ODHS Aging and People with Disabilities

Payment Processing for In-Home Care Agencies

2023

Oregon Department of Human Services

Table of Contents

Acronym Used in this Guide

- APD – Aging and People with Disabilities
- CA/PS – Client Assessment and Planning System
- CM – Case Manager
- HCW – Home Care Worker
- HFLC – Health Facility Licensing and Certification Program
- HIPAA – Health Insurance Portability and Accountability Act of 1996
- IHCA – In Home Care Agency
- LO – Local Office
- MMIS – Medicaid Management Information System
- NS – Natural Support
- OA – Oregon ACCESS
- OAR – Oregon Administrative Rule
- POC – Plan of Care
- SA – Service Agreement
- SELG – Service Eligibility
- TOA – Type of Assistance

In Home Care Agency Background

In Home Care Agencies (IHCA's) are licensed through the Health Facility Licensing and Certification Program (HFLC), Public Health Division of Oregon's Health Authority. IHCA's who provide services to Medicaid consumers must be an enrolled Medicaid Provider.

Eligible individuals may hire a Home Care Worker (HCW), an IHCA, or a combination of both.

Referrals

Before making a referral to an IHCA, the Local Office confirms:

- The IHCA is enrolled as a Medicaid Provider. A current list is available on CM Tools.

- The consumer qualifies for services
- The consumer's eligibility is current

The local office must use an equitable process to rotate referrals between local IHCAs when the consumer does not have a preferred IHCA.
Next, the case manager (CM), case aid, or consumer contacts the IHCA to discuss the consumer's care plan and determine fit.
This discussion may include:

- Allowable hours, mileage and service dates
- Care plan specifications and preferences *(only male providers, Spanish speaking, scheduling preferences, etc.)*
- Challenges that may prevent an IHCA from meeting the consumer's care needs
- Other information deemed pertinent to help the IHCA determine if they are able to meet the consumer's care needs without violating the consumers right to confidentiality under HIPAA

IHCAs cannot accept referrals if they do not have the capabilities, resources or staffing to provide the required services necessary to meet the consumer's needs.

IHCA Assessment

After an IHCA accepts a referral, they perform an assessment. The IHCA assessment does not constitute acceptance of the individual for services. They may bill for the assessment using procedure code T2024 in MMIS, regardless of the outcome.

A POC in MMIS is not necessary for this service, but the consumer must have an approved In-home Care Service Plan with a corresponding SELG line and approved TOA in the ONE system for the claim to be processed.

The IHCA must notify the local office as soon as possible if they can or cannot meet the needs of the consumer, so the local office can consider the next service option.

Setting Up Services

Once an IHCA accepts the consumer, the CM must immediately send the IHCA the following, using a secure format (email, fax, or mail):

- A 598N Task List with the agreed-upon tasks the IHCA will be providing.
- An authorized 546N Service Plan with the agreed upon hours and dates of service.
    - In the remarks section, the CM must calculate the weekly authorized **units** and miles for the POC. A unit is 15 minutes (4 units/hour).
    - For example, if you authorize 56 units in a pay period, your remarks will say you authorize 28 units per week.
- Authorize units weekly and in whole miles. Include the authorization in the remarks section of the POC.

Next, the local office must set up the POC into MMIS. It is critical to set up the POC as soon as possible and no later than the following business day. Electronic Visit Verification may prevent the IHCA to start services until this is done.

Creating a POC

Before creating a POC in MMIS, verify:

- The Benefit and Service plan in OA are in approved status
- The Type of Assistance (TOA) is current in ONE, and
- The start and end dates of benefits and hour segments align

MMIS TIP! Do not press the Enter key on your keyboard when working on a POC. Pressing Enter key ‘activates’ the add button, which inserts another POC line. Use your mouse or tab to move from field to field.
To delete a line created by mistake click ‘cancel’ on the maintenance panel and re-enter the POC, starting with the Base Information panel.
For detailed step-by-step instructions and screenshots review the MMIS In Home POC Resource Guide

http://www.dhs.state.or.us/spd/tools/mmis/10_3_v1_1_MMIS_In_Home_POC_Resource_Guide_092618.pdf

Updating and Adjusting a POC

The POC must reflect the current service plan. Update the authorized hours immediately when changes occur, including when hours change for shift coverage between multiple providers.

- When there is a temporary change in the authorized hours for an IHCA the local office staff must:
  - End the existing POC in MMIS.
  - Create a new POC for the duration of the temporary change. If the duration is unknown, align the end date with the current service benefit period.
  - If the duration of the change is known, create another POC to begin when the previous plan resumes.

Example – A consumer's natural support (NS) will be out of town for two months, and the IHCA has agreed to cover the unassigned hours on the service plan for tasks provided by the NS.

- The CM ends the POC with an end date of the day before the service plan changes.
- Next, the CM creates a new POC with the new hours to cover the time frame the NS will be unavailable.
- The CM also creates another POC for the date the NS will return.

POC Change tip: Align dates of changes with the pay period whenever possible.

Annual Reviews and Reassessments

Consumers receiving In-Home Care services must have a CA/PS assessment annually. The CM may coordinate the date and time with the IHCA when the consumer wants the IHCA to be present. If the consumer

does not wish to have the IHCA present, the CM will contact the IHCA for additional information or clarification on care needs.

In most circumstances, the IHCA must provide individuals with a 30-day notice when ending services. (See page 9 for more information about IHCA notices.) For this reason, it is imperative to communicate with the IHCA the assessment outcome at least 15 days before the current POC end date.

When the re-assessment is complete:

- Create and provide the IHCA new 546Ns, prior to the end of the current POC. Highlight any changes on the 546N.
- Contact the IHCA and communicate any change to services through a case staffing.
- If the consumer is no longer eligible for services, provide the end date to the IHCA, allowing the IHCA to end their services as well. Failing to notify the IHCA may result in the Department needing to pay for services rendered after Medicaid service benefits end via General Funds.
- If Medicaid services are ending in less than 30-days, the agency must give the consumer the option to pay privately for the duration of the 30-day period.
- If the IHCA does not receive updated 546Ns within fifteen (15) days of the current POC, and efforts to contact the CM and their supervisor have failed, as a last resort the IHCA may inform the local office in writing they will serve a 30-day notice to terminate services if the local office fails to provide an updated 546N.

Late Assessments or Extended Service Plans

If the assessment and service plan cannot be completed before the current POC's end date:

- The CM must request a 30-day administrative extension from their local office supervisor.
- Once extended in OA, the CM must extend the POC in MMIS; and

- Send updated 546Ns with new end dates and allowed hours to the IHCA.

Reporting Changes

The consumer and IHCA share the responsibility to report changes to care needs to the CM. The CM must promptly respond when notified of a potential change and determine if it will impact the allowed hours on the service plan.

- If the change does not impact hours, document the conversations and outcomes communicated to the consumer and IHCA.
- If the reported change impacts the consumer's hours or eligibility, the CM must take appropriate actions and promptly communicate that information to the IHCA.
- If the reported change may result in a reduction or closure, the CM must immediately send a Buckley Bill notice and schedule an assessment with the consumer.
- If the reported change likely results in an increase in hours, the CM must schedule an assessment with the consumer as soon as possible and inform the consumer or their representative that not all assessments result in increased hours. Narrate if the consumer has waived the Buckley Bill notice and wish to complete the assessment within 14 days.

It is crucial to communicate any plan change to the IHCA in a timely manner to allow them to adjust accordingly.

Provider Number Change

Policy Transmittals notify local office staff if an IHCAs Medicaid provider number changes. This is most commonly due to a change in ownership.

When the IHCA provider number changes, Local Office Staff must

- End the existing Service Plan (in OA) and POCs (in MMIS)
- Create a new Service Plan for the remainder of the Benefit period.

- Create a new POC (in MMIS) with the new provider number that matches the benefit and service plan in OA

If an IHCA mistakenly uses their old provider number after the new numbers issued, the IHCA must back out those claims before LO staff can end the POC. A POC cannot have claims after the end date.

These changes must be made in a timely manner. The longer an incorrect POC stays in place, the more claims must be backed out and rebilled under the correct POC.

Billing for Services

IHCA must bill for services rendered to Medicaid consumers through MMIS using the IHCA POC Billing Guide.

A week is defined in MMIS as Sunday through Saturday.

There are two methods IHCAs can use to bill for services:

Professional billing allows the provider to submit one claim for one consumer for up to a maximum of weekly units. Adding additional claim details is also allowed.

Roster billing allows the provider to submit multiple claims for one consumer for multiple weeks. Roster billing does not have a modifier field for providers claiming the enhanced wage add-on rate.

An IHCA may submit a claim for more than one week of service when the total units do not exceed the allowed units for a one-week authorization. (Example: The IHCA provided 38 units during the month and the weekly authorization is 40 units. The IHCA may submit a claim for the entire month because the total units do not exceed the weekly authorization.)

Medicaid allows providers to bill up to 365 days after the date of service and allows for adjustments up to 18 months from the date of service. Medicaid will not reimburse anything beyond this.

IHCA Notices

IHCAs must provide an individual with a 30-day notice of their intent to end services and give the option for the individual to pay privately if Medicaid services will end prior to the end of the 30 days.

IHCAs may give less than 30 days' notice in the following circumstances:

(1) If the IHCA determines the safety of its staff or the consumer is at risk, they may provide an immediate oral or written notice of termination of services.

(2) In the event of nonpayment in accordance with the IHCA disclosed payment requirements, they may issue a 48-hour notice of termination of services.

Common Billing and System Errors

Claims exceed the maximum allowed units for a one-week authorization.

- This most commonly happens when a calendar month changes during the week and for accounting purposes the IHCA separates billing for a month.

Local office staff attempts to adjust the POC end date when there are paid claims outside of the POC dates.

- This most commonly happens when a change accrued that was not timely updated in the system.
    - To resolve, void the claims after the effective date of change.
- This also happens when attempting to adjust a POC/SA when the first claim on the SA crosses authorizations.

- To resolve, void the initial claim and create two new claims splitting the authorization.

Reporting Complaints

Consumers have the right to report concerns or issues with an IHCA through a formal complaint process. Local office staff may complete the complaint on the consumer's behalf based on the information provided by the consumer or the consumer's representative.

Complaints regarding IHCA are investigated by an enforcement team with the Public Health department. Public Health reviews the administrative procedures and policies outlined in OARs 333-536 to determine compliance and works with APD to determine appropriate corrective actions for substantiated complaints.

IHCA Complaint Form

Frequently Asked Questions

Are IHCAs required to provide services to Medicaid Consumers if they are a Medicaid enrolled provider?
Declining to provide services to a consumer solely because the consumer is a Medicaid recipient is discrimination. However, are not obligated to provide services to Medicaid consumers and are required to decline to provide services to a consumer when they cannot meet consumer's needs. Once an IHCA accepts a consumer, they must provide services outlined in the consumer's service plan.

Can an IHCA still bill for an assessment if they determine they cannot provide services to the consumer?
Yes. IHCAs may bill for an assessment regardless of the outcome. Prior to accepting a consumer, they must determine they have the ability and staff to meet the consumer's assessed needs.

Can an IHCA require a minimum number of hours needed to accept a consumer?

Yes. An IHCA may have an established minimum hours requirement. This is established prior to the consumer accepting services and must align with the consumer's needs. In some cases, the IHCA may not have the staffing capacity to take on a smaller case because the number of approved hours is not enough for an IHCA to justify hiring additional staff.

- IHCA may not set a minimum hours per shift for the purpose of the provider's convenience after they've accepted the consumer.
- The consumer or their representative drives the person-centered service planning process.
- Schedules must reflect the consumer's needs and preferences with consideration of the provider's availability.

Contacts and Resources

IHCA Licensing Information:
https://www.oregon.gov/oha/ph/providerpartnerresources/healthcareprovidersfacilities/healthcarehealthcareregulationqualityimprovement/pages/forms.aspx#IHC

Current list of IHCA Medicaid Providers:
CM Tools Webpage

Current list of all licensed IHCAs (Including those not enrolled in Medicaid):
Health and Licensed Certification Website

For questions or clarification:
APD.MedicaidPolicy@odhsoha.oregon.gov

For IHCAs with questions about enrollment send questions to:
APD.ProviderEnrollment@odhsoha.oregon.gov

For licensing or related requirements send question to: mailbox.inhomecare@odhsoha.oregon.gov

For provider inquiries on claim review, denials, members eligibility, etc. send questions to: DMAP.ProviderServices@odhsoha.oregon.gov