

Ohio Home Care Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

The Electronic Publishing Unit makes every attempt to publish accurate and current information, however, we disclaim any liability or responsibility for any typographical errors, out of date information and/or other inaccuracies that may appear in this document.

To receive eMail notifications of policy updates, go to the **ODM Email List Sign-up site** (<http://www.medicaid.ohio.gov/HOME/ODMEmailListSignup.aspx>) and subscribe to the type of communications in which you are interested. eMail notifications are sent as updates are posted to the eManuals site.

eManual Contents

Please send comments to ePubs_updates@jfs.ohio.gov

[Community Services Transmittal Letters \(CSTL\)](#)

[Managed Care Medical Assistance Letters \(MALs\)](#)

[Ohio Home Care Rules](#)

[Ohio Home Care Forms](#)

Medical Assistance Letters

MAL 537

Medical Assistance Letter (MAL) 537

Community Services Transmittal Letter (CSTL) 04-03

September 20, 2007

TO: All Eligible Non-Agency Medicaid Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Suspension of Medicaid Provider Agreements and Changes in Chapter 119 Hearing Rights for Non-Agency Providers that Provide Home and Community-Based Services to Consumers with Disabilities

EFFECTIVE OCTOBER 1, 2007

The purpose of this Medical Assistance Letter (MAL) is to announce that ODJFS shall implement new policies allowing suspension of Ohio Medicaid Provider Agreements and changes in hearing rights provided under Chapter 119. of the Revised Code for certain departmental actions taken against non-agency providers.

Suspension of Ohio Medicaid Provider Agreements (Non-Agency Providers)

Long-term care nursing facilities, intermediate care facilities for the mentally retarded and Medicaid contracting managed care plans are exempt from suspension of provider agreements.

ODJFS shall implement a new policy to suspend Ohio Medicaid Provider agreements upon receiving notice and a copy of an indictment that charges a non-agency Ohio Medicaid provider with committing an act that would constitute any one of the disqualifying offenses specified in division (D) of Section 5111.034 of the Revised Code. This applies to individuals that are providing home and community-based services to consumers with disabilities. The suspension would continue to be in effect until the proceedings in the criminal case are completed through conviction, dismissal of the indictment, plea, or finding of not guilty.

During a suspension, a non-agency Medicaid provider:

- Shall not provide services to Medicaid consumers; and
- Shall not receive reimbursement in the form of direct payments from ODJFS or indirect payments of Medicaid funds in the form of salary, shared fees, contracts, kickbacks, or rebates from or through any participating provider or risk contractor.

ODJFS is not required to provide Chapter 119 hearing rights when a Medicaid provider agreement is subject to suspension. However, a provider subject to a suspension may request a reconsideration.

Proposed ODJFS Actions on Medicaid Provider Agreements Without Appeal Rights

Section 5111.06 of the Revised Code increased the number of circumstances in which ODJFS may deny, terminate, or not renew a Medicaid provider agreement without granting the provider Chapter 119 hearing rights. These circumstances are as follows:

- When a managed care plan or fee-for-service provider fails to hold and/or maintain proper licensures, permits, certificates or certifications as required by the terms of the provider agreement to do business with the Ohio Medicaid program.
- When a provider agreement for a fee-for-service provider has been suspended in accordance with this MAL.
- When a provider agreement for a fee-for-service provider is converted from an open-ended provider agreement to a time-limited provider agreement.
- When a fee-for-service provider fails to properly re-enroll with the Ohio Medicaid program.

- When a fee-for-service provider has not billed or otherwise submitted a Medicaid claim to ODJFS for two years or longer, and the provider has not left a forwarding address with ODJFS.

Additional Information

For more information regarding suspension of Medicaid provider agreements or regarding ODJFS actions to deny, terminate or not renew a Medicaid provider agreement, please visit our website at http://jfs.ohio.gov/OHP/Latest_News.stm.

Effective October 1, 2007, ODJFS has statutory authority to suspend a Medicaid provider agreement or deny, terminate or not renew a Medicaid provider agreement without a Chapter 119 hearing under the circumstances above. Ohio Administrative Code rules will be promulgated in the future to reflect the new statute. The new or amended rules will go through the Clearance and Public Hearing process where testimony regarding the rules may be given.

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll free telephone number: 1-800-686-1516

MAL 532

Medical Assistance Letter No 532 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Ambulatory Surgery Center Services e-book.

[**Click here to view MAL 532, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.**](#)

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

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)

CSTL 10-07 (Amendment of ODJFS-administered Waiver Program Provider Rules)

Community Services Transmittal Letter (CSTL) No. 10-07

October 25, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Amendment of ODJFS-administered Waiver Program Provider Rules

The Ohio Department of Job and Family Services (ODJFS) has rescinded rule 5101:3-45-10 and replaced it with a new rule bearing the same number, and has amended rules 5101:3-46-04 and 5101:3-50-04 of the Administrative Code. Respectively, these rules set forth the provider conditions of participation for the ODJFS-administered waiver program, and the definitions of the covered services and provider requirements and specifications governing Transitions Carve-Out Waivers and the Ohio Home Care Waiver. They became effective on October 25, 2010.

Rule 5101:3-45-10, entitled Conditions of Participation for Ohio Department of Jobs and Family Services (ODJFS) administered Waiver Service Providers, contains the core conditions of participation that a provider must meet in order to furnish Medicaid ODJFS-administered waiver services. This rule replaced rule 5101:3-45-10, which was rescinded because of five-year review.

Rule 5101:3-46-04, entitled Ohio Home Care Waiver Program: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the service definitions, provider requirements and specifications for the delivery of Medicaid Ohio Home Care Waiver services. The rule was amended because of five-year review and to clarify the service-specific requirements an agency or individual must meet in order to be a provider and to submit a claim for reimbursement under the Ohio Home Care Waiver.

Changes include making home delivered meal services and emergency response services consistent with the service specifications and provider requirements recently developed by ODJFS, the Ohio Department of Aging, and the Ohio Department of Developmental Disabilities under the advisement of the Executive Medicaid Management Agency (EMMA). These service specifications and provider requirements will be adopted by each state agency when such services are added or amended.

Rule 5101:3-50-04, entitled Transitions Carve-Out Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the service definitions, provider requirements and specifications for the delivery of Medicaid Transitions Carve-Out Waiver services. The rule was also amended because of five-year review and to clarify the service-specific requirements an agency or individual must meet in order to be a provider and to submit a claim for reimbursement under the Transitions Carve-Out Waiver. The changes are the same as those affecting the Ohio Home Care Waiver.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-45-10 (effective 08/05/2005)	<u>5101:3-45-10</u> (effective 10/25/2010)
5101:3-46-04 (effective 07/01/2006)	<u>5101:3-46-04</u> (effective 10/25/2010)
5101:3-50-04 (effective 07/01/2006)	<u>5101:3-50-04</u> (effective 10/25/2010)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Supports
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

CSTL 10-06 (Amendment of ODJFS-administered Waiver Program Definition Rule)

Community Services Transmittal Letter (CSTL) No. 10-06

October 19, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Amendment of ODJFS-administered Waiver Program Definition Rule

The Ohio Department of Job and Family Services (ODJFS) has amended rule [5101:3-45-01](#) of the Administrative Code. This rule sets forth the ODJFS-administered Waiver program definitions associated with the Ohio Home Care, Transitions DD and Transitions Carve-Out Waivers. Paragraph (QQ) "Plan of Care" is being amended to read as follows:

(QQ) "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 and dated by the treating physician prior to requesting reimbursement for a service. ~~It must include the name(s) of all of the agency and nonagency providers who are working under that plan of care.~~ The plan of care is not the same as the all services plan."

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-45-01 (effective 07/01/2010)	5101:3-45-01 (effective 10/25/2010)

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 transmittal letter and attachments may be viewed as follows:

(1) Select "Ohio Health Plans - Provider" (right column).

- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Long Term Care Services and Support
P.O. Box 182709
Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
(614) 466-6742

CSTL 10-05 (Amendment of HOME Choice [Money Follows the Person] Demonstration Program Rules)

Community Services Transmittal Letter (CSTL) No. 10-05

September 10, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care and Hospice
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Amendment of HOME Choice (Money Follows the Person) Demonstration Program Rules

The Ohio Department of Job and Family Services (ODJFS) has amended rules [5101:3-51-01](#), [5101:3-51-02](#), [5101:3-51-03](#), [5101:3-51-04](#), [5101:3-51-05](#) and [5101:3-51-06](#) of the Administrative Code to clarify policy governing the HOME Choice (Money Follows the Person) Demonstration Program.

These rules set forth HOME Choice Demonstration Program definitions, participant eligibility requirements, provider conditions of participation, service specifications and provider requirements, the provider enrollment process, and service rates and reimbursement procedures. Among the changes are the following:

- Program definitions have been modified to correct terminology and/or offer additional clarity;
- Residential treatment facilities (RTF) have been approved by the Centers for Medicare and Medicaid Services (CMS) as a qualified residence for the purpose of determining HOME Choice participant program eligibility. An RTF, under the HOME Choice Demonstration Program, is a facility greater than 16 beds, or a facility located on a campus of multiple facilities that total more than 16 beds, and that serve children and are licensed as a Type 1 residential facility by the Ohio Department of Mental Health in accordance with rule 5122-30-03 of the Administrative Code.
- Provider conditions of participation have been amended to address documentation requirements, monitoring and oversight, and to clarify and strengthen policy regarding when to notify the case manager or service and support administrator, and what a provider can and cannot do while furnishing HOME Choice services.

- A new respite service has been approved by CMS and added to the HOME Choice Demonstration Program. It can be provided in the HOME Choice participant's home, in an out-of-home setting or in a day camp setting. In-home respite will be reimbursed at a rate of \$9/hour, out-of-home respite will be reimbursed at a rate of \$200/day and camp respite will be reimbursed at a rate of \$125 day or a maximum of \$625/week. Altogether, a HOME Choice participant can receive up to \$2000 in respite services during the 365-day demonstration period.
- Nutritional consultation and social work/counseling have been amended to make them consistent with the service specifications and provider requirements recently developed by ODJFS, the Ohio Department of Aging and the Ohio Department of Developmental Disabilities under the advisement of the Executive Medicaid Management Agency (EMMA). These service specifications and provider requirements will be adopted by each state agency when such services are added or amended.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-51-01 (effective 07/01/2008)	<u>5101:3-51-01</u> (effective 09/09/2010)
5101:3-51-02 (effective 07/01/2008)	<u>5101:3-51-02</u> (effective 09/09/2010)
5101:3-51-03 (effective 07/01/2008)	<u>5101:3-51-03</u> (effective 09/09/2010)
5101:3-51-04 (effective 06/01/2009)	<u>5101:3-51-04</u> (effective 09/09/2010)
5101:3-51-05 (effective 07/01/2008)	<u>5101:3-51-05</u> (effective 09/09/2010)
5101:3-51-06 (effective 06/01/2009)	<u>5101:3-51-06</u> (effective 09 /09/2010)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Additional information about the HOME Choice Demonstration Program can be found at:

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>.

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
 Bureau of Long Term Care Services and Supports
 P.O. Box 182709
 Columbus, Ohio 43218-2709
BLTCSS@jfs.ohio.gov
 (614) 466-6742

CSTL 10-04 (New Home Care Attendant Services Form - JFS 02392, "Designation of Authorized Representative for Home Care Attendant Services")

Community Services Transmittal Letter (CSTL) No. 10-04

July 26, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: New Home Care Attendant Services Form - JFS 02392, "Designation of Authorized Representative for Home Care Attendant Services"

Pursuant to Sections 5111.88 to 5111.8810 of the Revised Code (enacted as part of Am. Sub. H.B. 1 of the 128th General Assembly), the Ohio Department of Job and Family Services (ODJFS) has amended the Ohio Home Care and Transitions Carve-Out waivers to add a new consumer-directed home care attendant service (HCAS) effective July 1, 2010.

Attached is form [JFS 02392](#), "Designation of Authorized Representative for Home Care Attendant Services." The JFS 02392 is the form on which an adult consumer enrolled on the Ohio Home Care or Transitions Carve-Out Waiver grants authority to an individual to assume responsibility for directing the provision of home care attendant services on his or her behalf. It is to be completed and signed by the consumer and the consumer's authorized representative.

Instructions:

Insert

JFS 02392 (effective 07/2010)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

Select "Forms Central" (top right column).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Services and Support

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

CSTL 10-03 (Amendment of ODJFS-Administered Waiver Program Provider Rules)

Community Services Transmittal Letter (CSTL) No. 10-03

June 24, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Amendment of ODJFS-administered Waiver Program Provider Rules

The Ohio Department of Job and Family Services (ODJFS) have amended rules [5101:3-45-01](#), [5101:3-45-03](#), and [5101:3-47-04](#) of the Administrative Code. These rules set forth the program definitions, consumer choice options, and service specifications and provider requirements governing the Transitions DD waivers. They became effective on 07/01/2010.

OAC Rule [5101:3-45-01](#), ODJFS-administered Waiver Program: Definitions, contains key definitions associated with ODJFS-administered waivers. Among the changes are the following:

- The definition of "assurance of health and welfare agreement" has been deleted and replaced with "consumer acknowledgement of risk agreement" to reflect changes in the form used to remedy risks to consumers' health and welfare.
- The definition of "family member" has been removed because that term, as it is used in the Transitions DD Waiver, has been modified to only refer to the legally responsible family member. Likewise, "legally responsible family member" and "non-legally responsible family member" have been amended. With these changes, non-legally responsible family members will be able to be paid providers of personal care aide services, home modification services, supplemental transportation services and waiver nursing services.
- Other definitions have been modified to correct terminology and/or offer additional clarity.

OAC Rule [5101:3-45-03](#), ODJFS-administered Waiver Program: Consumer Choice and Control, sets forth the extent to which a consumer enrolled on an ODJFS-administered waiver has choice and control over the arrangement/direction of his/her home and community-based waiver services, and the selection and control over the direction of the providers of those services. The rule is being amended in order to add the

new home care attendant provider to the definition of "non-agency provider." It is also being amended to update OAC rule cites, and to clarify that if a consumer and/or authorized representative chooses to receive waiver services from a non-agency provider, the consumer and/or authorized representative shall work with the case management agency and the non-agency provider to identify and secure continuing education within the non-agency provider's scope of practice. The consumer may participate in or conduct the continuing education.

OAC Rule 5101:3-47-04, Transitions DD Waiver: Definitions of the Covered Services and Provider Requirements and Specifications, sets forth the definitions of the services covered by the Transitions DD Waiver. Like OAC rule 5101:3-46-04, this rule sets forth the provider requirements and specifications for the delivery of waiver services. The changes are the same as in OAC rule 5101:3-46-04, but they also include the following:

- References to the Transitions MR/DD Waiver have been removed and replaced with Transitions DD Waiver to reflect the change in terminology that has been embraced statewide.
- Non-legally-responsible family members will be permitted to be paid providers of personal care aide services, home modification services, supplemental transportation services and waiver nursing services.

Instructions:

Remove as Obsolete	Insert Replacement
5101:3-45-01 (effective 10/25/2009)	<u>5101:3-45-01</u> (effective 07/01/2010)
5101:3-45-03 (effective 08/13/2007)	<u>5101:3-45-03</u> (effective 07/01/2010)
5101:3-47-04 (effective 07/01/2006)	<u>5101:3-47-04</u> (effective 07/01/2010)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
 Bureau of Long Term Care Services and Support
 P.O. Box 182709
 Columbus, Ohio 43218-2709
 BLTCSS@jfs.ohio.gov
 (614) 466-6742

CSTL 10-02 (New Home Care Attendant Service Forms)

Community Services Transmittal Letter (CSTL) No. 10-02

July 26, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: New Home Care Attendant Service Forms

Pursuant to Sections 5111.88 to 5111.8810 of the Revised Code (enacted as part of Am. Sub. H.B. 1 of the 128th General Assembly), the Ohio Department of Job and Family Services (ODJFS) has amended the Ohio Home Care and Transitions Carve-Out waivers to add a new consumer-directed home care attendant service (HCAS) effective July 1, 2010.

Attached please find three new forms recently created by ODJFS that are to be used in concert with Ohio Administrative Code (OAC) rules 5101:3-46-04.1, 5101:3-46-06.1, 5101:3-50-04.1 and 5101:3-50-06.1 governing the provision of HCAS:

- [JFS 02389](#) "Home Care Attendant Medication Authorization,"
- [JFS 02390](#) "Home Care Attendant Skilled Task Authorization," and
- [JFS 02391](#) "Provider Enrollment Application Addendum M Non-Agency Waiver Service Provider."

The JFS 02389 and the JFS 02390 are to be completed and signed by a consumer or the consumer's authorized representative, the consumer's authorizing health care professional (i.e., a physician or registered nurse), and the home care attendant. The forms contain the following information related to the provision of HCAS:

- Written consent from the consumer or authorized representative allowing for the provision of HCAS, and assuming responsibility for directing the provision of HCAS.
- Written consent from the consumer's authorizing health care professional attesting to:

- The consumer's ability to direct the home care attendant; and
- The home care attendant's successful demonstration of his/her ability to furnish the consumer-specific HCAS (i.e., nursing task or assistance with self- administration of medication) to the consumer.
- A description of the consumer-specific HCAS that the home care attendant will assist the consumer with, including, in the case of assistance with self-administration of medication, the name, dosage and route of administration of the medication.

The JFS 02391 is the provider agreement addendum that must be completed as part of the Medicaid provider application process by any individual who wants to become an HCAS provider under the Ohio Home Care or Transitions Carve-Out Waiver.

Instructions:

Insert
<u>JFS 02389</u> (effective 07/2010)
<u>JFS 02390</u> (effective 07/2010)
<u>JFS 02391</u> (effective 07/2010)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

Select "Forms Central" (top right column).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Services and Support

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

CSTL 10-01 (Addition of New Home Care Attendant Services to the Ohio Home Care and Transitions Carve-Out Waivers)

Community Services Transmittal Letter (CSTL) No. 10-01

June 24, 2010

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Addition of New Home Care Attendant Services to the Ohio Home Care and Transitions Carve-Out Waivers

The Ohio Department of Job and Family Services (ODJFS) adopted new rules [5101:3-46-04.1](#), [5101:3-46-06.1](#), [5101:3-50-04.1](#) and [5101:3-50-06.1](#) of the Administrative Code. These rules set forth the service specifications and provider requirements, and the reimbursement rates and billing procedures related to the new home care attendant services that has been added to the Ohio Home Care and Transitions Carve-Out Waivers effective 07/01/2010.

Pursuant to Sections 5111.88 to 5111.8810 of the Revised Code (enacted as part of Am. Sub. H.B. 1 of the 128th General Assembly) ODJFS amended the Ohio Home Care and Transitions Carve-Out waivers to add a new consumer-driven home care attendant services (HCAS). HCAS permits unlicensed individuals (nonagency providers) to assist a consumer enrolled on one of those waivers with self-administration of medications and the performance of certain nursing tasks that must otherwise be performed by a licensed health care professional. In addition, the attendant can perform personal care aide tasks as part of the services.

Upon authorization by a licensed physician or a registered nurse, a home care attendant can assist a consumer with the self-administration of oral/topical medications (including schedule II through V drugs), subcutaneous injections of routine doses of insulin, programming of a pump to deliver routine doses of insulin, and medications administered via G and J tubes using pre-programmed pumps. HCAS DOES NOT include IV insertion, removal, or discontinuation; intramuscular injections; IV medication administration; insertion or initiation of infusion therapies; or central line dressing changes.

OAC Rule 5101:3-46-04.1, Ohio Home Care Waiver Program: Home Care Attendant Services, and OAC Rule 5101:3-50-04.1, Transitions Carve-Out Waiver Program: Home Care Attendant Services, establish the requirements a home care attendant must meet in order to provide HCAS, as well as the requirements the attendant must follow when providing HCAS. The consumer can train the attendant in cooperation with the authorizing health care professional.

OAC Rule 5101:3-46-06.1, Ohio Home Care Waiver Program: Home Care Attendant Services Reimbursement Rates and Billing Procedures, and OAC Rule 5101:3-50-06.1, Transitions Carve-Out Waiver Program: Home Care Attendant Services Reimbursement Rates and Billing Procedures, establish the reimbursement rates and billing procedures an attendant must follow in order to be paid for providing HCAS. The reimbursement rate for HCAS is \$33.34 for the first hour. The unit rate is \$4.17 for a fifteen-minute unit of assistance with self-administration of medications and the performance of nursing tasks, while personal care aide tasks are reimbursed at a fifteen-minute unit rate of \$3.00. These rates are less than what a nurse is currently paid for waiver nursing and private duty nursing, but greater than the rate for personal care aide services also available through the Ohio Home Care and Transitions Carve-Out Waivers.

Instructions:

Insert Replacement
<u>5101:3-46-04.1</u> (effective 07/01/2010)
<u>5101:3-46-06.1</u> (effective 07/01/2010)
<u>5101:3-50-04.1</u> (effective 07/01/2010)
<u>5101:3-50-06.1</u> (effective 07/01/2010)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Long Term Services and Support

P.O. Box 182709

Columbus, Ohio 43218-2709

BLTSS@jfs.ohio.gov

(614) 466-6742

CSTL 09-08 (ODJFS-Administered Waiver Programs: Waiver Service Provider Fee Decrease)

Community Services Transmittal Letter (CSTL) No. 09-08

December 23, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Providers, Home Health Agencies
Providers, Otherwise-accredited Agencies
Providers, Independent Private Duty Nursing
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: ODJFS-Administered Waiver Programs: Waiver Service Provider Fee Decrease

This letter provides information regarding the amendment of Rules [5101:3-46-06](#), [5101:3-47-06](#) and [5101:3-50-06](#) of the Administrative Code governing reimbursement of ODJFS-administered waiver services. These rules have been amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain Medicaid providers effective for dates of service on or after January 1, 2010.

All ODJFS-administered waiver services that have Medicaid maximum rates established in rule have been reduced by three percent effective for services delivered on or after January 1, 2010. Therefore, the base rate for Waiver Nursing Services (T1002 and T1003) has been reduced to \$54.95, and the unit rate has been reduced to \$5.69. Similarly, the base rate for Personal Care Aide Services (T1019) has been reduced to \$23.98 and the unit rate has been reduced to \$3.00.

Other ODJFS-administered waiver service rates are as follows:

H0045	Out-of-home Respite Services	\$199.82
S0215	Supplemental Transportation Services	\$ 0.38

S5101	Adult Day Health Center Services (half-day)	\$ 32.48
S5102	Adult Day Health Center Services (whole day)	\$ 64.94
S5160	Emergency Response Services (installation/testing)	\$ 44.96
S5161	Emergency Response Services (monthly fee)	\$ 44.96
S5170	Home Delivered Meal Services	\$ 6.99

These rules have also been amended to remove reference to Administrative Code rules that were previously rescinded.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-46-06 (effective 7/01/2008)	<u>5101:3-46-06</u> (effective 1/01/2010)
5101:3-47-06 (effective 7/01/2008)	<u>5101:3-47-06</u> (effective 1/01/2010)
5101:3-50-06 (effective 7/01/2008)	<u>5101:3-50-06</u> (effective 1/01/2010)

Web Pages:

ODJFS 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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp>

(614) 466-6742

CSTL 09-07 (Rule Changes Affecting ODJFS-Administered Waiver Programs and Private Duty Nursing; and Changes in the JFS 02374 "Private Duty Nursing Services Request")

Community Services Transmittal Letter (CSTL) No. 09-07

Medical Assistance Letter (MAL) 558

October 26, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Providers, Home Health Agencies
Providers, Otherwise-accredited Agencies
Providers, Independent Private Duty Nursing
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Rule Changes Affecting ODJFS-Administered Waiver Programs and Private Duty Nursing; and Changes in the JFS 02374 "Private Duty Nursing Services Request"

The Ohio Department of Job and Family Services (ODJFS) has amended rules 5101:3-45-01 and 5101:3-12-03.1 of the Administrative Code (OAC). These rules expand certain program-related definitions. A description of the amended rules follows below.

OAC rule [5101:3-45-01](#), ODJFS-administered Waiver Program: Definitions, contains key definitions associated with ODJFS-administered waivers. The definition of "otherwise-accredited agency" has been amended to include an agency that has and maintains accreditation by a national organization for the provision of home health services, private duty nursing, personal care services and support services upon execution of a Medicaid provider agreement in accordance with OAC rule 5101:3-1-17.2. The national accreditation organization must be approved by the Centers for Medicare and Medicaid Services (CMS), and shall include, but not be limited to, the Accreditation Commission for Health Care (ACHC), the Community Health Accreditation Program (CHAP) and the Joint Commission. OAC rule 5101:3-45-01 also includes a

definition for ACHC, as well as modifications to the definitions of CHAP, Joint Commission, and a number of other definitions in order to update rule cites and offer additional clarity.

OAC rule 5101:3-12-03.1, Non-Agency Nurses and Otherwise Accredited Agencies: Qualifications and Requirements, sets forth the provider qualifications and requirements for non-agency nurses and otherwise-accredited agencies providing Private Duty Nursing services. Like OAC rule 5101:3-45-01, it is amending the definition of "otherwise-accredited agency."

In addition to the aforementioned rule changes, ODJFS has revised the **JFS 02374** "Private Duty Nursing (PDN) Services Request." Changes have been made in order to capture essential information that is necessary to process PDN requests on a timelier basis. Sister agency case managers and PDN providers submit the form to the ODJFS Bureau of Community Services Policy when requesting PDN services for consumers. This form is used in concert with OAC rules 5101:3-12-02 and 5101:3-12-02.3, however, no changes are being made to those rules at this time.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-45-01 (effective 7/01/2006)	<u>5101:3-45-01</u> (effective 10/26/2009)

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-12-03.1 (effective 7/01/2006)	<u>5101:3-12-03.1</u> (effective 10/26/2009)
ODJFS 2374 (5/2007)	<u>JFS 02374</u> (6/2009)

Web Pages:

ODJFS 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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

It may also be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Home Health-Private Duty Nursing" (left column).
- (3) Select "Medical Assistance Letters", "Home Health/Private Duty Nursing Rules" and "Forms" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Services Policy

P.O. Box 182709
Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp>

(614) 466-6742

Questions about this MAL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, Ohio 43216-1461

(800) 686-1516

CSTL 09-06 (Amendment of OAC Rules 5101:3-45-07 and 5101:3-45-08 Governing Criminal Records Checks for Providers Under the ODJFS-Administered Waiver Program)

Community Services Transmittal Letter (CSTL) No. 09-06

December 10, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Amendment of OAC Rules 5101:3-45-07 and 5101:3-45-08 Governing Criminal Records Checks for Providers Under the ODJFS-Administered Waiver Program

The Ohio Department of Job and Family Services has amended rules [5101:3-45-07](#) and [5101:3-45-08](#) of the Administrative Code. These rules set forth the process and requirements for the criminal records checks of existing providers, and persons under final consideration for employment to provide home and community-based services to consumers enrolled on an ODJFS-administered waiver. Rule changes include the following:

- Several offenses have been added to the list of disqualifying offenses;
- Language has been added to clarify that the application of a conviction, guilty plea or intervention will be applied retroactively;
- Language has been added to clarify that a disqualifying offense includes a violation of an existing or former municipal ordinance or law of the State of Ohio, any other state or the United States that is substantially equivalent to any other disqualifying offense set forth rules 5101:3-45-07 and 5101:3-45-08 of the Administrative Code;
- Language has been added to clarify that when two or more convictions or guilty pleas result from or are connected with the same act or result from offenses committed at the same time, they are counted as one conviction or guilty plea; and
- Language has been added to clarify that if a non-agency provider fails to submit a criminal records check within sixty days of notification, ODJFS or its designee shall immediately take steps to remove

the non-agency provider from all All Services Plans until such time as the non-agency provider has satisfactorily completed all requirements of the rule.

The first three items are a result of statutory changes in R.C. 109.572, 5111.033 and 5111.034 brought about by the enactment of Amended Substitute House Bill 1 of the 128th General Assembly.

Instructions:

Remove and File as Obsolete	Replace/Insert
5101:3-45-07, effective 11/19/07	<u>5101:3-45-07</u> , effective 12/10/09
5101:3-45-08, effective 11/19/07	<u>5101:3-45-08</u> , effective 12/10/09

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Services Policy
P.O. Box 182709
Columbus, Ohio 43218-2709
BCSP@jfs.ohio.gov
(614) 466-6742

CSTL 09-05 (Policy Changes Governing the Non-Medicaid-funded Ohio Access Success Project and Involving the HOME Choice Demonstration Program)

Community Services Transmittal Letter (CSTL) No. 09-05

December 16, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
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
Directors, Area Agencies on Aging
Directors, County Boards of Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas Lumpkin, Director

SUBJECT: Policy Changes Governing the Non-Medicaid-funded Ohio Access Success Project and Involving the HOME Choice Demonstration Program

The Ohio Department of Job and Family Services (ODJFS) has amended rule [5101:3-49-01](#) of the Administrative Code (OAC) to clarify policy governing the Ohio Access Success Project, some of which relates to Ohio's HOME Choice (Money Follows the Person) Demonstration Program.

OAC rule [5101:3-49-01](#) (Non-Medicaid-funded Ohio Access Success Project) sets forth the application process, eligibility requirements and benefit limitations for the Ohio Access Success Project. The rule has been amended as follows:

- Language requiring "a face-to-face interview between the applicant and ODJFS or its designee" has been replaced with language requiring "an assessment of the consumer's care needs in the community."
- Language has been added to clarify that eligibility for the Ohio Access Success Project is contingent upon, among other things, an individual's ineligibility for the HOME Choice (Money Follows the Person) Demonstration Program, as well as other services similar to the Ohio Access Success Project that are funded by the Ohio Medicaid Program.

Instructions:

Remove and File as Obsolete

Insert Replacement

5101:3-49-01
(effective 10/01/2005)

[5101:3-49-01](#)
(effective 12/10/2009)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Additional information about the HOME Choice Demonstration Program can be found at:

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>.

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Services Policy
P.O. Box 182709
Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>

(614) 466-6742

CSTL 09-04

Community Services Transmittal Letter (CSTL) No. 09-04

September 18, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group Chairperson, Ohio
Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: ODJFS-Administered Waiver Program: Provider Rule Changes

The Ohio Department of Job and Family Services (ODJFS) has rescinded rules 5101:3-12-28, 5101:3-12-29 and 5101:3-12-30 of the Administrative Code (OAC) governing provider enrollment, consumer incident management and investigation, and structural reviews and the provider occurrence process, as a result of its recent review of the rules in accordance with Section 119.032 of the Revised Code. The rules are being replaced with new rules [5101:3-45-04](#), [5101:3-45-05](#) and [5101:3-45-06](#) of the Administrative Code, respectively. A description of the new rules follows below.

OAC rule [5101:3-45-04](#), ODJFS-administered Waiver Program: Provider Enrollment Process, sets forth the application and enrollment process ODJFS-administered waiver providers must complete before being approved to furnish services to an ODJFS-administered waiver consumer. This rule replaces OAC rule 5101:3-12-28, which has been rescinded.

OAC rule [5101:3-45-05](#), ODJFS-administered Waiver Program: Consumer Incident Management, Investigation and Response System (IMIRS), sets forth the standards and procedures for operating the ODJFS-administered waiver program's IMIRS. The rule describes reportable incidents, as well as the requirements for reporting, investigating and responding to such incidents, and sets forth the corrective action and sanctioning possibilities that may be levied against providers. This rule replaces OAC rule 5101:3-12-29, which has been rescinded.

OAC rule [5101:3-45-06](#), ODJFS-administered Waiver Program: Structural Reviews of Providers and the Provider Occurrence Process, sets forth the ongoing provider monitoring activities that must take place as part of the ODJFS-administered waiver program. Structural reviews shall be subject to a schedule and format. Specifically,

- All non-agency waiver service providers shall be subject to a structural review.

- New non-agency waiver service providers who enter into their first three-year Medicaid provider agreement in accordance with rule 5101:3-1-17.4 of the Administrative Code shall have a face-to-face structural review for each of the first three years after the date on which the provider begins furnishing billable waiver services. Upon renewal of the three-year provider agreement, and if the non-agency provider has not been substantiated as a violator of a reportable incident, has not been substantiated as having two or more provider occurrences within a twelve-month period, has not received cumulative overpayments of \$250 or more over a twelve-month period, or does not live with the consumer, he or she will only be subject to a biennial face-to-face structural review.
- Medicare-certified home health agencies and otherwise-accredited agencies shall be subject to reviews in accordance with their certification or accreditation bodies, and are therefore exempt from a regularly-scheduled structural review.
- All other ODJFS-administered waiver service providers shall be subject to a biennial structural review. The first structural review must occur no later than two years after the date on which the provider begins furnishing billable waiver services.
- All ODJFS-administered waiver service providers may be subject to an announced or unannounced structural review when ODJFS is notified of:
 - A provider occurrence,
 - Health and welfare issues involving the provider and an ODJFS-administered waiver consumer; or
 - Any other provider performance issues.

OAC rule 5101:3-45-06 also sets forth policy and procedures for the continuous monitoring of provider compliance and performance via ODJFS' provider occurrence process, and sets forth the corrective action and sanctioning possibilities that may be levied against providers as part of this process.

Instructions:

Remove and File as Obsolete	Insert Replacement
<u>5101:3-12-28</u> (effective 7/01/2004)	<u>5101:3-45-04</u> (effective 09/19/2009)
<u>5101:3-12-29</u> (effective 7/01/2004)	<u>5101:3-45-05</u> (effective 09/19/2009)
<u>5101:3-12-30</u> (effective 7/01/2004)	<u>5101:3-45-06</u> (effective 09/19/2009)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp>

(614) 466-6742

CSTL 09-02

Community Services Transmittal Letter (CSTL) No. 09-02

May 21, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Policy Changes Governing HOME Choice Demonstration Program Services and Reimbursement

The Ohio Department of Job and Family Services (ODJFS) has amended rules 5101:3-51-04 and 5101:3-51-06 of the Administrative Code (OAC) to clarify policy governing Ohio's HOME Choice Demonstration Program (Money Follows the Person). They will become effective June 1, 2009.

OAC rule [5101:3-51-04](#), "HOME Choice ("Helping Ohioans Move, Expanding Choice") Demonstration Program: Definitions of the Covered Services and Program Service Limitations, Provider Qualifications and Specifications," has been amended for the purpose of clarifying that a not-for-profit agency provider does not have to be certified by the Ohio Department of Mental Health (ODMH) in order to provide independent living skills training or community support coaching. It has also been amended to clarify who shall coordinate the purchase of a HOME Choice participant's community transition services (goods and services) during the demonstration period, and how such services are to be accessed when the participant is enrolling on a home and community-based services (HCBS) waiver administered by the Ohio Department of Aging (ODA).

OAC rule [5101:3-51-06](#), "HOME Choice ("Helping Ohioans Move, Expanding Choice") Demonstration Program: Reimbursement Rates and Billing Procedures," has been amended to change "maximum hours/days" to "maximum usage amounts." To reflect that change, the corresponding definition and applicable parts of the reimbursement table have been revised. It has also been amended to remove reference to the Medicaid reimbursement criteria set forth in OAC rule 5101:3-1-60, and replace it with specific non-Medicaid reimbursement criteria. Finally, it has been amended to establish the maximum reimbursement allowed for community transition services when the HOME Choice participant is enrolling on an HCBS waiver administered by ODA.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-51-04 (effective 7/01/2008)	<u>5101:3-51-04</u> (effective 6/01/2009)
5101:3-51-06 (effective 7/01/2008)	<u>5101:3-51-06</u> (effective 6/01/2009)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Additional information about the HOME Choice Demonstration Program can be found at:

<http://ifs.ohio.gov/ohp/consumers/HOME choice.stm>.

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://ifs.ohio.gov/ohp/consumers/HOME choice.stm>

(614) 466-6742

CSTL 09-01

Community Services Transmittal Letter (CSTL) No. 09-01

February 3, 2009

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: Policy Changes Governing the Ohio Home Care Waiver Waiting List

The Ohio Department of Job and Family Services (ODJFS) has amended rule [5101:3-46-07](#) of the Administrative Code (OAC) as part of the implementation of Ohio's HOME Choice Demonstration Program.

New language expands opportunities for priority to include: (a) applicants who are residents of a Medicaid-funded NF at the time of application (regardless of their projected monthly cost of services); and (b) applicants who are inpatients of a hospital and have been determined by ODJFS to be eligible for the HOME Choice Demonstration Program (Money Follows the Person).

Prior to this amendment, OAC rule 5101:3-46-07 (Ohio Home Care Waiver: Enrollment and Waiting List Process) limited Ohio Home Care Waiver slot priority to two groups of people:

- (1) Children who are from birth up to, but not including, their sixth birthday, and who have been residing in an inpatient hospital setting at the time of, and at least thirty days prior to, application for the waiver; and
- (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 80 percent of the average monthly Medicaid cost of a Medicaid recipient residing in a NF.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-46-07 (effective 7/01/2006)	5101:3-46-07 (effective 2/08/2009)

Web Pages:

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Additional information about the HOME Choice Demonstration Program can be found at:

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>.

Questions:

Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Community Services Policy

P.O. Box 182709

Columbus, Ohio 43218-2709

<http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>

(614) 466-6742

CSTL 08-03

Community Services Transmittal Letter (CSTL) No. 08-03

October 15, 2008

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
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
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Ohio's HOME Choice (Helping Ohioans Move, Expanding Choice) Demonstration Program Provider Enrollment Application/Time-Limited Agreement and Addenda

Attached please find the new [JFS 02216](#) "Ohio HOME Choice Demonstration Program Provider Enrollment Application/Time-Limited Agreement." Also attached are the new [JFS 02200](#) to [JFS 02210](#) "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum." The forms have been created for use by providers of HOME Choice Demonstration Program services. Each addendum is specific to the particular HOME Choice service to be provided, and to either agency or non-agency providers who are authorized to furnish the service. Providers can begin using these forms October 1, 2008.

On June 30, 2008, Ohio received approval from the Centers for Medicare and Medicaid Services (CMS) of its "Money Follows the Person (MFP) Rebalancing Demonstration Grant Operational Protocol." MFP is a demonstration project enacted by Congress as part of the Deficit Reduction Act of 2005. Ohio's MFP demonstration project is called the "HOME Choice Demonstration Program." The CMS-approved Operational Protocol will be used to guide the time-limited demonstration program's implementation and operation. Ohio will receive enhanced federal matching funds that will be used to relocate approximately 2,200 seniors and persons with disabilities from institutions to home and community-based settings, and help Ohio balance its long term service and support structure.

The HOME Choice Demonstration Program IS NOT a Medicaid program. Therefore, in order for providers to be authorized to furnish HOME Choice Demonstration Program services, they must first complete the JFS 02216, and the addendum that is specific to the service they want to provide, and submit them and all required documentation to the ODJFS Bureau of Community Services Policy. Once approved, providers will then be assigned a HOME Choice provider number that must be used when billing for services that have

been rendered to a HOME Choice participant. The provider will be reimbursed through a financial management service provider.

Providers are not authorized to provide HOME Choice Demonstration Program services until their application/agreement has been approved by ODJFS and they have been issued a HOME Choice provider number. Additionally, if the provider bills for HOME Choice Demonstration Program services using a Medicaid number, or if the provider bills the services through the Medicaid claims process, the provider will not be paid.

Questions about the JFS 02216 "Ohio HOME Choice Demonstration Program Provider Enrollment Application/Time-Limited Agreement" and/or the JFS 02200 to 02210 "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum" should be directed to the Bureau of Community Services Policy online at <http://jfs.ohio.gov/ohp/consumers/HOMEchoice.stm>, or by calling (614) 466-6742. HOME Choice Demonstration Program provider rules can be found in Chapter 5101:3-51 of the Administrative Code.

Attachments

Instructions:

Location	Insert
//jfs.ohio.gov/ohp/consumers/HOMEchoice.stm	<u>JFS 02200</u> "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Nursing Services (HCA 100)"
//jfs.ohio.gov/ohp/consumers/HOMEchoice.stm	<u>JFS 02201</u> "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Non-Agency Nursing Services (HCNA 101 or HCNA 102)"
//jfs.ohio.gov/ohp/consumers/HOMEchoice.stm	<u>JFS 02202</u> "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Independent Living Skills Training (HCA 200)"
//jfs.ohio.gov/ohp/consumers/HOMEchoice.stm	<u>JFS 02203</u> "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Community Support Coaching (HCA 300)"
//jfs.ohio.gov/ohp/consumers/HOMEchoice.stm	<u>JFS 02204</u> "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Non-Agency Community Support Coaching (HCNA 301)"
//jfs.ohio.gov/ohp/consumers/HOMEchoice.stm	<u>JFS 02205</u> "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Social Work/Counseling Services (HCA 400)"
//jfs.ohio.gov/ohp/consumers/HOME	<u>JFS 02206</u> "Ohio HOME Choice Demonstration Program Provider

choice.stm	Enrollment Application Addendum - Non-Agency Social Work/Counseling Services (HCNA 401)"
//jfs.ohio.gov/ohp/consumers/HOME choice.stm	JFS 02207 "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Nutritional Consultation Services (HCA 500)"
//jfs.ohio.gov/ohp/consumers/HOME choice.stm	JFS 02208 "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Non-Agency Nutritional Consultation Services (HCNA 501)"
//jfs.ohio.gov/ohp/consumers/HOME choice.stm	JFS 02209 "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Communication Aid Services (HCA 600)"
//jfs.ohio.gov/ohp/consumers/HOME choice.stm	JFS 02210 "Ohio HOME Choice Demonstration Program Provider Enrollment Application Addendum - Agency Service Animal Provider (HCA 700)"
//jfs.ohio.gov/ohp/consumers/HOME choice.stm	JFS 02216 "Ohio HOME Choice Demonstration Program Provider Enrollment Application/Time-Limited Agreement"

CSTL 08-02

Community Services Transmittal Letter (CSTL) No. 08-02

June 20, 2008

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
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
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Members, HOME Choice Planning and Advisory Group Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Adoption of New OAC Rules 5101:3-47-02.1, 5101:3-50-02.1 and Rules 5101:3-51-01 through 5101:3-51-06 of the Administrative Code Governing Ohio's HOME Choice (Helping Ohioans Move, Expanding Choice) Demonstration Program

The Ohio Department of Job and Family Services (ODJFS) has created eight new rules governing Ohio's new HOME Choice (Helping Ohioans Move, Expanding Choice) Demonstration Program. The requirements of rules [5101:3-47-02.1](#) and [5101:3-50-02.1](#) of the Administrative Code and rules [5101:3-51-01](#) through [5101:3-51-06](#) of the Administrative Code begin when ODJFS receives approval of the HOME Choice Demonstration Program from the Centers for Medicare and Medicaid Services (CMS), or on the effective date of these rules (July 1, 2008), whichever is later.

In January 2007, Ohio was one of 17 states awarded a Money Follows the Person (MFP) Rebalancing Demonstration Grant from CMS. The MFP Demonstration grant was enacted by Congress as part of the Deficit Reduction Act of 2005. Ohio will receive enhanced federal matching funds for specific services rendered when the HOME Choice Demonstration Program begins, through September 30, 2012. Over the life of the HOME Choice Demonstration Program, the funds will be used to relocate approximately 2,200 seniors and persons with disabilities from institutions to home and community-based settings, and help Ohio balance its long term service and support structure. Because of the latter, the HOME Choice Demonstration Program is also closely linked with Ohio's Unified Long Term Care Budget activities.

Among the key elements of HOME Choice are the following:

- Use of existing home and community-based service (HCBS) options such as Medicaid waivers administered by ODJFS, the Ohio Department of Aging (ODA) and the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD), and state plan Medicaid benefits, including, but not limited to, behavioral health and alcohol and drug-related treatment services. The Transitions MR/DD and Transitions Carve-Out Waivers administered by ODJFS are being opened on a time-limited basis for the purpose of enrolling HOME Choice participants who meet those waivers' specific eligibility requirements. Additionally, individuals who are not enrolled on a Medicaid waiver and are

eligible for only state plan Medicaid benefits may participate in HOME Choice on a limited basis, as long as they meet the HOME Choice eligibility requirements.

- Identification and incorporation of existing qualified services (i.e., waiver and state plan services); new demonstration services (i.e., independent living skills training, community support coaching, nursing, social work/counseling, nutritional consultation, and community transition services); and new supplemental services (i.e., communication aid services and service animals). With the exception of community transition services (goods and services), all demonstration and supplemental services are available to the HOME Choice participant for up to 365 days beginning the day the participant moves from an institutional setting into the community. Community transition services are available during the pre-transition period as well as during the 365-day demonstration period.
- Promotion of consumer direction of services. HOME Choice participants have choice and control over the selection of their providers, and the direction of the provision of the services they receive. In addition, participants have budget authority over their community transition services, while the goods and services are paid for through a financial management service (FMS) entity under contract with ODJFS.
- Implementation of transition coordination services that are available to individuals residing in institutions during the pre-transition period to help them plan and arrange for services and supports they need during their move. Transition coordination services include:
 - The process of determining the participant's readiness to move from an institutional setting into the community;
 - Housing navigation that assists the participant in securing appropriate housing;
 - Benefits coordination that assists the participant in identifying and accessing a broad range of financial, medical and other benefits for which he/she may be eligible, and that allow the participant to move and live safely in the community; and
 - Assisting the participant with identifying and linking to a community support coach who guides, educates and empowers the participant when he/she moves, independent living skills training for the purpose of developing or increasing the skills, knowledge or abilities the participant needs to live more independently, and other benefits and social services for which the participant may be eligible.
- Incorporation of a referral and tracking system to track HOME Choice participation and data.
- Incorporation of quality management into all aspects of the HOME Choice operational protocol and demonstration.

The rules contained in this transmittal set forth the program definitions, eligibility requirements related to HOME Choice and the Transitions MR/DD and Transitions Carve-Out Waivers, provider conditions of participation, service definitions and provider specifications, provider enrollment, and provider reimbursement requirements. Specifications related to transition coordination services, and the FMS are not contained in these rules. They are included in service agreements with the providers.

Instructions:

Insert
<u>5101:3-51-01</u> , effective 07/01/08
<u>5101:3-51-02</u> , effective 07/01/08
<u>5101:3-51-03</u> , effective 07/01/08
<u>5101:3-51-04</u> , effective 07/01/08
<u>5101:3-51-05</u> , effective 07/01/08

[5101:3-51-06](#), effective **07/01/08**

[5101:3-47-02.1](#), effective **07/01/08**

[5101:3-50-02.1](#), effective **07/01/08**

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

P.O. Box 182709

Columbus, Ohio 43218-2709

BHCS@odjfs.state.oh.us

CSTL 08-01

Community Services Transmittal Letter (CSTL) No. 08-01

June 20, 2008

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
Director, Ohio Home Care Organization

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Amendment of OAC Rules 5101:3-46-06, 5101:3-47-06 and 5101:3-50-06 Governing Reimbursement Rates and Billing Procedures for the ODJFS-Administered Waiver Program

The Ohio Department of Job and Family Services (ODJFS) has amended rules governing reimbursement rates and billing procedures for the Ohio Home Care Waiver, the Transitions MR/DD Waiver and the Transitions Carve-Out Waiver. These rules reflect a three percent increase in base/unit rates for ODJFS-administered waivers. The rate increase is pursuant to Am. Sub. H.B. 119, 127th General Assembly, and the amended rules become effective July 1, 2008. The increase in rates pertains to those services rendered on or after July 1, 2008.

As a result of the rate increase,

- Waiver Nursing Services provided by RNs and LPNs will be reimbursed \$56.65 for the first hour, and \$5.87 for every fifteen minute unit provided thereafter.
- Personal Care Aide Services will be reimbursed \$24.72 for the first hour, and \$3.09 for every fifteen minute unit provided thereafter.
- Out of Home Respite will be reimbursed \$206.00 per day.
- Supplemental Transportation Services will be reimbursed \$.39 per mile.
- Adult Day Health Center Services will be reimbursed \$66.95 for a full day, and \$33.48 for a half day.
- Emergency Response Services will be reimbursed \$46.35 for installation/testing of emergency response systems, and \$46.35 for the monthly fee.
- Home Delivered Meal Services will be reimbursed \$7.21 per meal.

Home Modification Services and Supplemental Adaptive and Assistive Device Services will continue to be reimbursed the amount that is prior authorized on the consumer's all services plan.

Instructions:

Remove and File as Obsolete	Replace/Insert
5101:3-46-06, effective 7/1/06	<u>5101:3-46-06</u> , effective 7/1/08
5101:3-47-06, effective 7/1/06	<u>5101:3-47-06</u> , effective 7/1/08
5101:3-50-06, effective 7/1/06	<u>5101:3-50-06</u> , effective 7/1/08

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services

Bureau of Home and Community Services

P.O. Box 182709

Columbus, Ohio 43218-2709

BHCS@odjfs.state.oh.us

CSTL 07-06

Community Services Transmittal Letter (CSTL) No. 07-06

November 16, 2007

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
Director, Ohio Home Care Organization

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Adoption of New OAC Rules 5101:3-45-07 and 5101:3-45-08 and Rescission of OAC Rules 5101:3-12-25 and 5101:3-12-26 Governing Criminal Records Checks for Providers Under the ODJFS-Administered Waiver Program

The Ohio Department of Job and Family Services (ODJFS) has created new rules governing criminal records checks for agency and non-agency providers of home and community-based services under the ODJFS-administered waiver program. These rules reflect changes in the Revised Code as a result of the enactment of Amended Substitute House Bill 119, and are replacing existing rules that are being rescinded. These rules are effective November 19, 2007.

Among other things,

- Rule [5101:3-45-07](#), entitled "ODJFS-Administered Waiver Program: Criminal Records Checks Involving Agency Providers," is replacing OAC rule 5101:3-12-25, entitled "Criminal Records Checks Involving Agency-Employed Providers of ODJFS-administered Waiver Services." It 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.
- Rule [5101:3-45-08](#) entitled "ODJFS-Administered Waiver Program: Criminal Records Checks Involving Non-agency Providers," is replacing rule 5101:3-12-26, entitled "Criminal Records Checks Involving Independent Providers of ODJFS-administered Waiver Services." It sets forth the process and requirements for the criminal records checks of persons under final consideration for employment with a consumer, and existing employees with a consumer in a full-time, part-time or temporary position, and who are providing HCBS in an ODJFS-administered waiver. Please note: Pursuant to Revised Code Section 5111.034, ODJFS can no longer accept annual criminal background reports sent directly from non-agency providers. The background check reports must come directly to ODJFS from the Bureau of Criminal Identification and Investigation (BCII). Criminal background checks will be rejected if they are not received directly from BCII. Failure to comply with this requirement may result in

additional expense to the non-agency provider and may impact the non-agency provider's eligibility to furnish services. Instruction for proper submission are listed in the Annual Criminal Background Check Instructions that are included with the non-agency provider's background check notification packet.

- Statutory language has been moved from Revised Code Sections 5111.95 and 5111.96 to 5111.033 and 5111.034.
- Both rules also add soliciting, Workers' Compensation fraud, identity fraud, disorderly conduct, endangering children, falsification (in a theft offense or to purchase a firearm), attempting to commit an offense, engaging in a pattern of corrupt activity, and drug paraphernalia to the list of disqualifying offenses.

Instructions:

Remove and File as Obsolete	Replace/Insert
5101:3-12-25, effective 7/1/04	5101:3-45-07 , effective 11/19/07
5101:3-12-26, effective 7/1/04	5101:3-45-08 , effective 11/19/07

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Home and Community Services
P.O. Box 182709
Columbus, Ohio 43218-2709
BHCS@odjfs.state.oh.us

CSTL 07-04

Community Services Transmittal Letter (CSTL) No. 07-04

August 17, 2007

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
Director, Ohio Home Care Organization

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Adoption of New OAC Rule 5101:3-45-03 and Rescission of OAC Rule 5101:3-12-12 Governing Consumer Options Under the ODJFS-Administered Waiver Program; Adoption of New OAC Rule 5101:3-45-09 and Rescission of OAC Rule 5101:3-12-08 Governing Quality Assurance Monitoring and Oversight of ODJFS-Administered Waiver Service Providers and the Contracted Case Management Agency (CMA); and Rescission of OAC Rule 5101:3-12-11 Governing Home Services Facilitation

The Ohio Department of Job and Family Services (ODJFS) has created new rules governing consumer choice and control of ODJFS-administered waiver service providers, and quality assurance monitoring and oversight of ODJFS-administered waiver service providers and the agency under contract with ODJFS to provide case management services to ODJFS-administered waiver consumers. These rules are replacing existing rules that have been rescinded. Additionally, ODJFS has rescinded its rule governing home services facilitation under the ODJFS-administered waiver program. These rules are effective August 13, 2007.

Among other things,

- Rule [5101:3-45-03](#), entitled ODJFS-Administered Waiver Program: Consumer Choice and Control, is replacing OAC rule 5101:3-12-12, entitled Consumer Options Under the Ohio Home Care Program. It sets forth the extent to which a consumer enrolled on an ODJFS-administered waiver has choice and control over the arrangement/direction of his/her home and community-based waiver services, and the selection and control over the direction of the providers of those services. Differences between the new rule and the rescinded rule include the following:
 - The consumer and/or authorized representative shall decide who, besides themselves, shall:
 1. Participate in the development of the all services plan and all plans of care;
 2. Communicate to providers their personal preferences about duties, tasks and procedures to be performed;
 3. Work with the CMA and providers to identify and secure additional training to meet the consumer's specific needs; and

4. Participate in the recruitment, selection and dismissal of providers.
- The rule also sets forth case management, reporting and documentation requirements to be met by the CMA to assure the consumer's health and welfare while exercising his/her right to choice and control.
 - Rule [5101:3-45-09](#) entitled ODJFS-Administered Waivers: Quality Assurance Monitoring and Oversight of ODJFS-Administered Waiver Service Providers and the Contracted Case Management Agency, is replacing rule 5101:3-12-08, entitled Quality Assurance Monitoring of the Ohio Home Care Program, for the purpose of renumbering rule 5101:3-12-08. This rule sets forth quality assurance monitoring and oversight policies and practices related to the ODJFS-administered waiver program. There are no substantive changes between rules 5101:3-45-09 and 5101:3-12-08.
 - Rule 5101:3-12-11 entitled Home Services Facilitation, has been rescinded because provisions of the rule are set forth in a contract between ODJFS and the CMA now providing case management services to consumers enrolled on an ODJFS-administered waiver.

Instructions:

Remove and file as obsolete OAC rule 5101:3-12-08, 5101:3-12-11 and 5101:3-12-12.

Insert new OAC rules 5101:3-45-03 and 5101:3-45-09.

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Home and Community Services
P.O. Box 182709
Columbus, Ohio 43218-2709
BHCS@ODJFS.state.oh.us

CSTL 07-03

Community Services Transmittal Letter (CSTL) No. 07-03

July 9, 2007

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
Director, Ohio Home Care Organization

FROM: Helen E. Jones-Kelley, Director

SUBJECT: REVISION OF ODJFS FORMS IN COMPLIANCE WITH NEW NATIONAL PROVIDER IDENTIFIER

The Ohio Department of Job and Family Services (ODJFS) Bureau of Home and Community Services (BHCS) has revised the JFS 02374 "Private Duty Nursing Services Request" and the JFS 02219 "Affidavit of Tax Payment Compliance for Non-Agency-Employed ODJFS-Administered Waiver Service Providers" in order to add space for Medicaid providers' new National Provider Identifier (NPI). By federal mandate, the NPI became the standard number used to identify Medicaid providers on May 23, 2007. Space will still be provided on the JFS 02374 and the JFS 02219 for current Medicaid legacy provider numbers, however, all providers must also include their new NPI when completing these forms. No other changes are being made to these forms at this time.

Web Page Instructions:

The JFS 02374 and the JFS 02219 can be accessed electronically at:

www.odjfs.state.oh.us/forms/inter.asp.

Click on "form number" next to words "search/sort by."

Click on box below "search/sort by" and type in form number.

Click on "search."

Click on red "PDF" in the box next to the form name.

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Home and Community Services
P.O. Box 182709

Columbus, Ohio 43218-2709

BHCS@odjfs.state.oh.us

Attachment - JFS 02219 "Affidavit of Tax Payment Compliance for Non-Agency-Employed ODJFS-Administered Waiver Service Providers"

[Click to view the JFS 02219, Affidavit of Tax Payment Compliance for Non-Agency-Employed ODJFS-Administered Waiver Service Providers](#)

Attachment - JFS 02374 "Private Duty Nursing Services Request"

[Click to view the JFS 02374, Private Duty Nursing Services Request](#)

CSTL 07-02

Community Services Transmittal Letter (CSTL) No. 07-02

March 16, 2007

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
Director, Ohio Home Care Organization

FROM: Helen E. Jones-Kelley, Director

SUBJECT: ADOPTION OF NEW OAC RULES 5101:3-46-05, 5101:3-47-05 AND 5101:3-50-05 GOVERNING THE ESTABLISHMENT OF INDIVIDUAL COST CAPS FOR OHIO HOME CARE, TRANSITIONS MR/DD AND TRANSITIONS CARVE-OUT WAIVER CONSUMERS, THE AMENDMENT OF OAC RULE 5101:3-45-01 GOVERNING ODJFS-ADMINISTERED WAIVER PROGRAM DEFINITIONS, AND THE RESCISSION OF OAC RULE 5101:3-12-09 GOVERNING INDIVIDUAL COST CAPS FOR CORE-PLUS AND ODHS WAIVER BENEFIT PACKAGES

The Ohio Department of Job and Family Services (ODJFS) has created new rules governing the establishment of individual cost caps for Ohio Home Care, Transitions MR/DD and Transitions Carve-Out Waiver consumers. Also as part of this package, the OAC rule that contains definitions for all ODJFS-administered waiver programs has been amended to reflect the establishment of these new rules, and an existing OAC rule has been rescinded. These rules became effective on February 15, 2007.

Among other things,

- The new rules replace OAC rule 5101:3-12-09 which was subject to five-year agency rule review in February 2007. The applicable contents are being moved to new rules [5101:3-46-05](#), [5101:3-47-05](#) and [5101:3-50-05](#) of the Administrative Code, where the three waivers' rules are now housed. The three new rules do not contain any substantive changes over the previous policy. The current individual cost cap methodology and funding ranges will not change under the Ohio Home Care, Transitions MR/DD and Transitions Carve-Out Waivers at this time.
- OAC rule [5101:3-45-01](#) was amended to reflect the addition of the three new cost cap rules and to make minor corrections to the rule.

Instructions:

Remove and file as obsolete OAC rule 5101:3-12-09.

Remove and replace OAC rule 5101:3-45-01.

Insert new OAC rules 5101:3-46-05, 5101:3-47-05 and 5101:3-50-05.

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 transmittal letter and attachments may be viewed as follows:

- (1) Select "Ohio Health Plans - Provider "(left column).
- (2) Select "Ohio Home Care" (left column).
- (3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:

Questions pertaining to this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Home and Community Services
P.O. Box 182709
Columbus, Ohio 43218-2709
BHCS@odjfs.state.oh.us

CSTL 07-01

Community Services Transmittal Letter (CSTL) No. 07-01

Medical Assistance Letter (MAL) No. 519

June 28, 2007

To: Medicare-Certified Home Health Agencies
Non-Agency Nurses
Otherwise Accredited Agencies
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
Superintendents/Executive Directors, County Boards of Mental Retardation and Developmental Disabilities
Executive Director, Ohio Board of Nursing
Executive Director, Ohio Nurses Association
Executive Director, Licensed Practical Nurse Association of Ohio
Co-Chairpersons, Ohio Olmstead Task Force
Executive Director, Ohio Council for Home Care
Vice President of Government Affairs, Ohio Home Care Organization
Hospital Discharge Planners

From: Helen E. Jones-Kelley, Director

Subject: Private duty nursing (PDN) service authorization

This Medical Assistance Letter (MAL) / Community Services Transmittal Letter (CSTL) transmits rule [5101:3-12-02.3](#), *Private duty nursing: procedures for service authorization*, which was previously emergency-filed with an effective date of September 1, 2006, and transmitted by [MAL 515](#).

This rule, which became effective on December 7, 2006, sets forth the procedures that must be followed by Medicaid providers and case managers when requesting prior authorization for PDN services for consumers who are not enrolled on a home- and community-based services (HCBS) waiver, consumers who are enrolled on an ODMR/DD- or ODA-administered waiver, and consumers who are enrolled on an ODJFS-administered waiver. It also sets forth the procedures to be followed when PDN services are required on an emergency basis. Specifically:

- 1) A PDN service provider must contact ODJFS to request PDN services when the consumer is not enrolled on an HCBS waiver.
- 2) An ODMR/DD or ODA case manager must assist a consumer and/or authorized representative in locating a PDN service provider when the consumer is enrolled on an ODMR/DD- or ODA-administered waiver.
- 3) A PDN service provider must contact an ODMR/DD or ODA case manager to request PDN services when the consumer is enrolled on an ODMR/DD- or ODA-administered waiver.

- 4) An ODJFS-designated case manager must assist an ODJFS-administered waiver consumer and/or authorized representative in locating a PDN service provider as part of the all services planning process.
- 5) ODJFS must notify the consumer and/or authorized representative, the PDN service provider, and/or the ODMR/DD or ODA case manager in writing of the authorized amount, scope, and duration of PDN services.
- 6) A consumer and/or authorized representative may request a hearing in the event of a disagreement about the authorized amount, scope, or duration of PDN services.

Providers will receive one printed copy of this transmittal letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form. Or they may view ODJFS transmittal letters, rules, manuals, forms, and handbooks online at the ODJFS "electronic manuals" web page, <http://emanuals.odjfs.state.oh.us/emanuals/>.

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

Bureau of Plan Operations
Provider Network Management Section

P.O. Box 1461

Columbus, OH 43216

In-state toll-free telephone number (800) 686-1516

Attachment

[Click to view the JFS 03400, Service Provider Update Request Form for CSTL 07-01.](#)

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:

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 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.

CSTL 00-01

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

CSTL 06-02

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.

Effective Date: 07/01/2006

R.C. 119.032 review dates: 03/24/2006 and 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: 10/1/87, 7/1/98, 1/1/04

5160-1-39 **Verification Of Home Care Service Provision To Home Care Dependent Adults**

***Formerly* 5101:3-1-39** **Verification Of Home Care Service Provision To Home Care Dependent Adults**

5160-1-39 is maintained in the ODJFS Ohio Administrative Code eManual, located in the Legal Services collection.

CSTL 10-06

Effective Date: October 25, 2010

Most Current Prior Effective Date: July 1, 2010

- (A) "Accreditation commission for health care (ACHC)" is a national organization that evaluates and accredits home health agencies seeking to participate in the medicare and medicaid programs.
- (B) "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.
- (C) "Agency-consumer agreement" means the ODJFS-approved agreement signed by the consumer and/or authorized representative and the case manager (CM) that assures that the consumer is voluntarily enrolling in an ODJFS-administered waiver as an alternative to receiving services in a facility or hospital. It identifies the conditions and responsibilities a waiver consumer must agree to as a condition of enrollment.
- (D) "Agency provider" is a provider that is eligible to participate in the medicaid program upon execution of a medicaid provider agreement in accordance with rule [5101:3-1-17.2](#) of the Administrative Code.
- (E) "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.
- (F) "Applicant" is a person who completes a [JFS 02399](#) "Request for Medicaid Home and Community-Based Services" (rev. 1/2006) and submits it to the county department of job and family services (CDJFS) requesting an eligibility determination for an ODJFS-administered waiver.
- (G) "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.
- (H) "Authorized representative" is a person the waiver applicant or consumer identifies in writing to ODJFS or its designee as a person who will act on his or her behalf for specifically identified purposes. The authorized representative shall not be the consumer's ODJFS-administered waiver service provider.
- (I) "Case management agency (CMA)" is the entity designated by ODJFS to provide 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 designate 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 accreditation program (CHAP)" is a national organization that evaluates and accredits home health agencies seeking to participate in the medicare and medicaid programs. 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 ACHC-accredited and joint commission-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) "Consumer acknowledgement of risk agreement" is the document created between ODJFS or its designee and the consumer identifying and setting forth the interventions recommended by the case manager to remedy risks to the consumer's health and welfare.
- (R) "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.
- (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 certain waiver 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 in which certain service providers furnish 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 "Ohio Home Care Waiver," "Transitions DD Waiver" or "Transitions Carve-Out Waiver." ODJFS or its designee oversees that the cost of 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" is a national organization that evaluates and accredits home health agencies that seek to participate in the medicare and medicaid programs. For the purpose of providing services to ODJFS-administered waiver consumers, joint commission-accredited agencies are "otherwise-accredited agencies" that may provide the same ODJFS-administered waiver services that AHC-accredited and 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, the transitions DD waiver set forth in Chapter 5101:3-47 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 in accordance with rule 5101:3-1-17.2 of the Administrative Code.
- (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 in accordance with rule 5101:3-1-17.2 of the Administrative Code.
- (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, the transitions DD waiver set forth in Chapter 5101:3-47 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 Chapter 5101:3-45 of the Administrative Code, and Chapter 5101:3-46, 5101:3-47 and/or 5101:3-50 of the Administrative Code, as applicable.
- (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 in accordance with rule 5101:3-1-17.2 of the Administrative Code.
- (NN) "Ohio Home Care Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

- (OO) "Otherwise-accredited agency" is an agency that has and maintains accreditation by a national accreditation organization for the provision of home health services, private duty nursing, personal care services and support services upon execution of a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. The national accreditation organization shall be approved by CMS, and shall include, but not be limited to: ACHC, CHAP and the joint commission.
- (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) "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 and dated by the treating physician prior to requesting reimbursement for a service. ~~It must include the name(s) of all of the agency and nonagency providers who are working under that plan of care.~~ The plan of care is not the same as the all services plan.
- (RR) "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
- (SS) "Residential address" is any physical dwelling with a unique mailing address where an ODJFS-administered waiver consumer lives. A residential address shall include, but is not limited to an apartment within an apartment complex. It shall not include the entire apartment building or complex.
- (TT) "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.
- (UU) "Skilled level of care (SLOC)" is the institutional level of care set forth in rule 5101:3-3-05 of the Administrative Code.
- (VV) "Transitions Carve-Out Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
- (WW) "Transitions DD Waiver" is a CMS-approved home and community-based services waiver administered by ODJFS that serves consumers in accordance with Chapters 5101:3-45 and 5101:3-47 of the Administrative Code.

Effective: 10/25/2010

R.C. 119.032 review dates: 10/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 10/14/2010

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, 7/1/06, 2/15/07, 10/26/09, 7/1/10

[LTCSTL 15-06](#)

Effective Date: April 1, 2015

Most Current Prior Effective Date: [July 1, 2010](#)

Enrollment on an Ohio department of medicaid (ODM) -administered waiver is voluntary. Individuals enrolled on an ODM-administered waiver in accordance with rule [5160-46-02](#), [5160-50-02](#) or [5160-58-02.2](#) of the Administrative Code shall be informed of their rights and responsibilities. Individuals also have choice and control over the arrangement and provision of home and community-based waiver services, and the selection and control over the direction of approved waiver service providers.

(A) Individual rights.

An individual enrolled in an ODM-administered waiver has the right to:

- (1) Be treated with dignity and respect.
- (2) Be protected from abuse, neglect, exploitation and other threats to personal health, safety and well-being.
- (3) Appoint an authorized representative to act on their behalf in accordance with rules [5160:1-1-50.1](#) and [5160:1-1-55.1](#) of the Administrative Code.
- (4) Receive waiver services in a person-centered manner that is in accordance with an approved all services plan, is attentive to the individual's needs and maximizes personal independence.
- (5) Choose his or her case management agency and case managers, and
 - (a) Have the case manager explain what the ODM-administered waiver is, how it will assist the individual and what the individual's rights and responsibilities are;
 - (b) Participate with the case manager and the team in the person-centered all services plan development process, and when possible, lead the process;
 - (c) Request assistance with recruitment of providers;
 - (d) Be able to effectively communicate with the case manager and team and receive information in a manner that is easy to understand;
 - (e) Be able to meet privately with the case manager;
 - (f) Receive ongoing assistance from the case manager; and
 - (g) Be able to request changes in case management agency and/or case manager, as necessary.
- (6) Make informed choices regarding the services and supports he or she receives and from whom, including agency providers and/or non-agency providers as those terms are defined in rule [5160-45-01](#) of the Administrative Code.
- (7) Request reports of any criminal records checks about current providers or provider applicants conducted in accordance with rules [5160-45-07](#) and [5160-45-08](#) of the Administrative Code.
- (8) Access files, records or other information related to the individual's health care.
- (9) Be assured of confidentiality of personal and sensitive health care information pursuant to relevant confidentiality and information disclosure laws.
- (10) Request assistance with problems, concerns and issues, and suggest changes without fear of repercussion.
- (11) Be fully informed about how to contact the case manager and ODM with problems, concerns, issues or inquiries.

(12) Be informed of the right to appeal decisions made by ODM or its designee about waiver eligibility or services pursuant to division 5101:6 of the Administrative Code.

(B) Individual responsibilities.

- (1) Upon enrollment in an ODM-administered waiver, the individual must sign an ODM-approved waiver agreement accepting responsibility to:
- (a) Participate in, and cooperate during assessments to determine eligibility and enrollment in the waiver and service needs.
 - (b) Decide who, besides the case manager, will participate in the service planning process.
 - (c) Participate in, and cooperate with, the case manager and team in the development and implementation of all services plans and plans of care.
 - (d) Participate in the recruitment, selection and dismissal of his or her providers.
 - (e) Participate in the development and maintenance of back-up plans that meet the needs of the individual.
 - (f) Work with the case manager and/or physician and the provider to identify and secure additional training within the provider's scope of practice in order to meet the individual's specific needs.
 - (g) Not direct the service provider to act in a manner that is contrary to relevant ODM-administered waiver program requirements, medicaid rules and regulations and all other applicable laws, rules and regulations.
 - (h) Validate service delivery in a manner that includes, but is not limited to, the date and location of service delivery, arrival and departure times of the provider, the dated signature of the provider and the dated signature of the individual. All signatures shall be obtained at the end of every visit or upon completion of the scheduled service. When services are rendered in multiple visits per day, signatures must be obtained upon completion of each visit.
 - (i) Notify the case manager when any change in provider is necessary. Notification shall include the end date of the former provider, and the start date of the new provider.
 - (j) Authorize the exchange of information for development of the all services plan with all of the individual's service providers, and in compliance with the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (January 25, 2013) and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.000 to 431.306 (November 1, 2013) along with sections 5160.45 to 5160.481 of the Revised Code.
 - (k) Provide accurate and complete information including, but not limited to medical history.
 - (l) Utilize services in accordance with the approved all services plan.
 - (m) Communicate to the provider personal preferences about the duties, tasks and procedures to be performed, and when appropriate, about provider performance concerns.
 - (n) Report to the case manager any service delivery issues including, but not limited to, service disruption, complaints and concerns about the provider, and/or health and safety issues.
 - (o) Pay a patient liability pursuant to rule [5160:1-3-24](#) of the Administrative Code, if one is required as a condition of financial eligibility for medicaid.
 - (p) Comply with third-party liability requirements set forth in rules [5160:1-2-01](#) and [5160:1-2-01.8](#) of the Administrative Code prior to seeking reimbursement for waiver services through the Ohio medicaid program.

- (q) Keep scheduled appointments and notify the provider and case manager if he or she is going to miss a scheduled visit or service.
 - (r) Treat the case manager, team and providers with respect.
 - (s) Report to the case manager any significant changes, as defined in rule [5160-45-01](#) of the Administrative Code, that may affect the provision of services.
 - (t) Report to the case manager, in accordance with rule [5160-45-05](#) of the Administrative Code, incidents that may impact the health and welfare of the individual.
 - (u) Work with the case manager and team to resolve problems and concerns.
 - (v) Refuse to participate in dishonest or illegal activities involving providers, caregivers and team members.
- (2) When an individual receives services from an agency provider, the individual shall identify a location in his or her residence where a file containing a copy of his or her medication profile, if one exists, shall be safely maintained. The file may also include the individual's medication administration record, treatment administration record, aide assignment, all services plan and plans of care.
- (3) When an individual receives services from a non-agency provider, the individual shall identify a location in his or her residence where a copy of the clinical record will be safely maintained.
- (C) If the individual fails to meet the requirements set forth in paragraph (B) of this rule, and/or the health and welfare of the individual receiving services from a non-agency provider cannot be assured, then the individual may be required to receive services from only agency providers. The individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Replaces: 5160-45-03

Effective: 04/01/2015

Five Year Review (FYR) Dates: 04/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 03/12/2015

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5162.03, 5164.02, 5166.02

Prior Effective Dates: 7/1/98, 8/13/07, 7/1/10

LTCSTL 11-01

Effective Date: April 1, 2011

Most Current Prior Effective Date: September 19, 2009

- (A) Waiver provider applicants must complete the enrollment process set forth in this rule and receive approval from the Ohio department of job and family services (ODJFS) before providing services to an ODJFS-administered waiver consumer. Services provided before ODJFS issues such approval are not reimbursable.
- (B) All applicants must complete and submit a waiver provider application to ODJFS or the entity designated by ODJFS to process such applications. The waiver provider application shall be completed and submitted in accordance with the requirements set forth in Chapter 5101:3-1 of the Administrative Code. Each applicant must submit with its application a signed statement affirming that the applicant received and read all of the Administrative Code rules governing the ODJFS-administered waiver program.
- (C) Upon receipt of a waiver provider application, ODJFS shall verify all of the following:
 - (1) The applicant meets the requirements set forth in Chapter 5101:3-45 of the Administrative Code, and depending upon the provider type for which the applicant is requesting authorization to furnish services, Chapter 5101:3-46, 5101:3-47 or 5101:3-50 of the Administrative Code.
 - (2) The application contains all of the documentation required on the applicant's specific medicaid provider agreement provider type addendum.
 - (3) The individual, agency and/or agency's primary officer, director or owner is not listed on:
 - (a) The U.S. department of health and human services' exclusionary participant list;
 - (b) The Ohio department of mental retardation and developmental disabilities' abuser registry; and
 - (c) Any additional federal or state exclusionary lists ODJFS may consider when determining provider eligibility.
 - (4) If the applicant is a medicare-certified home health agency, evidence that the applicant's certification status is current.
 - (5) If the applicant is an otherwise-accredited agency, evidence that the applicant's accreditation status is current.
 - (6) If the applicant is a non-agency personal care aide service provider, evidence that:
 - (a) The applicant:
 - (i) Meets the training requirements set forth in rule 5101:3-46-04, 5101:3-47-04 or 5101:3-50-04 of the Administrative Code, as appropriate, and
 - (ii) Has successfully completed a criminal records check as set forth in rule 5101:3-45-08 of the Administrative Code; and
 - (b) The consumer has requested that the applicant provide the service for which application is being made.
 - (7) If the applicant is a non-agency nurse, evidence that the applicant:
 - (a) Possesses a current, valid and unrestricted license as a registered nurse (RN) or licensed practical nurse (LPN) with the Ohio board of nursing;
 - (b) Has no pending actions or sanctions against the non-agency nurse by the Ohio board of nursing; and

(c) Has successfully completed a criminal records check as set forth in rule 5101:3-45-08 of the Administrative Code.

(8) If the applicant is a non-agency LPN, additional evidence that the applicant works at the direction of an RN who possesses a current, valid and unrestricted license with the Ohio board of nursing.

(D) ODJFS shall review all documentation and make a determination regarding the applicant's eligibility for enrollment. If the application does not contain all of the documentation required by this rule, then ODJFS shall notify the applicant in writing of the missing documentation.

(E) The applicant shall have thirty calendar days from the date of written notification to provide the missing documentation ODJFS identifies pursuant to paragraph (D) of this rule. If the applicant does not submit the required documentation within the thirty calendar-day period, ODJFS shall terminate the application process.

(F) ODJFS shall notify the applicant in writing of its approval or denial as a waiver provider. If ODJFS determines the applicant is ineligible to provide waiver services, ODJFS shall inform the applicant of his or her appeal rights in accordance with rule [5101:3-1-17.6](#) of the Administrative Code.

Effective: 04/01/2011

R.C. 119.032 review dates: 09/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 03/18/2011

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 7/1/04, 9/19/09

LTCSTL 14-03

Effective Date: April 1, 2014

Most Current Prior Effective Date: September 19, 2009

(A) For the purposes of this rule,

- (1) "Alert" means an incident that must be reported to the Ohio department of medicaid (ODM) due to the severity and/or impact on an individual enrolled on an ODM-administered waiver or the need for ODM involvement in the incident investigation. Alerts include, but are not limited to the events described in paragraph (J) of this rule.
- (2) "Incident" means an alleged, suspected or actual event that is not consistent with the routine care of, and/or service delivery to, an individual. Incidents include, but are not limited to the events described in paragraph (F) of this rule.
- (3) "Individual" means a person who is enrolled in an ODM-administered waiver or who participates in any ODM-administered program that is directed to adhere to this rule.
- (4) "Provider" means an ODM-administered waiver service provider, any other service provider that is directed to adhere to this rule, and all of their respective staff who have direct contact with individuals.

(B) ODM shall operate an incident management system that includes responsibilities for reporting, responding to, investigating and remediating incidents. This rule sets forth the standards and procedures for operating that system. It applies to ODM, its designees, individuals and providers. ODM may designate other agencies or entities to perform one or more of the incident management functions set forth in this rule.

(C) ODM and its designees shall assure the health and welfare of individuals enrolled on an ODM-administered waiver. ODM, its designees and providers are responsible for ensuring individuals are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being.

(D) Upon entering into a medicaid provider agreement, and annually thereafter, all providers, including all employees who have direct contact with individuals enrolled on an ODM-administered waiver, must acknowledge in writing they have reviewed this rule and related procedures.

(E) Upon an individual's enrollment in an ODM-administered waiver, and at the time of each reassessment, ODM or the designated case management contractor shall provide the individual and/or the individual's authorized representative or legal guardian with a waiver handbook that includes information about how to report abuse, neglect, exploitation and other incidents. The case management contractor shall secure from the individual, authorized representative and/or legal guardian written confirmation of receipt of the handbook and it shall be maintained in the individual's case record.

(F) Incidents include, but are not limited to, all of the following:

- (1) Abuse: the injury, confinement, control, intimidation or punishment of an individual by another person that has resulted, or could reasonably be expected to result, in physical harm, pain, fear or mental anguish. Abuse includes, but is not limited to physical, emotional, verbal and/or sexual abuse, and use of restraint, seclusion or restrictive intervention that results in, or could reasonably be expected to result in, physical harm, pain, fear or mental anguish to the individual.
- (2) Neglect: when there is a duty to do so, the failure to provide goods, services and/or treatment necessary to assure the health and welfare of an individual.

- (3) Exploitation: the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit or gain.
- (4) Misappropriation: depriving, defrauding or otherwise obtaining the money, or real or personal property (including medication) of an individual by any means prohibited by law.
- (5) Death of an individual.
- (6) Hospitalization or emergency department visit (including observation) as a result of:
 - (a) Accident, injury or fall;
 - (b) Injury or illness of an unknown cause or origin; and
 - (c) Reoccurrence of an illness or medical condition within seven calendar days of the individual's discharge from a hospital.
- (7) Unauthorized use of restraint, seclusion and/or restrictive intervention that does not result in, or cannot reasonably be expected to result in, injury to the individual.
- (8) An unexpected crisis in the individual's family or environment that results in an inability to assure the individual's health and welfare in his or her primary place of residence.
- (9) Inappropriate service delivery including, but not limited to:
 - (a) A provider's violation of the conditions of participation set forth in rule [5160-45-10](#) of the Administrative Code;
 - (b) Services provided to the individual that are beyond the provider's scope of practice;
 - (c) Services delivered to the individual without, or not in accordance with, physician's orders; and
 - (d) Medication administration errors involving the individual.
- (10) Actions on the part of the individual that place the health and welfare of the individual or others at risk including, but not limited to:
 - (a) The individual cannot be located;
 - (b) Activities that involve law enforcement;
 - (c) Misuse of medications; and
 - (d) Use of illegal substances.

(G) Incident reporter responsibilities.

- (1) ODM, its designees and all providers are required to report incidents in accordance with the procedures set forth in this rule.
- (2) Individuals and/or their authorized representative or legal guardian should report incidents to the individual's case manager and the appropriate authorities.
- (3) If a person or an entity identified in paragraph (G)(1) of this rule learns of an incident, the person or entity shall do all of the following:
 - (a) Take immediate action to assure the health and welfare of the individual which may include, but is not limited to, seeking or providing medical attention.
 - (b) Immediately report any incident(s) set forth in paragraphs (F)(1) to (F)(5) of this rule to the case manager and the appropriate authorities set forth in paragraph (G)(5)(a) of this rule.
 - (c) Report any incident(s) set forth in paragraphs (F)(6) to (F)(9) of this rule to the case manager within twenty-four hours unless bound by federal, state or local law or professional licensure or certification requirements to report sooner.
- (4) At a minimum, all incident reports shall include:

- (a) The facts that are relevant to the incident;
- (b) The incident type; and
- (c) The names of, and when available, the contact information for, all persons involved.

(5) Appropriate authorities include, but are not limited to:

- (a) The following agencies that hold investigative and/or protective authority:
 - (i) Local law enforcement if the incident involves conduct that constitutes a possible criminal act including but not limited to, abuse, neglect, exploitation, misappropriation or death of the individual;
 - (ii) The local coronor's office;
 - (iii) The local county board of developmental disabilities (CBDD);
 - (iv) The local public children services agency (PCSA); and
 - (v) The local public adult protective services agency.
- (b) The following regulatory, oversight and/or advocacy agencies:
 - (i) The Ohio long term care ombudsman;
 - (ii) The alcohol, drug addiction and mental health service board, if alcohol, drug addiction or mental health services are identified on the individual's all services plan;
 - (iii) The Ohio department of health (ODH), or other licensure or certification board or accreditation body when the allegation involves a provider regulated by that entity;
 - (iv) The Ohio attorney general when the allegation is suspected to involve medicaid fraud; and
 - (v) The local probate court when the allegation is suspected to involve the legal guardian.

(6) The incident reporter must also notify his or her supervisor if he or she has one.

(H) Case management contractor responsibilities.

- (1) The case management contractor shall do all of the following upon discovery of an incident:
 - (a) Ensure that immediate action was taken to protect the health and welfare of the individual and any other individuals who may be at-risk.
 - (b) Notify the agencies that hold investigative and/or protective authority as set forth in paragraph (G)(5)(a) of this rule if the incident was one of those set forth in paragraph (F)(1) to (F)(5) of this rule.
 - (c) Notify the appropriate additional regulatory, oversight and/or advocacy agencies set forth in paragraph (G)(5)(b) of this rule.
 - (d) Notify the individual's lead physician.
- (2) Complete an incident report in ODM's electronic case management system within twenty-four hours of discovery.
- (3) The case management contractor shall notify ODM within one business day of any incident that meets the criteria of an alert as set forth in paragraph (J) of this rule.
- (4) The case management contractor shall notify the individual and/or the individual's authorized representative or legal guardian as long as such notification will not jeopardize the incident investigation and/or place the health and welfare of the individual or reporter at risk.

(I) Provider oversight responsibilities.

- (1) ODM or its designated provider oversight contractor must review all reported incidents within one business day of notification via ODM's electronic case management system, and shall do all of the following as part of its review:
 - (a) Verify that immediate action was taken to protect the health and welfare of the individual and any other individuals who may be at-risk. If such action was not taken, the provider oversight contractor must do so immediately.
 - (b) Verify that the county coroner was notified in the event of the death of an individual. If such action was not taken, the provider oversight contractor must do so immediately.
 - (c) Verify that the appropriate authorities have been notified as required by this rule. If such action was not taken, the provider oversight contractor must do so immediately.
 - (d) Verify that the incident was reported within the timeframe required by this rule.
 - (e) Notify ODM of any incident that meets the criteria of an alert as set forth in paragraph (J) of this rule.
- (2) The provider oversight contractor shall initiate an investigation no later than two business days after having been notified of an incident. At a minimum, the provider oversight contractor shall:
 - (a) Contact and work cooperatively with protective agencies and any other entities to whom the incident was reported and that may be conducting a separate investigation.
 - (b) Conduct a review of all relevant documents including, but not limited to, all services plans, assessments, clinical notes, communication notes, coroner's reports, documentation available from other authorities, provider documentation, plans of care, provider billing records, medical reports, police and fire department reports and emergency response system reports.
 - (c) Conduct and document interviews with anyone who may have information relevant to the incident investigation including, but not limited to, the reporter, individuals, authorized representatives and/or legal guardians and providers.
 - (d) Include the individual and the reporter in the incident investigation process, as long as such involvement is both safe and appropriate.
 - (e) When applicable, make referrals to appropriate licensure or certification boards, accreditation bodies, and/or other entities based on the information obtained during the investigation.
 - (f) Document all investigative activities.
 - (g) Document if and why any of the steps set forth in paragraph (1) of this rule were omitted from the incident investigation.
- (3) If, at any time during the investigation of a death, it is determined the incident meets the criteria for a suspicious death as described in paragraph (J)(2)(a) of this rule, or the death may have been preventable, the provider oversight contractor must notify ODM within one business day of the contractor's discovery. If ODM agrees the death is suspicious in nature or was preventable, it shall maintain lead responsibility for the investigation and follow all of the steps set forth in paragraph (1) of this rule and the ODM-approved death investigation protocol. All other deaths shall be investigated by the provider oversight contractor in accordance with the steps set forth in paragraph (1) of this rule and the ODM-approved death investigation protocol.
- (4) Concluding an incident investigation.
 - (a) The provider oversight contractor must conclude its incident investigation no later than forty-five days after the provider oversight contractor's initial receipt of the incident report. Extension of this deadline is only permissible upon prior approval by ODM.
 - (b) At the conclusion of the investigation, the provider oversight contractor shall:

- (i) Submit to ODM and the individual, authorized representative and/or legal guardian a written report that:

 - (a) Summarizes the investigation;
 - (b) Identifies if the incident was substantiated and whether it was preventable; and
 - (c) Includes a prevention plan for the individual that identifies the steps necessary to mitigate the effects of a substantiated incident, eliminate the causes and contributing factors that resulted in risk to the health and welfare of the individual and any other persons impacted by the incident and prevent future incidents.
- (ii) Notify ODM-administered waiver service providers who are subject to the incident investigation in writing upon substantiation of an incident. The notification shall specify:

 - (a) The findings of the investigation that substantiate the occurrence of the incident;
 - (b) The Administrative Code rule(s) that support(s) the finding(s) of the investigation;
 - (c) What steps the provider must take in order to mitigate against the causes of and factors contributing to the incident; and
 - (d) The timeframe within which the provider must submit a plan of correction to the provider oversight contractor in accordance with rule [5160-45-06](#) of the Administrative Code, not to exceed fifteen calendar days after the date the letter was mailed.
- (iii) Provide a written summary of the investigative findings to the reporter of the incident unless such action could jeopardize the health and welfare of the individual.
- (iv) Assure that all such reports issued pursuant to paragraph (I)(4) of this rule shall comply with all applicable state and federal confidentiality and information disclosure laws.

(J) Alerts.

- (1) The provider oversight contractor shall ensure that incidents that rise to the level of an alert are reported to ODM within one business day of the incident's identification and report submission.
- (2) The following incidents are cause for an alert:

 - (a) A suspicious death in which the circumstances and/or the cause of death are not related to any known medical condition of the individual, and/or; in which someone's action or inaction may have caused or contributed to the individual's death;
 - (b) Abuse or neglect that required the individual's removal from his or her place of residence;
 - (c) Hospitalization or emergency department visit (including observation) as a result of:

 - (i) Abuse or neglect,
 - (ii) Accident, injury or fall,
 - (iii) Injury or illness of an unknown cause or origin, and
 - (iv) Reoccurrence within seven calendar days of the individual's discharge from a hospital;
 - (d) Harm to multiple individuals as a result of an incident;

- (e) Injury resulting from the authorized or unauthorized use of a restraint, seclusion or restrictive intervention;
- (f) Incidents involving an employee of the case management contractor or provider oversight contractor;
- (g) Misappropriation that is valued at five hundred dollars or more;
- (h) Incidents generated from correspondence received from the Ohio attorney general, office of the governor, the centers for medicare and medicaid services (CMS) or the federal office of civil rights; and
- (i) Incidents identified by a public media source.

- (K) At its discretion, ODM may request further review of any incident under investigation, and/or conduct a separate, independent review or investigation of any incident.
- (L) ODM shall determine when to close incident investigations, and shall be responsible for ensuring that all cases are properly closed.
- (M) If, at any time during the discovery or investigation of an incident, it is determined that an employee of the case management contractor or provider oversight contractor is or may be responsible for, or contributed to, the abuse, neglect, exploitation or death of an individual, the case management contractor or provider oversight contractor shall immediately notify ODM. ODM shall assume responsibility for the investigation in accordance with the procedures set forth in this rule.
- (N) ODM may impose sanctions upon the provider in accordance with rules 5160-45-06 and [5160-45-09](#) of the Administrative Code based upon the substantiation of an incident, failure to comply with any of the requirements set forth in this rule, failure to assure the health and welfare of the individual and/or failure to comply with all applicable federal, state and local laws and regulations.

Replaces: 5160-45-05

Effective: 04/01/2014

R.C. 119.032 review dates: 04/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 03/17/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 5166.11, 5166.13

Prior Effective Dates: 7/7/04, 9/19/09

[LTCSSTL 15-04](#)

Effective Date: February 1, 2015

Most Current Prior Effective Date: [September 19, 2009](#)

- (A) The Ohio department of medicaid (ODM) or its designee shall continuously monitor every ODM-administered waiver provider. Monitoring activities shall include, but not be limited to:
- (1) A structural review of compliance with all ODM-administered waiver provider requirements in accordance with paragraph (B) of this rule.
 - (2) Investigation of provider occurrences in accordance with paragraph (C) of this rule.
- (B) Structural reviews.
- (1) Medicare-certified and/or otherwise accredited agencies as defined in rule [5160-45-01](#) of the Administrative Code are subject to reviews in accordance with their certification and accreditation bodies, and therefore shall be exempt from a regularly scheduled structural review. Such agencies shall submit a copy of their updated certification and/or accreditation, and upon request of ODM or its designee, shall make available to ODM or its designee within ten business days, all review reports and accepted plans of correction from the certification and/or accreditation bodies.
 - (2) All other ODM-administered waiver providers shall be subject to structural reviews by ODM or its designee during each of the first three years after a provider begins furnishing billable services. Thereafter, structural reviews shall be conducted annually unless, at the discretion of ODM or its designee, biennial structural reviews may be conducted with a provider, when all of the following apply:
 - (a) There were no findings against the provider during the provider's most recent structural review;
 - (b) The provider was not substantiated to be the violator in an incident described in rule [5160-45-05](#) of the Administrative Code;
 - (c) The provider was not the subject of more than one provider occurrence during the previous twelve months; and
 - (d) The provider does not live with an individual receiving ODM-administered waiver services.
 - (3) All ODM-administered waiver providers may be subject to an announced or unannounced structural review at any time as determined by ODM or its designee.
 - (4) Structural reviews must be conducted in person between the provider and ODM or its designee, unless prior-approved by ODM and in a manner consistent with paragraph (B)(3) of rule [5160-45-09](#) of the Administrative Code.
 - (5) All structural reviews must use an ODM-approved structural review tool.
 - (6) Structural reviews shall not occur while the provider is furnishing services to an individual.
 - (7) The structural review process consists of the following activities:
 - (a) Except for unannounced structural reviews, the provider shall be notified in advance of the review to arrange a mutually acceptable time, date and location for the review. Advance notification shall also include identification of the time period for which the review is being conducted and a list of the type of documents required for the review.

- (b) The provider shall ensure the availability of required documents and maintain the confidentiality of information about the individual enrolled on the ODM-administered waiver.
 - (c) ODM or its designee shall examine any incident reports or provider occurrences related to the provider. Documented findings of noncompliance shall be addressed during the review.
 - (d) The structural review shall include an evaluation of compliance with Chapter 5160-45 of the Administrative Code and Chapter 5160-46, 5160-50 and/or 5160-58 of the Administrative Code, depending upon the waiver(s) under which the provider is furnishing services.
 - (e) A unit of service verification shall be conducted by ODM or its designee to assure that all waiver services are authorized, delivered and reimbursed in accordance with the approved all services plan for the individual receiving waiver services.
 - (f) An evaluation shall be conducted to determine whether the provider has implemented all plans of correction that were approved since the last review.
 - (g) At the conclusion of the review, ODM or its designee shall conduct an exit conference with the non-agency provider, or in the case of an agency provider, the agency administrator or his or her designee, about its preliminary findings, any individual remediation and other required follow-up.
- (8) ODM or its designee shall issue a written findings report to the provider. The report shall summarize the overall outcome of the structural review, specify the Administrative Code rules that are the basis for which noncompliance has been determined, and outline the specific findings of noncompliance the provider must address in a plan of correction, including any individual remediation.

(C) Provider occurrences.

- (1) "Provider occurrence" means any alleged, suspected or actual performance or operational issue by a provider furnishing ODM-administered waiver services that does not meet the definition of an incident as set forth in rule 5160-45-05 of the Administrative Code. Provider occurrences include, but are not limited to alleged violations of provider eligibility and/or service specification requirements, billing issues including overpayments, and medicaid fraud.
- (2) Upon discovery, ODM or its designee shall investigate provider occurrences including requesting any documentation required for the investigation.
- (3) If ODM or its designee substantiates the provider occurrence, it shall notify the provider in a manner that confirms provider receipt. The notification shall specify:
 - (a) The provider's action or inaction that constituted the provider occurrence;
 - (b) The Administrative Code rule(s) that support the finding(s) of noncompliance;
 - (c) What the provider must do to correct the finding(s) of noncompliance, including any individual remediation or required payment adjustments;

(D) Plans of correction for structural reviews and provider occurrences.

- (1) The provider must submit to ODM or its designee a plan of correction for all identified findings of noncompliance, including any individual remediation, within forty-five calendar days after the date on the written report.
- (2) If ODM or its designee finds the provider's plan of correction acceptable, it shall acknowledge, in writing, to the provider that the plan addresses the findings outlined in the written report. If ODM or its designee determines that it cannot approve the provider's plan of correction, it shall inform the provider of this determination, in writing, require that the provider submit a new plan of correction and specify the required actions that must be included in the plan of correction. The provider must submit the new plan of correction within ten calendar days.

- (E) If ODM or its designee determines through the structural review process or the investigation of a provider occurrence that an overpayment of a provider claim has occurred, the provider shall make all payment adjustments in accordance with rule 5160-1-19 of the Administrative Code and the provider's approved plan of correction.
- (F) ODM may take action against the provider in accordance with rule 5160-45-09 of the Administrative Code for failure to comply with any of the requirements set forth in this rule.

Replaces: 5160-45-06

Effective: 02/01/2015

Five Year Review (FYR) Dates: 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5162.03, 5164.02, 5166.02

Prior Effective Dates: 7/1/04, 9/19/09

5160-45-07 Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Agency Providers

***Formerly* 5101:3-45-07 Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Criminal Records Checks Involving Agency Providers**

LTCSSSTL 13-10

Effective Date: January 1, 2014

Most Current Prior Effective Date: January 1, 2013

- (A) Unless otherwise stated in paragraphs (A)(1) and (A)(2) of this rule, 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 Ohio home care waiver, transitions DD waiver and/or transitions carve-out waiver. This rule does not apply to:
- (1) Any individual who is subject to a database review or a criminal records check under section 3701.881 of the Revised Code and rules adopted thereunder.
 - (2) Applicants and employees of a waiver agency that is also a community-based long term care agency who are subject to database reviews and criminal records checks in accordance with section [173.394](#) of the Revised Code and rules adopted thereunder.
- (B) For the purposes of this rule,
- (1) "Applicant" means a person who is under final consideration for employment with a waiver agency in a full-time, part-time or temporary position, that involves providing HCBS.
 - (2) "Chief administrator" means the head of a waiver agency, or his or her designee.
 - (3) "Community-based long term care agency" has the same meaning as in section [173.39](#) of the Revised Code.
 - (4) "Criminal records check" has the same meaning as in section [109.572](#) of the Revised Code.
 - (5) "Department" means the Ohio ~~office of medical assistance~~ department of medicaid (~~OMA~~ODM).
 - (6) "Disqualifying offense" means any of the following:
 - (a) A violation of section 959.13, 959.131, 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.211, 2903.22, 2903.34, 2903.341, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2905.32, 2905.33, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2907.33, 2909.02, 2909.03, 2909.04, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.05, 2913.11, 2913.21, 2913.31, 2913.32, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2913.51, 2917.01, 2917.02, 2917.03, 2917.31, 2919.12, 2919.121, 2919.123, 2919.22, 2919.23, 2919.24, 2919.25, 2921.03, 2921.11, 2921.12, 2921.13, 2921.21, 2921.24, 2921.32, 2921.321, 2921.34, 2921.35, 2921.36, 2921.51, 2923.12, 2923.122, 2923.123, 2923.13, 2923.161, 2923.162, 2923.21, 2923.32, 2923.42, 2925.02, 2925.03, 2925.04, 2925.041, 2925.05, 2925.06, 2925.09, 2925.11, 2925.13, 2925.14, 2925.141, 2925.22, 2925.23, 2925.24, 2925.36, 2925.55, 2925.56, 2927.12 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; or
 - (b) A violation of section 2923.01, 2923.02, or 2923.03 of the Revised Code when the underlying offense that is the object of the conspiracy, attempt, or complicity is one of the offenses listed in paragraph (B)(6)(a) of this rule; or

(c) A violation of an existing or former municipal ordinance or law of the state of Ohio, any other state, or the United States that is substantially equivalent to any of the disqualifying offenses as set forth in paragraph (B)(6)(a) or (B)(6)(b) of this rule.

(7) "Employee" means a person employed by a waiver agency in a full-time, part-time, or temporary position that involves providing HCBS.

(8) "Home and community-based services medicaid waiver component" has the same meaning as in section [5111.85](#) of the Revised Code. For the purposes of this rule, "home and community-based services medicaid waiver component" is interchangeable with Ohio home care waiver, transitions DD waiver and/or transitions carve-out waiver.

(9) "Waiver agency" means a person or government entity that provides HCBS under an Ohio home care waiver, transitions DD waiver or transitions carve-out waiver, other than such a person or government entity that is certified under the medicare program. "Waiver agency" does not mean an independent provider as defined in section [5111.034](#) of the Revised Code or rule [5101:3-45-08](#) of the Administrative Code.

(C) No waiver agency shall employ an applicant or continue to employ an employee in a position that involves providing HCBS in an Ohio home care waiver, transitions DD waiver or transitions carve-out waiver if the applicant or employee:

(1) Is included on one or more of the following databases:

(a) The system for award management (SAM) maintained by the United States general services administration;

(b) The list of excluded individuals and entities maintained by the office of inspector general in the United States department of health and human services pursuant to section 1128 of the "Social Security Act," 94 Stat. 2619 (1980), 42 U.S.C. 1320a-7, as amended, and section 1156 of the "Social Security Act," 96 Stat. 388 (1982), 42 U.S.C. 1320c-5, as amended;

(c) The Ohio department of developmental disabilities (DODD) online abuser registry established under section [5123.52](#) of the Revised Code;

(d) The internet-based sex offender and child-victim offender database established under division (A)(11) of section [2950.13](#) of the Revised Code;

(e) The internet-based database of inmates established under section [5120.66](#) of the Revised Code; or

(f) Is included on the state nurse aide registry established under section 3721.32 of the Revised Code, and there is a statement detailing findings by the director of health that the applicant or employee neglected or abused a long-term care facility or residential care facility resident or misappropriated property of such a resident.

(2) Fails to:

(a) Submit to a criminal records check conducted by the bureau of criminal identification and investigation (BCII), including failing to access, complete and forward to the superintendent the form or the standard fingerprint impression sheet; or

(b) Instruct the superintendent of BCII to submit the completed report of the criminal records check directly to the chief administrator of the waiver agency.

(3) Except as provided for in paragraphs (F) and (G) of this rule, the applicant or employee has been convicted of, or pleaded guilty to, a disqualifying offense, regardless of the date of the conviction or date of entry of the guilty plea.

(D) Process for conducting criminal records checks.

(1) At the time of each applicant's initial application for employment in a position that involves providing HCBS in an Ohio home care waiver, transitions DD waiver or transitions carve-out

waiver, the chief administrator of the waiver agency shall conduct a review of the databases listed in paragraph (C)(1) of this rule to determine whether the waiver agency is prohibited from employing the applicant in that position. The chief administrator of the waiver agency shall provide the applicant with a copy of any disqualifying information disclosed in the review of the databases.

- (2) Except as otherwise noted in paragraph (C)(1) of this rule, the chief administrator of a waiver agency shall require each applicant to request that the BCII superintendent conduct a criminal records check with respect to the waiver agency applicant, and pursuant to sections [109.572](#) and [5111.033](#) of the Revised Code. The applicant must provide a set of fingerprint impressions as part of the criminal records check.
 - (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) in a criminal records check, the chief administrator shall require the applicant to request that the superintendent obtain information from the FBI as part of the criminal records check.
 - (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 require the applicant to request that the superintendent obtain information from the FBI in the criminal records check.
- (3) The chief administrator of a waiver agency shall provide the following to each applicant for whom a criminal records check is required by this rule:
 - (a) Information about accessing, completing and forwarding to the superintendent the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet presented pursuant to division (C)(2) of that section; and
 - (b) Written notification that the applicant is to instruct the superintendent to submit the completed report of the criminal records check directly to the chief administrator of the waiver agency.
- (4) Conditional employment.
 - (a) 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 waiver agency has conducted a review of the databases listed in paragraph (C)(1) of this rule and has determined the waiver agency is not prohibited from employing the applicant in that position. The chief administrator must require the applicant to request a criminal records check no later than five business days after he or she begins conditional employment.
 - (b) The waiver agency shall terminate conditional employment if the results of the criminal records check request, other than the results of any request for information from the FBI, are not obtained within sixty days of the criminal records check request.
- (5) If the results of the criminal records check indicate that the individual has been convicted of, or has pleaded guilty to any of the disqualifying offenses set forth in paragraph (B)(6) of this rule, and regardless of the date of conviction or the date of entry of the guilty plea, then the waiver agency shall either:
 - (a) Terminate his or her employment; or
 - (b) Choose to employ the individual because he or she meets the conditions set forth in paragraph (F) of this rule.
- (6) If the waiver agency determines that two or more convictions or guilty pleas result from or are connected with the same act or result from offenses committed at the same time, they shall be counted as one conviction or guilty plea.

- (7) 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.
- (8) A waiver agency shall pay to BCII the fee prescribed pursuant to division (C)(3) of section 109.572 of the Revised Code for any criminal records check required by this rule. However, a waiver agency may require an applicant to pay to BCII the fee for a criminal records check of the applicant. If the waiver agency pays the fee for an applicant, it may charge the applicant a fee not exceeding the amount the waiver agency pays to BCII pursuant to this rule if the waiver agency notifies the applicant at the time of 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.
- (9) 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 that requires the applicant to request the criminal records check or the administrator's representative;
 - (c) The director of ~~OMA~~ODM and the staff of the department who are involved in the administration of the Ohio medicaid program;
 - (d) The director of ODA or the director's designee if the waiver agency also is a community-based long-term care agency; ~~and~~
 - (e) An individual who receives, or may receive, waiver services from the person who is the subject of the criminal records check; and
 - ~~(e)~~(f) Any court, hearing officer or other necessary individual involved in a case dealing with a denial of employment of the applicant or termination of the employee; employment or unemployment benefits of the applicant or employee; or a civil or criminal action regarding the Ohio medicaid program.

(E) As a condition of continuing to employ an individual in a position that involves providing HCBS in the Ohio home care waiver, transitions DD waiver or transitions carve-out waiver, the chief administrator of the waiver agency shall conduct a criminal records check of that employee at least once every five years according to one of the following three schedules set forth in paragraphs (E)(1) to (E)(3) of this rule. The chief administrator shall follow the same process set forth in paragraphs (D)(1) to (D)(9) of this rule.

- (1) If the chief administrator of the waiver agency hired the employee before January 1, 2008, the chief administrator shall conduct a criminal records check of the employee no later than thirty days after the 2013 anniversary of the employee's date of hire and no later than thirty days after each anniversary date every five years after 2013.
- (2) If the chief administrator of the waiver agency hired the employee on or after January 1, 2008, the chief administrator shall conduct a criminal records check of the employee no later than thirty days after the fifth anniversary of the employee's date of hire and no later than thirty days after each anniversary date every five years after the first fifth-year anniversary.
- (3) The chief administrator of the waiver agency may conduct a criminal records check on any employee more frequently than every five years without any need to conduct a criminal records check according to the schedules set forth in paragraphs (E)(1) and (E)(2) of this rule.

(F) A waiver agency may choose to employ an applicant or continue to employ an employee who has been convicted of, or has pleaded guilty to, a disqualifying offense set forth in paragraph (B)(6) of this rule if:

- (1) The applicant or employee has satisfied the conditions associated with the exclusionary periods set forth in rule [5101:3-45-11](#) of the Administrative Code; or

- (2) The applicant or employee has obtained a certificate of qualification for employment issued by a court of common pleas with competent jurisdiction pursuant to section 2953.25 of the Revised Code, and in accordance with rule 5101:3-45-11 of the Administrative Code; or
 - (3) The applicant or employee has obtained a certificate of achievement and employability in an HCBS-related field, issued by the Ohio department of rehabilitation and corrections pursuant to section 2961.22 of the Revised Code, and in accordance with rule 5101:3-45-11 of the Administrative Code; and
 - (4) The applicant or employee has agreed, in writing, to have the waiver agency inform each potential consumer of the disqualifying offense, and has acknowledged, in writing, that the potential consumer has the right to select or reject to receive services from the applicant or employee, prior to commencing service delivery.
- (G) A waiver agency may choose to continue to employ an employee who is otherwise excluded by paragraph (B)(6) of this rule if:
- (1) The offense is a tier IV offense as set forth in paragraph (F) of rule 5101:3-45-11 of the Administrative Code;
 - (2) The employee was hired prior to January 1, 2013;
 - (3) The conviction or guilty plea occurred prior to January 1, 2013; and
 - (4) The waiver agency has considered the nature and seriousness of the offense(s), and attests in writing prior to April 1, 2013, to the character and fitness of the employee based on their demonstrated work performance. The required written attestation shall be maintained in the employee's personnel record.
- (H) Pardons.
- A conviction of, or a plea of guilty to, an offense as set forth in paragraph (B)(6) of this rule shall not prevent an agency from considering an applicant for employment or an employee for continued employment if any of the following circumstances apply:
- (1) The applicant or employee has been granted an unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;
 - (2) The applicant or employee 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 or employee 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 applicant's or employee's conviction or guilty plea has been set aside pursuant to law.
- (I) Documentation of compliance. Each waiver agency shall maintain a roster of applicants and employees, accessible by the director, which includes, but is not limited to:
- (1) The name of each applicant and employee;
 - (2) The date the applicant or employee started work;
 - (3) The date the criminal records check request is submitted to BCII;
 - (4) The date the criminal records check is received; and
 - (5) A determination of whether the results of the check revealed that the applicant or employee committed a disqualifying offense(s).

Effective: 01/01/2014

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/09/2013

Promulgated Under: 119.03

Statutory Authority: 5111.033, 5111.85

Rule Amplifies: 109.572, 5111.01, 5111.02, 5111.033, 5111.85

Prior Effective Dates: 7/1/04, 11/19/07, 12/10/09, 1/1/13

LTCSSSTL 13-01

Effective Date: January 1, 2013

Most Current Prior Effective Date: December 10, 2009

- (A) This rule sets forth the process and requirements for the criminal records checks of independent providers of home and community-based services (HCBS) in the Ohio home care, transitions DD and transitions carve-out waivers.
- (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 **5111.034** of the Revised Code (September 26, 2003).
 - (2) "Applicant" means a person who has applied for a medicaid provider agreement to provide HCBS as an independent provider under the Ohio home care, transitions DD or transitions carve-out waiver.
 - (3) "Criminal records check" has the same meaning as in section **109.572** of the Revised Code.
 - (4) "Department" means Ohio office of medical assistance (OMA).
 - (5) "Disqualifying offense" means any of the following:
 - (a) A violation of section 959.13, 959.131, 2903.01, 2903.02, 2903.03, 2903.04, 2903.041, 2903.11, 2903.12, 2903.13, 2903.15, 2903.16, 2903.21, 2903.211, 2903.22, 2903.34, 2903.341, 2905.01, 2905.02, 2905.05, 2905.11, 2905.12, 2905.32, 2905.33, 2907.02, 2907.03, 2907.04, 2907.05, 2907.06, 2907.07, 2907.08, 2907.09, 2907.21, 2907.22, 2907.23, 2907.24, 2907.25, 2907.31, 2907.32, 2907.321, 2907.322, 2907.323, 2907.33, 2909.02, 2909.03, 2909.04, 2909.22, 2909.23, 2909.24, 2911.01, 2911.02, 2911.11, 2911.12, 2911.13, 2913.02, 2913.03, 2913.04, 2913.05, 2913.11, 2913.21, 2913.31, 2913.32, 2913.40, 2913.41, 2913.42, 2913.43, 2913.44, 2913.441, 2913.45, 2913.46, 2913.47, 2913.48, 2913.49, 2913.51, 2917.01, 2917.02, 2917.03, 2917.31, 2919.12, 2919.121, 2919.321, 2919.22, 2919.23, 2919.24, 2919.25, 2921.03, 2921.11, 2921.12, 2921.13, 2921.21, 2921.24, 2921.32, 2921.123, 2921.34, 2921.35, 2921.36, 2921.51, 2923.12, 2923.122, 2923.123, 2923.13, 2923.161, 2923.162, 2923.21, 2923.32, 2923.42, 2925.02, 2925.03, 2925.04, 2925.041, 2925.05, 2925.06, 2925.09, 2925.11, 2925.13, 2925.14, 2925.141, 2925.22, 2925.23, 2925.24, 2925.36, 2925.55, 2925.56, 2927.12 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; or
 - (b) A violation of section 2903.01, 2903.02, or 2923.03 of the Revised Code when the underlying offense that is the object of the conspiracy, attempt, or complicity is one of the offenses listed in paragraph (B)(5)(a) of this rule; or
 - (c) A violation of an existing or former municipal ordinance or law of the state of Ohio, any other state, or the United States that is substantially equivalent to any of the disqualifying offenses set forth in paragraph (B)(5)(a) or (B)(5)(b) of this rule.
 - (6) "Effective date of provider agreement" means the month in which the initial provider agreement was entered into between the department and the provider.
 - (7) "Home and community-based services medicaid waiver component" has the same meaning as in section **5111.85** of the Revised Code. For the purposes of this rule, "home and community-

based services medicaid waiver component" is interchangeable with Ohio home care waiver, transitions DD waiver and/or transitions carve-out waiver.

(8) "Independent provider" means a person who has a medicaid provider agreement to provide HCBS as an independent provider in the Ohio home care waiver, transitions DD waiver and/or the transitions carve-out waiver. The term "independent provider" is interchangeable with the term "non-agency provider" in chapters 5101:3-45, 5101:3-46, 5101:3-47 and 5101:3-50 of the Administrative Code.

(9) "Superintendent" means superintendent of the bureau of criminal identification and investigation (BCII).

(C) ODJFS or its designee shall deny an applicant's application for a medicaid provider agreement, and shall immediately take steps to terminate an independent provider's medicaid provider agreement, if either of the following applies:

(1) After the applicant or independent provider is given the information and notification required by paragraphs (D)(3)(a) and (D)(3)(b) of this rule, the applicant or independent provider fails to do any of the following:

(a) Access, complete, and forward to the superintendent of BCII the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code, or the standard impression sheet prescribed pursuant to division (C)(2) of that section;

(b) Submit a criminal records check within sixty days of notification;

(c) Instruct the superintendent to submit the completed report of the criminal records check directly to OMA or its designee; or

(2) Except as provided in paragraph (E) of this rule, the applicant or independent provider is found by a criminal records check to have been convicted of, or pleaded guilty to, a disqualifying offense, regardless of the date of the conviction, or the date of entry of the guilty plea. If the department determines that two or more convictions or guilty pleas result from or are connected with the same act or result from offenses committed at the same time, they shall be counted as one conviction or guilty plea.

(D) Process for conducting criminal records checks.

(1) The department or its designee shall inform:

(a) Each applicant, at the time of initial application for a medicaid provider agreement, is required to provide a set of his or her fingerprint impressions, and a criminal records check must be conducted as a condition of the department's approving the application; and

(b) Each currently-enrolled independent provider, before the anniversary date of their medicaid provider agreement, that he or she is required to provide a set of his or her fingerprint impressions and that a criminal records check must be conducted as a condition of continued approval as an independent provider in the Ohio medicaid program.

(2) The department or its designee shall require the applicant to complete a criminal records check prior to entering into a medicaid provider agreement with the applicant, and once an independent provider, at least annually thereafter.

(a) If an applicant or 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 applicant or independent provider from the federal bureau of investigation (FBI) in a criminal records check, the department or its designee shall request that the superintendent obtain a criminal records check from the FBI as part of the criminal records check.

(b) Even if an applicant or independent provider presents proof of having been a resident of the state of Ohio for the five-year period, the department or its designee may request that the superintendent obtain information from the FBI in the criminal records check.

(3) The department or its designee shall provide the following to each applicant and independent provider for whom a criminal records check is required by this rule:

(a) Information about accessing, completing and forwarding to the superintendent the form prescribed pursuant to division (C)(1) of section 109.572 of the Revised Code and the standard fingerprint impression sheet prescribed pursuant to division (C)(2) of that section; and

(b) Written notification that the applicant or independent provider is to instruct the superintendent to submit the completed report of the criminal records check directly to the department or its designee.

(4) The applicant and independent provider shall pay BCII 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) 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 his or her representative;

(b) The director of OMA and the staff of the department involved in the administration of the Ohio medicaid program;

(c) The department's designee;

(d) An individual who receives, or may receive, waiver services from the person who is the subject of the criminal records check; and

(e) A court, hearing officer or other necessary individual involved in a case dealing with either a denial or termination of a medicaid provider agreement related to the criminal records check, or a civil or criminal action regarding the Ohio medicaid program.

(6) If the independent provider fails to comply with the provisions of this rule, the department shall initiate termination of the medicaid provider agreement.

(E) A consumer may choose to receive waiver services from an applicant or independent provider who has been convicted of, or pleaded guilty to, a disqualifying offense set forth in paragraph (B)(5) of this rule if:

(1) The applicant or independent provider has satisfied the conditions associated with the exclusionary periods set forth in rule 5101:3-45-11 of the Administrative Code; or

(2) The applicant or independent provider has obtained a certificate of qualification for employment issued by a court of common pleas with competent jurisdiction pursuant to section 2953.25 of the Revised Code, and in accordance with rule 5101:3-45-11 of the Administrative Code; or

(3) The applicant or independent provider has obtained a certificate of achievement and employability in an HCBS-related field issued by the Ohio department of rehabilitation and corrections pursuant to section 2961.22 of the Revised Code, and in accordance with rule 5101:3-45-11 of the Administrative Code.

(F) Pardons.

A conviction of, or a plea of guilty to, an offense as set forth in paragraph (B)(5) of this rule shall not prevent a consumer from choosing to receive services from an applicant or independent provider if any of the following circumstances apply:

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

- (2) The applicant or 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 applicant or 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 applicant's or independent providers' conviction or guilty plea has been set aside pursuant to law.

Replaces: 5101:3-45-08

Effective: 01/01/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.034, 5111.85

Rule Amplifies: 109.572, 5111.01, 5111.02, 5111.034, 5111.85

Prior Effective Dates: 7/1/04, 11/19/07, 12/10/09

LTCSTL 14-03

Effective Date: April 1, 2014

Most Current Prior Effective Date: August 13, 2007

- (A) The Ohio department of medicaid (ODM) is responsible for the ongoing monitoring and oversight of all ODM-administered waiver service providers and all ODM-administered waiver contractors in order to assure providers' and contractors' compliance with ODM-administered waiver program requirements.
- (B) Monitoring and oversight of ODM-administered waiver service providers.
- (1) ODM and its designee shall conduct ongoing monitoring and oversight of ODM-administered waiver service providers to verify that each provider is:
- (a) Complying with the terms and conditions of its medicaid provider agreement, the ODM-administered waiver program and all applicable federal, state and local laws and regulations.
- (b) Ensuring the health and welfare of individuals to whom they are providing services.
- (c) Ensuring the provision of quality services as part of the ODM-administered waiver program.
- (2) Monitoring and oversight includes, but is not limited to the following:
- (a) Interviews with individuals enrolled on the ODM-administered waivers and/or their authorized representative or legal guardian, providers and contractor staff.
- (b) Visits to the provider's place of business or another agreed upon location for the purpose of examining or collecting records, reviewing documentation, and conducting structural reviews.
- (c) Reviews of electronic and/or hard copy records and billing documentation, etc.
- (3) Providers shall fully cooperate with all requests made by ODM, and/or its designee as part of the monitoring and oversight process. This includes, but is not limited to the following:
- (a) Upon request, arranging for or otherwise furnishing an adequate workspace for ODM and/or its designee to conduct visits as described in paragraph (B)(2)(b) of this rule. This workspace must be in a secure location which protects sensitive and confidential information from being disclosed contrary to relevant confidentiality and information disclosure laws.
- (b) Making all requested information available at the time of review.
- (c) Ensuring the availability of supervisors and/or other staff who may possess relevant information to answer questions.
- (4) At the conclusion of a provider's monitoring and oversight review:
- (a) ODM or its designee shall notify the provider in writing of its findings. ODM or its designee may do any of the following:
- (i) Request that the provider prepare and submit to ODM or its designee a plan of correction within the prescribed time frame. The plan of correction shall set forth the action(s) that must be taken by the provider to correct each finding, and establish a target date by which the corrective action must be completed. If ODM or its designee does not approve the submitted plan of correction, ODM or its designee may request a new plan of correction or take other appropriate action.

- (ii) Provide technical assistance to the provider.
- (iii) Refer the provider to other entities for further investigation. Such entities include, but are not limited to:
 - (a) The surveillance and utilization review section (SURS) or other program area(s) within ODM;
 - (b) The Ohio attorney general;
 - (c) The Ohio department of health (ODH);
 - (d) The Ohio board of nursing (OBN);
 - (e) Other licensing, certification or credentialing bodies, as appropriate; and
 - (f) Law enforcement.

(b) ODM may:

- (i) Issue the provider a notice of operational deficiency (NOD) based upon its or its designee's review findings.
- (ii) Propose suspension or termination of the provider's medicaid provider agreement pursuant to section [5164.38](#) of the Revised Code and rules [5160-1-17.5](#) and [5160-1-17.6](#) of the Administrative Code.

(C) Monitoring and oversight of ODM-administered waiver contractors.

- (1) ODM shall conduct ongoing monitoring and oversight of the ODM-administered waiver contractors to verify that each contractor is:
 - (a) Complying with the terms and conditions of its contract and all applicable federal, state and local laws and regulations.
 - (b) Ensuring the health and welfare of individuals to whom they are providing services.
 - (c) Ensuring the provision of quality services as part of the ODM-administered waiver program.
- (2) Monitoring and oversight may include, but are not limited to the following:
 - (a) Interviews with individuals enrolled on the ODM-administered waivers and/or their authorized representative or legal guardian, providers and contractor staff.
 - (b) Visits to the contractor's place of business or another agreed upon location for the purpose of examining or collecting records, reviews of documentation, structural reviews.
 - (c) Reviews of electronic and/or hard copy records and billing documentation, etc.
- (3) Contractors shall fully cooperate with all requests made by ODM as part of the monitoring and oversight process. This includes, but is not limited to the following:
 - (a) Upon request, arranging for or otherwise furnishing an adequate workspace for ODM to conduct visits as described in paragraph (C)(2)(b) of this rule. This workspace must be in a secure location which protects sensitive and confidential information from being disclosed contrary to relevant confidentiality and information disclosure laws.
 - (b) Making all requested information available at the time of review, and in accordance with the terms of compliance with contracts.
 - (c) Ensuring the availability of supervisors and/or other staff who may possess relevant information to answer questions.
- (4) At the conclusion of a contractor's monitoring and oversight review, ODM shall notify the contractor of its findings. Additionally, if determined appropriate, ODM may do any of the following:

- (a) Request that the contractor prepare and submit to ODM a plan of correction within the prescribed time frame. The plan of correction shall set forth the action(s) that must be taken to correct each finding, and establish a target date by which the corrective action must be completed. If ODM does not approve the submitted plan of correction, ODM may request a new plan of correction or take other appropriate action.
- (b) Provide technical assistance to the contractor.
- (c) Refer the contractor to other entities for further investigation. Such entities include, but are not limited to:
 - (i) SURS;
 - (ii) The Ohio attorney general;
 - (iii) ODH;
 - (iv) OBN;
 - (v) Other licensing, certification or credentialing bodies, as appropriate; and
 - (vi) Law enforcement.
- (d) Issue the contractor a NOD based upon review findings.
- (e) Terminate the contractor's contract pursuant to its terms.

Replaces: 5160-45-09

Effective: 04/01/2014

R.C. 119.032 review dates: 04/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 03/17/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5166.02, 5166.11, 5166.13

Prior Effective Dates: 7/1/98, 8/13/07

LTCSTL 15-04

Effective Date: February 1, 2015

Most Current Prior Effective Date: October 25, 2010

- (A) ODM-administered waiver service providers shall maintain a professional relationship with the individuals to whom they provide services. Providers shall furnish services in a person-centered manner that is in accordance with the individual's approved all services plan, is attentive to the individual's needs, and maximizes the individual's independence. Providers shall refrain from any behavior that may detract from the goals, objectives and services outlined in the individual's approved all services plan and/or that may jeopardize the individual's health and welfare.
- (B) ODM-administered waiver service providers shall:
- (1) Maintain an active, valid medicaid provider agreement as set forth in rule 5160-1-17.2 of the Administrative Code.
 - (2) Comply with all provider requirements as set forth in chapter 5101:3-45 of the Administrative Code, and chapter 5160-3-46, 5160-50 or 5160-3-58 of the Administrative Code, depending upon the waiver(s) for which the provider is furnishing services. Provider requirements include, but are not limited to:
 - (a) Provider enrollment as set forth in rule 5160-45-04 of the Administrative Code;
 - (b) Provider service specifications as set forth in rule [5160-46-04](#), [5160-46-04.1](#), [5160-50-04](#), [5160-50-04.1](#) or 5160-58-04 of the Administrative Code, as applicable;
 - (c) Criminal record checks as set forth in rule [5160-45-07](#) or [5160-45-08](#), as applicable, and rule [5160-45-11](#) of the Administrative Code;
 - (d) Incident reporting as set forth in rule [5160-45-05](#) of the Administrative Code; and
 - (e) Provider monitoring, reviews and oversight as set forth in rules [5160-45-06](#) and [5160-45-09](#) of the Administrative Code.
 - (3) Deliver services professionally, respectfully and legally.
 - (4) Ensure that individuals to whom the provider is furnishing ODM-administered waiver services are protected from abuse, neglect, exploitation and other threats to their health, safety and well-being. Upon entering into a medicaid provider agreement, and annually thereafter, all providers including all employees who have direct contact with individuals enrolled on an ODM-administered waiver, must acknowledge in writing they have reviewed rule 5160-45-05 of the Administrative Code regarding incident management and related procedures.
 - (5) Work with the individual and case manager to coordinate service delivery, including, but not limited to:
 - (a) Agreeing to provide and providing services in the amount, scope, location and duration they have capacity to provide, and as specified on the individual's approved all services plan.
 - (b) Participating in the development of a back-up plan in the event that providers are unable to furnish services on the appointed date and time.
 - (c) Contacting the individual and the case manager in the event the provider is unable to render services on the appointed date and time.
 - (i) In the case of an emergency or unplanned absence, the provider shall immediately activate the back-up plan as set forth in the individual's approved all services plan, and contact the individual and case manager and verify their receipt of information about the absence.

- (ii) In the event of a planned absence, the provider shall contact the individual and case manager no later than seventy-two hours prior to the absence and verify their receipt of information about the absence.
- (6) Upon request and within the timeframe prescribed in the request, provide information and documentation to ODM, its designee and the centers for medicare and medicaid services (CMS).
- (7) Participate in all appropriate provider trainings mandated or sponsored by ODM or its designees, including but not limited to those set forth in chapters 5160-45, 5160-46, 5160-50 and 5160-58 of the Administrative Code.
- (8) Be knowledgeable about and comply with all applicable federal and state laws, including the "Health Insurance Portability and Accountability Act of 1996" (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (January 25, 2013), and the medicaid safeguarding information requirements set forth in 42 C.F.R. 431.300 to 431.306 (November 1, 2013), along with sections 5160.45 to 5160.481 of the Revised Code.
- (9) Ensure that the provider's contact information, including but not limited to address, telephone number, fax number and email address, is current. In the event of a change in contact information, the provider shall notify ODM via the medicaid information technology system (MITS) and its designee, no later than seven calendar days after such changes have occurred.
- (10) Maintain and retain all required documentation related to the services delivered during the visit, including but not limited to: an individual-specific description and details of the tasks performed or not performed in accordance with the approved all services plan and when required, the individual's plan of care.
 - (a) Validation of service delivery shall include, but not be limited to the date and location of service delivery, arrival and departure times, the dated signature of the provider and the dated signature of the individual or authorized representative. All signatures shall be obtained at the end of every visit or upon completion of the scheduled service. When services are rendered in multiple visits per day, signatures must be obtained upon completion of each visit.
 - (b) Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature. Any accommodations to the individual's or authorized representative's signature shall be documented on the all services plan.
 - (c) Collection and maintenance of documentation, including through technology-based systems, must be in compliance with the requirements set forth in paragraph (B)(10) of this rule.
- (11) 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.
- (12) Cooperate with ODM and its designee during all provider monitoring and oversight activities by being available to answer questions during reviews, and by assuring the availability and confidentiality of individual information and other documents that may be requested as part of provider monitoring activities.
- (13) To the extent not otherwise required by rule 5160-45-05 of the Administrative Code, notify ODM or its designee within twenty-four hours when the provider is aware of issues that may affect the individual and/or provider's ability to render services as directed in the individual's all services plan. Issues may include, but are not limited to the following:
 - (a) The individual consistently declines services
 - (b) The individual plans to or has moved to another residential address.
 - (c) There are changes in the physical, mental and/or emotional status of the individual.

- (d) There are changes in the individual's environmental conditions.
- (e) The individual's caregiver status has changed.
- (f) The individual no longer requires medically necessary services as defined in rule 5160-1-01 of the Administrative Code.
- (g) The individual's actions toward the provider are threatening or the provider feels unsafe or threatened in the individual's environment.
- (h) The individual is consistently noncompliant with physician orders, or is noncompliant with physician orders in a manner that may jeopardize his or her health and welfare.
- (i) The individual's requests conflict with his or her all services plan and/or may jeopardize his or her health and welfare.
- (j) Any other situation that affects the individual's health and welfare.
- (14) Make arrangements to accept all correspondence sent by ODM or its designee, including but not limited to, certified mail.
- (15) Provide and maintain a current e-mail address to ODM and/or its designee in order to receive electronic notification of any rule adoption, amendment or rescission, and any other communications from ODM or its designee
- (16) Submit written notification to the individual and ODM or its designee at least thirty calendar days before the anticipated last date of service if the provider is terminating the provision of ODM-administered waiver services to the individual. Exceptions to the thirty-day advance notification requirement are set forth in paragraphs (B)(16)(a) and (B)(16)(b) of this rule.
 - (a) The provider must submit verbal and written notification to the individual and ODM or its designee at least ten days before the anticipated last date of service if the individual:
 - (i) Has been admitted to a hospital;
 - (ii) Has been placed in an institutional setting; or
 - (iii) Has been incarcerated.
 - (b) ODM may waive advance notification for a provider upon request and on a case-by-case basis.

(C) At no time, shall the ODM-administered waiver service providers:

- (1) Engage in any behavior that causes or may cause physical, verbal, mental or emotional abuse or distress to the individual.
- (2) Engage in any other behavior that may compromise the health and welfare of the individual.
- (3) Engage in any activity or behavior that may take advantage of or manipulate the individual or his or her authorized representative, family or household members or may result in a conflict of interest, exploitation, or any other advantage for personal gain. This includes, but is not limited to:
 - (a) Misrepresentation.
 - (b) Accepting, obtaining, attempting to obtain, borrowing, or receiving money or anything of value including, but not limited to gifts, tips, credit cards or other items.
 - (c) Being designated on any financial account including, but not limited to bank accounts and credit cards.
 - (d) Using real or personal property of another.
 - (e) Using information of another.
 - (f) Lending or giving money or anything of value.
 - (g) Engaging in the sale or purchase of products, services or personal items.

(h) Engaging in any activity that takes advantage of or manipulates ODM-administered waiver program rules.

(4) Falsify the individual's signature, including using copies of the signature.

(5) Make fraudulent, deceptive or misleading statements in the advertising, solicitation, administration or billing of services.

(6) Submit a claim for waiver services rendered while the individual is hospitalized, institutionalized or incarcerated. The only exception is when the individual is receiving out-of-home respite as set forth on his or her all services plan.

(D) While rendering services, ODM-administered waiver service providers shall not:

(1) Take the individual to the provider's place of residence.

(2) Bring children, animals, friends, relatives, other individuals or anyone else to the individual's place of residence.

(3) Provide care to persons other than the individual.

(4) Smoke without the consent of the individual.

(5) Sleep.

(6) Engage in any activity that is not related to the provision of services to the extent the activity distracts from, or interferes with, service delivery. Such activities include, but are not limited to the following:

(a) Using electronic devices for personal or entertainment purposes including, but not limited to watching television, using the computer or playing games.

(b) Making or receiving personal communications.

(c) Engaging in socialization with persons other than the individual.

(7) Deliver services when the provider is medically, physically or emotionally unfit.

(8) Use or be under the influence of the following while providing services:

(a) Alcohol.

(b) Illegal drugs.

(c) Chemical substances.

(d) Controlled substances that may adversely affect the provider's ability to furnish services.

(9) Engage in any activity or conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not it is consensual.

(10) Engage in any behavior that may reasonably be interpreted as inappropriate involvement in the individual's personal beliefs or relationships including, but not limited to discussing religion, politics or personal issues.

(11) Consume the individual's food and/or drink without his or her offer and consent.

(E) ODM-administered waiver service providers shall not be designated to serve or make decisions for the individual in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative, or as a representative payee as that term is described in paragraph (E)(3) of this rule, except as provided in paragraphs (E)(1) to (E)(4) of this rule.

(1) A provider may be appointed by the court to serve as legal guardian for the individual pursuant to Chapter 2111. of the Revised Code if the provider is a family member.

(2) A provider may serve as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship if the provider is the individual's parent or spouse.

- (3) A provider may serve as the individual's representative payee if the provider is the individual's parent or spouse. For purposes of this rule, "representative payee" means a parent or spouse the individual designates to receive and manage payments that would otherwise be made directly to the individual.
- (4) A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship for the individual if:
- (a) The provider was serving in that capacity prior to September 1, 2005; and
 - (b) The provider was the individual's paid medical provider prior to September 1, 2005; and
 - (c) The designation is not otherwise prohibited by law.
- (F) Agency providers shall 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.
- (G) Non-agency providers shall 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, non-agency providers must submit an ODM-approved affidavit stating that they paid their applicable federal, state and local income and employment taxes.
- (H) Failure to meet the requirements set forth in this rule may result in any of the actions set forth in rules 5160-45-05 and 5160-45-09 of the Administrative Code including, but not limited to, termination of the medicaid provider agreement in accordance with rule 5160-1-17.6 of the Administrative Code. In the event ODM proposes termination of the medicaid provider agreement, the provider shall be entitled to a hearing under Chapter 119. of the Revised Code in accordance with division 5101:6 of the Administrative Code.

Replaces: 5160-45-10

Effective: 02/01/2015

Five Year Review (FYR) Dates: 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5162.03, 5164.02, 5166.02

Prior Effective Dates: 08/01/05, 10/25/10

5160-45-11 Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Exclusionary Periods for Disqualifying Offenses; Certificates; and Pardons

***Formerly* 5101:3-45-11 Ohio Home Care Waiver, Transitions DD Waiver and Transitions Carve-Out Waiver Programs: Exclusionary Periods for Disqualifying Offenses; Certificates; and Pardons**

LTCSTL 13-01

Effective Date: January 1, 2013

- (A) Except as set forth in paragraph (H) of this rule, a waiver agency may employ an applicant or continue to employ an employee who has been convicted of or pleaded guilty to an offense listed in paragraph (B)(6) of rule **5101:3-45-07** of the Administrative Code in a position involving providing home and community-based services (HCBS) to a consumer enrolled on the Ohio home care waiver, transitions DD waiver or transitions carve-out waiver pursuant to the timeframes set forth in this rule.
- (B) Except as set forth in paragraph (H) of this rule, an applicant or independent provider who has been convicted of or pleaded guilty to an offense listed in paragraph (B)(5) of rule **5101:3-45-08** of the Administrative Code may be selected by a consumer enrolled on the Ohio home care waiver, transitions DD waiver or transitions carve-out waiver to provide them with HCBS pursuant to the timeframes set forth in this rule.
- (C) Tier I. Permanent exclusion.
- (1) No waiver agency shall employ an applicant or continue to employ an employee in a position that involves providing HCBS to a consumer, nor shall an independent provider provide HCBS to a consumer, if the applicant, employee or independent provider has been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code:
- (a) 2903.01 (aggravated murder);
 - (b) 2903.02 (murder);
 - (c) 2903.03 (voluntary manslaughter);
 - (d) 2903.11 (felonious assault);
 - (e) 2903.15 (permitting child abuse);
 - (f) 2903.16 (failing to provide for a functionally-impaired person);
 - (g) 2903.34 (patient abuse or neglect);
 - (h) 2903.341 (patient endangerment);
 - (i) 2905.01 (kidnapping);
 - (j) 2905.02 (abduction);
 - (k) 2905.32 (human trafficking);
 - (l) 2905.33 (unlawful conduct with respect to documents);
 - (m) 2907.02 (rape);
 - (n) 2907.03 (sexual battery);
 - (o) 2907.04 (unlawful sexual conduct with a minor, formerly corruption of a minor);
 - (p) 2907.05 (gross sexual imposition);
 - (q) 2907.06 (sexual imposition);
 - (r) 2907.07 (importuning);
 - (s) 2907.08 (voyeurism);
 - (t) 2907.12 (felonious sexual penetration, as that offense existed prior to September 3, 1996);

- (u) 2907.31 (disseminating matter harmful to juveniles);
- (v) 2907.32 (pandering obscenity);
- (w) 2907.321 (pandering obscenity involving a minor);
- (x) 2907.322 (pandering sexually-oriented matter involving a minor);
- (y) 2907.323 (illegal use of a minor in nudity-oriented material or performance);
- (z) 2909.22 (soliciting or providing support for act of terrorism);
- (aa) 2909.23 (making terroristic threats);
- (bb) 2909.24 (terrorism);
- (cc) 2913.40 (medicaid fraud);
- (dd) If related to another offense under paragraph (C)(1) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

(2) A conviction related to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct involving a federal or state-funded program, excluding the disqualifying offenses set forth in section 2913.46 (illegal use of supplemental nutrition assistance program (SNAP) or women, infants, and children (WIC) program benefits) and paragraph (D)(1)(m) of this rule; or.

(3) A violation of an existing or former municipal ordinance or law of this state, any other state, or the United States that is substantially equivalent to any of the offenses or violations described in paragraphs (B)(1) or (B)(2) of this rule.

(D) Tier II. Ten-year exclusionary period.

(1) No waiver agency shall employ an applicant or continue to employ an employee in a position that involves providing HCBS to a consumer, nor shall an independent provider provide HCBS to a consumer, for a period of ten years from the date the applicant, employee or independent provider was fully discharged from all imprisonment, probation or parole, if the applicant, employee or independent provider has been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code:

- (a) 2903.04 (involuntary manslaughter);
- (b) 2903.041 (reckless homicide);
- (c) 2905.04 (child stealing, as that offense existed prior to July 1, 1996);
- (d) 2905.05 (child enticement);
- (e) 2905.11 (extortion);
- (f) 2907.21 (compelling prostitution);
- (g) 2907.22 (promoting prostitution);
- (h) 2907.23 (enticement or solicitation to patronize a prostitute; procurement of a prostitute for another);
- (i) 2909.02 (aggravated arson);
- (j) 2909.03 (arson);
- (k) 2911.01 (aggravated robbery);
- (l) 2911.11 (aggravated burglary);
- (m) 2913.46 (illegal use of SNAP or WIC program benefits);
- (n) 2913.48 (worker's compensation fraud);
- (o) 2913.49 (identity fraud);

- (p) 2917.02 (aggravated riot);
- (q) 2923.12 (carrying concealed weapons);
- (r) 2923.122 (illegal conveyance or possession of deadly weapon or dangerous ordnance in a school safety zone, illegal possession of an object indistinguishable from a firearm in a school safety zone);
- (s) 2923.123 (illegal conveyance, possession, or control of deadly weapon or ordnance into courthouse);
- (t) 2923.13 (having weapons while under a disability);
- (u) 2923.161 (improperly discharging a firearm at or into a habitation or school);
- (v) 2923.162 (discharge of firearm on or near prohibited premises);
- (w) 2923.21 (improperly furnishing firearms to minor);
- (x) 2923.32 (engaging in a pattern of corrupt activity);
- (y) 2923.42 (participating in a criminal gang);
- (z) 2925.02 (corrupting another with drugs);
- (aa) 2925.03 (trafficking in drugs);
- (bb) 2925.04 (illegal manufacture of drugs or cultivation of marijuana);
- (cc) 2925.041 (illegal assembly or possession of chemicals for the manufacture of drugs);
- (dd) 3716.11 (placing harmful or hazardous objects in food or confection); or
- (ee) If related to an offense under paragraph (D)(1) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

(2) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (D)(1) of this rule.

(3) If an applicant, employee or independent provider has been convicted of multiple disqualifying offenses, including an offense listed in paragraphs (D)(1) or (D)(2) of this rule, and another offense or offenses listed in paragraphs (D)(1), (D)(2), (E)(1), (E)(2), (F)(1) or (F)(2) of this rule, the applicant, employee or independent provider is subject to a fifteen-year exclusionary period beginning on the date the applicant, employee or independent provider was fully discharged from all imprisonment, probation or parole for the most recent offense.

(E) Tier III. Seven-year exclusionary period.

(1) No waiver agency shall employ an applicant or continue to employ an employee in a position that a involves providing HCBS to a consumer, nor shall an independent provider provide HCBS to a consumer, for a period of seven years from the date the applicant, employee or independent provider was fully discharged from all imprisonment, probation or parole, if the applicant, employee or independent provider has been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code:

- (a) 959.13 (cruelty to animals);
- (b) 959.131 (prohibitions concerning companion animals);
- (c) 2903.12 (aggravated assault);
- (d) 2903.21 (aggravated menacing);
- (e) 2903.211 (menacing by stalking);
- (f) 2905.12 (coercion);
- (g) 2909.04 (disrupting public services);

- (h) 2911.02 (robbery);
- (i) 2911.12 (burglary);
- (j) 2913.47 (insurance fraud);
- (k) 2917.01 (inciting to violence);
- (l) 2917.03 (riot);
- (m) 2917.31 (inducing panic);
- (n) 2919.22 (endangering children);
- (o) 2919.25 (domestic violence);
- (p) 2921.03 (intimidation);
- (q) 2921.11 (perjury);
- (r) 2921.13 (falsification, falsification in a theft offense, falsification to purchase a firearm, or falsification to obtain a concealed handgun license);
- (s) 2921.34 (escape);
- (t) 2921.35 (aiding escape or resistance to lawful authority);
- (u) 2921.36 (illegal conveyance of weapons, drugs or other prohibited items onto the grounds of a detention facility or institution);
- (v) 2925.05 (funding drug trafficking);
- (w) 2925.06 (illegal administration or distribution of anabolic steroids);
- (x) 2925.24 (tampering with drugs);
- (y) 2927.12 (ethnic intimidation); or
- (z) If related to an offense under paragraph (E)(1) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

- (2) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (E)(1) of this rule.
- (3) If an applicant, employee or independent provider has been convicted of multiple disqualifying offenses, including an offense listed in paragraphs (E)(1) or (E)(2) of this rule, and another offense or offenses listed in paragraphs (E)(1), (E)(2), (F)(1) or (F)(2) of this rule, the applicant, employee or independent provider is subject to a ten-year exclusionary period beginning on the date the applicant, employee or independent provider was fully discharged from all imprisonment, probation or parole for the most recent offense.

(F) Tier IV. Five-year exclusionary period.

- (1) No waiver agency shall employ an applicant or continue to employ an employee in a position that involves providing HCBS to a consumer, nor shall an independent provider provide HCBS to a consumer, for a period of five years from the date the applicant, employee or independent provider was fully discharged from all imprisonment, probation or parole, if the applicant, employee or independent provider has been convicted of or pleaded guilty to, an offense in any of the following sections of the Revised Code:
 - (a) 2903.13 (assault);
 - (b) 2903.22 (menacing);
 - (c) 2907.09 (public indecency);
 - (d) 2907.24 (soliciting);
 - (e) 2907.25 (prostitution);

- (f) 2907.33 (deception to obtain matter harmful to juveniles);
- (g) 2911.13 (breaking and entering);
- (h) 2913.02 (theft);
- (i) 2913.03 (unauthorized use of a vehicle);
- (j) 2913.04 (unauthorized use of computer, cable or telecommunication property);
- (k) 2913.05 (telecommunication fraud);
- (l) 2913.11 (passing bad checks);
- (m) 2913.21 (misuse of credit cards);
- (n) 2913.31 (forgery - forging identification cards or selling or distributing forged identification cards);
- (o) 2913.32 (criminal simulation);
- (p) 2913.41 (defrauding a rental agency or hostelry);
- (q) 2913.42 (tampering with records);
- (r) 2913.43 (securing writings by deception);
- (s) 2913.44 (personating an officer);
- (t) 2913.441 (unlawful display of law enforcement emblem);
- (u) 2913.45 (defrauding creditors);
- (v) 2913.51 (receiving stolen property);
- (w) 2919.12 (unlawful abortion);
- (x) 2919.121 (unlawful abortion upon minor);
- (y) 2919.123 (unlawful distribution of an abortion-inducing drug);
- (z) 2919.23 (interference with custody);
- (aa) 2919.24 (contributing to the unruliness or delinquency of a child);
- (bb) 2921.12 (tampering with evidence);
- (cc) 2921.21 (compounding a crime);
- (dd) 2921.24 (disclosure of confidential information);
- (ee) 2921.32 (obstructing justice);
- (ff) 2921.321 (assaulting or harassing a police dog, horse, or service animal);
- (gg) 2921.51 (impersonation of peace officer);
- (hh) 2925.09 (illegal administration, dispensing, distribution, manufacture, possession, selling, or using of any dangerous veterinary drug);
- (ii) 2925.11 (drug possession, other than a minor drug possession offense);
- (jj) 2925.13 (permitting drug abuse);
- (kk) 2925.22 (deception to obtain a dangerous drug);
- (ll) 2925.23 (illegal processing of drug documents);
- (mm) 2925.36 (illegal dispensing of drug samples);
- (nn) 2925.55 (unlawful purchase of pseudoephedrine product);
- (oo) 2925.56 (unlawful sale of pseudoephedrine product);

(pp) If related to an offense under paragraph (F)(1) of this rule, 2923.01 (conspiracy), 2923.02 (attempt), or 2923.03 (complicity); or

- (2) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (F)(1) of this rule.
- (3) If an applicant, employee or independent provider has been convicted of multiple disqualifying offenses listed in paragraphs (F)(1) or (F)(2) of this rule, the applicant, employee or independent provider is subject to a seven-year exclusionary period beginning on the date the applicant, employee or independent provider was fully discharged from all imprisonment, probation or parole for the most recent offense.

(G) Tier V. No exclusionary period.

- (1) A waiver agency may employ an applicant or continue to employ an employee in a position that involves providing HCBS to a consumer, and an independent provider may provide HCBS to a consumer if the applicant, employee or independent provider has been convicted of or pleaded guilty to, any of the following offenses:
 - (a) 2919.21 (non-support/contributing to non-support of dependents);
 - (b) 2925.11 (drug possession that is a minor drug possession offense); or
 - (c) 2925.14 (drug paraphernalia); or
 - (d) 2925.141 (illegal use or possession of marihuana drug paraphernalia); or
- (2) A violation of an existing or former municipal ordinance or law of this state, any other state or the United States that is substantially equivalent to any of the offenses or violations described under paragraph (G)(1) of this rule.

(H) Certificates.

Except for individuals who have been convicted of or pleaded guilty to, a disqualifying offense set forth in paragraph (C) of this rule, a waiver agency may employ an applicant or continue to employ an employee in a position involving providing HCBS to a consumer, and a consumer may chose to receive services from an applicant or independent provider, if the applicant, employee or independent provider has been issued either of the following:

- (1) A certificate of qualification for employment issued by a court of common pleas with competent jurisdiction pursuant to section 2953.25 of the Revised Code; or
- (2) A certificate of achievement and employability in an HCBS-related field, issued by the Ohio department of rehabilitation and corections pursuant to section 2961.22 of the Revised Code.

(I) Pardons.

- (1) A conviction of, or plea of guilty to, an offense as set forth in paragraph (B)(6) of rule 5101:3-45-07 of the Administrative Code shall not prevent a waiver agency from considering an applicant for employment or an employee for continued employment, if any of the following circumstances apply:
 - (a) The applicant or employee has been granted:
 - (i) An unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;
 - (ii) An unconditional pardon for the offense pursuant to an existing or former law of this state, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code; or
 - (iii) A conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the conditions under which the pardon was granted have been satisfied.

- (b) The applicant's or employee's conviction or guilty plea has been set aside pursuant to law.
- (2) A conviction of, or plea of guilty to, an offense as set forth in paragraph (B)(5) of rule 5101:3-45-08 of the Administrative Code shall not prevent a consumer from choosing to receive services from an applicant or independent provider, if any of the following circumstances apply:

 - (a) The applicant or independent provider has been granted:

 - (i) An unconditional pardon for the offense pursuant to Chapter 2967. of the Revised Code;
 - (ii) An unconditional pardon for the offense pursuant to an existing or former law of this state, any other state, or the United States, if the law is substantially equivalent to Chapter 2967. of the Revised Code; or
 - (iii) A conditional pardon for the offense pursuant to Chapter 2967. of the Revised Code, and the conditions under which the pardon was granted have been satisfied.
 - (b) The applicant's or independent provider's conviction or guilty plea has been set aside pursuant to law.

Replaces: 5101:3-45-07 (in part), 5101:3-45-08 (in part)

Effective: 01/01/2013

R.C. 119.032 review dates: 01/01/2018

Certification: CERTIFIED ELECTRONICALLY

Date: 12/21/2012

Promulgated Under: 119.03

Statutory Authority: 5111.033, 5111.034, 5111.85

Rule Amplifies: 109.572, 5111.01, 5111.02, 5111.033, 5111.034, 5111.85

Prior Effective Dates: 7/1/04, 11/19/07, 12/10/09

LTCSTL 14-11

Effective Date: December 1, 2014

Most Current Prior Effective Date: July 1, 2006

- (A) To be eligible for enrollment in the Ohio home care waiver program, an individual must meet all of the following requirements:
- (1) Be between the ages of birth through age fifty-nine;
 - (2) Be determined eligible for Ohio medicaid in accordance with rules [5160:1-2-01.6](#) and [5160:1-3-24](#) of the Administrative Code;
 - (3) Participate in an initial assessment to determine if the individual has needs that can be met through the Ohio home care waiver program;
 - (4) Be determined to have a nursing facility (NF) -based level of care (i.e., intermediate or skilled) in accordance with rule [5160-3-08](#) of the Administrative Code;
 - (5) In the absence of the Ohio home care waiver program, require hospitalization or institutionalization in a NF to meet his or her needs;
 - (6) Be determined to require and agree to receive at least one waiver service monthly that is otherwise unavailable through another source (including, but not limited to, private pay, community resources and/or the medicaid state plan) in an amount sufficient to meet the individual's assessed needs;
 - (7) Be able to establish residency in a place that is not a hospital, NF, intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (March 2, 2004)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.
 - (8) Sign an agreement prior to waiver enrollment confirming that the individual has been informed of service alternatives, choice of qualified providers available in the Ohio home care waiver program and the options of institutional and community-based care, and he or she elects to receive Ohio home care waiver services; and
 - (9) Have needs that can be safely met through the Ohio home care waiver in a home or community setting as determined by the Ohio department of medicaid (ODM) or its designee.
- (B) To be enrolled, and maintain enrollment in the Ohio home care waiver program, an individual must be determined by ODM or its designee to meet all of the following requirements:
- (1) Be determined eligible for the Ohio home care waiver program in accordance with paragraph (A) of this rule;
 - (2) Not reside in a hospital, NF, intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (March 2, 2004)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.
 - (3) Have his or her health and welfare assured while enrolled on the waiver;
 - (4) Participate in the development and implementation of a person-centered all services plan, and consent to the plan by signing and dating it;
 - (5) Agree to and receive case management services from ODM or its designee including, but not limited to:
 - (a) Annual and other assessments, as needed,

(b) Home safety evaluations,

(c) Contact with the case manager and/or the individual's team members, including, but not limited to telephone communications, and face-to-face and in-home visits; and

(6) Agree to and participate in quality assurance and participant satisfaction activities during his or her enrollment on the Ohio home care waiver program including, but not limited to, face-to-face visits.

(C) An individual shall be given priority for assessment to determine eligibility for enrollment in the Ohio home care waiver when ODM is made aware that he or she meets the criteria for any of the priority categories set forth in paragraphs (C)(1) to (C)(6) of this rule.

(1) The individual is under twenty-one years of age, and at the time of application,:

(a) Received inpatient hospital services for at least fourteen consecutive days; or

(b) Had at least three inpatient hospital stays during the preceding twelve months.

(2) The individual is at least twenty-one but less than sixty years of age and received inpatient hospital services for at least fourteen consecutive days immediately preceding the date of application.

(3) The individual is under sixty years of age and received private duty nursing services in accordance with rule [5160-12-02](#) of the Administrative Code for at least twelve consecutive months immediately preceding application.

(4) The individual is under sixty years of age, lives in the community and is at imminent risk of institutionalization due to the documented loss of a primary caregiver. In such instances, there must be written evidence (such as a doctor's order, a death certificate, or documentation that the primary caregiver is institutionalized or relocated out of the area) that substantiates the primary caregiver is unavailable to provide care and support, and without Ohio home care waiver services, the individual will require care in an inpatient hospital setting or a nursing facility (NF).

(5) The individual is under sixty years of age and resides in a medicaid-funded NF at the time of application.

(6) The individual is under sixty years of age, is determined by ODM to be eligible for the HOME choice ("Helping Ohioans Move, Expanding Choice") demonstration program in accordance with rule [5160-51-02](#) of the Administrative Code, and resides in a residential treatment facility as defined in rule [5160-51-01](#) of the Administrative Code, or an inpatient hospital setting.

(D) If an individual fails to meet any of the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, the individual shall be denied enrollment on the Ohio home care waiver program.

(E) Once enrolled on the Ohio home care waiver program, an individual's NF level of care shall be reassessed at least annually, and more frequently if there is a significant change in the individual's situation that may impact his or her health and welfare. If the reassessment determines the individual no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the Ohio home care waiver program.

(F) If, at any other time, it is determined that an individual enrolled on the Ohio home care waiver program no longer meets the requirements set forth in paragraph (A) and/or paragraph (B) of this rule, he or she shall be disenrolled from the Ohio home care waiver program. Reassessment pursuant to paragraph (E) is not required to make this determination.

(G) If an individual is denied enrollment in the Ohio home care waiver program pursuant to paragraph (D) of this rule, or is disenrolled from the waiver pursuant to paragraph (E) or (F) of this rule, the individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Effective: 12/01/2014

Five Year Review (FYR) Dates: 12/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 11/10/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5164.02, 5162.03, 5166.121

Prior Effective Dates: 4/4/77, 12/21/77, 6/1/80, 5/1/87, 4/1/88, 5/15/89, 3/1/92 (Emer), 6/1/92, 7/31/92 (Emer), 10/30/92, 4/30/93 (Emer), 7/30/93, 7/1/98, 9/29/00, 3/1/02 (Emer), 5/30/02, 7/1/06

~~*Formerly*~~ 5101:3-46-04 Ohio Home Care Waiver: Definitions of the Covered Services and Provider Requirements and Specifications

CSTL 10-07

Effective Date: October 25, 2010

Most Current Prior 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~~ thereunder, and shall possess a current, ~~and~~ valid and unrestricted 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~~ thereunder 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~~ paragraph (B)(6)(c) ~~and (B)(6)(d)~~ of this rule; ~~or~~
 - (d) Visits performed for the sole purpose of conducting an "OASIS" (outcome and assessment information set) assessment or any other assessment;
 - (e) Visits performed for the sole purpose of meeting the home care attendant service nurse consultation requirements set forth in rules [5101:3-46-04.1](#) and [5101:3-50-04.1](#) of the Administrative Code; or
 - ~~(d)~~(f) Services performed in excess of the number of hours approved pursuant to, and as specified on, the consumer's all services plan.
- (4) In order to be a provider and submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must meet all of the following requirements:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule [5101:3-46-06](#) of the Administrative Code.
 - ~~(a)~~(c) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider; ~~;~~
 - ~~(b)~~(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, unless the legally

responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency;

~~(e)~~(e) Not be the foster caregiver of the consumer;

~~(d)~~(f) Be identified as the provider ~~on~~ and have specified on, the consumer's all services plan that is prior-approved by ~~the designated case management agency (CMA)~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish waiver nursing services to the consumer;

~~(e)~~(g) Be identified as the provider on, and be performing nursing services pursuant to ~~signed and dated written orders from the treating physician; and~~ the consumer's plan of care, as that term is defined in rule 5101:3-45-01 of the Administrative Code. The plan of care must be signed and dated by the consumer's treating physician.

~~(f)~~(h) 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~~ before initiating services and at least 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~~ At a minimum, the clinical record must contain the information listed in paragraphs (A)(6)(a) to (A)(6)(~~k~~)(l) of this rule.

(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~~ any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if ~~one exists~~ they exist.
- (i) Documentation of all drug and food interactions, allergies and dietary restrictions.
- ~~(j)(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.~~ Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider, and consumer or authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.
- ~~(j)(k)~~ ~~Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.~~ Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- ~~(k)(l)~~ ~~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. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.~~ 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. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(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~~ needs. If the consumer's 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 paragraphs (B)(1)(a) to (B)(1)(e) of this rule. ~~Personal care aide service providers may elect not to furnish one or more of the listed services.~~ If the provider ~~so elects~~ cannot perform IADLs, the provider must notify ~~the designated CMA,~~ ODJFS or its designee, in writing, of the ~~services the provider elects not to furnish~~ service limitations before inclusion on the consumer's all services plan.
 - (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, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph ~~(B)~~ (C) of rule ~~4723-13-04~~ 4723-13-02 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 be a provider and submit a claim for reimbursement, all individuals providing personal care aide services must meet the following:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - ~~(a)~~(c) Be at least eighteen years of age;.
 - ~~(b)~~(d) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA;~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish personal care aide services to the consumer.
 - ~~(c)~~(e) 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)~~(f) 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)~~(g) Not be the foster caregiver of the consumer;.
 - ~~(f)~~(h) 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)~~(i) 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~~ Before commencing service delivery, the personal care aide must:
- (i) Obtain a certificate of completion of either ~~the nurse aide~~ a competency evaluation program or training and competency evaluation program approved or 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 42~~ C.F.R. 484.36 (2005 August 12, 2005), and
 - (ii) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.
- (b) Maintain evidence of the completion of ~~eight~~ twelve 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~~ while the personal care aide is present and providing care to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, and personal care aide performance. The visit must be documented in the consumer's record.
 - ~~(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)~~(iii) 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~~ Before 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~~ a competency evaluation program or training and competency evaluation program approved or 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 42~~ C.F.R. 484.36 (2005 August 12, 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~~ the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

- (ii) Obtained and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.
 - (b) Complete ~~eight~~ twelve 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~~ 5101:3-45-06 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~~ At a minimum, the clinical record must contain the information listed in paragraphs (B)(8)(a) to (B)(8)(i) of this rule.
- (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~~ all drug and food interactions, allergies and dietary restrictions.
 - (f) A copy of ~~the "do not resuscitate"~~ (any advance directives including, but not limited to, DNR) order or medical power of attorney, if ~~one exists~~ they exist.
 - (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.~~ Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the use of collection and maintenance of documentation through technology-based systems ~~in collecting and maintaining the documentation required by this paragraph.~~ The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.
 - (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. The summary should include documentation regarding progress made toward achievement of goals as specified on the consumer's all services plan and indicate any recommended follow-ups or referrals.

(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~~ shall not be used for other purposes during the provision of ADHCS.
 - (a) The services the adult day health center must ~~make available~~ provide 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~~ At least one meal, but no more than two meals, ~~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, and specified on, the consumer's all services plan.
- (3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - ~~(a)~~(c) Be identified as the provider on the consumer's all services plan that is prior-approved by ~~the designated CMA; and~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish adult day health center services to the consumer.
 - ~~(b)~~(d) 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~~ 45 C.F.R. part 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-GMA~~ designee verifying the coverage.

- (c) Maintain evidence of non-licensed direct care staff's completion of ~~eight~~ twelve 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~~ 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~~ set forth in paragraph (B)(1) of this rule.
- (f) Maintain, at all times, a paid direct care 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~~ At a minimum, the clinical record must contain the information listed in paragraphs (C)(5)(a) to (C)(5)(i) of this rule.
 - (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"~~ (any advance directive including, but not limited to, DNR) order or medical power of attorney, if one exists they exist.
 - (f) Documentation of ~~drug~~ all drug and food interactions, 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. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.
 - (i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), ~~and~~ (A)(6)(j) and (A)(6)(k) 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 paragraphs (D)(4)(a) to (D)(4)(d) of this rule.~~
- (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.~~

(D) Home delivered meal services.

- (1) "Home delivered meal service" is defined as the provision of meals to a consumer who has a need for a home delivered meal based on a deficit in an ADL or a deficit in an IADL identified during the assessment process. The service includes the preparation, packaging and delivery of a safe and nutritious meal(s) to a consumer at his or her home. A consumer may be authorized to receive up to two home delivered meals per day.
- (2) Home delivered meals:
- (a) Shall be furnished in accordance with menus that are approved in writing by a licensed dietitian who is currently registered with the commission on dietetic registration.
 - (b) Shall take into consideration the consumer's medical restrictions, religious, cultural and ethnic background and dietary preferences.
 - (c) Shall be prepared by a provider who is in compliance with Chapters 918., 3715. and 3717. of the Revised Code, and all applicable Administrative Code rules adopted thereunder. For the purposes of this rule, reheating a prepared home delivered meal is not the same as preparing a meal.
 - (d) Shall be individually packaged if it is a heated meal.
 - (e) May be individually packaged if it is an unheated, shelf-stable meal, or may have components separately packaged, so long as the components are clearly marked as components of a single meal.

- (f) May include a therapeutic diet that requires a daily amount or distribution of one or more specific nutrients in order to treat a disease or clinical condition, or eliminate, decrease or increase certain substances in the consumer's diet. A therapeutic diet must be ordered by a licensed physician. A new order must be documented in the consumer's clinical record every ninety days.
- (3) Home delivered meals shall not:
- (a) Include services or activities performed in excess of what is approved on the consumer's all services plan.
 - (b) Supplement or replace meal preparation activities that occur during the provision of waiver nursing, personal care aide, adult day health center, home care attendant or any other similar services.
 - (c) Supplement or replace the purchase of food or groceries.
 - (d) Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include, but are not limited to: food that must be portioned out and prepared, or any food that must be cooked or prepared.
 - (e) Be provided while the consumer is hospitalized or is residing in an institutional setting.
- (4) In order to be a provider and to submit a claim for reimbursement, all home delivered meal providers must meet all of the following requirements:
- (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - (c) Be identified as the home delivered meal provider, and be specified, on the consumer's all services plan that is prior-approved by the department or its designee.
 - (d) Possess any applicable current, valid license or certificate from the local health department, and retain records of all reports related to the licensure or certification.
 - (e) Assure that all meals are provided as identified on the consumer's all services plan.
 - (f) Submit claims that do not exceed two meals per day per consumer.
 - (g) Maintain documentation as set forth in paragraph (D)(8) of this rule.
- (5) Home delivered meal service providers shall assure all meals, with the exception of a therapeutic diet prescribed and prepared in accordance with paragraph (D)(2)(f) of this rule, meet the following requirements with regard to nutritional adequacy:
- (a) Meet one-third of the current dietary reference intakes (DRI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.
 - (b) Follow the current dietary guidelines for Americans as published by the U.S. department of agriculture.
- (6) Home delivered meal service providers shall assure the safe delivery of meals as authorized by the department or its designee on the consumer's all services plan.
- (a) Ready-to-eat, temperature-controlled meals must be labeled with a preparation date. The date shall include the month, day and year the meals were prepared, and shall list, immediately adjacent to this date, the phrase "packing" or "pack date." All other meals shall be labeled with the month, day and year by which the meal shall be consumed or discarded, and shall list the date immediately following the phrase "sell by" or "use before."
 - (b) The provider must document evidence of a time and temperature monitoring system for food preparation, handling and delivery.

- (c) The provider shall ensure all transportation vehicles and containers are safe and sanitary.
 - (d) When using a thermostatically-controlled meal delivery vehicle, the provider must maintain verification of testing meal temperatures no less than monthly. When using other meal delivery vehicles, the provider must maintain verification of testing meal temperatures no less than weekly.
 - (e) The provider must establish with the consumer, and document in the consumer's record, a routine date and time for meal delivery. The provider must notify the consumer if delivery of the meal(s) will be delayed more than one hour past established delivery time.
 - (f) The provider must furnish written delivery instructions to the driver.
 - (g) The provider must furnish the consumer or authorized representative with clear instructions on how to safely heat or reheat each meal.
- (7) Home delivered meal service providers shall assure the following with regard to training and continuing education:
- (a) All personnel who participate in food preparation, food handling and/or delivery, including volunteers, must:
 - (i) Receive training and orientation on the following as relevant with the individual's job duties:
 - (a) Sensitivity to the needs of older adults and people with physical disabilities or cognitive impairments;
 - (b) Handling emergencies;
 - (c) Food storage, preparation and handling;
 - (d) Food safety and sanitation;
 - (e) Meal delivery; and
 - (f) Handling hazardous materials.
 - (ii) Successfully complete four hours of continuing education each year on the topics relevant to the individual's job duties.
 - (b) The provider must develop a training plan and conduct and document annual training and continuing education activities.
- (8) At a minimum, home delivered meal service providers must maintain and make available, upon request, the following:
- (a) A record for each consumer served that contains a copy of the initial and all subsequent all services plans, all dietary orders and instructions prepared by the physician, menus approved by the dietitian, and any additional information supporting meal delivery as specified on the all services plan.
 - (b) Documentation that each meal complies with paragraphs (D)(5)(a) and (D)(5)(b) of this rule.
 - (c) Documentation of each consumer's therapeutic diet as set forth in paragraph (D)(2)(f) of this rule.
 - (d) Documentation from the provider that the consumer or authorized representative has been furnished clear instructions about how to safely heat or reheat each meal.
 - (e) Documentation that verifies delivery of home delivered meals as authorized on the consumer's all services plan. Documentation shall include, but not be limited to, the consumer's name, the dated signature of the home delivered meal service provider, the established delivery date and time, the actual time of delivery of all meals and the number of meals delivered, signature or initials of the person delivering the meal(s) and the signature or initials of the consumer or authorized representative receiving the

meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

- (f) Documentation that the home delivered meal delivery staff possesses a current and valid driver's license.
- (g) Documentation of vehicle owner's liability insurance.
- (h) Documentation that the provider has established a routine delivery time with the consumer.
- (i) All local health department inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.
- (j) All Ohio department of agriculture inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.
- (k) All U.S. department of agriculture inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.
- (l) All licensure/certification documents required as a result of paragraph (D)(4) of this rule.
- (9) Home delivered meal provider inspections and follow-up.
 - (a) Home delivered meal service providers cited for critical violations, as that term "critical violations" is used in paragraph (B) of rule 3717-1-02.4 of the Administrative Code, during their local health department inspections, shall notify ODJFS or its designee no more than forty-eight hours after issuance of the citation. The provider shall, within forty-eight hours, send to ODJFS or its designee a copy of the inspection report, any plans of correction and any follow-up reports.
 - (b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority status or notice status shall notify ODJFS or its designee no more than two business days after the issuance of the report of priority status, or after the issuance of the report of notice status in accordance with section 913.42 of the Revised Code. The provider shall, within five business days, send to ODJFS or its designee, a copy of the report(s) with documented findings, any notices issued by the Ohio department of agriculture, and any resulting plans of correction and follow-up reports.
 - (c) Home delivered meal service providers inspected by the Ohio department of agriculture division of meat inspection or the U.S. department of agriculture food safety inspection service shall notify ODJFS or its designee no more than two business days after it takes a withholding action against, or it suspends the provider in accordance with 9 C.F.R. 500.3 (November 29,1999) and/or 9 C.F.R. 500.4 (November 29,1999). The provider shall, within five business days, send to ODJFS or its designee, a copy of the action issued by the Ohio department of agriculture or the U.S. department of agriculture food safety inspection service, any resulting plans of correction and any follow-up reports.
 - (d) ODJFS may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to section 5111.06 of the Revised Code and rule 5101:3-1-17.6 of the Administrative Code if ODJFS or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more consumers due to noncompliance with one or more of the requirements set forth in this rule.
- (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 are not otherwise available through any other funding source and must be suitable to enable the consumer to function with greater independence, avoid institutionalization and reduce the need for human assistance. They shall not exceed a total of ten thousand dollars within a twelve-month calendar year period per consumer. ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.

- (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~~ 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the consumer present.
 - (c) Home modifications include repairs of previous home modifications excluding those described in paragraph (E)(2)(e) of this rule.
- (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, and specified on, the consumer's all services plan.
 - (d) The same type of home modification for the same consumer during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the consumer's medical and/or physical condition that requires the replacement.
 - (e) New home modifications or repair of previously approved home modifications that have been damaged as a result of confirmed misuse, abuse or negligence.
- (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~~ ODJFS or its designee and the adjustment is warranted. Family members and volunteers will shall meet all of the provider requirements set forth in paragraph (E) of this rule, however they shall only be reimbursed for the cost of materials.
- (4) In order to be a provider and submit a claim for reimbursement, providers of home modification services must:
- (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - ~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the home modification services that the provider is authorized to furnish to the consumer;
 - ~~(b)~~(d) Assure Provide documentation that the home modification was completed in accordance with the agreed upon specifications using all of the materials and equipment cited in the bid;

- ~~(e)(e)~~ Assure Provide documentation that the home modification was tested and in proper working order;
- ~~(d)(f)~~ Assure Provide documentation that the home modification ~~met~~ meets all applicable state and local building codes ~~and complies with the Americans with Disabilities Act (ADA);~~
- (g) Provide documentation that the home modification meets the consumer's needs and complies with the Americans with Disabilities Act (ADA) (September 25, 2008), the Uniform Federal Accessibility Standards (UFAS) (January 18, 1991) or the Fair Housing Act (FHA) (April 11, 1968), as applicable. If a home modification must be customized in order to meet the consumer's needs, and that customization will not be compliant with the ADA, UFAS or FHA, it must be prior-approved by ODJFS or its designee, in consultation with the consumer and/or authorized representative and the consumer's interdisciplinary team.
- ~~(e)(h)~~ Maintain licensure, insurance and bonding for general contracting services of applicable jurisdictions and provide proof to ~~the designated CMA~~ ODJFS or its designee upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the consumer; ~~and.~~
- ~~(f)(i)~~ Obtain a final written approval from the consumer and ~~the designated CMA~~ ODJFS or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

- (a) ~~The designated CMA~~ In consultation with the consumer, authorized representative and/or caregiver(s), ODJFS or its designee shall develop job specifications ~~in consultation with the consumer, authorized representative, and/or caregiver(s) to~~ based on the in-person evaluation required in paragraph (E)(1)(b) of this rule to meet the consumer's environmental accessibility needs with the lowest cost alternative.
- (b) ~~The designated CMA~~ At a minimum, ODJFS or its designee shall send the home modification specifications to every known home modification service provider in the consumer's ~~region~~ county of residence and all contiguous counties, and shall invite the submission of competitive bids. ~~The following must be submitted with all bids~~ Home modification providers shall submit bids that include all of the following:
 - (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, including at a minimum, a minimum one-year warranty for all materials and workmanship associated with the home modification; 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, and meet all of the provider requirements set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
- (c) ~~The designated CMA~~ ODJFS or its designee 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 GMA.~~
- (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)~~(F) 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;~~ or a family member, or someone who resides in the same household as the consumer, 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. All supplemental adaptive and assistive device services shall be prior-approved by ODJFS or its designee. ~~The designated GMA~~ ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.
 - (a) Reimbursement for medical equipment, ~~and~~ supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a twelve-month period calendar

~~year 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) ODJFS or its designee shall not approve the same type of medical equipment, supplies and devices for the same consumer during the same calendar year, unless there is a documented need for ongoing medical equipment, supplies or devices as documented by a licensed health care professional, or a documented change in the consumer's medical and/or physical condition requiring the replacement.

~~(b)(c) Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA~~ ODJFS or its designee shall not approve the same type of vehicle modification for the same consumer for a within the same three-year period, unless there is a documented change in the consumer's medical and/or physical condition requiring the replacement.

(d) Supplemental adaptive and assistive device services do not include:

(i) Items considered by the federal food and drug administration as experimental or investigational;

(ii) Funding of downpayments toward the purchase or lease of any supplemental adaptive and assistive device services;

(iii) Equipment, supplies or services furnished in excess of what is approved pursuant to, and as specified on the consumer's all services plan;

(iv) New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence;
and

(v) Activities described in paragraph (F)(2)(c) of this rule.

(2) Vehicle modifications.

(a) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, 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. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.

~~(2)(b) 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~~ Before 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~~ ODJFS or its designee with documentation of:

~~(a)(i) Evidence of a~~ A valid driver's license, with appropriate restrictions, and if requested, evidence of the successful completion of driver training from a qualified driver rehabilitation specialist, or a written statement from a qualified driver rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other person(s) operating the vehicle;

(ii) Proof of ownership of the vehicle to be modified;

~~(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)(iii)~~ ~~Evidence of the vehicle~~ Vehicle owner's collision and liability insurance for the vehicle being modified; and

~~(d)(iv)~~ A written statement from a certified mechanic stating the vehicle is in good operating condition.

~~(3)(c)~~ ~~Supplemental adaptive and assistive device services~~ Vehicle modifications 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;~~

~~(e)(i)~~ Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (F)(2)(a) of this rule;

~~(d)(ii)~~ Routine care and maintenance of vehicle modifications and devices;

~~(e)(iii)~~ Permanent modification of leased vehicles;

~~(f)(iv)~~ Vehicle inspection costs;

~~(g)(v)~~ Vehicle insurance costs; ~~and~~

~~(vi)~~ New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and

~~(h)(vii)~~ Services performed in excess of what is approved pursuant to, and specified on, the consumer's all services plan.

~~(4)(3)~~ In order to be a provider and submit a claim for supplemental adaptive and assistive device services, the provider must:

~~(a)~~ Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

~~(b)~~ Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.

~~(a)(c)~~ Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the consumer;

~~(b)(d)~~ Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services; ~~and.~~

~~(c)(e)~~ 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)(4)~~ 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~~ At a minimum, the clinical record must contain the information listed in paragraphs ~~(G)(5)(a) to (G)(5)(d)~~ (F)(4)(a) to (F)(4)(d) of this rule.

(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)~~(G) 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)~~(G)(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, and specified on, the consumer's all services plan.
- (3) In order to be a provider and submit a claim for reimbursement, providers of out-of-home respite services must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - ~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish out-of-home respite services to the consumer.
 - ~~(b)~~(d) Be either:
 - (i) An intermediate care facility 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~~ licensed setting approved by ~~the designated CMA~~ ODJFS or its designee.
 - ~~(e)~~(e) 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~~ 45 C.F.R. part 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~~ designee 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. At a minimum, the ~~The~~ clinical record must contain the information listed in paragraphs ~~(H)(G)(5)(a) to (H)(G)(5)(i)~~ of this rule.
 - (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~~ any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if ~~one exists~~ they exist.
 - (f) Documentation of ~~drug~~ all drug and food interactions, 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. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.
 - (i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) ~~and~~, (A)(6)(j) and (A)(6)(k) of this rule when the consumer is provided waiver nursing.

~~(4) 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.~~

(H) Emergency response services.

- (1) "Emergency response services (ERS)" are emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the consumer and the emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment.
- (2) ERS equipment shall include a variety of remote or other specialty activation devices from which the consumer can choose in accordance with the consumer's specific needs. All ERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:
- (a) Wearable waterproof activation devices;
 - (b) Devices that offer:
 - (i) Voice-to-voice communication capability,
 - (ii) Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
 - (iii) Audible indication of an alarm that may be appropriate if the consumer is visually impaired;
- (3) ERS does not include the following:
- (a) Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.

- (b) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen.
 - (c) Remote monitoring services.
 - (d) Services performed in excess of what is approved pursuant to a consumer's all services plan.
 - (e) New equipment or repair of previously approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence.
- (4) In order to be a provider and submit a claim for ERS, the provider must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - (c) Be identified as the provider, and have specified on the consumer's all services plan, the ERS that the provider is authorized to furnish.
- (5) ERS provider requirements.
 - (a) Providers shall assure that all consumers are able to choose the ERS equipment that meets their specific needs as set forth on their all services plan.
 - (b) Providers shall furnish each ERS consumer with an initial face-to-face demonstration and training on how to use their ERS equipment. Additional training shall be provided to designated responders as part of the monthly service in accordance with paragraph (H)(5)(c) of this rule, and to the consumer, caregiver and ODJFS or its designee upon request.
 - (c) Before, or during the delivery of ERS equipment, the provider shall work with the consumer and/or the consumer's authorized representative, and the consumer's case manager to develop a written response plan regarding how to proceed in the event the ERS signals an alarm. The written response plan shall be updated as often as desired by the consumer and/or the consumer's authorized representative, but shall be reviewed no less than every six months.
 - (i) The written response plan shall include a summary of the consumer's health history and functioning level, as well as the name of, and contact information for, at least one individual who will serve as the consumer's designated responder. If the consumer identifies more than one designated responder, the consumer shall also indicate the order in which the responders should be contacted. For the purposes of this rule, "designated responder" means an individual or individuals who the consumer and/or the consumer's authorized representative chooses to be contacted by the ERS provider in the event the ERS signals an alarm. If fewer than two individuals are designated as responders, then emergency service personnel shall be designated as responders in the plan.
 - (ii) The provider shall furnish initial training to all designated responders before activation of the consumer's ERS equipment, and on an annual basis. At a minimum, the training shall include:
 - (a) Instruction regarding how to respond to an emergency, including how to contact emergency service personnel; and
 - (b) Distribution of written materials regarding how to respond to an ERS signal.
 - (iii) The provider shall work with the consumer and/or the consumer's authorized representative, and the case manager to revise the written response plan when there is a change in designated responders.

- (f) A written record of the monthly testing conducted on each consumer's ERS equipment, including date, time and results of the test.
- (g) A record of each service-related consumer contact including, but not limited to, the date and time of the contact, a summary of the incident, the service delivered (including the service of responding to a false alarm), and the name of each person having contact with the consumer.
- (h) A copy of the consumer's written response plan as set forth in paragraph (H)(5)(c) of this rule.

(I) Supplemental transportation services.

- (1) "Supplemental transportation services" are transportation services that are not available through any other resource that enable a consumer to access waiver services and other community resources specified on the consumer's all services plan. Supplemental transportation services include, but are not limited to 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, and specified on, the consumer's all services plan.
- (3) In order to be a provider and submit a claim for supplemental transportation services, the provider must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-46-06 of the Administrative Code.
 - (c) Be identified as the provider, and have specified on, the consumer's all services plan that is prior-approved by ODJFS or its designee, the amount of supplemental transportation services the provider is authorized to furnish to the consumer.
- (4) Agency supplemental transportation service providers must:
 - (a) Maintain a current list of drivers.
 - (b) Maintain documentation 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) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services that:
 - (i) Is not provided solely through the internet;
 - (ii) Includes hands-on training provided by a certified first aid instructor; and
 - (iii) Requires the individual to perform a successful return demonstration of what was learned in the course.
 - (g) Assure that drivers are not the consumer's legally responsible family member as that term is defined in rule [5101:3-45-01](#) of the Administrative Code.
 - (h) Assure that drivers are not the consumer's 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) Obtain and maintain a certificate of completion of a course in first aid that:
 - (i) Is not provided solely through the internet;
 - (ii) Includes hands-on training provided by a certified first aid instructor; and
 - (iii) Requires the individual to perform a successful return demonstration of what was learned in the course.
- (f) Not be the consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.
- (g) Not be the consumer's foster caregiver.
- (6) All supplemental transportation service providers must maintain documentation that, at a minimum, 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 the consumer's authorized representative. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan and shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

Effective: 10/25/2010

R.C. 119.032 review dates: 08/10/2010 and 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 10/15/2010

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule 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, 7/1/06

CSTL 10-01

Effective Date: July 1, 2010

The requirements set forth in this rule begin when the Ohio department of job and family services (ODJFS) receives approval from the centers of medicare and medicaid services (CMS) of an amendment adding home care attendant services to the Ohio home care waiver, or on the effective date of this rule, whichever is later.

(A) The following definitions are applicable to this rule:

- (1) "Adult" means an individual at least eighteen years of age.
- (2) "Authorized representative" means the following:
 - (a) In the case of a consumer who is a minor, the consumer's parent, custodian, or guardian. The authorized representative shall be present and awake during the delivery of home care attendant services.
 - (b) In the case of a consumer who is an adult, an individual selected by the consumer to act on the consumer's behalf for the purposes regarding home care attendant services. The authorized representative shall be present and awake during the delivery of home care attendant services.
- (3) "Authorizing health care professional" means a health care professional who, pursuant to section [5111.887](#) of the Revised Code, authorizes a home care attendant to assist a consumer with self-administration of medication, nursing tasks, or both. The consumer, authorized representative, legally responsible family member, legal guardian, and foster caregiver are prohibited from being the authorizing health care professional.
- (4) "Consumer" means an individual to whom all of the following apply:
 - (a) The individual is enrolled in the Ohio home care waiver.
 - (b) The individual has a medically determinable physical impairment to which both of the following apply:
 - (i) It is expected to last for a continuous period of not less than twelve months.
 - (ii) It causes the individual to require assistance with activities of daily living, self-care, and mobility, including either assistance with self-administration of medication or the performance of nursing tasks, or both.
 - (c) In the case of an individual who is an adult, the individual is mentally alert and is, or has an authorized representative who is, capable of freely choosing home care attendant service providers in accordance with rule 5101:3-45-03 of the Administrative Code, and selecting, directing the actions of, and dismissing a home care attendant.
 - (i) In accordance with section [5111.8810](#) of the Revised Code, a consumer who is an adult may select an authorized representative by submitting a written notice of the consumer's selection to the director of ODJFS. The notice shall specifically identify the individual the consumer selects as authorized representative and may limit what the authorized representative may do on the consumer's behalf regarding home care attendant services.
 - (ii) A consumer may not select the consumer's home care attendant to be the consumer's authorized representative.
 - (d) In the case of an individual who is a minor, the individual has an authorized representative who is capable of freely choosing home care attendant service provides in accordance with rule [5101:3-45-03](#) of the Administrative Code, and selecting, directing the actions of, and dismissing a home care attendant.

- (5) "Controlled substance" has the same meaning as in section 3719.01 of the Revised Code.
- (6) "Custodian" has the same meaning as in section 2151.011 of the Revised Code.
- (7) "Gastrostomy tube" means a percutaneously inserted catheter that terminates in the stomach.
- (8) "Group setting" means a situation in which a home care attendant service provider furnishes home care attendant services in accordance with this rule, and as authorized by ODJFS, to two or three individuals who reside at the same address.
- (9) "Guardian" has the same meaning as in section 2111.01 of the Revised Code.
- (10) "Health care professional" means a physician or registered nurse who holds a current, valid, unrestricted license.
- (11) "Home care attendant" means an individual holding a valid medicaid provider agreement in accordance with section 5111.881 of the Revised Code and paragraph (E)(2) of this rule that authorizes the individual to provide home care attendant services to a consumer.
- (12) "Jejunostomy tube" means a percutaneously inserted catheter that terminates in the jejunum.
- (13) "Medication" means a drug as defined in section 4729.01 of the Revised Code.
- (14) "Minor" means an individual under eighteen years of age.
- (15) "Nursing tasks" means skilled tasks that would otherwise be performed by a registered nurse (RN), or a licensed practical nurse (LPN) at the direction of an RN.
- (16) "Oral medication" means any medication that can be administered through the mouth, or through a gastrostomy tube or jejunostomy tube if through a pre-programmed pump or through a syringe. Oral medication may include medication administered through a metered dose inhaler.
- (17) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.
- (18) "Practice of nursing as a registered nurse," "practice of nursing as a licensed practical nurse (LPN)," and "registered nurse (RN)" have the same meanings as in section 4723.01 of the Revised Code. "Registered nurse" includes an advanced practice nurse as defined in section 4723.01 of the Revised Code.
- (19) "Schedule II," "schedule III," "schedule IV," and "schedule V" have the same meaning as in section 3719.01 of the Revised Code.
- (20) "Topical medication" means any medication that is applied to the outer skin, including transdermal medications and eye, ear, and nose drops. Topical medication may also include vaginal or rectal suppositories.

(B) Home care attendant services are services provided to a consumer enrolled on the Ohio home care waiver by an unlicensed non-agency provider in accordance with this rule. Home care attendant services include, but are not limited to, tasks that would otherwise be performed by an RN or an LPN at the direction of an RN. Home care attendant services include:

- (1) Assistance with self-administration of medications as set forth in paragraph (C) of this rule.
- (2) Assistance with the performance of nursing tasks as set forth in paragraph (D) of this rule.
- (3) Personal care aide tasks as described in paragraph (B)(1) of rule 5101:3-46-04 of the Administrative Code when performed during a home care attendant service visit. Personal care aide tasks are not reimbursable separately as personal care aide services when they are performed during a home care attendant service visit.

(C) Assistance with self-administration of medication.

- (1) A home care attendant shall assist a consumer with the self-administration of only the following medication:

- (a) Oral medications;
- (b) Topical medications;
- (c) Subcutaneous injections only for routine doses of insulin;
- (d) Programming of a pump only used to deliver a routine dose of insulin;
- (e) Medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and
- (f) Doses of schedule II, schedule III, schedule IV, and schedule V drugs only when administered orally or topically.

(2) Medication shall be maintained in its original container and the attached label shall match the dosage and means of administration set forth on the [JFS 2389](#) "Home Care Attendant Medication Authorization Form" (7/10). The label on the container shall display all of the following:

- (a) The consumer's full name in print;
- (b) A dispensing date within the prior twelve months; and
- (c) The exact dosage and means of administration.

(3) Schedule II, schedule III, schedule IV, and schedule V drugs shall meet all of the following additional requirements:

- (a) The medication(s) has a warning label on the bottle.
- (b) The home care attendant shall count the medication(s) in the consumer's or authorized representative's presence and record the count on a log located in the consumer's clinical record.
- (c) The medication(s) is recounted by the home care attendant in the consumer's or authorized representative's presence at least monthly, and the count is reconciled on a log located in the consumer's clinical record. The home care attendant shall notify the authorizing health care professional, in writing, within twenty-four hours if:
 - (i) The medication(s) is missing; and
 - (ii) The count of medication(s) cannot be reconciled.
- (d) The medication(s) is stored separately from all other medications, and is secured and locked at all times when not being administered to the consumer in order to prevent access by unauthorized individuals.

(D) Assistance with the performance of nursing tasks.

(1) A home care attendant may provide assistance with the performance of nursing tasks that are not expressly excluded in accordance with paragraph (D)(2) of this rule.

(2) A home care attendant shall not assist a consumer with the performance of any of the following nursing tasks:

- (a) Intravenous (IV) insertion, removal, or discontinuation;
- (b) Intramuscular injections;
- (c) IV medication administration;
- (d) Subcutaneous injections, except for routine doses of insulin pursuant to paragraph (C)(1)(c) of this rule;
- (e) Programming of a pump used to deliver medications (including but not limited to epidural, subcutaneous, and IV), except for routine doses of insulin pursuant to paragraph (C)(1)(d) of this rule;
- (f) Insertion or initiation of infusion therapies; and

(g) Central line dressing changes.

(3) Performance of nursing tasks shall be summarized and submitted on the [JFS 02390](#) "Home Care Attendant Skilled Task Authorization Form" (7/10).

(E) In order to provide services and to submit a claim for reimbursement, home care attendant service providers must meet all of the following requirements:

(1) Be at least eighteen years of age.

(2) Be a non-agency provider who holds a current, valid agreement as a home care attendant service provider in accordance with sections [5111.01](#), [5111.02](#), and 5111.8810 of the Revised Code and this rule, and complies with all rules set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

(3) Request reimbursement for the provision of home care attendant services in accordance with rule [5101:3-46-06.1](#) of the Administrative Code.

(4) Not be the consumer's authorized representative.

(5) Not be the consumer's legally responsible family member as that term is defined in rule [5101:3-45-01](#) of the Administrative Code.

(6) Not be the consumer's legal guardian or foster caregiver.

(7) Not be the consumer's authorizing health care professional.

(8) Be identified as the provider, and have specified on the consumer's all services plan that is prior-approved by ODJFS or its designee, the number of hours for which the provider is authorized to furnish home care attendant services to the consumer.

(9) Have a valid social security number, and one of the following forms of identification:

(a) Alien identification;

(b) State of Ohio identification;

(c) A valid driver's license; or

(d) Other government-issued photo identification.

(10) 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.

(11) Be able to effectively communicate with the consumer.

(12) Enter into a medicaid provider agreement with ODJFS to provide home care attendant services to consumers enrolled on the Ohio home care waiver. In order for ODJFS to approve an individual's application to become a home care attendant, the individual shall do all of the following:

(a) Comply with the medicaid provider requirements set forth in division 5101:3 of the Administrative Code.

(b) Comply with the ODJFS-administered waiver service provider requirements set forth in Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

(c) Agree to comply with the requirements set forth in sections [5111.88](#) to 5111.8810 of the Revised Code and all requirements set forth in this rule.

(d) Provide ODJFS with evidence to its satisfaction of all of the following:

(i) The home care attendant submits the [JFS 02389](#) "Home Care Attendant Medication Authorization Form" (7/10) and/or [JFS 02390](#) "Home Care Attendant Skilled Task Authorization Form" (7/10) as prescribed by paragraph (F)(2) of this rule.

- (ii) The home care attendant either meets the personnel qualifications specified in 42 C.F.R. 484.4 (as in effect on the effective date of this rule) for home health aides, or has successfully completed at least one of the following:

 - (a) A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio department of health under section 3721.31 of the Revised Code; or
 - (b) A training program approved by ODJFS that includes training in at least all of the following and provides training equivalent to a training and competency evaluation program specified in paragraph (E)(12)(d)(ii)(a) of this rule, or meets the requirements of 42 C.F.R. 484.36(a) (as in effect on the effective date of this rule):

 - (i) Basic home safety;
 - (ii) Universal precautions for the prevention of disease transmission, including hand-washing, and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken;
 - (iii) Consumer-specific personal care aide services; and
 - (iv) The labeling, counting and storage requirements for schedule II, schedule III, schedule IV, and schedule V medications.
- (iii) Prior to beginning home care attendant services, the home care attendant received training and instruction about how to deliver the specific home care attendant services authorized by the consumer's authorizing health care professional. The training shall be consumer-specific and may be provided by the consumer's authorizing health care professional, and/or the consumer or the authorized representative in cooperation with the consumer's licensed health care professional as indicated on the JFS 02389 "Home Care Attendant Medication Authorization Form" (7/10) and/or JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10), as appropriate.
- (iv) Upon request of the consumer or the consumer's authorizing health care professional, the home care attendant has performed a successful return demonstration of the home care attendant service to be provided.
- (v) The home care attendant has obtained a certificate of completion of a course in first aid that:

 - (a) Is not provided solely through the internet;
 - (b) Includes hands-on training provided by a certified first aid instructor; and
 - (c) Requires the individual to perform a successful return demonstration of what was learned in the course.
- (vi) The home care attendant has received education from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.
- (13) Provide home care attendant services for one individual, unless authorized to provide services in a group setting in accordance with paragraph (E)(14) of this rule.
- (14) The home care attendant may provide services to two or three consumers in a group setting on a case-by-case basis. Authorization is subject to approval based on a clinical review conducted by ODJFS in consultation with the consumer, authorized representative, authorizing health care professional, case manager, and multidisciplinary team. The clinical review will address the consumers' needs and desires, the skill level and training needs of the home care attendant, and the ability to assure the consumers' health and welfare.

(15) The home care attendant shall secure the services of an RN, in agreement with the consumer or authorized representative, and participate in a face-to-face visit every ninety days with the consumer, authorized representative, and the RN for the purpose of monitoring the consumer's health and welfare. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, consumer, and/or authorized representative have about consumer care needs, medications, and other issues.

(a) The first visit between the home care attendant and the RN shall occur upon the initiation of home care attendant services. The case manager shall also be present at the first visit.

(b) The home care attendant and the RN shall document the activities of the visit in the consumer's clinical record.

(c) The home care attendant shall discuss the results of the face-to-face visit with the case manager and the consumer and/or authorized representative.

(16) Completes at least twelve hours of in-service continuing education regarding home care attendant services annually. Evidence of completion must be submitted to ODJFS no later than the annual anniversary of the issuance of the home care attendant's initial medicaid provider agreement. 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.

(F) A home care attendant shall not provide home care attendant services until:

(1) The consumer and/or authorized representative chooses to receive home care attendant services from a non-agency provider and complies with the requirements set forth in rule 5101:3-45-03 of the Administrative Code.

(2) ODJFS receives a JFS 2389 "Home Care Attendant Medication Authorization Form" (7/10) and/or a JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10), as appropriate, that contains all of the following:

(a) Written consent from the consumer or the authorized representative allowing the home care attendant to provide home care attendant services, and assuming responsibility for directing the home care attendant. When an authorized representative is directing the home care attendant, the authorized representative shall be present and awake during the delivery of home care attendant services.

(b) Written consent from the consumer's authorizing health care professional attesting that the consumer or the authorized representative has demonstrated the ability to direct the home care attendant. The written consent shall also indicate that the home care attendant has demonstrated the ability to furnish the consumer-specific home care attendant service to the consumer. The consent shall include all of the following:

(i) The consumer's name and address;

(ii) A description of the specific nursing task or self-administration of medication that the home care attendant will assist the consumer with, including, in the case of assistance with self-administration of medication, the name, dosage, and route of administration of the medication;

(iii) The times or intervals when the home care attendant is to assist the consumer with the self-administration of each dosage of the medication or with the performance of nursing tasks;

(iv) The dates on which the home care attendant is to begin and cease providing assistance;

(v) A list of severe adverse reactions that the home care attendant must report to the consumer's health care professional should the consumer experience one or more reactions;

- (vi) At least one telephone number at which the home care attendant can reach the consumer's health care professional in an emergency for consultation after contacting emergency personnel;
- (vii) At least one fax number at which the home care attendant can reach the consumer's authorizing health care professional when the home care attendant observes that scheduled medication(s) is missing or cannot be reconciled; and
- (viii) Instructions the home care attendant must follow when assisting the consumer with the performance of a nursing task or the self-administration of medications, including, but not limited to, instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies.

(G) Upon initiation of services, the consumer and/or authorized representative and case manager shall participate in the development and maintenance of a written back-up plan. The authorizing health care professional and/or the home care attendant may also participate in the development and maintenance of the back-up plan.

(1) The back-up plan shall meet the needs of the consumer in the event:

- (a) The regularly scheduled home care attendant cannot or does not meet his or her obligation to provide services to the consumer; or
- (b) The consumer and/or authorized representative is not able to direct home care attendant services.

(2) As authorized by the case manager,

- (a) Waiver nursing as set forth in rule [5101:3-46-04](#) of the Administrative Code, and/or private duty nursing or home health nursing as set forth in Chapter 5101:3-12 of the Administrative Code, may be used as back-up to provide assistance with self-administration of medications and the performance of nursing tasks;
- (b) Personal care aide services as set forth in rule 5101:3-46-04 of the Administrative Code may be used as back-up for personal care aide tasks; and
- (c) Back-up may include informal caregivers.

(H) All home care attendants must maintain a clinical record for each consumer served in a manner that protects the consumer's privacy and the confidentiality of these records. Home care attendants 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 paragraphs (H)(1) to (H)(12) of this rule.

- (1) Consumer identifying information including, but not limited to, name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health identification numbers.
- (2) Consumer medical history.
- (3) Name of, and contact information for all of the consumer's licensed health care professionals.
- (4) A copy of the initial and all subsequent all services plans.
- (5) Documentation of all drug and food interactions, allergies, and dietary restrictions.
- (6) A copy of any advance directives including, but not limited to, a "do not resuscitate order" ("DNR") or a "medical power of attorney" if they exist.
- (7) The JFS 2389 "Home Care Attendant Medication Authorization Form" (7/10) and/or a JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10), as appropriate.
- (8) Documentation of home care attendant services performed or not performed, arrival and departure times, and the dated signature of the provider, and consumer or authorized representative, verifying the service delivery upon its completion. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The

consumer's or authorized representative's signature of choice shall be documented on the all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

- (9) A copy of the log detailing the count and reconciliation of schedule II, schedule III, schedule IV, and schedule V drugs for which assistance with self-administration is provided.
- (10) Progress notes signed and dated by the home care attendant, documenting all communications with the case manager, licensed health care professionals including the authorizing health care professional, and other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.
- (11) Documentation of the face-to-face visits occurring every ninety days between the home care attendant, consumer, authorized representative, and RN, and any resulting activities, in accordance with paragraph (E)(15) of this rule.
- (12) A discharge summary, signed and dated by the departing home care attendant at the point the home care attendant is no longer going to provide services to the consumer, or when the consumer no longer wants or needs home care attendant services. The summary should include documentation regarding progress made toward achievement of goals as specified on the all services plan.

(I) If ODJFS or its designee determines that the consumer and/or authorized representative cannot meet the requirements of this rule, or the health and welfare of the consumer receiving home care attendant services cannot be assured, then ODJFS or its designee may prohibit the consumer from receiving home care attendant services. The consumer shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

(J) A home care attendant who provides home care attendant services to a consumer in accordance with the limitations set forth in this rule, including activities in accordance with the authorizing health care professional's authorization, shall not be considered to be engaging in the practice of nursing as an RN or an LPN in violation of section **4723.03** of the Revised Code.

- (1) The consumer who is receiving home care attendant services, the authorized representative, or a provider shall report to ODJFS all instances in which a home care attendant appears to have:
 - (a) Provided nursing services, other than assistance with self-administration of medication or the performance of nursing tasks as authorized in this rule; or
 - (b) Provided services not in accordance with the authorizing health care professional's authorization.
- (2) ODJFS may initiate an investigation based on the report, and shall report its findings to the Ohio board of nursing.

Effective: 07/01/2010

R.C. 119.032 review dates: 07/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 06/21/2010

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.8811

Rule Amplifies: 5111.01, 5111.02, 5111.88, 5111.881, 5111.882, 5111.883, 5111.884, 5111.885, 5111.886, 5111.887, 5111.888, 5111.889, 5111.8810

CSTL 07-02

Effective Date: February 15, 2007

- (A) An individual cost cap shall be assigned for consumers receiving services under the Ohio home care waiver. The individual cost cap shall be reassigned annually and when a consumer experiences a significant change as defined in rule [5101:3-45-01](#) of the Administrative Code.
- (B) Individual cost cap has the same definition as set forth in rule [5101:3-45-01](#) 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) Before services begin, and at the time of any change in the all services plan affecting the individual cost cap, the consumer shall be informed by the case management agency, or ODJFS, of the individual cost cap assigned. The consumer shall be afforded notice and hearing rights in accordance with division [5101:6](#) of the Administrative Code.

Replaces: Part of 5101:3-12-09

Effective: 02/15/2007

R.C. 119.032 review dates: 02/01/2012

Certification: CERTIFIED ELECTRONICALLY

Date: 02/05/2007

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.01, 5111.02, 5111.85

Prior Effective Dates: 7/1/98

5160-46-06.1 Ohio Home Care Waiver Program: Home Care Attendant Services Reimbursement Rates and Billing Procedures

***Formerly* 5101:3-46-06.1 Ohio Home Care Waiver Program: Home Care Attendant Services Reimbursement Rates and Billing Procedures**

LTCSTL 11-10

Effective Date: October 1, 2011

Most Current Prior Effective Date: July 1, 2010

- (A) Definitions of terms used for billing and calculating home care attendant services (HCAS) rates.
- (1) "Base rate," as set forth in column 3 of tables A and B of this rule, means the amount paid to a provider for up to four units of HCAS delivered. The base rate accounts for up to four units of assistance with self-administration of medications and the performance of nursing tasks provided during a single visit.
 - (2) "Continuous nursing" means nursing services (waiver nursing and/or private duty nursing) that are more than four hours in length and during which personal care aide tasks as described in paragraph (B)(1) of rule [5101:3-46-04](#) of the Administrative Code may be provided incidental to nursing services.
 - (3) "Group rate" means the amount that HCAS providers shall be reimbursed when the service is provided in a group setting.
 - (4) "Group setting" means a situation in which an HCAS provider furnishes HCAS in accordance with rule 5101:3-46-06.1 of the Administrative Code, and as authorized by the Ohio department of job and family services (ODJFS), to two or three individuals who reside at the same address.
 - (5) "HCAS visit" is a visit during which HCAS is provided in accordance with rule [5101:3-46-04.1](#) of the Administrative Code. An HCAS visit shall not exceed twelve hours or forty-eight units in duration.
 - (6) "Intermittent nursing" means nursing services (waiver nursing and/or home health nursing) that are four hours or less in length.
 - (7) "Medicaid maximum rate" means the maximum amount that shall be paid by the Ohio medicaid program for the service rendered. The base rate in column 3 and the unit rate in column 4 of table A of this rule, and the base rate in column 3 and the unit rates in column 5 of table B of this rule represent the medicaid maximum rates for HCAS.
 - (8) "Modifier" means the additional two-alpha-numeric-digit billing code set forth in paragraph (H) of this rule that HCAS providers shall use to provide additional information regarding service delivery.
 - (9) "Unit rate," as set forth in column 4 of table A of this rule and column 5 of table B of this rule, means the amount paid for each fifteen-minute unit of HCAS following the base rate paid for the first four units of HCAS provided.
- (B) Providers shall bill for reimbursement using table A when HCAS is provided in lieu of continuous nursing as described in paragraph (A)(2) of this rule. Personal care aide tasks are included in the unit rate.

-Table A-

Column 1	Column 2	Column 3	Column 4
Billing code	Home care attendant service description	Base rate	Unit rate
S5125	Assistance with self-administration of medications and/or the performance	\$33.36 <u>\$25.89</u>	\$4.17 per fifteen minute unit of HCAS/N delivered during visit

	of nursing tasks (HCAS/N)		(beginning with the fifth unit of service)
--	---------------------------	--	--

- (C) Providers shall bill for reimbursement using table B when HCAS is provided in lieu of intermittent nursing as described in paragraph (A)(6) of this rule. The first four units of HCAS shall be billed for at the base rate. Beginning with the fifth unit of HCAS, assistance with self-administration of medications and the performance of nursing tasks (HCAS/N) shall be billed at the HCAS/N unit rate; and personal care tasks (HCAS/PC) shall be billed at the HCAS/PC unit rate using the U8 modifier.

-Table B-

Column 1	Column 2	Column 3	Column 4	Column 5
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	HCAS/N	\$33.36 <u>\$25.89</u>	N/A	\$4.17 per fifteen minute unit of HCAS/N delivered during the visit (beginning with the fifth unit of service)
S5125	HCAS/PC	N/A	U8	\$3.00 per fifteen minute of HCAS/PC delivered during the visit

- (D) In order for a provider to submit a claim for HCAS under the Ohio home care waiver, the services must be provided in accordance with Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.
- (E) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.
- (F) When HCAS/N and HCAS/PC are provided during an uninterrupted period of time, the visit shall be considered a single HCAS visit. An HCAS provider is entitled to only one base rate during an HCAS visit.
- (G) HCAS providers shall be limited to a maximum of twelve hours or forty-eight units of HCAS during a twenty-four-hour period, regardless of the number of consumers served.
- (H) Required modifiers.
- (1) The "HQ" modifier must be used when a provider submits a claim if HCAS 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 rate.
 - (2) The "U2" modifier must be used when a provider submits a claim for a second HCAS visit to a consumer for the same date of service.
 - (3) The "U3" modifier must be used when the same provider submits a claim for three or more HCAS visits to a consumer for the same date of service.
 - (4) The "U8" modifier must be used when a provider submits a claim for an HCAS visit that is in lieu of intermittent nursing as described in paragraph (A)(6) of this rule, and for units of service that are HCAS/PC.
- (I) Reimbursement shall be provided in accordance with paragraphs (A) to (D) of rule 5101:3-1-60 of the Administrative Code. Claims shall be submitted to, and reimbursement shall be provided by, the Ohio department of job and family services in accordance with Chapter 5101:3-1 of the Administrative Code.

Effective: 10/01/2011

R.C. 119.032 review dates: 07/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0213, 5111.85, 5111.8811

Rule Amplifies: 5111.02, 5111.021, 5111.0213, 5111.85, 5111.88, 5111.881, 5111.882, 5111.883, 5111.884, 5111.885, 5111.886, 5111.887, 5111.888, 5111.889, 5111.8810 Prior Effective Dates: 7/1/10

LTCSTL 11-11

Effective Date: October 1, 2011

Most Current Prior Effective Date: December 10, 2009

- (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) "HOME choice demonstration program" is Ohio's money follows the person (MFP) demonstration project funded by the centers for medicare and medicaid services (CMS).
 - (3) "Individual" is defined as a medicaid recipient who is residing in a nursing facility (NF) ~~resident who~~ and is seeking non-medicaid Ohio access success project benefits.
 - (4) "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.
 - (5) "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.
 - (6) "ODJFS" is defined as the Ohio department of job and family services.
 - (7) "ODA" is defined as the Ohio department of aging.
 - (8) "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~~ an 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 and other expenses not covered by the medicaid program to that facilitate the securing of residence in~~ a medicaid recipient's move from a NF to a community setting. A maximum, one-time benefit of two thousand dollars can be spent at the time of relocation. No participant may receive more than two thousand dollars worth of goods and services under the non-medicaid-funded Ohio access success project, and part of their allocation shall, if appropriate, be paid to a contractor for costs associated with the administration of the benefit.
- (D) The application process for the non-medicaid-funded Ohio access success project requires:
- (1) Completion of the "non-medicaid Ohio access success project referral"; and
 - (2) An assessment of the consumer's care needs in the community.
- (E) In order to qualify for non-medicaid-funded Ohio access success project benefits an individual must meet all of the criteria set forth in this rule:
- (1) Be a medicaid recipient of medicaid-funded NF services at the time of application;
 - (2) ~~Need the level of care provided by the NF~~ Be able to remain in the community as a result of receiving project benefits; ~~(3) Not meet the ICF-MR level of care as set forth in rule 5101:3-3-07 of the Administrative Code;~~
 - ~~(4)~~(3) 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; Receive a determination from

ODJFS or its designee that the individual's projected cost of services as described in paragraph (E)(3)(a) of this rule shall not exceed eighty percent of the state average monthly medicaid cost of care for a medicaid recipient residing in a NF as described in paragraph (E)(3)(b) of this rule.(a) The calculation of projected monthly service costs for the individual in the community shall include all of the following:

(i) The average medicaid per member per month costs for hospital, physician and pharmacy services as determined by ODJFS; and

(ii) The individual's assessed monthly need for medicaid covered services.

(b) The calculation of average monthly costs for an individual residing in a NF shall be the sum of all of the following:

(i) The average medicaid per diem paid to all NFs on the first date of the state fiscal year in which the participant's eligibility for the non-medicaid-funded Ohio access success project is being determined; and

(ii) The average per member per month medicaid costs for medicaid services not covered in paragraph (E)(3)(b)(i) of this rule for a NF resident.

~~(5)(4)~~ Not qualify for similar services that are reimbursable by medicaid; ~~and~~.

~~(6)(5)~~ Have been determined ineligible for the HOME choice demonstration program as set forth in Chapter 5101:3-51 of the Administrative Code.

~~(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)(F)~~ An individual applying for, or a participant receiving, benefits under the non-medicaid Ohio access success project shall ~~retain the right to appropriate notice for a hearing~~ be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

~~(I)(G)~~ ODJFS has the authority to limit the number of ~~individuals participating~~ participants 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.

Effective: 10/01/2011

R.C. 119.032 review dates: 07/14/2011 and 10/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.97

Rule Amplifies: 5111.97

Prior Effective Dates: 7/1/04, 10/1/05, 12/10/09

LTCSTL 14-11

Effective Date: December 1, 2014

Most Current Prior Effective Date: July 1, 2006

- (A) Enrollment on the transitions carve-out waiver is available only to individuals who, on the effective date of this rule, were enrolled on the Ohio home care waiver or are participating in the HOME choice (helping Ohioans move, expanding choice) demonstration program. Transfer from the Ohio home care waiver to the transitions carve-out waiver will occur after ODM or its designee determines the criteria in paragraphs (B) and (C) are met.
- (B) To be eligible for enrollment in the transitions carve-out waiver program, an individual must meet all of the following requirements:
- (1) Be age sixty or older;
 - (2) Be determined eligible for Ohio medicaid in accordance with rules [5160:1-2-01.6](#) and [5160:1-3-24](#) of the Administrative Code;
 - (3) Participate in an assessment to determine if the individual has needs that can be met through the transitions carve-out waiver program;
 - (4) Be determined to have a nursing facility (NF) -based level of care (i.e., intermediate or skilled) in accordance with rule [5160-3-08](#) of the Administrative Code;
 - (5) In the absence of the transitions carve-out waiver program, require hospitalization or institutionalization in a NF to meet his or her needs;
 - (6) Be determined to require and agree to receive at least one waiver service monthly that is otherwise unavailable through another source (including, but not limited to, private pay, community resources and/or the medicaid state plan) in an amount sufficient to meet the individual's assessed needs;
 - (7) Be able to establish residency in a place that is not a hospital, NF, intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (March 2, 2004)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.
 - (8) Sign an agreement prior to waiver enrollment confirming that the individual has been informed of service alternatives, choice of qualified providers available in the transitions carve-out waiver program and the options of institutional and community-based care, and he or she elects to receive transitions carve-out waiver services; and
 - (9) Have needs that can be safely met through the transitions carve-out waiver in a home or community setting as determined by ODM or its designee.
- (C) To be enrolled, and maintain enrollment in the transitions carve-out waiver program, an individual must be determined by ODM or its designee to meet all of the following requirements:
- (1) Be determined eligible for the transitions carve-out waiver program in accordance with paragraph (B) of this rule;
 - (2) Not reside in a hospital, NF, intermediate care facility for individuals with an intellectual disability (ICF-IID) or another licensed/certified facility, any facility covered by section 1616(e) of the Social Security Act (42 U.S.C. 1382(e) (March 2, 2004)), residential care facility, adult foster home or another group living arrangement subject to state licensure or certification.
 - (3) Have his or her health and welfare assured while enrolled on the waiver;

- (4) Participate in the development and implementation of a person-centered all services plan, and consent to the plan by signing and dating it;
- (5) Agree to and receive case management services from ODM or its designee including, but not limited to:
 - (a) Annual and other assessments, as needed,
 - (b) Home safety evaluations,
 - (c) Contact with the case manager and/or the individual's team members, including, but not limited to telephone communications, and face-to-face and in-home visits; and
- (6) Agree to and participate in quality assurance and participant satisfaction activities during his or her enrollment on the transitions carve-out waiver program including, but not limited to, face-to-face visits.
- (D) If an individual fails to meet any of the requirements set forth in paragraph (B) and/or paragraph (C) of this rule, the individual shall be denied enrollment on the transitions carve-out waiver program.
- (E) Once enrolled on the transitions carve-out waiver program, an individual's NF level of care shall be reassessed at least annually, and more frequently if there is a significant change in the individual's situation that may impact his or her health and welfare. If the reassessment determines the individual no longer meets the requirements set forth in paragraph (B) and/or paragraph (C) of this rule, he or she shall be disenrolled from the transitions carve-out waiver program.
- (F) If, at any other time, it is determined that an individual enrolled on the transitions carve-out waiver program no longer meets the requirements set forth in paragraph (B) and/or paragraph (C) of this rule, he or she shall be disenrolled from the transitions carve-out waiver program. Reassessment pursuant to paragraph (E) is not required to make this determination.
- (G) If an individual is denied enrollment in the transitions carve-out waiver program pursuant to paragraph (D) of this rule, or is disenrolled from the waiver pursuant to paragraph (E) or (F) of this rule, the individual shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Replaces: 5160-50-02 and 5160-50-02.1

Effective: 12/01/2014

Five Year Review (FYR) Dates: 12/01/2019

Certification: CERTIFIED ELECTRONICALLY

Date: 11/10/2014

Promulgated Under: 119.03

Statutory Authority: 5166.02

Rule Amplifies: 5164.02, 5162.03

Prior Effective Dates: 4/4/77, 12/21/77, 6/1/80, 5/1/87, 4/1/88, 5/15/89, 3/12/92 (Emer), 6/1/92, 7/31/92 (Emer), 10/30/92, 4/30/93 (Emer), 7/30/93, 7/1/98, 9/29/00, 3/1/02 (Emer), 5/30/02, 7/1/06, 7/1/08

5160-50-04 Transitions Carve-Out Waiver: Definitions of the Covered Services and Provider Requirements and Specifications

~~*Formerly*~~ 5101:3-50-04 Transitions Carve-Out Waiver: Definitions of the Covered Services and Provider Requirements and Specifications

CSTL 10-07

Effective Date: October 25, 2010

Most Current Prior 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~~ thereunder, and shall possess a current, ~~and~~-valid and unrestricted 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~~ thereunder, 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~~ paragraph (B)(6)(c) and (B)(6)(d) of this rule; ~~or~~
 - (d) Visits performed for the sole purpose of conducting an "OASIS" (outcome and assessment information set) assessment or any other assessment;
 - (e) Visits performed for the sole purpose of meeting the home care attendant service nurse consultation requirements set forth in rules 5101:3-46-04.1 and 5101:3-50-04.1 of the Administrative Code; or
 - ~~(e)~~(f) Services performed in excess of the number of hours approved pursuant to, and as specified on, the consumer's all services plan.
- (4) In order to be a provider and submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must meet the following requirements:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - ~~(a)~~(c) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider; ~~;~~
 - ~~(b)~~(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, unless the legally

responsible family member is employed by a medicare-certified, or otherwise-accredited home health agency;

~~(e)~~(e) Not be the foster caregiver of the consumer;

~~(d)~~(f) Be identified as the provider ~~on~~ and have specified on, the consumer's all services plan that is prior-approved by ~~the designated case management agency (CMA);~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish waiver nursing services to the consumer.

~~(e)~~(g) Be identified as the provider on, and be performing nursing services pursuant to ~~signed and dated written orders from the treating physician;~~ and the consumer's plan of care, as that term is defined in rule 5101:3-45-01 of the Administrative Code. The plan of care must be signed and dated by the consumer's treating physician.

~~(f)~~(h) 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~~ before initiating services and at least 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~~ At a minimum, the clinical record must contain the information listed in paragraphs (A)(6)(a) to (A)(6)(~~k~~)(l) of this rule.

(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~~ any advance directives including, but not limited to, "do not resuscitate" (DNR) order or medical power of attorney, if ~~one exists~~ they exist.
- (i) Documentation of all drug and food interactions, allergies and dietary restrictions.
- ~~(j)(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.~~ Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature. ~~(j)(k)~~ Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- ~~(k)(l)~~ 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. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.

(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 needs. If the consumer's 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 paragraphs (B)(1)(a) to (B)(1)(e) of this rule. ~~Personal care aide service providers may elect not to furnish one or more of the listed services.~~ If the provider ~~so elects~~, cannot perform IADLs, the provider must notify ~~the designated CMA~~ ODJFS or its designee, in writing, of the ~~services the provider elects not to furnish~~ service limitations before inclusion on the consumer's all services plan.
 - (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, unless otherwise prohibited by the provider's certification or accreditation status, pursuant to paragraph ~~(B)~~ (C) of rule ~~4723-13-04~~ 4723-13-02 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 be a provider and submit a claim for reimbursement, all individuals providing personal care aide services must meet the following:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - ~~(a)~~(c) Be at least eighteen years of age;.
 - ~~(b)~~(d) Be identified as the provider, and have specified on, on the consumer's all services plan that is prior-approved by ~~the designated CMA;~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish personal care aide services to the consumer.
 - ~~(c)~~(e) 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)~~(f) 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)~~(g) Not be the foster caregiver of the consumer;.
 - ~~(f)~~(h) 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)~~(i) 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~~ Before commencing service delivery, the personal care aide must:
- (i) Obtain a certificate of completion of either ~~the nurse aide~~ a competency evaluation program or training and competency evaluation program approved or 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 42 C.F.R. 484.36 (~~2005~~August 12, 2005), and
 - (ii) Obtain and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.
- (b) Maintain evidence of the completion of ~~eight~~ twelve 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~~ while the personal care aide is present and providing care to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, and personal care aide performance. The visit must be documented in the consumer's record.
 - ~~(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)~~(iii) 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~~ Before 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~~ a competency evaluation program or training and competency evaluation program approved or 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 42 C.F.R. 484.36 (~~2005~~August 12, 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~~ the prevention of disease transmission, including hand-washing and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken.

- (ii) Obtained and maintain first aid certification from a class that is not solely internet-based and that includes hands-on training by a certified first aid instructor and a successful return demonstration of what was learned in the course.
 - (b) Complete ~~eight~~ twelve 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~~ 5101:3-45-06 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~~ At a minimum, the clinical record must contain the information listed in paragraphs (B)(8)(a) to (B)(8)(i) of this rule.
- (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~~ all drug and food interactions, allergies and dietary restrictions.
 - (f) A copy of ~~the "do not resuscitate" (DNR) order, if one exists~~ any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.
 - (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.~~ Documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and consumer or authorized representative, verifying the service delivery upon completion of service delivery. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.
 - (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. The summary should include documentation regarding progress made toward achievement of goals as specified on the consumer's all services plan and indicate any recommended follow-ups or referrals.

(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~~ shall not be used for other purposes during the provision of ADHCS.
 - (a) The services the adult day health center must ~~make available~~ provide 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~~ At least one meal, but 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, and specified on, the consumer's all services plan.
- (3) In order to be a provider and submit a claim for reimbursement, providers of ADHCS must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - ~~(a)~~(c) Be identified as the provider on the consumer's all services plan that is prior-approved by ~~the designated CMA; and~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish ADHCS to the consumer.
 - ~~(b)~~(d) 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~~ 45 C.F.R. part 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-GMA~~ designee verifying the coverage.

- (c) Maintain evidence of non-licensed direct care staff's completion of ~~eight~~ twelve 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 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 set forth in paragraph (B)(1) of this rule.
- (f) Maintain, at all times, a paid direct care 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~~ At a minimum, the clinical record must contain the information listed in paragraphs (C)(5)(a) to (C)(5)(i) of this rule.
 - (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~~ any advance directive including, but not limited to, DNR order or medical power of attorney, if they exist.
 - (f) Documentation of ~~drug~~ all drug and food interactions, 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. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-ups or referrals.
 - (i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i), ~~and~~ (A)(6)(j) and (A)(6)(k) 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 paragraphs (D)(4)(a) to (D)(4)(d) of this rule.~~
- (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.~~

(D) Home delivered meal services.

- (1) "Home delivered meal service" is defined as the provision of meals to a consumer who has a need for a home delivered meal based on a deficit in an ADL or a deficit in an IADL identified during the assessment process. The service includes the preparation, packaging and delivery of a safe and nutritious meal(s) to a consumer at his or her home. A consumer may be authorized to receive up to two home delivered meals per day.
- (2) Home delivered meals:
- (a) Shall be furnished in accordance with menus that are approved in writing by a licensed dietitian who is currently registered with the commission on dietetic registration.
 - (b) Shall take into consideration the consumer's medical restrictions, religious, cultural and ethnic background and dietary preferences.
 - (c) Shall be prepared by a provider who is in compliance with Chapters 918., 3715. and 3717. of the Revised Code and all applicable Administrative Code rules adopted thereunder. For the purposes of this rule, reheating a prepared home delivered meal is not the same as preparing a meal.
 - (d) Shall be individually packaged if it is a heated meal.
 - (e) May be individually packaged if it is an unheated, shelf-stable meal, or may have components separately packaged, so long as the components are clearly marked as components of a single meal.

- (f) May include a therapeutic diet that requires a daily amount or distribution of one or more specified nutrients in order to treat a disease or clinical condition, or eliminate, decrease or increase certain substances in the consumer's diet. A therapeutic diet must be prescribed by a licensed physician or dietitian. A new order must be documented in the consumer's clinical record every ninety days.
- (3) Home delivered meals shall not:
- (a) Include services or activities performed in excess of what is approved on the consumer's all services plan.
 - (b) Supplement or replace meal preparation activities that occur during the provision of waiver nursing, personal care aide, adult day health center, home care attendant or any other similar services.
 - (c) Supplement or replace the purchase of food or groceries.
 - (d) Include bulk ingredients, liquids and other food used to prepare meals independently or with assistance. Bulk ingredients and liquids include, but are not limited to: food that must be portioned out and prepared, or any food that must be cooked or prepared.
 - (e) Be prepared while the consumer is hospitalized or is residing in an institutional setting.
- (4) In order to be a provider and to submit a claim for reimbursement, all home delivered meal providers must meet all of the following requirements:
- (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of home delivered meal services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - (c) Be identified as the home delivered meal provider, and be specified, on the consumer's all services plan that is prior-approved by the department or its designee.
 - (d) Possess any applicable current, valid license or certificate from the local health department, and retain records of all reports related to the licensure or certification.
 - (e) Assure that all meals are provided as identified on the consumer's all services plan.
 - (f) Submit claims that do not exceed two meals per day per consumer.
 - (g) Maintain documentation as set forth in paragraph (D)(8) of this rule.
- (5) Home delivered meal service providers shall assure all meals, with the exception of a therapeutic diet prescribed and prepared in accordance with paragraph (D)(2)(f) of this rule, meet the following requirements with regard to nutritional adequacy:
- (a) Meet one-third of the current dietary reference intakes (DRI) established by the food and nutrition board of the institute of medicine of the national academy of sciences.
 - (b) Follow the current dietary guidelines for Americans as published by the U.S. department of agriculture.
- (6) Home delivered meal service providers shall assure the safe delivery of meals as authorized by the department or its designee on the consumer's all services plan.
- (a) Ready-to-eat, temperature-controlled meals must be labeled with a preparation date. The date shall include the month, day and year the meals were prepared, and shall list, immediately adjacent to this date, the phrase "packing" or "pack date." All other meals shall be labeled with the month, day and year by which the meal shall be consumed or discarded, and shall list the date immediately following the phrase "sell by" or "use before."
 - (b) The provider must document evidence of a time and temperature monitoring system for food preparation, handling and delivery.

- (c) The provider shall ensure all transportation vehicles and containers are safe and sanitary.
 - (d) When using a thermostatically-controlled meal delivery vehicle, the provider must maintain verification of testing meal temperatures no less than monthly. When using other meal delivery vehicles, the provider must maintain verification of testing meal temperatures no less than weekly.
 - (e) The provider must establish with the consumer, and document in the consumer's record, a routine date and time for meal delivery. The provider must notify the consumer if delivery of the meal(s) will be delayed more than one hour past established time.
 - (f) The provider must furnish written delivery instructions to the driver.
 - (g) The provider must furnish the consumer or authorized representative with clear instruction on how to safely heat or reheat each meal.
- (7) Home delivered meal service providers shall assure the following with regard to training and continuing education:
- (a) All personnel who participate in food preparation, food handling and/or delivery, including volunteers, must:
 - (i) Receive training and orientation on the following as relevant with the individual's job duties:
 - (a) Sensitivity to the needs of older adults and people with physical disabilities or cognitive impairments;
 - (b) Handling emergencies;
 - (c) Food storage, preparation and handling;
 - (d) Food safety and sanitation;
 - (e) Meal delivery; and
 - (f) Handling hazardous materials.
 - (ii) Successfully complete four hours of continuing education each year on the topics relevant to the individual's job duties.
 - (b) The provider must develop a training plan and conduct and document annual training and continuing education activities.
- (8) At a minimum, home delivered meal service providers must maintain and make available, upon request, the following:
- (a) A record for each consumer served that contains a copy of the initial and all subsequent all services plans, all dietary orders and instructions prepared by the physician, menus approved by the dietitian, and any additional information supporting meal delivery as specified on the all services plan.
 - (b) Documentation that each meal complies with paragraphs (D)(5)(a) and (D)(5)(b) of this rule.
 - (c) Documentation of each consumer's therapeutic diet as set forth in paragraph (D)(2)(f) of this rule.
 - (d) Documentation from the provider that the consumer or authorized representative has been furnished with clear instructions about how to safely heat or reheat each meal.
 - (e) Documentation that verifies delivery of home delivered meals as authorized on the consumer's all services plan. Documentation shall include, but not be limited to, the consumer's name, the dated signature of the home delivered meal service provider, the established delivery date and time, the actual time of delivery of all meals and the number of meals delivered, signature or initials of the person delivering the meal(s) and the signature or initials of the consumer or authorized representative receiving the

meal(s). Nothing shall prohibit the collection or maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

- (f) Documentation that the home delivered meal delivery staff possesses a current and valid driver's license.
- (g) Documentation of vehicle owner's liability insurance.
- (h) Documentation that the provider has established a routine delivery time with the consumer.
- (i) All local health department inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.
- (j) All Ohio department of agriculture inspection reports and documented findings, any resulting plans of correction and any follow-up reports.
- (k) All U.S. department of agriculture inspection reports and documented findings, any resulting plans of correction, and any follow-up reports.
- (l) All licensure/certification documents required as a result of paragraph (D)(4)(e) of this rule.

(9) Home delivered meal provider inspections and follow-up.

- (a) Home delivered meal service providers cited for critical violations, as that term "critical violations" is used in paragraph (B) of rule [3717-1-02.4](#) of the Administrative Code, during their local health department inspections, shall notify ODJFS or its designee no more than forty-eight hours after issuance of the citation. The provider shall, within forty-eight hours, send to ODJFS or its designee a copy of the inspection report, any plans of correction and any follow-up reports.
- (b) Home delivered meal service providers inspected by the Ohio department of agriculture division of food safety and placed on priority status or notice status shall notify ODJFS or its designee no more than two business days after the issuance of the report of priority status, or after the issuance of the report of notice status in accordance with section 913.42 of the Revised Code. The provider shall, within five business days, send to ODJFS or its designee, a copy of the report(s) with documented findings, any notices issued by the Ohio department of agriculture, and any resulting plans of correction and follow-up reports.
- (c) Home delivered meal service providers inspected by the Ohio department of agriculture division of meat inspection or the U.S. department of agriculture food safety inspection service shall notify ODJFS or its designee no more than two business days after it takes a withholding action against, or it suspends the provider in accordance with 9 C.F.R. 500.3 (November 29, 1999) and/or 9 C.F.R. 500.4 (November 29, 1999). The provider shall, within five business days, send to ODJFS or its designee, a copy of the action issued by the Ohio department of agriculture or the U.S. department of agriculture food safety inspection service, any resulting plans of correction and any follow-up reports.
- (d) ODJFS may immediately suspend and terminate a provider's authorization to furnish home delivered meal services pursuant to section 5111.6 of the Revised Code and rule 5101:3-1-17.6 of the Administrative Code if ODJFS or its designee receives credible information that the provider poses a significant threat to the health and welfare of one or more consumers due to noncompliance with one or more of the requirements set forth in this rule.

(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 are not otherwise available through any other funding source and must be suitable to enable the consumer to function with greater independence, avoid institutionalization and reduce the need for human assistance. They shall not exceed ~~ten~~ a total of ten thousand dollars within a twelve-month calendar year period per consumer. ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.
 - (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~~ 4755.08 and 4755.44 of the Revised Code, during an in-person evaluation of the site to be modified, and with the consumer present.
 - (c) Home modifications include repairs of previous home modifications excluding those described in paragraph (E)(2)(e) of this rule.
- (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.);₂
 - (b) Adaptations that add to the total square footage of the home; ~~and,~~
 - (c) Services performed in excess of what is approved pursuant to, and specified on, the consumer's all services plan.
 - (d) The same type of home modification for the same consumer during the same twelve-month calendar year, unless there is a documented need for the home modification or a documented change in the consumer's medical and/or physical condition that requires the replacement.
 - (e) New home modifications or repair of previously approved home modifications that have been damaged as a result of confirmed misuse, abuse or negligence.
- (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~~ ODJFS or its designee and the adjustment is warranted. Family members and volunteers ~~will~~ shall meet all of the provider requirements set forth in paragraph (E) of this rule, however, they shall only be reimbursed for the cost of materials.
- (4) In order to be a provider and submit a claim for reimbursement, providers of home modification services must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - ~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~; ODJFS or its designee, the home modification services that the provider is authorized to furnish to the consumer.

- ~~(b)~~(d) Assure Provide documentation 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)~~(e) Assure Provide documentation that the home modification was tested and in proper working order;
- ~~(d)~~(f) Assure Provide documentation that the home modification met all applicable state and local building codes ~~and complies with the Americans with Disabilities Act (ADA);~~
- (g) Provide documentation that the home modification meets the consumer's needs and complies with the Americans with Disabilities Act (ADA) (September 25, 2008), the Uniform Federal Accessibility Standards (UFAS) (January 18, 1991) or the Fair Housing Act (FHA) (April 11, 1968), as applicable. If a home modification must be customized in order to meet the consumer's needs, and that customization will not be compliant with the ADA, UFAS or FHA, it must be prior-approved by ODJFS or its designee, in consultation with the consumer and/or authorized representative and the consumer's interdisciplinary team.
- ~~(e)~~(h) Maintain licensure, insurance and bonding for general contracting services of applicable jurisdictions and provide proof to ~~the designated CMA~~ ODJFS or its designee upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the consumer; ~~and~~.
- ~~(f)~~(i) Obtain a final written approval from the consumer and ~~the designated CMA~~ ODJFS or its designee after completion of the home modification service.

(5) Selection of home modification service providers.

- (a) ~~The designated CMA~~ In consultation with the consumer, authorized representative and/or caregiver(s), ODJFS or its designee shall develop job specifications ~~in consultation with the consumer, authorized representative, and/or caregiver(s) to~~ based on the in-person evaluation required in paragraph (E)(1)(b) of this rule to meet the consumer's environmental accessibility needs with the lowest cost alternative.
- (b) ~~The designated CMA~~ At a minimum, ODJFS or its designee shall send the home modification specifications to every known home modification service provider in the consumer's ~~region~~ county of residence and all contiguous counties, and shall invite the submission of competitive bids. ~~The following must be submitted with all bids:~~ Home modification providers shall submit bids that include all of the following:
 - (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 including, at a minimum, a minimum one-year warranty for all materials and workmanship associated with the home modification; 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, and meet all of the provider requirements set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
- (c) ~~The designated CMA~~ ODJFS or its designee 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)~~(F) 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,~~ or a family member, or someone who resides in the same household as the consumer, 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. All supplemental adaptive and assistive device services shall be prior-approved by ODJFS or its designee. ~~The designated~~

~~CMA~~ ODJFS or its designee shall only approve the lowest cost alternative that meets the consumer's needs as determined during the assessment process.

- (a) Reimbursement for medical equipment, ~~and~~ supplies and vehicle modifications shall not exceed a combined total of ten thousand dollars within a ~~twelve-month period~~ calendar year 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) ODJFS or its designee shall not approve the same type of medical equipment, supplies and devices for the same consumer during the same calendar year, unless there is a documented need for ongoing medical equipment, or a documented change in the consumer's medical and/or physical condition requiring the replacement.
- ~~(b)(c)~~ Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. ~~The designated CMA~~ ODJFS or its designee shall not approve the same type of vehicle modification for the same consumer ~~for a~~ within the same three-year period, unless there is a documented change in the consumer's medical and/or physical condition requiring the replacement.
- (d) Supplemental adaptive and assistive device services do not include:
- (i) Items considered by the federal food and drug administration as experimental or investigational;
 - (ii) Funding of downpayments toward the purchase or lease of any supplemental adaptive and assistive device services;
 - (iii) Equipment, supplies or services furnished in excess of what is approved pursuant to, and as specified on the consumer's all services plan;
 - (iv) New equipment or supplies or repair of previously approved equipment or supplies that have been damaged as a result of confirmed misuse, abuse or negligence;
and
 - (v) Activities described in paragraph (F)(2)(c) of this rule.

(2) Vehicle modifications.

- (a) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, wheelchair tie-downs, 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. Vehicle modifications may also include the itemized cost, and separate invoicing of vehicle adaptations associated with the purchase of a vehicle that has not been pre-owned or pre-leased.
- ~~(2)(b)~~ 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 Before 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~~ ODJFS or its designee with documentation of:
- ~~(a)(i)~~ Evidence of a A valid driver's license, with appropriate restrictions, and if requested, evidence of the successful completion of driver training from a qualified driver rehabilitation specialist, or a written statement from a qualified driver rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other person(s) operating the vehicle;
 - (ii) Proof of ownership of the vehicle to be modified;

- ~~(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)~~(iii) Evidence of the vehicle Vehicle owner's collision and liability insurance for the vehicle being modified; and
- ~~(d)~~(iv) A written statement from a certified mechanic stating the vehicle is in good operating condition.

~~(3)~~(c) ~~Supplemental adaptive and assistive device services~~ Vehicle modifications 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)~~(i) Payment toward the purchase or lease of a vehicle, except as set forth in paragraph (F)(2)(a) of this rule;
- ~~(d)~~(ii) Routine care and maintenance of vehicle modifications and devices;
- ~~(e)~~(iii) Permanent modification of leased vehicles;
- ~~(f)~~(iv) Vehicle inspection costs;
- ~~(g)~~(v) Vehicle insurance costs; ~~and~~
- ~~(v)~~(vi) New vehicle modifications or repair of previously approved modifications that have been damaged as a result of confirmed misuse, abuse or negligence; and
- ~~(h)~~(vii) Services performed in excess of what is approved pursuant to, and specified on, the consumer's all services plan.

~~(4)~~(3) In order to be a provider and submit a claim for supplemental adaptive and assistive device services, the provider must:

- ~~(a)~~ Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
- ~~(b)~~ Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
- ~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the supplemental adaptive and assistive device services the provider is authorized to furnish to the consumer.;
- ~~(b)~~(d) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services; ~~and.~~
- ~~(c)~~(e) 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)~~(4) 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~~ At a minimum, the clinical record must contain the information listed in paragraphs ~~(G)(5)(a) to (G)(5)(d)~~ (F)(4)(a) to (F)(4)(d) of this rule.

- (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)~~(G) 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)~~(G)(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, and specified on, the consumer's all services plan.
- (3) In order to be a provider and submit a claim for reimbursement, providers of out-of-home respite services must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - ~~(a)~~(c) Be identified as the provider, and have specified, on the consumer's all services plan that is prior-approved by ~~the designated CMA~~ ODJFS or its designee, the number of hours for which the provider is authorized to furnish out-of-home respite services to the consumer.
 - ~~(b)~~(d) Be either:
 - (i) An intermediate care facility 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~~ licensed setting approved by ~~the designated CMA~~ ODJFS or its designee.
 - ~~(e)~~(e) 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~~ 45 C.F.R. part 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~~ designee 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 paragraphs ~~(H)(G)~~(5)(a) to ~~(H)(G)~~(5)(i) of this rule.
- (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~~ any advance directives including, but not limited to, DNR order or medical power of attorney, if they exist.
 - (f) Documentation of ~~drug~~ all drug and food interactions, 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) and (A)(6)(k)~~ of this rule when the consumer is provided waiver nursing.

~~(I) 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.~~

(H) Emergency response services.

- (1) "Emergency response services (ERS)" are emergency intervention services composed of telecommunications equipment (ERS equipment), an emergency response center and a medium for two-way, hands-free communication between the consumer and the emergency response center. Personnel at the emergency response center intervene in an emergency when the center receives an alarm signal from the ERS equipment.
- (2) ERS equipment shall include a variety of remote or other specialty activation devices from which the consumer can choose in accordance with the consumer's specific needs. All ERS equipment shall have an internal battery that provides at least twenty-four hours of power without recharging and sends notification to the emergency response center when the battery's level is low. Equipment includes, but is not limited to:
 - (a) Wearable waterproof activation devices;
 - (b) Devices that offer:
 - (i) Voice-to-voice communication capability,
 - (ii) Visual indication of an alarm that may be appropriate if the consumer is hearing impaired, or
 - (iii) Audible indication of an alarm that may be appropriate if the consumer is visually impaired.
- (3) ERS does not include the following:
 - (a) Equipment such as a boundary alarm, a medication dispenser, a medication reminder, or any other equipment or home medical equipment or supplies, regardless of whether such equipment is connected to the ERS equipment.

- (b) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen.
 - (c) Remote monitoring services.
 - (d) Services performed in excess of what is approved pursuant to a consumer's all services plan.
 - (e) New equipment or repair of previously approved equipment that has been damaged as a result of confirmed misuse, abuse or negligence.
- (4) In order to be a provider and submit a claim for ERS, the provider must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - (c) Be identified as the provider, and have specified on the consumer's all services plan, the ERS that the provider is authorized to furnish.
- (5) ERS requirements.
 - (a) Providers shall assure that all consumers are able to choose the ERS equipment that meets their specific needs as set forth on their all services plan.
 - (b) Providers shall furnish each ERS consumer with an initial face-to-face demonstration and training on how to use their ERS equipment. Additional training shall be provided to designated responders as part of the monthly service in accordance with paragraph (H)(5)(c) of this rule, and to the consumer, caregiver and ODJFS or its designee upon request.
 - (c) Before, or during the delivery of ERS equipment, the provider shall work with the consumer and/or the consumer's authorized representative, and the consumer's case manager to develop a written response plan regarding how to proceed in the event the ERS signals an alarm. The written response plan shall be updated as often as desired by the consumer and/or the consumer's authorized representative, but shall be reviewed no less than every six months.
 - (i) The written response plan shall include a summary of the consumer's health history and functioning level, as well as the name of, and contact information for, at least one individual who will serve as the consumer's designated responder. If the consumer identifies more than one designated responder, the consumer shall also indicate the order in which the responders should be contacted. For the purposes of this rule, "designated responder" means an individual or individuals who the consumer and/or authorized representative chooses to be contacted by the ERS provider in the event the ERS signals an alarm. If fewer than two individuals are designated as responders, then emergency service personnel shall be designated as responders in the plan.
 - (ii) The provider shall furnish initial training to all designated responders before activation of the consumer's ERS equipment, and on an annual basis. At a minimum, the training shall include:
 - (a) Instruction regarding how to respond to an emergency, including how to contact emergency service personnel; and
 - (b) Distribution of written materials regarding how to respond to an ERS signal.
 - (iii) The provider shall work with the consumer and/or the consumer's authorized representative, and the case manager to revise the written response plan when there is a change in designated responders.

- (f) A written record of the monthly testing conducted on each consumer's ERS equipment, including date, time and results of the test.
- (g) A record of each service-related consumer contact including, but not limited to, the date and time of the contact, a summary of the incident, the service delivered (including the service of responding to a false alarm), and the name of each person having contact with the consumer.
- (h) A copy of the consumer's written response plan as set forth in paragraph (H)(5)(c) of this rule.

(I) Supplemental transportation services.

- (1) "Supplemental transportation services" are transportation services that are not available through any other resource that enable a consumer to access waiver services and other community resources specified on the consumer's all services plan. Supplemental transportation services include, but are not limited to 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, and specified on, the consumer's all services plan.
- (3) In order to be a provider and submit a claim for supplemental transportation services, the provider must:
 - (a) Comply with all applicable rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (b) Request reimbursement for the provision of services in accordance with rule 5101:3-50-06 of the Administrative Code.
 - (c) Be identified as the provider, and have specified on, the consumer's all services plan that is prior-approved by ODJFS or its designee, the amount of supplemental transportation services the provider is authorized to furnish to the consumer.
- (4) Agency supplemental transportation service providers must:
 - (a) Maintain a current list of drivers.
 - (b) Maintain documentation 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) Obtain and maintain a certificate of completion of a course in first aid for each driver used to provide supplemental transportation services that:
 - (i) Is not provided solely through the internet;
 - (ii) Includes hands-on training provided by a certified first aid instructor; and
 - (iii) Requires the individual to perform a successful return demonstration of what was learned in the course.
 - (g) Assure that drivers are not the consumer's legally responsible family member as that term is defined in rule [5101:3-45-01](#) of the Administrative Code.
 - (h) Assure that drivers are not the consumer's 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) Obtain and maintain a certificate of completion of a course in first aid that:
 - (i) Is not provided solely through the internet;
 - (ii) Includes hands-on training provided by a certified first aid instructor;
 - (iii) Requires the individual to perform a successful return demonstration of what was learned in the course.
 - (f) Not be the consumer's legally responsible family member as that term is defined in rule 5101:3-45-01 of the Administrative Code.
 - (g) Not be the consumer's foster caregiver.
- (6) All supplemental transportation service providers must maintain documentation that, at a minimum, includes a log identifying the consumer transported, the date of the service, pick-up point, destination point, mileage for each trip, and the signature of the consumer receiving supplemental transportation services, or the consumer's authorized representative. The consumer's or authorized representative's signature of choice shall be documented on the consumer's all services plan and shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.

Effective: 10/25/2010

R.C. 119.032 review dates: 08/10/2010 and 10/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 10/15/2010

Promulgated Under: 119.03

Statutory Authority: 5111.85

Rule Amplifies: 5111.01, 5111.02, 5111.85, 5111.856

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, 7/1/06

CSTL 10-01

Effective Date: July 1, 2010

The requirements set forth in this rule begin when the Ohio department of job and family services (ODJFS) receives approval from the centers of medicare and medicaid services (CMS) of an amendment adding home care attendant services to the transitions carve-out waiver, or on the effective date of this rule, whichever is later.

(A) The following definitions are applicable to this rule:

(1) "Adult" means an individual at least eighteen years of age.

(2) "Authorized representative" means the following:

(a) In the case of a consumer who is a minor, the consumer's parent, custodian, or guardian. The authorized representative shall be present and awake during the delivery of home care attendant services.

(b) In the case of a consumer who is an adult, an individual selected by the consumer to act on the consumer's behalf for the purposes regarding home care attendant services. The authorized representative shall be present and awake during the delivery of home care attendant services.

(3) "Authorizing health care professional" means a health care professional who, pursuant to section **5111.887** of the Revised Code, authorizes a home care attendant to assist a consumer with self-administration of medication, nursing tasks, or both. The consumer, authorized representative, legally responsible family member, legal guardian, and foster caregiver are prohibited from being the authorizing health care professional.

(4) "Consumer" means an individual to whom all of the following apply:

(a) The individual is enrolled in the transitions carve-out waiver.

(b) The individual has a medically determinable physical impairment to which both of the following apply:

(i) It is expected to last for a continuous period of not less than twelve months.

(ii) It causes the individual to require assistance with activities of daily living, self-care, and mobility, including either assistance with self-administration of medication or the performance of nursing tasks, or both.

(c) In the case of an individual who is an adult, the individual is mentally alert and is, or has an authorized representative who is, capable of freely choosing home care attendant service providers in accordance with rule 5101:3-45-03 of the Administrative Code, and selecting, directing the actions of, and dismissing a home care attendant.

(i) In accordance with section **5111.8810** of the Revised Code, a consumer who is an adult may select an authorized representative by submitting a written notice of the consumer's selection to the director of ODJFS. The notice shall specifically identify the individual the consumer selects as authorized representative and may limit what the authorized representative may do on the consumer's behalf regarding home care attendant services.

(ii) A consumer may not select the consumer's home care attendant to be the consumer's authorized representative.

(d) In the case of an individual who is a minor, the individual has an authorized representative who is capable of freely choosing home care attendant service providers

in accordance with rule [5101:3-45-03](#) of the Administrative Code, and selecting, directing the actions of, and dismissing a home care attendant.

- (5) "Controlled substance" has the same meaning as in section [3719.01](#) of the Revised Code.
- (6) "Custodian" has the same meaning as in section [2151.011](#) of the Revised Code.
- (7) "Gastrostomy tube" means a percutaneously inserted catheter that terminates in the stomach.
- (8) "Group setting" means a situation in which a home care attendant service provider furnishes home care attendant services in accordance with this rule, and as authorized by ODJFS, to two or three individuals who reside at the same address.
- (9) "Guardian" has the same meaning as in section [2111.01](#) of the Revised Code.
- (10) "Health care professional" means a physician or registered nurse who holds a current, valid, unrestricted license.
- (11) "Home care attendant" means an individual holding a valid medicaid provider agreement in accordance with section [5111.881](#) of the Revised Code and paragraph (E)(2) of this rule that authorizes the individual to provide home care attendant services to a consumer.
- (12) "Jejunostomy tube" means a percutaneously inserted catheter that terminates in the jejunum.
- (13) "Medication" means a drug as defined in section [4729.01](#) of the Revised Code.
- (14) "Minor" means an individual under eighteen years of age.
- (15) "Nursing tasks" means skilled tasks that would otherwise be performed by a registered nurse (RN), or a licensed practical nurse (LPN) at the direction of an RN.
- (16) "Oral medication" means any medication that can be administered through the mouth, or through a gastrostomy tube or jejunostomy tube if through a pre-programmed pump or through a syringe. Oral medication may include medication administered through a metered dose inhaler.
- (17) "Physician" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.
- (18) "Practice of nursing as a registered nurse," "practice of nursing as a licensed practical nurse (LPN)," and "registered nurse (RN)" have the same meanings as in section [4723.01](#) of the Revised Code. "Registered nurse" includes an advanced practice nurse as defined in section [4723.01](#) of the Revised Code.
- (19) "Schedule II," schedule III," "schedule IV," and "schedule V" have the same meaning as in section [3719.01](#) of the Revised Code.
- (20) "Topical medication" means any medication that is applied to the outer skin, including transdermal medications and eye, ear, and nose drops. Topical medication may also include vaginal or rectal suppositories.

(B) Home care attendant services are services provided to a consumer enrolled on the transitions carve-out waiver by an unlicensed non-agency provider in accordance with this rule. Home care attendant services include, but are not limited to, tasks that would otherwise be performed by an RN or an LPN at the direction of an RN. Home care attendant services include:

- (1) Assistance with self-administration of medications as set forth in paragraph (C) of this rule.
- (2) Assistance with the performance of nursing tasks as set forth in paragraph (D) of this rule.
- (3) Personal care aide tasks as described in paragraph (B)(1) of rule [5101:3-50-04](#) of the Administrative Code when performed during a home care attendant service visit. Personal care aide tasks are not reimbursable separately as personal care aide services when they are performed during a home care attendant service visit.

(C) Assistance with self-administration of medication.

- (1) A home care attendant shall assist a consumer with the self-administration of only the following medication:
 - (a) Oral medications;
 - (b) Topical medications;
 - (c) Subcutaneous injections only for routine doses of insulin;
 - (d) Programming of a pump only used to deliver a routine dose of insulin;
 - (e) Medication administered via stable, labeled gastrostomy or jejunostomy tubes using pre-programmed pumps; and
 - (f) Doses of schedule II, schedule III, schedule IV, and schedule V drugs only when administered orally or topically.
- (2) Medication shall be maintained in its original container and the attached label shall match the dosage and means of administration set forth on the [JFS 2389](#) "Home Care Attendant Medication Authorization Form" (7/10). The label on the container shall display all of the following:
 - (a) The consumer's full name in print;
 - (b) A dispensing date within the prior twelve months; and
 - (c) The exact dosage and means of administration.
- (3) Schedule II, schedule III, schedule IV, and schedule V drugs shall meet all of the following additional requirements:
 - (a) The medication(s) has a warning label on the bottle.
 - (b) The home care attendant shall count the medication(s) in the consumer's or authorized representative's presence and record the count on a log located in the consumer's clinical record.
 - (c) The medication(s) is recounted by the home care attendant in the consumer's or authorized representative's presence at least monthly, and the count is reconciled on a log located in the consumer's clinical record. The home care attendant shall notify the authorizing health care professional, in writing, within twenty-four hours if:
 - (i) The medication(s) is missing; and
 - (ii) The count of medication(s) cannot be reconciled.
 - (d) The medication(s) is stored separately from all other medications, and is secured and locked at all times when not being administered to the consumer in order to prevent access by unauthorized individuals.
- (D) Assistance with the performance of nursing tasks.
 - (1) A home care attendant may provide assistance with the performance of nursing tasks that are not expressly excluded in accordance with paragraph (D)(2) of this rule.
 - (2) A home care attendant shall not assist a consumer with the performance of any of the following nursing tasks:
 - (a) Intravenous (IV) insertion, removal, or discontinuation;
 - (b) Intramuscular injections;
 - (c) IV medication administration;
 - (d) Subcutaneous injections, except for routine doses of insulin pursuant to paragraph (C)(1)(c) of this rule;

- (e) Programming of a pump used to deliver medications (including but not limited to epidural, subcutaneous, and IV), except for routine doses of insulin pursuant to paragraph (C)(1)(d) of this rule;
- (f) Insertion or initiation of infusion therapies; and
- (g) Central line dressing changes.

(3) Performance of nursing tasks shall be summarized and submitted on the [JFS 02390](#) "Home Care Attendant Skilled Task Authorization Form" (7/10).

(E) In order to provide services and to submit a claim for reimbursement, home care attendant service providers must meet all of the following requirements:

- (1) Be at least eighteen years of age.
- (2) Be a non-agency provider who holds a current, valid agreement as a home care attendant service provider in accordance with sections [5111.01](#), [5111.02](#), and 5111.8810 of the Revised Code and this rule, and complies with all rules set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
- (3) Request reimbursement for the provision of home care attendant services in accordance with rule [5101:3-50-06.1](#) of the Administrative Code.
- (4) Not be the consumer's authorized representative.
- (5) Not be the consumer's legally responsible family member as that term is defined in rule [5101:3-45-01](#) of the Administrative Code.
- (6) Not be the consumer's legal guardian or foster caregiver.
- (7) Not be the consumer's authorizing health care professional.
- (8) Be identified as the provider, and have specified on the consumer's all services plan that is prior-approved by ODJFS or its designee, the number of hours for which the provider is authorized to furnish home care attendant services to the consumer.
- (9) Have a valid social security number, and one of the following forms of identification:
 - (a) Alien identification;
 - (b) State of Ohio identification;
 - (c) A valid driver's license; or
 - (d) Other government-issued photo identification.
- (10) 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.
- (11) Be able to effectively communicate with the consumer.
- (12) Enter into a medicaid provider agreement with ODJFS to provide home care attendant services to consumers enrolled on the transitions carve-out waiver. In order for ODJFS to approve an individual's application to become a home care attendant, the individual shall do all of the following:
 - (a) Comply with the medicaid provider requirements set forth in division 5101:3 of the Administrative Code.
 - (b) Comply with the ODJFS-administered waiver service provider requirements set forth in Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
 - (c) Agree to comply with the requirements set forth in sections [5111.88](#) to 5111.8810 of the Revised Code and all requirements set forth in this rule.
 - (d) Provide ODJFS with evidence to its satisfaction of all of the following:

- (i) The home care attendant submits the JFS 02389 "Home Care Attendant Medication Authorization Form" (7/10) and/or JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10) as prescribed by paragraph (F)(2) of this rule.
- (ii) The home care attendant provider either meets the personnel qualifications specified in 42 C.F.R. 484.4 (as in effect on the effective date of this rule) for home health aides, or has successfully completed at least one of the following:

 - (a) A competency evaluation program, or training and competency evaluation program approved or conducted by the Ohio department of health under section [3721.31](#) of the Revised Code; or
 - (b) A training program approved by ODJFS that includes training in at least all of the following and provides training equivalent to a training and competency evaluation program specified in paragraph (E)(12)(d)(ii)(a) of this rule, or meets the requirements of 42 C.F.R. 484.36(a) (as in effect on the effective date of this rule):

 - (i) Basic home safety;
 - (ii) Universal precautions for the prevention of disease transmission, including hand-washing, and proper disposal of bodily waste and medical instruments that are sharp or may produce sharp pieces if broken;
 - (iii) Consumer-specific personal care aide services; and
 - (iv) The labeling, counting and storage requirements for schedule II, schedule III, schedule IV, and schedule V medications.
- (iii) Prior to beginning home care attendant services, the home care attendant received training and instruction about how to deliver the specific home care attendant services authorized by the consumer's authorizing health care professional. The training shall be consumer-specific and may be provided by the consumer's authorizing health care professional, and/or the consumer or the authorized representative in cooperation with the consumer's licensed health care professional as indicated on the JFS 02389 "Home Care Attendant Medication Authorization Form" (7/10) and/or JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10), as appropriate.
- (iv) Upon request of the consumer or the consumer's authorizing health care professional, the home care attendant has performed a successful return demonstration of the home care attendant service to be provided.
- (v) The home care attendant has obtained a certificate of completion of a course in first aid that:

 - (a) Is not provided solely through the internet;
 - (b) Includes hands-on training provided by a certified first aid instructor; and
 - (c) Requires the individual to perform a successful return demonstration of what was learned in the course.
- (vi) The home care attendant has received education from the authorizing health care professional about health and welfare considerations appropriate for an individual or group setting.
- (13) Provide home care attendant services for one individual, unless authorized to provide services in a group setting in accordance with paragraph (E)(14) of this rule.
- (14) The home care attendant may provide services to two or three consumers in a group setting on a case-by-case basis. Authorization is subject to approval based on a clinical review conducted

by ODJFS in consultation with the consumer, authorized representative, authorizing health care professional, case manager, and multidisciplinary team. The clinical review will address the consumers' needs and desires, the skill level and training needs of the home care attendant, and the ability to assure the consumers' health and welfare.

(15) The home care attendant shall secure the services of an RN, in agreement with the consumer or authorized representative, and participate in a face-to-face visit every ninety days with the consumer, authorized representative, and the RN for the purpose of monitoring the consumer's health and welfare. During the face-to-face visit, the RN shall serve as a resource for the purpose of answering any questions the home care attendant, consumer, and/or authorized representative have about consumer care needs, medications, and other issues.

(a) The first visit between the home care attendant and the RN shall occur upon the initiation of home care attendant services. The case manager shall also be present at the first visit.

(b) The home care attendant and the RN shall document the activities of the visit in the consumer's clinical record.

(c) The home care attendant shall discuss the results of the face-to-face visit with the case manager and the consumer and/or authorized representative.

(16) Completes at least twelve hours of in-service continuing education regarding home care attendant services annually. Evidence of completion must be submitted to ODJFS no later than the annual anniversary of the issuance of the home care attendant's initial medicaid provider agreement. 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.

(F) A home care attendant shall not provide home care attendant services until:

(1) The consumer and/or authorized representative chooses to receive home care attendant services from a non-agency provider and complies with the requirements set forth in rule 5101:3-45-03 of the Administrative Code.

(2) ODJFS receives a JFS 2389 "Home Care Attendant Medication Authorization Form" (7/10) and/or a JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10), as appropriate, that contains all of the following:

(a) Written consent from the consumer or the authorized representative allowing the home care attendant to provide home care attendant services, and assuming responsibility for directing the home care attendant. When an authorized representative is directing the home care attendant, the authorized representative shall be present and awake during the delivery of home care attendant services.

(b) Written consent from the consumer's authorizing health care professional attesting that the consumer or the authorized representative has demonstrated the ability to direct the home care attendant. The written consent shall also indicate that the home care attendant has demonstrated the ability to furnish the consumer-specific home care attendant service to the consumer. The consent shall include all of the following:

(i) The consumer's name and address;

(ii) A description of the specific nursing task or self-administration of medication that the home care attendant will assist the consumer with, including, in the case of assistance with self-administration of medication, the name, dosage, and route of administration of the medication;

(iii) The times or intervals when the home care attendant is to assist the consumer with the self-administration of each dosage of the medication or with the performance of nursing tasks;

- (iv) The dates on which the home care attendant is to begin and cease providing assistance;
- (v) A list of severe adverse reactions that the home care attendant must report to the consumer's health care professional should the consumer experience one or more reactions;
- (vi) At least one telephone number at which the home care attendant can reach the consumer's health care professional in an emergency for consultation after contacting emergency personnel;
- (vii) At least one fax number at which the home care attendant can reach the consumer's authorizing health care professional when the home care attendant observes that scheduled medication(s) is missing or cannot be reconciled; and
- (viii) Instructions the home care attendant must follow when assisting the consumer with the performance of a nursing task or the self-administration of medications, including, but not limited to, instructions for maintaining sterile conditions and for the storage of task-related equipment and supplies.

(G) Upon initiation of services, the consumer and/or authorized representative and case manager shall participate in the development and maintenance of a written back-up plan. The authorizing health care professional and/or the home care attendant may also participate in the development and maintenance of the back-up plan.

(1) The back-up plan shall meet the needs of the consumer in the event:

- (a) The regularly scheduled home care attendant cannot or does not meet his or her obligation to provide services to the consumer; or
- (b) The consumer and/or authorized representative is not able to direct home care attendant services.

(2) As authorized by the case manager,

- (a) Waiver nursing as set forth in rule [5101:3-50-04](#) of the Administrative Code, and/or private duty nursing or home health nursing as set forth in Chapter 5101:3-12 of the Administrative Code, may be used as back-up to provide assistance with self-administration of medications and the performance of nursing tasks;
- (b) Personal care aide services as set forth in rule 5101:3-50-04 of the Administrative Code may be used as back-up for personal care aides tasks; and
- (c) Back-up may include informal caregivers.

(H) All home care attendants must maintain a clinical record for each consumer served in a manner that protects the consumer's privacy and the confidentiality of these records. Home care attendants 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 paragraphs (H)(1) to (H)(12) of this rule.

- (1) Consumer identifying information including, but not limited to, name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health identification numbers.
- (2) Consumer medical history.
- (3) Name of, and contact information for all of the consumer's licensed health care professionals.
- (4) A copy of the initial and all subsequent all services plans.
- (5) Documentation of all drug and food interactions, allergies, and dietary restrictions.
- (6) A copy of any advance directives including, but not limited to, a "do not resuscitate order" ("DNR") or a "medical power of attorney" if they exist.

- (7) The JFS 2389 "Home Care Attendant Medication Authorization Form" (7/10) and/or a JFS 02390 "Home Care Attendant Skilled Task Authorization Form" (7/10), as appropriate.
- (8) Documentation of home care attendant services performed or not performed, arrival and departure times, and the dated signature of the provider, and consumer or authorized representative, verifying the service delivery upon its completion. Nothing shall prohibit the collection and maintenance of documentation through technology-based systems. The consumer's or authorized representative's signature of choice shall be documented on the all services plan, and shall include, but not be limited to, any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature.
- (9) A copy of the log detailing the count and reconciliation of schedule II, schedule III, schedule IV, and schedule V drugs for which assistance with self-administration is provided.
- (10) Progress notes signed and dated by the home care attendant, documenting all communications with the case manager, licensed health care professionals including the authorizing health care professional, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.
- (11) Documentation of the face-to-face visits occurring every ninety days between the home care attendant, consumer, authorized representative, and RN, and any resulting activities, in accordance with paragraph (E)(15) of this rule.
- (12) A discharge summary, signed and dated by the departing home care attendant at the point the home care attendant is no longer going to provide services to the consumer, or when the consumer no longer wants or needs home care attendant services. The summary should include documentation regarding progress made toward achievement of goals as specified on the all services plan.
- (I) If ODJFS or its designee determines that the consumer and/or authorized representative cannot meet the requirements of this rule, or the health and welfare of the consumer receiving home care attendant services cannot be assured, then ODJFS or its designee may prohibit the consumer from receiving home care attendant services. The consumer shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.
- (J) A home care attendant who provides home care attendant services to a consumer in accordance with the limitations set forth in this rule, including activities in accordance with the authorizing health care professional's authorization, shall not be considered to be engaging in the practice of nursing as an RN or an LPN in violation of section [4723.03](#) of the Revised Code.

 - (1) The consumer who is receiving home care attendant services, the authorized representative, or a provider shall report to ODJFS all instances in which a home care attendant appears to have:

 - (a) Provided nursing services, other than assistance with self-administration of medication or the performance of nursing tasks as authorized in this rule; or
 - (b) Provided services not in accordance with the authorizing health care professional's authorization.
 - (2) ODJFS may initiate an investigation based on the report, and shall report its findings to the Ohio board of nursing.

Effective: 07/01/2010

R.C. 119.032 review dates: 07/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 06/21/2010

Promulgated Under: 119.03

Statutory Authority: 5111.85, 5111.88

Rule Amplifies: 5111.01, 5111.02, 5111.88, 5111.881, 5111.882, 5111.883, 5111.884, 5111.885, 5111.886, 5111.887, 5111.888, 5111.889, 5111.8810

LTCSTL 11-10

Effective Date: October 1, 2011

Most Current Prior Effective Date: April 1, 2011

- (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-

Column 1	Column 2	Column 3	Column 4
Billing code	Service	Base rate	Unit rate
T1002	Waiver nursing services provided by an <u>agency</u> RN	\$54.95 <u>\$52.20</u>	\$5.69
<u>T1002</u>	<u>Waiver nursing services provided by a non-agency RN</u>	<u>\$41.76</u>	<u>\$5.69</u>
T1003	Waiver nursing services provided by an <u>agency</u> LPN	\$54.95 <u>\$52.20</u>	\$5.69

<u>T1003</u>	<u>Waiver nursing services provided by a non-agency LPN</u>	<u>\$41.76</u>	<u>\$5.69</u>
T1019	Personal care aide services <u>provided by an agency personal care aide</u>	\$23.98 <u>\$23.26</u>	\$3.00
<u>T1019</u>	<u>Personal care aide services provided by a non-agency personal care aide</u>	<u>\$18.61</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	\$199.82
S0215	Supplemental transportation services	Per mile	\$0.38
S5101	Adult day health center services	Per half day	\$32.48
S5102	Adult day health center services	Per Day	\$64.94
S5160	Emergency response services	Per installation and testing	\$44.96
S5161	Emergency response services	Per monthly fee	\$44.96
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 plan
S5170	Home delivered meal services	Per meal	\$6.99

- (C) In order for a provider to submit a claim for transitions carve-out waiver services, the services must be provided in accordance with 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) Claims shall be submitted to, and reimbursement shall be provided by, the Ohio department of job and family services in accordance with Chapter 5101:3-1 of the Administrative Code.

Effective: 10/01/2011

R.C. 119.032 review dates: 01/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0213, 5111.85

Rule Amplifies: 5111.02, 5111.021, 5111.0213, 5111.85

Prior Effective Dates: 1/1/04, 7/1/06, 7/1/08, 1/1/10, 4/1/11

5160-50-06.1 Transitions Carve-Out Waiver Program: Home Care Attendant Services Reimbursement Rates and Billing Procedures

***Formerly* 5101:3-50-06.1 Transitions Carve-Out Waiver Program: Home Care Attendant Services Reimbursement Rates and Billing Procedures**

LTCSSSTL 11-10

Effective Date: October 1, 2011

Most Current Prior Effective Date: July 1, 2010

- (A) Definitions of terms used for billing and calculating home care attendant services (HCAS) rates.
- (1) "Base rate," as set forth in column 3 of tables A and B of this rule, means the amount paid to a provider for up to four units of HCAS delivered. The base rate accounts for up to four units of assistance with self-administration of medications and the performance of nursing tasks provided during a single visit.
 - (2) "Continuous nursing" means nursing services (waiver nursing and/or private duty nursing) that are more than four hours in length and during which personal care aide tasks as described in paragraph (B)(1) of rule [5101:3-50-04](#) of the Administrative Code may be provided incidental to nursing services.
 - (3) "Group rate" means the amount that HCAS providers shall be reimbursed when the service is provided in a group setting.
 - (4) "Group setting" means a situation in which an HCAS provider furnishes HCAS in accordance with rule [5101:3-50-04.1](#) of the Administrative Code, and as authorized by the Ohio department of job and family services (ODJFS), to two or three individuals who reside at the same address.
 - (5) "HCAS visit" is a visit during which HCAS is provided in accordance with rule 5101:3-50-04.1 of the Administrative Code. An HCAS visit shall not exceed twelve hours or forty-eight units in duration.
 - (6) "Intermittent nursing" means nursing services (waiver nursing and/or home health nursing) that are four hours or less in length.
 - (7) "Medicaid maximum rate" means the maximum amount that shall be paid by the Ohio medicaid program for the service rendered. The base rate in column 3 and the unit rate in column 4 of table A of this rule, and the base rate in column 3 and the unit rates in column 5 of table B of this rule represent the medicaid maximum rates for HCAS.
 - (8) "Modifier" means the additional two-alpha-numeric-digit billing code set forth in paragraph (H) of this rule that HCAS providers shall use to provide additional information regarding service delivery.
 - (9) "Unit rate," as set forth in column 4 of table A of this rule and column 5 of table B of this rule, means the amount paid for each fifteen-minute unit of HCAS following the base rate paid for the first four units of HCAS provided.
- (B) Providers shall bill for reimbursement using table A when HCAS is provided in lieu of continuous nursing as described in paragraph (A)(2) of this rule. Personal care aide tasks are included in the unit rate.

-Table A-

Column 1	Column 2	Column 3	Column 4
Billing code	Home care attendant service description	Base rate	Unit rate
S5125	Assistance with self-administration of medications and/or the performance	\$33.36 <u>\$25.89</u>	\$4.17 per fifteen minute unit of HCAS/N delivered during visit

	of nursing tasks (HCAS/N)		(beginning with the fifth unit of service)
--	---------------------------	--	--

- (C) Providers shall bill for reimbursement using table B when HCAS is provided in lieu of intermittent nursing as described in paragraph (A)(6) of this rule. The first four units of HCAS shall be billed for at the base rate. Beginning with the fifth unit of HCAS, assistance with self-administration of medications and the performance of nursing tasks (HCAS/N) shall be billed at the HCAS/N unit rate; and personal care tasks (HCAS/PC) shall be billed at the HCAS/PC unit rate using the U8 modifier.

-Table B-

Column 1	Column 2	Column 3	Column 4	Column 5
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	HCAS/N	\$33.36 <u>\$25.89</u>	N/A	\$4.17 per fifteen minute unit of HCAS/N delivered during the visit (beginning with the fifth unit of service)
S5125	HCAS/PC	N/A	U8	\$3.00 per fifteen minute of HCAS/PC delivered during the visit

- (D) In order for a provider to submit a claim for HCAS under the transitions carve-out waiver, the services must be provided in accordance with Chapters 5101:3-45 and 5101:3-50 of the Administrative Code.
- (E) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the medicaid maximum rate.
- (F) When HCAS/N and HCAS/PC are provided during an uninterrupted period of time, the visit shall be considered a single HCAS visit. An HCAS provider is entitled to only one base rate during an HCAS visit.
- (G) HCAS providers shall be limited to a maximum of twelve hours or forty-eight units of HCAS during a twenty-four-hour period, regardless of the number of consumers served.
- (H) Required modifiers.
- (1) The "HQ" modifier must be used when a provider submits a claim if HCAS 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 rate.
 - (2) The "U2" modifier must be used when a provider submits a claim for a second HCAS visit to a consumer for the same date of service.
 - (3) The "U3" modifier must be used when the same provider submits a claim for three or more HCAS visits to a consumer for the same date of service.
 - (4) The "U8" modifier must be used when a provider submits a claim for an HCAS visit that is in lieu of intermittent nursing as described in paragraph (A)(6) of this rule, and for units of service that are HCAS/PC.
- (I) ~~Reimbursement shall be provided in accordance with paragraphs (A) to (D) of rule 5101:3-1-60 of the Administrative Code.~~ Claims shall be submitted to, and reimbursement shall be provided by, the Ohio department of job and family services in accordance with Chapter 5101:3-1 of the Administrative Code.

Effective: 10/01/2011

R.C. 119.032 review dates: 07/01/2015

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0213, 5111.85, 5111.8811

Rule Amplifies: 5111.02, 5111.021, 5111.0213, 5111.85, 5111.88, 5111.881, 5111.882, 5111.883, 5111.884, 5111.885, 5111.886, 5111.887, 5111.888, 5111.889, 5111.8810 Prior Effective Dates: 7/1/10

[LTCSSTL 15-02](#)

Effective Date: February 1, 2015

Most Current Prior Effective Date: [September 9, 2010](#)

- (A) The definitions in this rule are applicable to the money follows the person (MFP) transition program known as the helping Ohioans move, expanding choice (HOME choice) program (hereafter referred to as HOME choice).
- (B) Definitions.
- (1) "Agency provider" means an entity that is eligible to provide services in the HOME choice program.
 - (2) "Case management agency" means the entity designated by the Ohio department of medicaid (ODM) to provide case management services to individuals enrolled on an ODM-administered waiver.
 - (3) "Case manager" means a registered nurse (RN), licensed social worker (LSW) or licensed independent social worker (LISW) employed by the case management agency who provides case management services to individuals enrolled on an ODM-administered waiver, an RN or LSW employed by the Ohio Department of Aging's (ODA) designee, a medicaid managed care plan, or mycare Ohio plan, who is responsible for the planning, coordinating, monitoring, evaluation, and authorization of medicaid waiver-funded community-based long-term care services and the non-medicaid waiver-funded PASSPORT program.
 - (4) "Demonstration period" means the three hundred sixty-five day period that begins the day a HOME choice participant is discharged from an institutional setting into a qualified residence in the community and during which the participant is eligible for HOME choice services.
 - (5) "Financial management services" are federally-mandated fiscal intermediary and administrative services that an ODM-designated entity provides for HOME choice participants.
 - (6) "Guardian" means, in accordance with section [2111.01](#) of the Revised Code, any person, association, or corporation appointed by the probate court to have the care and management of the person, the estate, or both of an individual who is incompetent or minor. When applicable, "guardian" includes, but is not limited to, a limited guardian, an interim guardian, a standby guardian, and an emergency guardian appointed pursuant to division (B) of section 2111.02 of the Revised Code. "Guardian" also includes an agency under contract with the Ohio department of developmental disabilities (DODD) for the provision of protective service under sections 5123.55 to 5123.59 of the Revised Code when appointed by the probate court to have the care and management of the person of an incompetent.
 - (7) "HOME choice application" means an official request for participation in the HOME choice program using the ODM 02361, "HOME Choice - Application" (rev. 7/2014).
 - (8) "HOME choice case management" means the provision of case management services to individuals participating in HOME choice who are not enrolled on a home and community based services (HCBS) waiver. These services are available immediately prior to a participant's enrollment in the program and continue through the participant's demonstration period.
 - (9) "HOME choice participant" or "participant" means a person who is receiving HOME choice services.
 - (10) "HOME choice service plan" means the plan that is approved by ODM that identifies and authorizes the HOME choice services, supports and activities to be provided to a HOME choice participant.
 - (11) "HOME choice services" means all services available to a HOME choice participant through the HOME choice program.

- (12) "Institutional level of care" means any of the levels of care as described in rules [5160-3-07](#) and [5160-3-08](#) of the Administrative Code.
- (13) "Institution" or "institutional setting" means a hospital, nursing facility, residential treatment facility, or an intermediate care facility for individuals with intellectual disabilities.
- (14) "Legally responsible family member" means an individual's spouse, or in the case of a minor, the individual's birth or adoptive parent.
- (15) "Money follows the person (MFP)" means the rebalancing demonstration program enacted by the Deficit Reduction Act of 2005. MFP is part of a comprehensive strategy to assist states in reforming long-term care support systems by reducing reliance on institutional care and developing community-based long-term care opportunities. The MFP rebalancing demonstration program in Ohio is titled HOME choice.
- (16) "Non-agency provider" means a provider who is not employed by an agency, and who is eligible to provide services in the HOME choice program.
- (17) "Plan of care" means the medical treatment plan that is established, approved, and signed by a treating physician prior to a provider requesting reimbursement for a service. The plan of care is not the same as an all services plan, service plan, individual service plan or HOME choice service plan.
- (18) "Qualified residence" is a home which meets specific criteria to transition a participant safely into the community.
- (a) A qualified residence must include:
- (i) Lockable access and egress to the HOME choice participant's unit;
 - (ii) Sleeping, bathing, living and cooking areas over which a HOME choice participant or a HOME choice participant's family has domain and control;
 - (iii) A lease, rental agreement or other written verification of residency; and
 - (iv) No more than four unrelated individuals residing together.
- (b) Examples of a qualified residence may include but are not limited to:
- (i) A home owned or leased by a HOME choice participant or a HOME choice participant's family member or friend.
 - (ii) An adult foster home certified by an area agency on aging that the Ohio department of mental health and addiction services (OhioMHAS) contracts with in accordance with Chapter 5122-35 of the Administrative Code;
 - (iii) An adult family home licensed by OhioMHAS in accordance with section 5119.70 of the Revised Code and Chapter 5122-33 of the Administrative Code;
 - (iv) Type 1 residential facilities licensed by OhioMHAS in accordance with Chapter 5122-30 of the Administrative Code;
 - (v) Type 2 residential facilities licensed by OhioMHAS in accordance with Chapter 5122-30 of the Administrative Code;
 - (vi) Adult foster care where providers are certified by DODD in accordance with rule [5123:2-9-33](#) of the Administrative Code;
 - (vii) Non-intermediate care facilities for individuals with intellectual disabilities (ICF-IID) residential facilities licensed by DODD in accordance with section [5123.19](#) of the Revised Code and Chapter 5123:2-3 of the Administrative Code;
 - (viii) A supported living arrangement with a provider certified by DODD in accordance with Chapter 5123 of the Administrative Code for an individual with a developmental disability who is enrolled on an HCBS waiver that is administered by DODD;

- (ix) Foster homes for children that are certified by the Ohio department of job and family services (ODJFS) in accordance with section 5103.03 of the Revised Code and Chapter 5101:2-7 of the Administrative code;
 - (x) Group homes for children that are licensed by ODJFS in accordance with Chapter 5101:2-5 of the Administrative Code, or certified by ODJFS in accordance with section [5103.03](#) of the Revised Code; or
 - (xi) Medically fragile foster homes for children that are certified by ODJFS in accordance with rule [5101:2-7-17](#) of the Administrative Code.
 - (xii) Any other community-based setting as approved by ODM.
- (19) "Qualified services" means HCBS waiver services and medicaid state plan services that have been determined by ODM to be non-acute, long-term support services. Qualified services do not include HOME choice services. Qualified services are services that a participant would still receive at the end of the demonstration period when a recipient remains eligible for medicaid.
- (20) "Residential treatment facility" means, in accordance with section [5166.01](#) of the Revised Code, a residential facility licensed by OhioMHAS under section [5119.34](#) of the Revised Code, or an institution certified by ODJFS under section 5103.03 of the Revised Code, that serves children and either has more than sixteen beds or is part of a campus of multiple facilities or institutions that, combined, have a total of more than sixteen beds.
- (21) "Service and support administrator" means a provider employed by or under contract with a county board of developmental disabilities who provides a variety of coordination activities for an individual enrolled on an HCBS waiver that is administered by DODD in accordance with section [5126.15](#) of the Revised Code.
- (22) "Transition coordination" is a service that helps a HOME choice participant plan for the move from an institutional setting into a qualified residence. The transition coordinator helps the participant locate benefits, secure housing, link with community services and make detailed plans for the services needed to move and remain in the community-based setting.

Replaces: 5160-51-01

Effective: 02/01/2015

Five Year Review (FYR) Dates: 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 119.03, 5164.02

Rule Amplifies: 5162.03, 5164.02, 5166.02, 5164.90

Prior Effective Dates: 7/1/2008, 9/9/2010

LTCSTL 15-02

Effective Date: February 1, 2015

Most Current Prior Effective Date: August 1, 2011

- (A) This rule describes the application process and the criteria for eligibility and enrollment of an individual into the helping Ohioans move, expanding choice program (hereafter referred to as HOME choice).
- (B) The application process for the HOME choice program is completed when an individual submits the ODM 02361, "HOME Choice - Application" (rev. 7/2014) to the Ohio department of medicaid (ODM).
- (C) To be eligible for participation in the HOME choice program, an individual must meet all of the following requirements:
- (1) Continuously reside in an institutional setting such as a nursing facility, intermediate care facility for individuals with intellectual disabilities (ICF-IID), residential treatment facility and/or hospital, or a combination thereof, for a period of not less than ninety consecutive days. If the hospital is an institution for mental diseases, the individual must be younger than age twenty-one or older than age sixty-five;
 - (2) Participate in an in-person meeting with a HOME choice pre-transition case manager to complete a HOME choice readiness assessment;
 - (3) Receive medicaid benefits for inpatient services furnished by the institutional setting prior to discharge;
 - (4) Have an institutional level of care;
 - (5) Be determined eligible for Ohio medicaid in accordance with division 5160-1 of the Administrative Code;
 - (6) Have needs that can be safely met through the HOME choice program, as determined by the Ohio department of medicaid (ODM) or its designee;
 - (7) Agree to move into a qualified residence upon discharge from the institutional setting; and
 - (8) Agree to and sign the ODM 02362 "HOME Choice - Informed Consent" (rev. 7/2014).
- (D) To be pre-enrolled and to maintain pre-enrollment status in the HOME choice program, the participant must:
- (1) Be determined eligible for the HOME choice program in accordance with paragraph (C) of this rule;
 - (2) Be in compliance with the ODM 02362; and
 - (3) Work with a transition coordinator to develop a comprehensive transition plan based on the participant's needs to facilitate a smooth transition from the institutional setting into a qualified residence. Transition plans include but are not limited to locating suitable housing, benefits coordination, and linking to community resources.
- (E) If an individual fails to meet any of the requirements set forth in paragraph (C) and/or paragraph (D) of this rule, the individual shall be denied pre-enrollment in the HOME choice program.
- (F) Once pre-enrolled in the HOME choice program, if a participant no longer meets all of the requirements set forth in paragraph (C) and/or paragraph (D) of this rule, the participant's pre-enrollment status in the HOME choice program shall be terminated.
- (G) If a participant is denied pre-enrollment in the HOME choice program, or the participant's pre-enrollment status is being terminated, the participant shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

- (H) A participant in pre-enrollment status is considered to be enrolled in the HOME choice program when he or she is discharged from the institutional setting into a qualified residence.
- (I) If, at any time, a participant enrolled in the HOME choice program no longer meets all of the requirements set forth in paragraph (C), or the requirements set forth in the ODM 02362, he or she shall be disenrolled from the HOME choice program.
- (J) If a participant is denied enrollment in the HOME choice program, or is being disenrolled in the HOME choice program, the participant shall be afforded notice and hearing rights in accordance with division 5101:6 of the Administrative Code.

Replaces: 5160-51-02

Effective: 02/01/2015

Five Year Review (FYR) Dates: 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 119.03, 5164.02

Rule Amplifies: 5162.03, 5164.02, 5166.02, 5164.90

Prior Effective Dates: 07/01/08, 09/09/10, 8/1/11

[LTCSSTL 15-02](#)

Effective Date: February 1, 2015

Most Current Prior Effective Date: [September 9, 2010](#)

- (A) This rule sets forth the conditions of participation and enrollment for providers furnishing services to participants in the helping Ohioans move, expanding choice (hereafter referred to as HOME choice) program.
- (B) In order to enroll as a HOME choice service provider and maintain provider status, the provider shall:
- (1) Submit a signed ODM 02216 "Ohio HOME Choice Demonstration Program Provider Enrollment Application/Time Limited Agreement" (Rev. 11/2014) and applicable addendum, or another applicable HOME choice provider agreement;
 - (2) Meet all requirements in the applicable provider service specifications set forth in rule [5160-51-04](#) of the Administrative Code;
 - (3) As applicable, comply with the criminal records check requirements set forth in:
 - (a) Rules [5160-45-07](#), [5160-45-08](#) and [5160-45-11](#) of the Administrative Code if the provider is approved by the Ohio department of medicaid (ODM);
 - (b) Rule [173-39-03](#) of the Administrative Code if the provider is certified by the Ohio department of aging (ODA);
 - (c) Rule [5123:2-2-01](#) of the Administrative Code if the provider is certified by the Ohio department of developmental disabilities (DODD); or
 - (d) Rules [5122-30-03](#) and [5122-30-04](#) of the Administrative Code, or rule 5122-26-06 of the Administrative Code, as applicable, if the provider is certified by the Ohio department of mental health and addiction services (OhioMHAS);
 - (4) Attend ODM-sponsored HOME choice program provider training sessions as required by ODM;
 - (5) Ensure participants receive HOME choice services in accordance with their HOME choice service plan;
 - (6) Upon request, and within the time frame prescribed in the request, provide all requested information to the state agency administering the home and community based services (HCBS) waiver on which the HOME choice participant is enrolled, or to ODM if the HOME choice participant is not enrolled on an HCBS waiver, to the centers for medicare and medicaid services (CMS) and to the entity under contract with ODM to provide HOME choice financial management services (FMS);
 - (7) Be knowledgeable about and comply with all federal and state privacy laws, including the health insurance portability and accountability act (HIPAA) regulations set forth in 45 C.F.R. parts 160 and 164 (as in effect on the effective date of this rule), and the medicaid safeguarding of information requirements set forth in 42 C.F.R. 421.300 to 306 (as in effect on the effective date of this rule), along with section [5160.45](#) of the Revised Code;
 - (8) Retain all required documentation related to the services delivered during the contact or visit, including but not limited to: an individual-specific description and details of the tasks performed or not performed in accordance with the participant's approved HOME choice service plan and when required, the participant's plan of care;
 - (9) As directed by ODM, retain validation of service delivery including, but not limited to: the date and location of service delivery, arrival and departure times, and the dated signatures of the provider and the participant or his/her guardian. All signatures shall be obtained at the end of

every visit or upon completion of the scheduled service. Acceptable signatures include, but are not limited to a handwritten signature, initials, a stamp or mark, or an electronic signature;

- (10) 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;
- (11) Cooperate with ODM and/or its designee during all provider monitoring activities by being available to answer questions during reviews, and by ensuring the availability and confidentiality of participant information and other documents that may be requested as part of provider monitoring activities;
- (12) Notify the participant's case manager (CM), the service and support administrator (SSA) or HOME choice case manager, as appropriate, within twenty-four hours and provide written documentation within five calendar days when the provider is aware of issues that may affect service delivery to the participant. Issues may include, but are not limited to the following:
 - (a) The participant consistently declines services;
 - (b) The participant moves to another residential address;
 - (c) There are changes in the physical, mental and/or emotional status of the participant;
 - (d) There are changes in environmental conditions affecting the participant;
 - (e) The participant's caregiver status has changed;
 - (f) The participant no longer requires medically necessary services as defined in rule [5160-1-01](#) of the Administrative Code;
 - (g) Abuse or neglect of the participant is suspected, a referral has been made to a protective service agency on the participant's behalf, or an active protective services case is pending;
 - (h) The participant is behaving inappropriately toward the provider;
 - (i) Threatening actions were made toward the provider or the provider feels unsafe in the participant's environment;
 - (j) The participant is consistently non-compliant with physician orders, or is non-compliant with physician orders in a manner that may jeopardize the participant's health and welfare;
 - (k) The participant's requests consistently conflict with his/her approved HOME choice service plan or may jeopardize the participant's health and welfare;
 - (l) The participant has been hospitalized or visited the emergency room;
 - (m) The participant has been placed in an institutional setting;
 - (n) The participant is experiencing other health and welfare issues;
- (13) Make arrangements to accept all correspondence sent by ODM, ODA, DODD, or OhioMHAS, as appropriate, or any of their designees, including but not limited to certified mail;
- (14) Provide and maintain a current e-mail address to ODM and/or its designee in order to receive electronic notification of any rule adoption, amendment, or rescission, and any other communications from ODM or its designee;
- (15) Submit written notification to the participant and ODM at least thirty calendar days prior to the anticipated last date of service if the provider is terminating the provision of HOME choice services to the participant. Exceptions to the thirty-day advance notification requirement are subject to oral notification within twenty-four hours of the last date of service, and written notification within five calendar days of the last date of service. Thirty-day advance notification may be waived by ODM upon request and on a case-by-case basis, including but not limited to, when the participant:

- (a) Has been hospitalized for at least three days;
- (b) Has been placed in an institutional setting;
- (c) Has been incarcerated.

- (16) Providers furnishing HOME choice services to participants enrolled on an ODA-administered waiver shall comply with the incident reporting requirements set forth in rule [173-39-02](#) of the Administrative Code.
- (17) Providers furnishing HOME choice services to participants enrolled on a DODD-administered waiver, or who are not enrolled on an HCBS waiver but are eligible for services through a county board of developmental disabilities (CBDD) shall comply with the major unusual incident requirements set forth in rule [5123:2-17-02](#) of the Administrative Code.
- (18) Providers furnishing HOME choice services to participants enrolled on an ODM-administered waiver, shall comply with the incident reporting requirements set forth in rule 5160-45-05 of the Administrative Code.
- (19) Providers furnishing HOME choice services to participants who are not enrolled on an HCBS waiver, or who are not eligible for services through a CBDD shall comply with the incident reporting requirements set forth in rule 5160-45-05 of the Administrative Code.
- (20) Agency providers shall 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.
- (21) Non-agency providers shall 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, non-agency providers must submit an ODM approved affidavit stating that they paid the applicable federal, state and local income and employment taxes.

(C) At no time shall HOME choice service providers:

- (1) Engage in any behavior that causes or may cause physical, verbal, mental or emotional abuse or distress to the participant;
- (2) Engage in any activity or behavior that may compromise the health and welfare of the participant;
- (3) Engage in any activity or behavior that may take advantage of or manipulate the participant or his or her guardian, family or household members, that may result or appear to result in a conflict of interest, exploitation, or any other advantage for personal gain, as determined by ODM. This includes, but is not limited to:
 - (a) Misrepresentation;
 - (b) Accepting, obtaining, attempting to obtain, borrowing, or receiving money or anything of value including, but not limited to gifts, tips, credit cards or other items;
 - (c) Being designated on any financial account including, but not limited to bank accounts and credit cards;
 - (d) Using real or personal property of another;
 - (e) Using information of another;
 - (f) Lending or giving money or anything of value;
 - (g) Engaging in the sale or purchase of products, services or personal items;
 - (h) Engaging in any activity or behavior that takes advantage of or manipulates HOME choice program rules;

(i) Engaging in any other activity or behavior where the provider's personal or professional interests are potentially at odds with the best interests of the participant, as determined by ODM.

(4) Falsify the participant's signature, including using copies of the signature;

(5) Make fraudulent, deceptive or misleading statements in the advertising, solicitation, administration or billing of services;

(6) Submit a claim for HOME choice services rendered while the participant is hospitalized, institutionalized or incarcerated. The only exception is when the participant is receiving out-of-home respite as set forth on his or her service plan.

(D) While rendering services, HOME choice service providers shall not:

(1) Take the participant to the provider's place of residence;

(2) Bring children, animals, friends, relatives, other individuals or anyone else to the participant's place of residence;

(3) Provide care to persons other than the participant.

(4) Smoke without the consent of the participant;

(5) Sleep;

(6) Engage in any activity that is not related to the provision of services to the extent the activity distracts from, or interferes with, service delivery. Such activities include, but are not limited to the following:

(a) Using electronic devices for personal or entertainment purposes including, but not limited to watching television, using the computer or playing games;

(b) Making or receiving personal communications;

(c) Engaging in socialization with persons other than the individual;

(7) Deliver services when the provider is medically, physically or emotionally unfit;

(8) Use or be under the influence of the following while providing services:

(a) Alcohol;

(b) Illegal drugs;

(c) Chemical substances;

(d) Controlled substances that may adversely affect the provider's ability to furnish services;

(9) Engage in any activity or conduct that may reasonably be interpreted as sexual in nature, regardless of whether or not it is consensual;

(10) Engage in any behavior that may reasonably be interpreted as inappropriate involvement in the participant's personal beliefs or relationships including, but not limited to discussing religion, politics or personal issues;

(11) Consume the participant's food and/or drink without his or her offer and consent.

(E) HOME choice service providers shall not be designated to serve or make decisions for the participant in any capacity involving a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney, guardianship pursuant to court order, as an authorized representative or a representative payee as that term is described in paragraph (E)(3) of this rule, except as provided in paragraphs (E)(1) to (E)(4) of this rule.

(1) A provider may be appointed by the court to serve as legal guardian for the participant pursuant to Chapter 2111. of the Revised Code if the provider is a family member.

- (2) A provider may serve as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship if the provider is the participant's parent or spouse.
- (3) A provider may serve as the participant's representative payee if the provider is the participant's parent or spouse. For purposes of this rule, "representative payee" means a parent or spouse the participant designates to receive and manage payments that would otherwise be made directly to the participant.
- (4) A provider may be designated as an authorized representative or pursuant to a declaration for mental health treatment, general power of attorney, health care power of attorney, financial power of attorney or guardianship for the participant if:
 - (a) The provider was serving in that capacity prior to October 1, 2008; and
 - (b) The provider was the participant's paid provider prior to October 1, 2008; and
 - (c) The designation is not otherwise prohibited by law.
- (F) ODM shall not process a service provider application packet for a prospective HOME choice service provider if the application packet does not contain information necessary to complete the required verifications as listed on the checklist attachment to the ODM 02216. ODM shall notify the prospective service provider in writing of any missing information, and shall provide the applicant thirty calendar days to submit the required documentation. If the applicant does not submit the required documentation within thirty calendar days, the service provider application process shall be terminated.
- (G) Failure to meet the requirements set forth in this rule and/or the applicable HOME choice provider agreement, may result in termination of the HOME choice provider's provider agreement.

Replaces: 5160-51-03, 5160-51-05

Effective: 02/01/2015

Five Year Review (FYR) Dates: 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 119.03, 5164.02

Rule Amplifies: 5162.03, 5164.02, 5166.02, 5164.90

Prior Effective Dates: 7/1/08, 9/9/10

LTCSTL 15-02**Effective Date: February 1, 2015****Most Current Prior Effective Date: August 1, 2011**

- (A) This rule sets forth the covered services available to a helping Ohioans move, expanding choice (hereafter referred to as HOME choice) program participant as well as provider requirements for those services.
- (B) "Communication aid services" include devices, systems or services necessary to assist a HOME choice participant with hearing, speech or vision impairments to effectively communicate with others.
- (1) Communication aid services include, but are not limited to:
- (a) Augmentative communication devices or systems that transmit or produce a message or symbols in a manner that compensates for the participant's communication impairment;
- (b) Computers and computer equipment;
- (c) Other mechanical and electronic devices;
- (d) Cable and internet access;
- (e) The cost of installation, repair, maintenance and support of any covered communication aid;
- (f) Interpreter services that support the HOME choice participant's integration into the community. Interpreter services refers to the process by which the interpreter conveys one person's message to another by incorporating both the message and the attitude of the communicator; and
- (g) New technologies and any other devices that achieve the objective of the service.
- (2) If the HOME choice participant is enrolled on a home and community based services (HCBS) waiver, the participant must exhaust similar waiver services that are available before utilizing communication aid services through HOME choice.
- (3) A provider of communication aid services must be an agency provider who is:
- (a) An Ohio department of medicaid (ODM)-approved provider of supplemental adaptive and assistive device services in accordance with rule [5160-46-04](#) or rule [5160-50-04](#) of the Administrative Code, as appropriate; or
- (b) An Ohio department of developmental disabilities (DODD)-certified provider of adaptive and assistive equipment services in accordance with rule [5123:2-2-01](#) of the Administrative Code; or
- (c) An Ohio department of aging (ODA)-certified long term care provider of home medical equipment and supplies in accordance with rule [173-39-03](#) of the Administrative Code.
- (4) Reimbursement for communication aid services shall not exceed a total of five thousand dollars during the participant's demonstration period. The same type of communication aid equipment may be approved by ODM for the HOME choice participant when there is a documented need.
- (5) In order to submit a claim and be reimbursed for communication aid services, the provider delivering the service must:
- (a) Meet the conditions of participation and enrollment criteria set forth in rule [5160-51-03](#) of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the communication aid service provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service

begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

- (C) "Community support coaching" is a service provided for the purpose of guiding, educating and empowering a HOME choice participant, and the participant's guardian and family members, as applicable, before, during and after the participant's transition from an institution into the community.
- (1) The community support coach shall:
 - (a) Communicate with and educate the participant about vital aspects of the transition process;
 - (b) Assist the HOME choice participant in:
 - (i) Making informed and independent choices,
 - (ii) Setting and achieving short-term and long-term goals,
 - (iii) Managing multiple tasks,
 - (iv) Identifying options and problem solving,
 - (v) Identifying community resources available to the participant, and
 - (vi) Connecting to potential employment opportunities before, during and after transition.
 - (c) Provide the case manager, service and support administrator, or HOME choice case manager, as appropriate, with written status reports during the participant's demonstration period, as prescribed by the HOME choice service plan.
 - (2) A provider of community support coaching services shall not be the same staff person, of a transition coordination agency, who provided transition coordination services to the same participant during their pre-transition period.
 - (3) Community support coaching shall not duplicate independent living skills training available through HOME choice, similar waiver services available to participants enrolled on an HCBS waiver, or services available through the medicaid state plan.
 - (4) A provider of community support coaching must:
 - (a) Be a non-agency provider, or
 - (b) Be an agency provider that is either:
 - (i) A community mental health provider certified by the Ohio department of mental health and addiction services (OhioMHAS) in accordance with chapters 5122-24 to 5122-29 of the Administrative Code, or
 - (ii) A non-profit agency provider.
 - (5) Non-agency providers of community support coaching services, and all staff members of agency providers of community support coaching services with direct participant contact must:
 - (a) Have either:
 - (i) A disability and has lived in an institution and successfully transitioned to the community, and/or
 - (ii) Experience transitioning individuals from an institution to the community.
 - (b) Be age eighteen or older;
 - (c) Possess a valid Ohio driver license and automobile liability insurance when providing transportation;
 - (d) Not be the participant's legally responsible family member; and

(e) Not be the participant's case manager or service and support administrator, as those terms are defined in rule 5160-51-01 of the Administrative Code.

(6) In order to a submit claim and be reimbursed for community support coaching, the provider delivering the service must:

(a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and

(b) Be identified as the community support coach provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(D) "Community transition services" are goods, services and support for the purpose of addressing an identified need in a participant's HOME choice service plan, including improving and maintaining the participant's opportunities for inclusion in the community.

(1) Community transition services are intended to:

(a) Decrease the need for formal support services and other medicaid services;

(b) Take into consideration the appropriateness and availability of a lower cost alternative for comparable services that meet the participant's needs;

(c) Promote community inclusion and family involvement;

(d) Improve the participant's health and welfare in the home and community;

(e) Be provided when the participant does not have the funds to purchase the services, or the services are not available through another source;

(f) Assist the participant in developing and maintaining personal, social, physical or work-related skills; and

(g) Assist the participant in living independently in the home and community.

(2) Community transition services include:

(a) Transportation expenses up to a maximum of five hundred dollars during the participant's pre-transition period and for thirty days after transitioning to the community;

(b) Initial transition expenses up to a maximum of two thousand dollars including, but not limited to the following:

(i) Security deposit and rent required to lease a qualified residence;

(ii) Essential household furnishings, including furniture, window coverings, food preparation items, and bed/bath linens;

(iii) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water;

(iv) Services necessary for the participant's health and welfare, such as pest control and one-time cleaning prior to moving in to the residence;

(v) Moving expenses;

(vi) Necessary home accessibility adaptations; and

(vii) Initial grocery purchase, i.e., food and household supplies.

(3) Community transition services do not include:

(a) Experimental or prohibited treatments;

- (b) The ongoing cost of rent;
- (c) Ongoing utility charges;
- (d) Ongoing grocery expenses;
- (e) Cigarettes and alcohol;
- (f) Electronics and other household appliances or items that are intended to be used for entertainment or recreational purposes; and
- (g) Cable and/or internet access.

(4) Community transition services shall not duplicate similar services available to a participant who is enrolled on an HCBS waiver except when the participant is enrolled on an ODA-administered waiver or ODM-administered waiver. Participants enrolled on an ODA-administered waiver or ODM-administered waiver shall use HOME choice community transition services in lieu of, but not in addition to, the community transition services available through the waiver.

(5) Reimbursement for community transition services shall not exceed a cumulative maximum of two thousand five hundred dollars for the items set forth in paragraph (D)(2) of this rule.

(6) In order to submit a claim and be reimbursed for community transition services:

(a) The specific goods and services purchased shall have been based upon the participant's needs; and

(b) The goods and/or services must have been identified on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date for which the provider is authorized to furnish community transition services to the participant. The provider will not be reimbursed for unauthorized community transition services including community transition services provided in excess of what is documented on the participant's service plan for that provider.

(7) During the HOME choice participant's demonstration period, the purchase of community transition services shall be coordinated by the participant's case manager, service and support administrator and/or HOME choice case manager as appropriate and as approved by ODM prior to submission for reimbursement to the ODM-designated HOME choice financial management service (FMS) provider.

(E) "HOME choice nursing services" are intermittent services provided to a HOME choice participant that require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing HOME choice nursing services shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and rules of the Administrative Code adopted thereunder, and shall possess a current, valid and unrestricted license with the Ohio board of nursing.

(1) HOME choice nursing services do not include:

(a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules of the Administrative Code adopted thereunder and to be performed by providers who are not licensed nurses;

(b) Services that require the skills of a psychiatric nurse;

(c) Visits performed for the purpose of conducting an RN assessment, including but not limited to an outcome and assessment information set (OASIS) assessment or any other assessment;

(d) Visits or communication performed by an RN either for the purpose of RN consultation or for the purpose of meeting supervisory requirements;

(e) Visits performed for the purpose of meeting the home care attendant service RN visit requirements set forth in rules [5160-46-04.1](#) and [5160-50-04.1](#) of the Administrative Code.

- (2) HOME choice nursing services shall not duplicate similar waiver services available to participants enrolled on an HCBS waiver or available through medicaid state plan home health nursing or private duty nursing services.
- (3) HOME choice nursing services may be provided on the same day as, but not concurrently with, an RN assessment or an RN consultation.
- (4) A provider of HOME choice nursing services must be a medicaid provider who is either:
 - (a) Employed by a medicare-certified, or otherwise-accredited home health agency; or
 - (b) An approved ODM-administered waiver non-agency nursing service provider in accordance with rule 5160-46-04 or 5160-50-04 of the Administrative Code.
- (5) A provider of HOME Choice nursing services must not be:
 - (a) The participant's legally responsible family member unless the family member is employed by a medicare-certified, or otherwise-accredited home health agency; or
 - (b) The foster caregiver of the participant.
- (6) Non-agency LPNs, at the direction of an RN, must:
 - (a) Meet with the directing RN at least every sixty days after the initial visit to evaluate the provision of HOME choice nursing services and the LPN's performance of those services, and to ensure that services are being provided in accordance with the approved plan of care and within the LPN's scope of practice; and
 - (b) Conduct an in-person visit with the participant and the directing RN before initiating services and at least once every one hundred twenty days for the purpose of evaluating the provision of HOME choice nursing services, the participant's satisfaction with care delivery and the LPN's performance, and to ensure that services are being provided in accordance with the approved plan of care and within the LPN's scope of practice
- (7) All HOME choice nursing service providers must maintain a clinical record for each participant 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 HOME choice nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the participant's residence. For the purposes of this rule, the place of business must be a location other than the participant's residence. At a minimum, the clinical record must include:
 - (a) Participant 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) The participant's medical history;
 - (c) Name of the participant's treating physician;
 - (d) A copy of the HOME choice service plan approved by ODM;
 - (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 plan 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 participant's condition;
 - (f) Documentation of verbal orders given by the treating physician to the nurse. The nurse must document, in writing, the physician's verbal 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) Clinical notes, signed and dated by the non-agency LPN, in all instances when a non-agency LPN is providing HOME choice nursing services. The LPN must maintain documentation of all consultations between the LPN and the directing RN, and the in-person visits between the LPN, the participant and the directing RN;
- (h) Documentation of all drug and food interactions, allergies and dietary restrictions;
- (i) A copy of any existing advanced directives including, but not limited to, do not resuscitate orders or medical powers of attorney;
- (j) Clinical notes and other documentation of tasks performed or not performed, arrival and departure times, and the dated signatures of the provider and the participant or their guardian verifying the service delivery upon completion of service delivery. The participant or their guardian's signature of choice shall be documented on the HOME choice service plan, and shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature;
- (k) Clinical notes, signed and dated by the nurse, documenting all communications between the treating physician and other members of the multidisciplinary team; and
- (l) A discharge summary, signed and dated by the nurse at the conclusion of the participant's demonstration period, or at the point the nurse is no longer going to provide services to the participant, or when the participant no longer needs HOME choice nursing services. The summary should include documentation regarding progress made toward goal achievement and indicate any recommended follow-up or referrals.

(8) In order to submit a claim and be reimbursed for HOME choice nursing services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the HOME choice nursing services provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider;
- (c) Be identified as the provider on, and be performing HOME choice nursing services pursuant to the participant's plan of care, as that term is defined in rule 5160-51-01 of the Administrative Code. The plan of care must be signed and dated by the participant's treating physician; and
- (d) Have provided the services for one participant during an in-person visit, or for two or three participants in a group setting during an in-person visit.

(F) "Independent living skills training" is information, educational supports and resources provided to a HOME choice participant for the purpose of developing skills, knowledge or abilities needed to live more independently.

(1) Independent living skills training focuses on:

- (a) Community living skills including, but not limited to:
 - (i) Identifying and accessing existing community resources,
 - (ii) Job training and seeking employment opportunities,
 - (iii) Linking to legal resources,
 - (iv) Negotiating transportation systems and arranging transportation,
 - (v) Safety in the community, and

(vi) Travel training.

(b) Financial management skills including, but not limited to:

(i) Budgeting,

(ii) Finding a bank and establishing an account,

(iii) Managing entitlements and insurance,

(iv) Paying bills and taxes,

(v) Understanding credit,

(vi) Understanding contracts,

(vii) Using a bank machine,

(c) Health management skills including, but not limited to:

(i) Assessing the need for, and accessing, adaptive and assistive devices,

(ii) Crisis care/recovery services,

(iii) Efficiently managing nutrition and diet,

(iv) Ensuring emergency preparedness,

(v) Linking to medical/dental services,

(vi) Managing and accessing medical supplies,

(vii) Managing medication,

(viii) Talking to the doctor, and

(ix) Training service providers;

(d) Home management skills including, but not limited to:

(i) Grocery shopping, cooking and meal planning,

(ii) Housekeeping and laundry,

(iii) Operating simple technology,

(iv) Personal shopping,

(v) Requesting and/or completing simple repairs, and

(vi) Safety at home;

(e) Personal skills including, but not limited to:

(i) Daily functions such as hygiene, dressing and undressing,

(ii) Scheduling, and

(iii) Utilization of leisure/education/physical/emotional activities; and

(f) Social skills development including, but not limited to:

(i) Building communication skills,

(ii) Knowing when and how to ask for help,

(iii) Learning how to be a good neighbor/roommate, and

(iv) Learning how to work with providers.

(2) Independent living skills training shall not duplicate community support coaching services available through HOME choice, similar waiver services available to participants enrolled on an HCBS waiver, or services available through the medicaid state plan.

- (3) If the HOME choice participant is enrolled on a DODD-administered waiver, the participant must access homemaker/personal care in lieu of independent living skills training.
- (4) The independent living skills training provider shall provide the case manager, service and support administrator, or HOME choice case manager, as appropriate, with written status reports as directed during the participant's demonstration period.
- (5) A provider of independent living skills training must be either:
 - (a) A community mental health provider certified by OhioMHAS in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code; or
 - (b) A non-profit agency provider whose staff with direct participant contact:
 - (i) Have either:
 - (a) A disability and has lived in an institution and successfully transitioned to the community and/or;
 - (b) Experience transitioning individuals from an institution to the community, and
 - (ii) Must have knowledge and experience about:
 - (a) Local community resources,
 - (b) Applicable disability laws and regulations, and
 - (iii) Are age eighteen or older; and
 - (iv) Possess a valid Ohio driver license and automobile liability insurance when providing transportation.

- (6) In order to submit a claim and be reimbursed for independent living skills training, the provider delivering the service must:
 - (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule;
 - (b) Be identified as the independent living skills training provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider; and
 - (c) Have provided the service to one participant, or to two or three participants in a group setting, or four or more participants in a classroom setting, during the same in-person visit.

(G) "Nutritional consultation services" are services that provide individualized guidance to a HOME choice participant who has special dietary needs. Nutritional consultation takes into consideration the participant's health, cultural, religious, ethnic and socio-economic background and dietary preferences and/or restrictions.

- (1) Nutritional consultation services shall not duplicate similar waiver services available to participants enrolled on an HCBS waiver or services available through the medicaid state plan.
- (2) A provider of nutritional consultation services must be:
 - (a) A medicaid provider of nutritional consultation services as certified by DODD in accordance with rule [5123:2-2-01](#) of the Administrative Code, or an ODA-certified long term care provider of nutritional consultation services in accordance with rule [173-39-02.10](#) of the Administrative Code; and,
 - (b) Be a dietitian who:

- (i) Is registered by the commission on dietetic registration; and
 - (ii) Maintains a license in good standing with the Ohio board of dietetics;
- (3) All providers of nutritional consultation services must:
 - (a) Conduct an initial individual assessment of the participant's nutritional needs, and subsequent assessments when necessary, using an assessment tool that identifies whether the participant is at nutritional risk or identifies a nutritional diagnosis that the dietitian will treat. The assessment must include:
 - (i) A history of the participant's height and weight;
 - (ii) An assessment of the participant's nutrient intake adequacy;
 - (iii) A review of the participant's medications, medical diagnoses and diagnostic test results;
 - (iv) An assessment of the participant's verbal, physical and motor skills that could be attributable to, or affect, nutrient needs;
 - (v) An assessment of caregiver and participant interactions during feeding; and
 - (vi) An assessment of the need for additional adaptive equipment and/or other community resources and/or services for the participant.
 - (b) Develop, implement, evaluate and revise, as necessary, a nutrition intervention plan with the assistance of the participant and/or their guardian, case manager and when applicable, the treating physician and other relevant service providers. The plan shall be used to prioritize and address the identified nutrition problems. It must include purposely planned actions designed to change nutrition-related behavior, risk factors, environmental conditions or health status, and at a minimum, it must address the following:
 - (i) Appropriate dietary restrictions and modifications;
 - (ii) Specific nutrients that may be required or limited;
 - (iii) Feeding modality;
 - (iv) Nutrition education and counseling; and
 - (v) Expected measurable indicators and outcomes related to the participant's nutrition goals.
 - (c) Provide services pursuant to a plan of care for nutritional consultation services that is signed and dated by the treating physician. The plan of care for nutritional consultation services must be re certified by the treating physician every sixty days, or more frequently if there is a significant change in the participant's condition.
 - (d) Furnish the case manager, service support administrator, or HOME choice case manager, as appropriate, as well as the participant and/or the participant's guardian with a copy of the assessment and the nutrition intervention plan no later than seven working days after completion of the assessment.
 - (e) Furnish evidence, upon request, that the nutrition intervention plan was developed and services were delivered in accordance with professional licensure requirements.
 - (f) Maintain a clinical record for each participant served. At a minimum, the clinical record must include:
 - (i) Participant 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;
 - (ii) The participant's medical history;
 - (iii) Name of the participant's treating physician;

- (iv) Treating physician's authorization for a nutritional assessment;
- (v) A copy of the HOME choice service plan approved by ODM;
- (vi) A copy of the initial and all subsequent individual assessments of the participant's nutritional needs;
- (vii) A copy of the initial and all subsequent plans of care for nutritional consultation services specifying the type, frequency, scope and duration of the services being performed;
- (viii) A copy of the initial and all subsequent nutrition intervention plans developed and implemented;
- (ix) Documentation of all drug and food interactions, allergies and dietary restrictions;
- (x) Documentation that clearly shows the date of nutritional consultation service delivery, including copies of all nutritional assessments conducted and all nutrition intervention plans developed and implemented; and
- (xi) A discharge summary, signed and dated by the nutritional consultation provider at the conclusion of the participant's demonstration period, or at the point the dietitian is no longer going to provide services to the participant, or when the participant no longer needs nutritional consultation services. The summary shall include progress made to date toward goal achievement and nutritional outcomes, and any recommended follow-ups and/or referrals.

(4) In order to submit a claim and be reimbursed for nutritional consultation services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and
- (b) Be identified as the nutritional consultation services provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(H) "Respite services" are services provided on a short-term basis to a HOME choice participant who is not enrolled on an HCBS waiver, and who is unable to care for himself or herself, due to the temporary absence of or periodic relief for the primary caregiver. Respite services include all of the necessary care that the primary caregiver would normally provide during that period. Respite services may be provided in-home, out-of-home or in a day camp setting in accordance with the participant's HOME choice service plan.

(1) In-home respite services are services provided in the participant's place of residence and shall include, but not be limited to:

- (a) General supervision of the participant;
- (b) Homemaker services to assist with housekeeping chores, meal preparation and shopping;
- (c) Personal care services to assist with bathing, dressing and exercise;
- (d) Skilled nursing services to assist with medical needs;
- (e) Accompanying the participant to community outings; and
- (f) Other related services.

- (2) Out-of-home respite services are services provided in an out-of-home setting that meets the requirements set forth in paragraph (H)(4)(b) of this rule, and that require an overnight stay. Out-of-home respite services shall include, but not be limited to:
- (a) Personal care services;
 - (b) Skilled nursing services; and
 - (c) Three meals per day that meet the participant's dietary needs.
- (3) Day camp respite services are provided by a day camp that is licensed or certified by a recognized, accredited entity. Day camp respite services shall:
- (a) Be provided for the purpose of therapeutic intervention that will meet the emotional and behavioral needs of the HOME choice participant;
 - (b) Include, but not be limited to:
 - (i) Personal care services;
 - (ii) Skilled nursing services; and
 - (iii) Meal services commensurate with the camp respite setting that meet the participant's dietary needs; and
 - (c) Not be provided in the HOME choice participant's place of residence.
- (4) A provider of respite services must be one of the following:
- (a) An in-home respite provider who is:
 - (i) A homemaker/personal care provider certified by DODD in accordance with rules [5123:2-9-30](#) and 5123:2-2-01 or 5123:2-3-19 of the Administrative Code, as applicable; or
 - (ii) An approved ODM-administered waiver personal care aide service provider or nursing service provider in accordance with rule 5160-46-04 or 5160-50-04 of the Administrative Code; or
 - (b) An out-of-home respite provider that is:
 - (i) Approved by ODM in accordance with rule [5160-45-04](#) of the Administrative Code; or
 - (ii) An intermediate care facility for individuals with intellectual disabilities (ICF-IID) that meets the requirements set forth in rules [5160-3-02](#) and [5160-3-02.3](#) of the Administrative Code; or
 - (iii) A non-ICF-IID entity (i.e., a group home) licensed by DODD in accordance with rule [5123:2-3-02](#) of the Administrative Code; or
 - (iv) A nursing facility that meets the requirements set forth in rules 5160-3-02 and [5160-3-02.3](#) of the Administrative Code; or
 - (v) Another licensed setting approved by ODM or its designee, including but not limited to, a hospice or hospital; or
 - (c) A camp respite provider that is licensed or certified by a recognized, accredited entity that includes, but is not limited to, the American camping association.
- (5) All providers of in-home respite services must:
- (a) Maintain evidence of the completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. Agency providers must maintain evidence of non-licensed direct care staff's completion of the same requirements. In order to maintain ongoing provider status, 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;

- (b) Not be the participant's legally responsible family member;
 - (c) Ensure that any skilled nursing services provided are within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code; and
 - (d) Provide care as specified by task-based instruction for the provision of personal care services. Agency providers must provide such task-based instruction to direct care staff providing personal care services. Non-agency providers will receive instruction regarding their necessary care from the participant and/or their guardian and as documented in their plan of care.
- (6) All providers of out-of-home respite services must:
- (a) Provide insurance coverage of a participant's loss due to theft, property damage or personal injury, and maintain a written procedure identifying the steps a participant takes to file a liability claim. Documentation verifying the coverage shall be provided to ODM upon request;
 - (b) Maintain evidence of non-licensed direct care staff's completion of twelve hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In order to maintain ongoing provider status, 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;
 - (c) Ensure that any skilled nursing services provided are within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code; and
 - (d) Provide task-based instruction to direct care staff providing personal care services.
- (7) All respite service providers must maintain a record for each participant served in a manner that protects the confidentiality of the records. Providers of in-home respite must ensure at a minimum the record contains the information set forth in paragraphs (H)(7)(a) to (H)(7)(g) of this rule. At a minimum, providers of out-of-home respite must ensure the record contains the information set forth in paragraphs (H)(7)(a) to (H)(7)(h) of this rule.
- (a) Participant identifying information including, but not limited to, name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification number;
 - (b) The participant's medical history;
 - (c) A copy of the initial and all subsequent HOME choice service plans;
 - (d) A copy of any existing advance directives including, but not limited to, do not resuscitate orders or medical powers of attorney;
 - (e) Documentation of all drug and food interactions, allergies and dietary restrictions;
 - (f) Documentation including, but not limited to, case notes clearly showing the date and outcome of respite service delivery, including tasks performed or not performed;
 - (g) Documentation required for providers of ODM administered waiver nursing services as set forth in rule 5160-46-04 or 5160-50-04 of the Administrative Code when skilled nursing services are provided during respite services;
 - (h) A discharge summary, signed and dated by the respite service provider, at the point the provider is no longer going to furnish respite services to the participant, or when the participant no longer needs respite services. The summary should indicate any recommended follow-ups or referrals.
- (8) In order to submit a claim and be reimbursed for respite services the provider must:
- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and

(b) Be identified as the respite services provider on the participant's HOME choice service plan as approved by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

(l) "Service animals" are animals that are trained to perform tasks for HOME choice participants that the participants are unable to perform for themselves.

(1) Tasks performed by service animals include, but are not limited to:

(a) Guiding people who are blind;

(b) Alerting people who are deaf;

(c) Pulling wheelchairs;

(d) Alerting and protecting participants who are having a seizure;

(e) Carrying and picking up things for participants with mobility impairments; and

(f) Assisting participants with mobility impairments with balance.

(2) Service animals may include, but are not limited to:

(a) Seeing eye dogs;

(b) Hearing dogs; and

(c) Service monkeys.

(3) Expenses related to the use of service animals include, but are not limited to:

(a) First-year costs associated with the raising of the animal;

(b) Housing, feeding, upkeep and medical care of the animal during training;

(c) Actual training of the animal, participant orientation and related transportation, room/board and administrative activities;

(d) Equipment and supplies;

(e) Animal health insurance; and

(f) Transportation to the veterinarian.

(4) If the HOME choice participant is enrolled on a DODD-administered waiver, the participant must exhaust similar waiver services that are available before utilizing the service animal service through HOME choice.

(5) A provider of service animal services must be an agency provider of adaptive and assistive equipment services as certified by DODD in accordance with rule 5123:2-2-01 of the Administrative Code.

(6) Reimbursement for service animal expenses shall not exceed a total of eight thousand dollars during the participant's demonstration period.

(7) In order to submit a claim and be reimbursed for service animal services, the provider delivering the service must:

(a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and

(b) Be identified as the service animal service provider on the participant's HOME choice service plan as authorized by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services

including services provided in excess of what is documented on the participant's service plan for that provider.

(J) "Social work/counseling services" are transitional services provided to a HOME choice participant, their guardian, caregiver and/or family member on a short-term basis to promote the participant's physical, social and emotional well-being. Social work/counseling services promote the development and maintenance of a stable and supportive environment for the participant.

- (1) Social work/counseling services can include, but are not limited to, crisis interventions, grief counseling and/or other social service interventions that support the participant's health and welfare.
- (2) Social work/counseling services shall not:
 - (a) Take the place of case management services; or
 - (b) Duplicate similar waiver services available to participants enrolled on an HCBS waiver or through the medicaid state plan.
- (3) A provider of social work/counseling services must be either:
 - (a) A non-agency provider who shall maintain documentation of licensure by the applicable Ohio licensure board and have at least one year of social work/counseling experience, and is:
 - (i) A licensed professional clinical counselor (LPCC), licensed independent social worker (LISW), or independent marriage and family therapist (IMFT) who holds a current, valid and unrestricted license to practice issued by the counselor, social worker, and marriage and family therapist board in accordance with Chapter 4757. of the Revised Code; or
 - (ii) A psychologist who holds a current, valid and unrestricted license to practice issued by the state board of psychology of Ohio in accordance with Chapter 4732. of the Revised Code; or
 - (iii) An RN who holds a current, valid and unrestricted license to practice issued by the Ohio board of nursing in accordance with Chapter 4723. of the Revised Code and holds a masters degree in nursing (MSN) with a specialization or concentration in psychiatric or mental health nursing; or
 - (b) An agency provider who shall maintain documentation that all direct care social work/counseling staff are licensed by the applicable Ohio licensure board, and have at least one year of social work/counseling experience, and:
 - (i) Is a medicaid provider of social work counseling services as certified by DODD in accordance with rule 5123:2-2-01 of the Administrative Code, or as certified by OhioMHAS in accordance with Chapters 5122-24 to 5122-29 of the Administrative Code, or is an ODA-certified long term care provider of social work counseling services in accordance with rule 173-39-02.12 of the Administrative Code; and
 - (ii) Ensures that staff providing direct care is one of the following:
 - (a) An LPCC, licensed professional counselor (LPC), LISW, licensed social worker (LSW), marriage and family therapist (MFT), or IMFT who holds a current, valid and unrestricted license to practice issued by the counselor, social worker, and marriage and family therapist board in accordance with Chapter 4757. of the Revised Code;
 - (b) A psychologist who holds a current, valid and unrestricted license to practice issued by the state board of psychology of Ohio in accordance with Chapter 4732. of the Revised Code; or
 - (c) An individual who holds a current, valid and unrestricted license as an RN from the Ohio board of nursing accordance to Chapter 4723. of the Revised

Code, and holds an MSN with a specialization or concentration in psychiatric or mental health nursing; and

(iii) Ensures that LSWs, LPCs and MFTs are supervised in accordance with Chapter 4757. of the Revised Code, and that the supervisor of an LSW, LPC or MFT co-signs all initial assessments and social work/counseling intervention plans prepared by the LSW, LPC, MFT or MSN.

(4) A provider of social work/counseling services must:

- (a) Conduct individual assessments in order to evaluate the HOME choice participant's psycho-social, financial and environmental status;
- (b) Develop and revise, as necessary, with the assistance of the participant, and/or the participant's guardian, caregiver(s) and the case manager or service and support administrator, as appropriate, a treatment plan that includes the recommended method of treatment and the recommended number of counseling sessions;
- (c) Ensure that the treatment plan is implemented; and
- (d) Furnish to the case manager, service and support administrator, or HOME choice case manager, a copy of the individual assessment report and the treatment plan no later than seven working days after completion of the individual assessment. The participant and/or the participant's guardian shall also be furnished with a copy of the individual assessment report and the treatment plan unless otherwise specified by the treatment plan.
- (e) Maintain a clinical record for each participant served. At a minimum, the clinical record must include:
 - (i) Participant identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification information;
 - (ii) The participant's medical history;
 - (iii) Name of the participant's treating physician;
 - (iv) A copy of the HOME choice service plan approved by ODM;
 - (v) A copy of the initial and all subsequent individual assessments;
 - (vi) A copy of the initial and all revised treatment plans;
 - (vii) A copy of any existing advanced directives including, but not limited to, do not resuscitate orders or medical powers of attorney;
 - (viii) Documentation of all drug and food interactions, allergies and dietary restrictions;
 - (ix) Documentation that clearly shows the date of social work/counseling service delivery;
 - (x) A discharge summary, signed and dated by the social work/counseling service provider at the conclusion of the participant's demonstration period, or at the point the provider is no longer going to provide services to the participant, or when the participant no longer needs social work/counseling services. The summary should include documentation regarding service outcomes and progress made toward goal achievement and indicate any recommended follow-ups and/or referrals.

(5) In order to submit a claim and be reimbursed for social work/counseling services, the provider delivering the service must:

- (a) Meet the conditions of participation and enrollment criteria set forth in rule 5160-51-03 of the Administrative Code, as well as all applicable provider qualifications set forth in this rule; and

(b) Be identified as the social work/counseling services provider on the participant's HOME choice service plan as approved by ODM. The authorized service plan will indicate the service begin date and the number of units/hours for which the provider is authorized to furnish services to the participant. The provider will not be reimbursed for unauthorized services including services provided in excess of what is documented on the participant's service plan for that provider.

Replaces: 5160-51-04, 5160-51-05

Effective: 02/01/2015

Five Year Review (FYR) Dates: 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 119.03, 5164.02

Rule Amplifies: 5162.03, 5164.02, 5166.02, 5164.90

Prior Effective Dates: 7/1/08, 6/1/09, 9/9/10, 8/1/11

LTCSSTL 15-02

Effective Date: February 1, 2015

Most Current Prior Effective Date: August 1, 2011

- (A) This rule sets forth the helping Ohioans move, expanding choice (hereafter referred to as HOME choice) program definitions of billing terms, reimbursement rates and billing procedures for providers of covered services. ~~used for billing and calculating rates.~~
- ~~(1)(B)~~ "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. Definitions of HOME choice billing terms:
- (1) "Base rate," as used in paragraph (C), table (A) of 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 (BC) of, table (B) of this rule, means a single fixed item or amount of time.
 - (3) "Classroom rate" is the amount that HOME choice independent living skills training ~~service~~ providers are reimbursed when the service is provided in a classroom setting. The rate is equivalent to fifty per cent of the reimbursement rate set forth in paragraph (BC), table (B) of this rule that is paid to a provider for furnishing HOME choice independent living skills training services to a single ~~individual~~ participant.
 - (4) "Classroom setting" is a situation in which a HOME choice independent living skills training ~~service~~ provider furnishes the same type of services to four or more ~~individuals~~ participants at the same address, during the same visit. The services provided in the classroom setting can be either the same type of HOME choice independent living skills training ~~service~~, or a combination of HOME choice independent living skills training services and similar independent living skills training services.
 - (5) "Group rate," as used in paragraph ~~(EF)~~(1) of this rule, is the amount that HOME choice nursing providers, or HOME choice independent living skills training ~~services~~ providers are reimbursed when the service is provided in a group setting. The rate is equivalent to seventy-five per cent of the reimbursement rate set forth in paragraph (BC), table (A) of this rule for HOME choice nursing services, and in paragraph (BC), table (B) of this rule for HOME choice independent living skills training services that is paid to a provider for delivering the HOME choice nursing services or HOME choice independent living skills training services to a single ~~individual~~ participant.
 - (6) "Group setting" is a situation in which a HOME choice nursing, service provider, or ~~a HOME choice~~ independent living skills training ~~service~~ provider furnishes the same type of services to two or three ~~individuals~~ participants at the same address, during the same visit. The services provided in the group setting can be either the same type of HOME choice nursing service or HOME choice independent living skills training service, or a combination of HOME choice nursing services and similar nursing services, or HOME choice independent living skills training services and similar independent living skills training services.
 - (7) "Maximum usage amounts," as used in ~~table B, column 6 of~~ paragraph (BC) of, table (B) of this rule, means the maximum number of hours, or the maximum dollar amount that a HOME choice ~~demonstration program~~ service can be reimbursed, ~~and~~ as set forth on the HOME choice ~~demonstration program~~ participant's ~~all services plan, service plan, ISP or non-waiver~~ HOME choice ~~demonstration program~~ service plan, ~~as appropriate.~~
 - (8) "Maximum hours per month," as used in ~~table A, column 5 of~~ paragraph (BC) of, table (A) of this rule, means the maximum number of hours that a HOME choice ~~demonstration program~~ service can be reimbursed per month, ~~and~~ as set forth on the HOME choice participant's ~~all services~~

~~plan, service plan, ISP or non-waiver~~ HOME choice ~~demonstration program~~ service plan, as appropriate.

- (9) "Maximum rate" means the maximum amount that will be paid for the HOME choice ~~demonstration program~~ service rendered.
- (a) For the billing codes in ~~table B of~~ paragraph (B)(C) ~~of~~, table (B) of this rule, the HOME choice ~~demonstration program~~ maximum rate is set forth in column (4).
- (b) For the billing codes in ~~table A of~~ paragraph (B)(C) ~~of~~, table (A) of this rule, the HOME choice ~~demonstration program~~ 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)(10)(11) of this rule for each additional unit of service delivered.
- (10) "Modifier," as used in paragraph (E) of this rule, means the additional alpha-numeric digit billing codes HOME choice ~~demonstration program~~ providers are required to use to provide additional information regarding service delivery.
- (11) "Unit rate," as used in ~~table A, column 4 of~~ paragraph (B)(C) ~~of~~, table (A) of this rule, and in ~~table B, column 5 of~~ paragraph (B)(C) ~~of~~, table (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)(C)~~ Billing code tables.

Table A

Column 1	Column 2	Column 3	Column 4	Column 5
Billing code	Service	Base rate	Unit rate	Maximum hours per month
HC001	HOME choice nursing provided by an RN	\$56.65	\$5.87	44 hours per month
HC002	HOME choice nursing provided by an LPN	\$56.65	\$5.87	44 hours per month

Table B

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Billing code	Service	Billing unit	Maximum rate	Unit rate	Maximum usage amounts
HC003	Independent living skills training	15 minutes	\$30.00 per hour	\$7.50	144 hours during the 365-day demonstration period
HC004	Community support coaching	15 minutes	\$25.00 per hour	\$6.25	72 hours during the pre-transition and 365-day demonstration periods, combined

HC005	Social work/ counseling services	15 minutes	\$64.12 per hour	\$16.03	36 hours during the 365-day demonstration period
HC006	Nutritional consultation services	15 minutes	\$52.56 per hour	\$13.14	36 hours during the 365-day demonstration period
HC007	Communication aids	Per item	A maximum of \$5,000.00 for all items	N/A	\$5,000 during the 365-day demonstration period
HC008	Service animals	Per item	A maximum of \$8,000.00 for all items	N/A	\$8,000 during the 365-day demonstration period
HC009	Community transition services	Per item	A maximum of \$2,500.00 for all items (included in this is a maximum of \$500 for pre- transition transportation expenses)	N/A	A maximum of \$2,500 for all items (included in this is a maximum of \$500 for pre- transition transportation expenses, and for all other approved community transition services, a maximum of \$2,000 during the pre-transition and 365-day demonstration periods, combined)
HC012	In-home respite services	15 minutes	\$9.00 per hour	\$2.25	\$2,000 for in- home, out-of- home and camp respite services, combined, during the 365-day demonstration period
HC013	Out-of-home respite services	Per day with overnight stay	\$200.00 per day	N/A	\$2,000 for in- home, out-of- home and camp respite services, combined, during the 365-day demonstration

					period
HC014	Camp respite services	Per day	A maximum of \$625 per week	\$125	\$2,000 for in-home, out-of-home and camp respite services, combined, during the 365-day demonstration period, and including a maximum of \$625/week for camp respite

~~(C)~~(D) In order for a provider to submit a claim for reimbursement of HOME choice demonstration program services, the services must be provided in accordance with Chapter ~~5101:3-51~~5160-51 of the Administrative Code.

~~(D)~~(E) The amount of reimbursement for a service shall be the lesser of the provider's billed charge or the HOME choice ~~demonstration program~~ maximum rate.

~~(E)~~(F) Required modifiers.

- (1) The "GS" modifier must be used when a provider submits a claim for HOME choice nursing services, or HOME choice independent living skills training services, 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 HOME choice ~~demonstration~~ program maximum for the specific service.
- (2) The "CS" modifier must be used when a provider submits a claim for HOME choice independent living skills training services if the service was delivered in a classroom setting. Reimbursement as a classroom rate shall be the lesser of the provider's billed charge or fifty per cent of the HOME choice ~~demonstration~~ program maximum.
- (3) The "N2" modifier must be used when the same provider submits a claim for HOME choice nursing services for a second visit to a participant for the same date of service.
- (4) The "N3" modifier must be used when the same provider submits a claim for HOME choice nursing services for three or more visits to a participant for the same date of service.
- (5) The "N4" modifier must be used when a provider submits a claim for HOME choice nursing services for a single visit that was more than twelve hours in length but did not exceed sixteen hours.

~~(F)~~(G) Reimbursement will be provided in accordance with the following:

- (1) Except as stated in paragraph ~~(FG)~~(2) of this rule, claims must be received by the financial management service (FMS) provider ~~(FMS)~~ within ninety calendar days of the actual date the HOME choice ~~demonstration~~ service was provided.
- (2) Reimbursement requests for community transition services must be received by the FMS provider within ~~fourteen~~thirty calendar days of the actual date goods and services were purchased. Reimbursement requests must be in the form of either an invoice, a receipt or a purchase order.
- (3) The payment for a covered HOME choice ~~demonstration program~~ service constitutes payment-in-full and shall not be construed as a partial payment when the reimbursement amount is less than the provider's charge. The provider may not collect and/or bill the participant for any difference between the HOME choice ~~demonstration program~~ payment and the provider's

charge, or request the participant to share in the cost through a deductible, coinsurance, co-payment or other similar charge.

- (4) Except ~~for~~ as stated in paragraphs (FG)(5) and (FG)(6) of this rule, HOME choice ~~demonstration program~~ providers shall not be reimbursed ~~reimbursement is not available~~ for non-covered services, or for ~~otherwise covered~~ ~~similar waiver or administrative~~ services which are available either through ~~on~~ the home and community based services (HCBS) waiver on which the HOME choice ~~demonstration program~~ participant is enrolled, or through the medicaid state plan.
 - (5) When the HOME choice ~~demonstration program~~ participant is enrolled on an HCBS waiver, HOME choice ~~demonstration program~~ reimbursement is available for communication aid services only after the participant has received and exhausted same or similar waiver services.
 - (6) When the HOME choice ~~demonstration program~~ participant is ~~enrolling~~ enrolled on an ODA-administered waiver or ODM-administered waiver, the participant ~~may~~ shall use HOME choice community transition services in lieu of, but not in addition to, ~~the~~ community transition ~~services~~ services available through the ~~ODA-administered~~ waiver.
 - (7) Reimbursement is made only for those HOME choice ~~demonstration program~~ services that are ~~set forth in~~ authorized on the participant's ~~all services plan, service plan, individual service plan or non-waiver~~ HOME choice ~~demonstration program~~ service plan, ~~as appropriate~~. The amount of payment is determined in accordance with federal and state laws and regulations. In establishing HOME choice ~~demonstration program~~ maximums, ODJFS ODM must assure that the maximum reimbursement is consistent with efficiency, economy and quality of care.
 - ~~(8) The state's appropriation determines the total amount of funds that may be expended for HOME choice demonstration program services. The maximums used by ODJFS may be less than the maximums permitted under federal law for same or similar services, but may not be more. Providers are expected to bill the FMS provider their usual and customary charge (i.e., the amount the provider charges the general public). If the amount billed to the FMS exceeds the maximum set forth in this rule, the amount paid will automatically be reduced to the maximum permitted.~~
- (H) ODM or its designee may recoup any overpayment by deducting that amount from a current or future payment or by another method prescribed by ODM. Overpayments include, but are not limited to payments made in error, payments for services that were not authorized, payments for services that were authorized but not provided, and payments that were made as a result of inaccurate billing.

Effective: 02/01/2015

Five Year Review (FYR) Dates: 10/20/2014 and 02/01/2020

Certification: CERTIFIED ELECTRONICALLY

Date: 01/22/2015

Promulgated Under: 119.03

Statutory Authority: 119.03, 5164.02

Rule Amplifies: 5162.03, 5164.02, 5166.02, 5164.90

Prior Effective Dates: 7/1/08, 6/1/09, 9/9/10, 8/1/11

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.1001.1.CMS 1500

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

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:

$$\text{Reported coinsurance} = [(\text{Medicare allowed amount} * .625) - (\text{deductible})] * .20$$

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 911115 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	07422	GOODYEAR TIRE and RUBBER	1144 EAST	AKRON	OH	44316	

nd RUBBER		COMPANY	MARKET STREET				
GOVERNMENT LIFE INSURANCE	07440	GOVERNMENT EMPLOYEES HOSPITAL ASSOCIATION	P.O. BOX 10304	KANSAS CITY	MO	64111	
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
TRAVELERS	18900	TRAVELERS INS CO, RAILROAD EMPLOYEES	P.O. BOX 1200	LANSING	IL	60438	
TRAVELERS	18900	TRAVELERS INSURANCE COMPANY	ONE TOWER SQUARE	HARTFORD	CT	6115	
UNION FIDEL	19150	UNION FIDELITY INSURANCE COMPANY	4850 STREET ROAD	TREVOSE	PA	19049	
BLUECROSS/BLUE SHIELD	22405	COMMUNITY MUTUAL INSURANCE CO	1351 WILLIAM TAFT ROAD	CINCINNATI	OH	45206	
BLUECROSS/BLUE SHIELD	32404	BLUE CROSS and BLUE SHIELD NORTHWEST	P.O. BOX 943	TOLEDO	OH	43656	
BLUECROSS/BLUE SHIELD	42403	COMMUNITY MUTUAL INSURANCE CO	6740 N. HIGH STREET	WORTHINGTON	OH	43085	
BLUECROSS/BLUE SHIELD	42404	BC/BS OF OH WESTERN DIV, WEST CENTRAL REGION	P.O. BOX 14646	DAYTON	OH	45414	
BLUECROSS/BLUE SHIELD	42405	CENTRAL BENEFITS MUTUAL and CASUAL INSURANCE CO	P.O. BOX 16526	COLUMBUS	OH	43216	
BLUECROSS/BLUE SHIELD	52405	BLUE CROSS and BLUE SHIELD	P.O. BOX 8590	CANTON	OH	44771	
COMMUNITY MUTUAL INSURANCE CO	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/BLUE 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	
EMPLOYEES BENEFIT MGMT CORP	05122	EMPLOYEES BENEFIT MANAGEMENT CORP	4789 RINGS ROAD	DUBLIN	OH	43017	-0750
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	
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
TRAVELERS	18900	TRAVELERS INS CO, RAILROAD EMPLOYEES	P.O. BOX 1200	LANSING	IL	60438	
TRAVELERS	18900	TRAVELERS INSURANCE COMPANY	ONE TOWER SQUARE	HARTFORD	CT	6115	
UNION FIDEL	19150	UNION FIDELITY INSURANCE COMPANY	4850 STREET ROAD	TREVOSE	PA	19049	
BLUECROSS/BLUE SHIELD	22405	COMMUNITY MUTUAL INSURANCE CO	1351 WILLIAM TAFT ROAD	CINCINNATI	OH	45206	
BLUECROSS/BLUE SHIELD	32404	BLUE CROSS and BLUE SHIELD NORTHWEST	P.O. BOX 943	TOLEDO	OH	43656	
BLUECROSS/BLUE SHIELD	42403	COMMUNITY MUTUAL INSURANCE CO	6740 N. HIGH STREET	WORTHINGTON	OH	43085	
BLUECROSS/BLUE SHIELD	42404	BC/BS OF OH WESTERN DIV, WEST CENTRAL REGION	P.O. BOX 14646	DAYTON	OH	45414	
BLUECROSS/BLUE SHIELD	42405	CENTRAL BENEFITS MUTUAL and CASUAL INSURANCE CO	P.O. BOX 16526	COLUMBUS	OH	43216	
BLUECROSS/BLUE SHIELD	52405	BLUE CROSS and BLUE SHIELD	P.O. BOX 8590	CANTON	OH	44771	
COMMUNITY MUTUAL INSURANCE CO	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/BLUE 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.	

Ohio Home Care Medicaid Forms

Home Care Attendant Medication Authorization (JFS 02389)

[Click here to view the JFS 02389](#)

Home Care Attendant Skilled Task Authorization (JFS 02390)

[Click here to view the JFS 02390](#)

Provider Enrollment Application Addendum M Non-Agency Waiver Service Provider (JFS 02391)

[Click here to view the JFS 02391](#)

Designation of Authorized Representative for Home Care Attendant Services (JFS 02392)

[Click here to view the JFS 02392](#)