIZATION
1	IN OFFICE SURGERY
2	OUTPATIENT SURGERY
3	AMBULATORY SURGERY CENTER
4	REDUCED NOT TO EXCEED LIMIT
5	LIMIT BY UNITS OF SERVICE
6	OUTPATIENT DRUG EXCEPTION
7	OUTPATIENT ROLL IN
8	OUTPATIENT PROCEDURE PERCENT OF PAYMENT

BIN.2003. Adjustment Reason Codes (Indicates the reason for crediting or adjusting the claim)

ADJUSTMENT REASON CODES		
(Indicates the reason for crediting or adjusting the claim)		
REMITTANCE VALUE	REMITTANCE DESCRIPTION	EXPLANATION
AA	Lien amount paid to provider.	The code is used for the payment to the pay to provider (i.e. IRS or other legal agency).
AB	Lien amount taken from the Medicaid provider.	The code is used for the credit deduction for the Medicaid provider in which the lien is taken against.
AG	Certified to Office of the Attorney General.	Claim referred for legal action.
BB	The Medicaid recoupment amount is temporarily suspended.	The code is used when the recoupment is temporarily suspended. Both the check amount and percent is set to zero until the recoupment process is to resume.
01	Payment is incorrect due to miscalculation in the day/cost outlier or the day/cost outlier amount was not paid.	The code is used when the payment was incorrect due to a miscalculation in the day/cost outlier amount or the day/cost outlier amount was not included in the payment.
02	The paid claim has overlapping service dates with another paid claim.	The code is used when the paid claim has overlapping service dates with another paid claim. The adjustment is processed to deduct payment. The provider needs to collapse the bills.
03	The claim is paid through the adjustment section as an exceptional cost outlier payment.	The code is used to pay a hospital claim that qualifies for an exceptional cost outlier payment. The criteria is the adjusted charges must exceed \$250,000. The payment is hand calculated by the adjustment section.
04	The claim is paid through the adjustment section because an ungroupable organ transplant service was performed.	The code is used to pay a hospital claim for an ungroupable transplant service. The payment is hand calculated by Provider Relations and forwarded to the Adjustment Section.

05	The claim is an interim payment. The final bill (admit through discharge) has been submitted to be paid.	The code is used on a claim to deduct a hospital interim payment because the final bill (admit through discharge) has been submitted for payment.
06	The provider billed a revenue center code in error or erroneously omitted it in the original	The code is used on a claim to add or correct a revenue center code as requested by the provider. Late charges can be added only for a DRG hospital and when payment will be affected.
07	Information shown on the original invoice differs from that on the remittance advice.	The code indicates that the department has erroneously altered the claim data which affected the payment and caused the information on the remittance advice to differ from that on the invoice. Two reasons would be: 1) data entry error; 2) scanner error. The adjustment is processed to correct the error.
08	The surgery claim has been reviewed by the medical consultant unit (MTA).	The code is specifically assigned to all claims reviewed by the medical consultant (MTA) unit for a change in payment.
09	The patient has exceeded the number of visit limitations.	The code indicates the recipient has exceeded the maximum number of visits allowed within a given time frame to a particular provider type. The adjustment is to deduct payment.
10	The patient has either partial or total Medicaid ineligibility for the claim dates of service.	The code indicates the recipient is either totally ineligible or has partial Medicaid eligibility for the claim dates of service. The adjustment is to correct payment accordingly.
11	The provider has received from a third party source subsequent to the Medicaid payment.	The code is used when the provider has received payment from a third party source after receiving payment from Medicaid. The adjustment action is initiated by the provider to reimburse the department.
12	The patient is responsible for the monthly spenddown amount or has paid a portion of the bill.	The code is used when the recipient has a spenddown amount and is financially obligated to pay a portion of the monthly cost incurred. The adjustment is to reimburse the department.

13	The patient has Medicare coverage for the claim dates of service.	The code is used when the recipient is also covered by Medicare for the claim dates of service. Medicare is the primary payor. The adjustment action is initiated by the provider and is to reimburse Medicaid for the total amount of the Medicaid payment made.
14	The provider has either omitted information or billed the incorrect code/modifier/units/minutes, etc.	The code is used when the provider has erroneously omitted information on the invoice or billed the incorrect information (i.e., wrong code, wrong modifier, wrong number of units, etc.).
15	Medicaid payment was made to the wrong provider.	The code is used when the wrong provider has been paid. For instance, payment was made to the servicing group number instead of the individual number or vice versa. The adjustment is processed to deduct a payment from the wrong provider number and/or to reimburse money to proper provider.
16	The claim or line item payment has been paid by Medicaid more than once.	The code indicates more than one (1) payment was made to a provider for the exact claim or line item service. The adjustment is to deduct a payment.
17	More than one deduction has been processed for a particular claim or line item leaving an underpayment to the provider.	The code indicates more than one adjustment action was taken to deduct an erroneous payment for a particular claim or line item service. The adjustment is to reimburse the provider. The code is used exclusively for the department to update the provider history file to reflect a finding due to a cost settlement.
18	The adjustment is due to an audit/cost settlement by the Bureau of Hospital Rates and Audits.	
19	The adjustment is to pay a health maintenance organization for stop-loss.	The code is used exclusively to reimburse HMOs for stop loss in accordance with the risk contract between Medicaid and the servicing HMO.

20	The adjustment is to correct an error made involving a capitation rate to the HMO.	The code is used exclusively to correct an underpayment or overpayment of the monthly capitation payment made to the HMO.
21	The claim has been reviewed by the peer review organization and adjusted accordingly.	The code is used exclusively for the peer review organization (PRO). The PRO has reviewed the hospital claim and the pertaining medical records and found the provider billed the original invoice incorrectly. The adjustment is to correct the claim information to reflect the PRO's findings.
22	The claim was underpaid due to a miscellaneous cause.	The code indicates an underpayment and is assigned to a claim in which the purpose for the adjustment is unspecified in any other reason codes.
23	The claim was paid at the incorrect rate.	The code indicates that the claim was paid at the incorrect reimbursement rate established for the service and/or special rate. The code is to used for all provider types. The adjustment is to correct the payment.
24	Historical data on the paid claim is incorrect.	The adjustment is to correct the history file concerning an error that does not affect payment.
25	The adjustment is due to an audit by the Bureau of Surveillance and Utilization Review.	The code is used exclusively for the department to update the provider history file to reflect an audit finding.
26	The claim was overpaid due to a miscellaneous or undetermined cause.	The code indicates an overpayment and is assigned to a claim which: 1) The provider provided no clear reason for the adjustment request; 2) The purpose for the adjustment is unspecified in any of the other reason codes.
27	The Third Party Section has discovered an existing insurance coverage for the claim dates of services.	The code is used only for the Third Party Section. Third party investigation reveals the provider did not make a reasonable effort to collect from the third party insurance carrier. The adjustment is to deduct payment from the provider.

28	The Third Party Section has discovered an overpayment due to the provider's collection of a payment from another insurance carrier.	The code is used only for the Third Party Unit. Third party investigation finds the provider collected from the company and from Medicaid for a recipient for the same dates of services. The adjustment is to deduct payment from the provider.
29	Touche Ross (contractor) has discovered/recovered Medicaid overpayments relative to Medicare part A, B, or other insurance.	The code is used only for Touche Ross. Touche Ross has discovered/recovered Medicaid overpayments relative to Medicare part A and B, or other insurance.
30	The claim is being reprocessed to the provider. A previous warrant was either cancelled or voided.	The adjustment is to reimburse the provider for services rendered. A previous warrant containing payment for those services were either cancelled or voided resulting in an underpayment to the provider.
31	The warrant for this claim was returned and cancelled.	A warrant is cancelled when the provider returns it to the department within the ninety (90) day deposit limitation. The adjustment is to update the history file to reflect the warrant was returned and cancelled.
32	The warrant for this claim was returned and voided.	A warrant is voided when the provider returns it to the department after the ninety (90) day deposit limitation has expired. The adjustment is to update the history file to reflect the warrant was returned and voided.
33	The claim was force paid in error and it should have been denied.	The code is used to indicate the claim was forced in error and it should have never been paid. The adjustment is forwarded to the Adjustment Unit for deduction.
34	The recipient is covered by a health maintenance organization.	The code is used on a claim to deduct payment from a Medicaid provider for a recipient who is covered by a health maintenance organization.
35	Temporarily unused.	The code is currently not used.
40	The adjustment is to reimburse the provider for the cost of replacing blood.	The code is used on a Medicare crossover claim to reimburse the provider for the cost of replacing blood that was billed on the original invoice but was not included in the payment.

41	The Medicare crossover claim was underpaid due to a miscellaneous cause.	The code indicates an underpayment in a Medicare crossover claim and is assigned to a claim in which the purpose for the adjustment is unspecified in any of the other reason codes.
42	The Medicare crossover claim was overpaid due to a miscellaneous or undetermined cause.	The code indicates an overpayment on a Medicare crossover claim. It was assigned to a claim which: 1) The provider provided no clear reason for the adjustment. 2) The purpose for the adjustment is unspecified in any of the other reason codes.
43	Information on a remittance advice differs from that on the invoice for a Medicare crossover claim.	The code is used on a Medicare crossover claim when the department has erroneously altered claim data causing information on the remittance advice to differ from that on the invoice. Two reasons would be: 1) Date entry error. 2) Scanner error. The adjustment is processed to correct the error.
50	The provider has received payment from a third party source for a Medicare crossover claim.	The code is used on a Medicare crossover claim when the provider received payment from a third party source subsequent to receiving a Medicaid payment. The adjustment is initiated by the provider to reimburse Medicaid.
51	The patient has spenddown or patient resources.	The code is used on a Medicare crossover claim when the patient has a monthly spenddown or resource amount and is financially obligated to pay a portion of the medical cost incurred. The adjustment is to reimburse the department.
52	The adjustment is to correct an error made by Medicare concerning the blood deductible amount owed by Medicare.	The code is used on a Medicare claim to deduct the blood deductible amount paid by Medicaid due to a Medicare error. Medicaid did not owe the blood deductible amount.
53	On a Medicare crossover claim more than one payment has been made for the claim or line item.	The code is used on a Medicare crossover claim to deduct a duplicate payment for a particular claim or line item service.

54	A Medicare crossover claim was deducted more than once for a particular claim or service.	The code is used on a Medicare crossover claim to reimburse the provider for a payment that was deducted more than once.
55	Medicare crossover payment was made to the wrong provider.	The code is used on a Medicare crossover claim when the wrong provider has been paid. For instance: a Medicare carrier error could have caused information to cross over incorrectly resulting in the provider getting paid for a service provided to a patient seen by another provider.
56	The adjustment is to correct an error made by Medicare concerning the coinsurance and/or deductible amount owed by Medicaid.	The code is used on a Medicare crossover and/or deductible amount paid by Medicaid due to a Medicare error. Medicaid did not owe the coinsurance and/or deductible amount.
57	A non dollar error on a Medicare crossover claim.	The code is used on a Medicare crossover claim to indicate a history adjustment that does not effect payment.
58	A crossover claim is being reprocessed to the same provider. A previous warrant was either cancelled or voided.	For a Medicare crossover claim, the adjustment is to reimburse the provider for services rendered. A previous warrant including payment for that service was either cancelled or voided resulting in an underpayment to the provider.
59	The warrant including payment for this Medicare crossover claim was returned or cancelled.	The code is for Medicare crossover claims. The provider returned the warrant to the department within the ninety (90) day deposit limitation. The adjustment is to update the history file to reflect the warrant was returned and cancelled.
60	The warrant including payment for the crossover claim was returned and voided.	The code is used for a Medicare crossover claim. The provider returned it to the department after the ninety (90) day deposit limitation had expired. The adjustment is to update the history file to reflect the warrant was returned and voided.

61	Retroactive eligibility for Medicare part A has been discovered for the patient for the claim dates of service.	The code is used on a claim which Medicaid paid because Medicare part A eligibility did not reflect on the recipient file at the time of payment. The error was systematically discovered and will be corrected by a system generated adjustment.
62	Retro eligibility for Medicare part B has been discovered for the patient for the claim dates of service.	The code is used on a claim in which Medicaid paid because the Medicare part B eligibility did not reflect on the recipient master file at the time of payment. The error was systematically discovered and corrected by a system generated adjustment.
70	LTCF-recoupment of overpaid noncovered days.	Provider was overpaid for noncovered leave days. Recipient has used more than the 30 day covered unit limit.
71	LTCF-recoupment of overpaid days to the provider.	Provider was overpaid for days due to the exit of/or ineligibility of recipient.
72	LTCF-recoupment of patient resources/liability applied towards cost of care.	Provider was overpaid because patient's resources/liability were not previously applied towards the monthly total cost of care.
73	LTCF-recoupment of additional patient resources/liability due to a monthly increase.	Provider was over paid due to a monthly increase of patient resources/liability received towards the cost of care.
74	LTCF-recoupment of lump sum applied to cost of care.	Provider was overpaid due to a lump sum received from recipient to apply to towards total cost of care.
75	LTCF-recoupment of maintenance voucher.	Recoupment of a maintenance voucher issued to a provider to prevent hardship or lack of care for the LTCF patients.
76	LTCF-interim settlement recoupment.	An interim rate decrease was initiated by the department.
77	LTCF-gross adjustment recoupment of retro rate decrease.	The department has initiated a retroactive rate decrease.
78	LTCF-final settlement recoupment.	The department has initiated a final payment settlement for the period of time indicated.
79	LTCF-quarterly settlement recoupment.	The department has initiated a quarterly rate decrease.

80	LTCF-provider has been underpaid days of services provided.	The provider has been underpaid days of service on previous claims processed for dates indicated. The adjustment is to reimburse provider for services rendered.
81	LTCF-provider has been overpaid due to a decrease in a patient's resources/liability.	Provider was underpaid due to a monthly decrease of a patient's resources/liability towards cost of care
82	LTCF-provider has been underpaid due to patient's resources previously reported were not received.	Provider has been underpaid due to the patient's resources/liability being applied.
83	LTCF payment received from provider which is not recipient specific.	The department received a payment from the provider which is not recipient specific to offset monies due to ODHS (i.e., a check to reimburse the department for a final settlement or credit balance).
84	LTCF-interim settlement payment.	The department has initiated an interim rate increase.
85	LTCF-gross adjustment of retro rate increase.	The department has initiated a retroactive rate increase.
86	LTCF-final settlement payment.	The department has initiated a final settlement payment for the period of time indicated.
87	LTCF quarterly rate settlement payment.	The department has initiated a quarterly rate increase.
90	LTCF-penalty due to the late filing of their cost report and /or facility capacity report.	For payment of a penalty for filing their cost report or facility capacity report late.
91	Third party section recovery due to health insurance, lump sums, or estates.	The code is used exclusively for third party section recovery regarding health insurance, lump sums, or estates. The adjustment is to reflect the amount recovered for a particular claim.
92	Third party section recovery due to tort settlements or workers compensation.	The code is used exclusively for a third party recovery regarding tort settlements or workers compensation. The adjustment is to reflect the amount recovered for the particular claim.

93	Third party section has received checks from county child support enforcement agency.	The code is used for paternity collections by the county as a result of court ordered support and paternity suits. The absent parent is responsible for the cost of prenatal, post partum care and regular health care.
94	The LTCF therapeutic covered leave days reimbursed at 50 percent.	Therapeutic covered leave days reimbursed at 50 percent.
95	LTCF-hospital covered leave days reimbursed at 50 percent.	The hospital covered leave days reimbursed at 50 percent.
96	LTCF-combination of hospital and therapeutic covered leave days reimbursed at 50 percent and noncovered leave days.	LTCF-combination of hospital and therapeutic leave days reimbursed at 50 percent and noncovered leave days.
CC	The credit adjustment is a recoupment of interest overpayment.	