Home and Community-Based Services (HCBS)

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This section contains instructions for billing Home and Community-Based Services (HCBS).

Home and Community-Based Services

HCBS waiver services are designed to provide in-home care and support to recipients who would otherwise require institutionalizationin a medical facility for a prolonged period of time.

The Department of Health Care Services (DHCS) administers the In-Home Operations (IHO) and the Nursing Facility/Acute Hospital (NF/AH) HCBS waivers for Medi-Cal eligible frail seniors and persons with disabilities.

These waiver programs are approved by the Centers for Medicare & Medicaid Services (CMS), and must continuously provide cost-effective alternatives to institutionalized care in order for the state to receive federal matching funds.

Background

The primary goal of the Medi-Cal Waiver Programs is to provide support to ensure that recipients' medical needs can be met appropriately and safely in a home environment. Another goal is for the recipients to experience an enhanced and enriched quality of life by receiving services in the home rather than in an institution. A further objective, and a Federal requirement, is that waiver programs must be less costly than the institutional alternative.

Service and Provider Definitions

The following are descriptions of services and professionals allowed to provide HCBS waiver services.

“Registered Nurse” means an individual, as defined in *California Code of Regulations* (CCR), Title 22, Section 51067.

“Licensed Vocational Nurse” means an individual, as defined in CCR, Title 22, Section 51069.

“Home Health Aide” means an individual, as defined in *Health and Safety Code*, Section 1727(c), and CCR, Title 22, Section 74624.

“Nursing Care, in the home” is synonymous with “Shift Nursing” and “Private Duty Nursing” terms that mean services provided by a Registered Nurse (RN) or a Licensed Vocational Nurse (LVN), which are more individual and continuous than State Plan intermittent nursing visits.

“HCBS Waiver Registered or Licensed Vocational Nurse” means an RN or LVN who provides individual nursing services and, in this capacity, is not employed by or otherwise affiliated with a Home Health Agency or any other licensed health care provider, agency or organization. An individual nurse provider may not be a parent, stepparent, foster parent, spouse or legal guardian of the patient.

“HCBS Benefit Provider” means a Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT), or licensed psychologist who provides individual HCBS waiver services as described in the waiver’s Standards of Participation (SOP), and is not employed by or otherwise affiliated with an agency or organization. A HCBS Benefit Provider cannot be a parent, stepparent, foster parent, spouse or legal guardian of the patient.

“Professional Corporation” means a provider who employs a LCSW, MFT or licensed psychologist, meets the HCBS waiver provider requirements, and renders HCBS waiver services as described in the waiver’s SOP.

“Home and Community-Based Services Nursing Facility” means a Congregate Living Health Facility or an Intermediate Care Facility for the Developmentally Disabled/Continuous Nursing that meets the HCBS waiver provider requirements and renders HCBS waiver services as described in the waiver’s SOP.

“Personal Care Services” means an unlicensed individual who is employed by a Home Health, Employment or Persona Care Agency that meets the HCBS waiver provider requirements and renders HCBS services as described in the HCBS waiver.

Scope of Practice by Provider Type

The following are licensing criteria providers must meet to be an HCBS waiver provider.

Services provided by an RN under a waiver program include only those services identified by the Board of Registered Nursing as being within the scope of practice for a Registered Nurse.

Services provided by an LVN under a waiver program include only those services identified by the Board of Vocational Nursing and Psychiatric Technicians within the scope of practice for a Licensed Vocational Nurse.

Services provided by a Certified Home Health Aide under a waiver program include only those services described in *Health and Safety Code*, Section 1727.

Services provided by a LCSW under a waiver program include only those services described in the HCBS waiver and the *Business and Professions Code*, Section 4996.9, within the scope of practice of a LCSW.

Services provided by an MFT under a waiver program include only those services described in the HCBS waiver and the *Business and Professions Code*, Sections 4980, 4980(b), 4980.02 and 4996.9, within the scope of practice of an MFT.

Services provided by a licensed psychologist under a waiver program include only those services described in the HCBS waiver and the *Business and Professions Code*, Sections 4980, 4980(b), 4980.02 and 4996.9, within the scope of practice of a licensed psychologist.

Services provided by a HCBS Nursing Facility under a waiver program include only those services described in the HCBS waiver and the *Health and Safety Code*, Sections 1250(i), 1267.12, 1267.13, 1267.16, 1267.17 and 1267.19.

Medi-Cal Eligibility

To be eligible to receive HCBS waiver services, an individual must meet Medi-Cal financial eligibility requirements. Medi-Cal eligibility can be met through the regular Medi-Cal eligibility or the special waiver eligibility rules.

Regular Medi-Cal eligibility rules require the income and resources of the family in determining whether the potential waiver service recipient is eligible for Medi-Cal when residing in the home. The appropriate county welfare department or Supplemental Security Income (SSI) office is responsible for making Medi-Cal eligibility determinations.

Special waiver eligibility rules require only the income and resources of the individual seeking HCBS waiver services in determining Medi-Cal eligibility. When using special waiver eligibility, IHO first assesses the individual to determine if they meet medical necessity criteria for the HCBS waiver. Once this determination is made, IHO then coordinates with the appropriate county welfare department for the Medi-Cal eligibility determination.

The authorization of HCBS waiver services depends upon the agreement of the recipient, guardian or authorized representative, primary care physician and the HCBS waiver provider in the decision to provide services in the home in lieu of institutional care. DHCS provides each party with an Informing Notice to ensure each party understands their roles and responsibilities, as well as the benefits and limitations of the waiver services.

A recipient may be enrolled in only one HCBS waiver program at a time. ‹‹If enrolled in the Multi-Purpose Senior Services Program (MSSP), Developmentally Disabled (DD) Waiver or Medi-Cal Waiver Program (MCWP), a recipient must first disenroll to be eligible for one of IHO's HCBS waivers.

Recipients are not required to disenroll from managed care plans (MCPs) to remain or enroll in an MCWP authorized under Section 1915(c) of the Social Security Act. This applies to HCBS waiver services including but not limited to the NF/AH Waiver Program and the MCWP.››

Seniors and persons with disabilities who are required to enroll in a MCP may continue to receive services from the waiver program in which they are enrolled.

HCBS Waivers

HCBS waiver services are designed to provide in-home care to recipients who otherwise require prolonged institutionalization in one of the following facility types:

- Acute care hospital
- Adult or pediatric subacute nursing facility
- Nursing Facility Level A-intermediate care or B-skilled nursing
- Intermediate Care Facility for the Developmentally Disabled

  Note: HCBS waiver services for recipients 20 years of age and younger will only be those services that are otherwise not covered under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

IHO and NF/AH Waivers

In-Home Operations (IHO) and the Nursing Facility/Acute Hospital (NF/AH) waivers provide services in the home to Medi-Cal recipients who would otherwise receive care in an intermediate care facility, an intermediate care facility for the developmentally disabled who require continuous nursing, a skilled nursing facility, a subacute nursing facility, or an acute care hospital. Services include private duty nursing, case management, waiver personal care services, and other home and community-based services.

The IHO waiver serves either: 1) participants who have been continuously enrolled in a DHCS In-Home Operations administered HCBS waiver prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse; or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the NF/AH Waiver for the participant's assessed level of care.

Waiver Requirements

The IHO and NF/AH waivers can extend Medi-Cal eligibility to certain individuals who otherwise would not be eligible for Medi-Cal. The individual must have medical care needs that meet the waiver's medical facility alternative level of care requirements and is able to safely receive medical care services in his/her home and community in lieu of institutional care.

Waiver recipients must use Medi-Cal services prior to using waiver services. For example, waiver recipients 20 years of age and younger are eligible to receive EPSDT Private Duty Nursing (PDN) and Pediatric Day Health Care (PDHC) services.

The two most frequently rendered, billed and paid waiver services for recipients who receive EPSDT PDN and/or PDHC services are Waiver Case Management and Family Training.

General Waiver Provisions

The approval of waiver services requires the active participation of the recipient, their family and/or primary caregiver, primary care physician and HCBS waiver Case Manager in the development of a Plan of Treatment (POT), to ensure the continued health and safety of the recipient.

Each request for waiver enrollment and for waiver services is carefully evaluated based on special circumstances of each recipient. Waiver enrollment and authorization of services are approved only under the following conditions:

- The recipient's medical care needs meet the HCBS waiver's level of care.
- The total cost of providing waiver services and all other medically necessary Medi-Cal services is less than the total cost incurred by the Medi-Cal program for providing institutional care to the recipient.
- The requested waiver services are prescribed by the recipient's primary care physician based on medical necessity and in accordance with meeting the criteria for the identified institutional alternative.
- The recipient's home is medically appropriate as determined by DHCS.

- A responsible adult, trained and available to perform the tasks necessary to care for the recipient, should be prepared to ensure that care is not interrupted by an unforeseen event (for example, the inability of a home health agency to provide nursing services due to staff illness, temporary staff shortage or natural disaster).
- The HCBS waiver provider is able and willing to commit to providing the number of nursing hours and waiver services requested.

In-Home Operations (IHO) Branch

The purpose of IHO is to oversee the development and implementation of a home program and to authorize quality, medically necessary, medical and direct care services.

IHO staff works cooperatively with the waiver service provider(s) to facilitate the development of the home program for the Medi-Cal recipient. This collaborative process allows for the review of issues including, but not limited to, the identified level of care for the recipient, evaluation of Durable Medical Equipment, medical necessity of requested waiver services, cost-effectiveness and assurance by IHO staff that the home environment is appropriate to meet the health and safety needs of the recipient and there is appropriate level of support. Final approvals of individual waiver requests are subject to review by a Medi-Cal physician as well as IHO staff.

In-Home Operations Inquiries

For more information, call or write to one of the following IHO offices.

New Service Requests (Statewide)

In-Home Operations Branch Intake Unit
Department of Health Care Services
MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437
(916) 552-9105

Reauthorization Requests – South

In-Home Operations Branch
Southern Regional Office
Department of Health Care Services
311 South Spring Street, Suite 313
Los Angeles, CA 90013
(213) 897-6774

(Serves Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara and Ventura counties.)

Reauthorization Requests – North

In-Home Operations Branch
Northern Regional Office
Department of Health Care Services
MS 4502
P.O. Box 997437
Sacramento, CA 95899-7437
(916) 552-9105

(Serves all other counties.)

Special Billing Instructions

Instructions to facilitate billing of HCBS services include the following:

Prior Authorization

All HCBS services require an approved *Treatment Authorization Request* (TAR). The 11-digit TAR number must be entered correctly on the claim form in Box 8. Providers should not send a copy of the TAR with the claim because the California MMIS Fiscal Intermediary is unable to accept it.

The claim form permits only one TAR number; therefore, all services billed on the claim form must be approved on the TAR for the dates of service referenced on the claim.

TAR Control Numbers (TCN) for services that have a negotiated reimbursement rate must end in "3."

HCPCS codes S5160, S5161, S5165 and T2035 have a negotiated rate and always have a TCN ending in "3." If the TCN does not end in "3," contact the appropriate IHO office listed on a previous page.

Provider Number

The provider number on the claim must be identical to the provider number on the TAR. Claims are denied reimbursement with Remittance Advice Details (RAD) code 267 if the provider numbers do not match. The provider number on the claim may be corrected with a *Claims Inquiry Form* (CIF). If the provider number on the TAR is incorrect, contact the appropriate IHO regional office (listed on a previous page in this section) to request correction.

Recipient ID Number

The recipient ID number on each claim must be identical to the number on the recipient's Benefits Identification Card (BIC).

Reimbursement

Providers are reimbursed only for prior authorized waiver services for recipients enrolled in one of IHO's HCBS waivers. Claims for non-authorized waiver services will be denied.

Home Modifications & Community Transition (HCPCS Codes S5165 HT)

When claims are submitted for the same person using either HCPCS Level II codes S5165 (Home modifications; per service) with modifier HT or T2038 (Community transition, waiver; per service) with modifier & T2038 HT) HT, and are submitted on the same or different days for different areas of the home, descriptions need to be included in the *Remarks* section of the claim or on an attachment, describing the area of the home and work being done.

"From-Through" Billing

"From-through" billing is a method of billing that allows providers to bill several days of the same service without having to complete a single line for each day.

"From-through" billing requires two consecutive lines on the claim. The first line contains the beginning date of service only; no other information is entered on the first line. The second line contains the ending date of service, service code, total number of hours/services being billed for the dates of service (nursing care hours not to exceed 24; all other services not to exceed 99), and the total service charge for the "from-through" period. The actual dates of service must be listed in the *Description* field (Box 43) of the claim.

If the quantity of other services exceeds 99, any remaining services, either individually or with the "from-through" method, must be included on separate lines.

Refer to *the UB-04 Special Billing Instructions for Outpatient Services* section in this manual for information about "from-through" billing.

Contact

Further information about HCBS waivers is available at In-Home Operations, (916) 552-9105.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.