# Medi-Cal Waiver Program (MCWP)

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This section contains instructions for billing Medi-Cal Waiver Program (MCWP) services. The Department of Health Care Services (DHCS) has received a federal waiver of certain Medicaid requirements, enabling the Medi-Cal program to cover home and community-based services for persons with a diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) with signs, symptoms or disabilities related to HIV disease or HIV disease treatment, as an alternative to institutionalized care. The MCWP is approved by the Centers for Medicare & Medicaid Services (CMS) and must continue to be cost-effective for the State to receive federal matching funds. The MCWP is administered by the California Department of Public Health (CDPH), Center for Infectious Diseases, Office of AIDS(OA), HIV Care Branch, Special Programs Section.

## Introduction

### Background

The MCWP allows agencies that contract with the state to bill Medi-Cal for the following services:

- Administrative expenses
- Services of home health/hospice aide in home health or hospice settings
- Attendant care
- Case management
- Home-delivered meals
- Homemaker services
- In-home skilled nursing care (registered nurse and licensed vocational nurse)
- Medi-Cal supplement for infants and children in foster care
- Minor physical adaptations to the home
- Non-emergency medical transportation
- Nutritional counseling
- Nutritional supplements
- Psychotherapy
- Specialized medical equipment and supplies

# Participant Information

## Eligibility

Medi-Cal recipients qualify for enrollment in the MCWP according to the following criteria:

- Must be an eligible Medi-Cal recipient on the date of enrollment. When verifying eligibility, ensure the Medi-Cal aid code has: 1) Federal financial participation of at least 50 percent; and 2) Full benefits excluding those who are in Long Term Care (LTC) (for example, nursing facility or hospital) or those with restricted benefits (for example, restricted to pregnancy and emergency services)

  **Note:** Refer to the Aid Codes Master Chart in the Part 1 manual for additional eligibility information
- Must have a written HIV/AIDS diagnosis from participant's primary care provider primary care provider. Refer to "Waiver Services, General Information" in this section.
- Must be certified by the OA nurse to meet the Nursing Facility level of care (NF-LOC), as described in the California Code of Regulations, Title 22, Sections 51334 through 51335.
- Must not be simultaneously enrolled in Medi-Cal Hospice or Medicare Hospice.
- Must not simultaneously receive case management services or use State Targeted Case Management Services Program funds to supplement the MCWP.

- Must have an attending primary care physician or primary medical provider willing to accept full professional responsibility for the participant's medical care.
- Must have a health status that is consistent with in-home services.
- Must have a home setting that is safe for both the waiver participant's and waiver service providers.
- Adults must have a Cognitive and Functional Ability Scale (CFA) score of 60 or less certified by the nurse case manager.
- Children must be classified as "A," "B," or "C" using the Centers for Disease Control and Prevention (CDC) classification system for Human Immunodeficiency Virus (HIV) infection in children younger than 13 years of age. (The CDC classification was published in the September 30, 1994, Morbidity and Mortality Weekly Report [MMWR].)
- May or may not have a Share of Cost (SOC), as this by itself is not a determining factor.
- May have a third-party source of payment. It must be established that all Other Health Coverage (OHC) and third-party insurance is exhausted or insufficient to pay for health services similar to those available in connection with the waiver.

  **Note:** MCWP services are rendered in addition to, not in place of, services authorized by other sources (for example, private insurance or Medi-Cal).
- Recipients are not required to disenroll from managed care plans to remain or enroll in the MCWP.

## Participation: Form MCWP1

At the time of enrollment, waiver programs are to use standard form MCWP1*, Informed Consent/Agreement to Participate*, to document that the participant and/or their legal representative has been given the choice of either institutional or home and community-based services. This form also assures that the participant has been informed about their participant rights, grievance, and State Fair Hearing appeal rights.

## Enrollment Process

To enroll participants in the MCWP, the waiver agency must fully complete:

- The initial nursing assessment
- Initial psychosocial assessment
- Cognitive and Functional Ability Form
- The enrollment section of the standard MCWP3, *Medi-Cal Waiver Enrollment/Disenrollment Form.*

The complete package must be submitted to OA for review and approval through secure RightFax. The OA nurse must certify Nursing Facility Level of Care for participants prior to enrollment. Claims submitted by waiver agencies for waiver services can be reimbursed only for participants who have been enrolled in the MCWP.

The Office of AIDS will process the enrollment and contact the waiver agency through encrypted email with the recipient’s Waiver Identification Number (ID), which confirms the enrollment.

## Transfer Between Waiver Programs

Participants cannot be enrolled with one waiver agency at more than one waiver agency at the same time. The original waiver agency must provide the following information to the OA when a participant transfers to another waiver agency:

- The disenrollment (“from” agency) and enrollment (“to” agency) dates (cannot be the same date).
- Excluding administrative expenses, the amount the initial waiver agency has billed against the $33,937 calendar year cap and the actual amount of funds available for the participant as of the transfer date.
- The name of the agency that will claim the “administrative” and “case management” fees during the transfer month (to be agreed upon between the agencies). The billing can be divided between waiver agencies with the “case management” fee to one agency and the “administrative fee” to the other agency or one agency can receive both fees. Neither fee can be split-billed. The OA will send written confirmation of the agreement to both agencies.

## Enrollment Limits

Waiver agencies are not subject to contract-imposed limits on their participant enrollment. Individual waiver agencies may enroll as many participants as is feasible for them, until total statewide enrollment reaches the current federally imposed limit. The OA will request an increase in the federally imposed limit, if necessary.

## Disenrollment

To disenroll a participant from the MCWP, the waiver agency must complete the disenrollment section of the standard form MCWP3, *Medi-Cal Waiver Enrollment/Disenrollment Form.* Include the actual disenrollment date, the participant's waiver ID number, and reason for disenrollment. The disenrollment date must be the same as the "Date Services Expire" date on the Notice of Action (NOA), or if a NOA is not required, the date the participant was disenrolled. Waiver agencies cannot RightFax the MCWP3 to the OA prior to the disenrollment date. However, the MCWP3 must be RightFaxed to the number provided by the OA no later than 30 calendar days after the disenrollment.

When a participant is institutionalized (for example, admitted to a hospital, rehabilitation program, or nursing facility) or incarcerated, the participant should be disenrolled as soon as it becomes clear that they will be institutionalized or incarcerated for more than 30 days. The date of disenrollment from the MCWP is the date of admission to an institution.

The case management and administrative fees can be billed only if the participant resided at home and received services as an actively enrolled waiver participant for some portion of the month

## Ineligibility/Discontinuance and Right to State Hearing

State law and Medi-Cal regulations *(California Code of Regulations), [CCR] Title 22, Section* 51014.1 and the intent of Code of Federal Regulations, Title 42, Chapter IV, Section 431.213) require that waiver programs give standard form MCWP2*, Notice of Action (Denial/Discontinuance) and State Hearing Notice Request, Your Right to Appeal the Notice of Action* to all applicants at initial application and to all existing participants when: 1) a participant disputes the reduction or discontinuation of one or more services; or 2) the participant is disenrolled from the MCWP. The NOA informs the participant of their right to a fair hearing. A copy of the completed NOA and supporting documents must be maintained in the participant file and the original sent to the participant.

The NOA is NOT required when:

- The participant dies.
- The post office has recently returned mail indicating no forwarding address and the participant's whereabouts are unknown.

Ten-Day Advance Notice: The NOA is required at least 10 calendar days (excluding the mailing date) before the effective date of termination/disenrollment or disputed reduction in frequency or units of service in whole or in part.

Same-Day Notice: The NOA must be provided to the participant no later than date of action when:

- The participant agrees with a reduction in frequency or units of service, or the discontinuance of one or more existing services within the MCWP.
- The participant signs a clear written statement that they no longer want services
- The participant signs an “Agreement to Participate” in another Medicaid program (for example, Medi-Cal Hospice) or another program which does not permit dual enrollment
- The participant has been admitted to an institution where they are ineligible for waiver services more than 30 days (for example, hospital or nursing facility, jail, or prison)
- The waiver agency establishes the fact that the participant has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

Additional Information

Participants requesting disenrollment must be given an NOA effective the date of the request. The disenrollment date on the RightFax to the OA must be that same date.

If a participant is found to be ineligible for the MCWP due to improved health status, a NOA must be given to the participant with an effective disenrollment date the same day that the "assessment/agreement to transfer" occurred.

If the participant is found to be ineligible for waiver services due to improved health status and does not agree to transfer, the participant must be given an NOA with an disenrollment date effective 10 calendar days from the date of the assessment. This allows the participant time to appeal and request a fair hearing from the State.

The disenrollment form should not be RightFaxed to the OA until after the 10-day period has passed. If the participant appeals the disenrollment decision, then enrollment must continue pending the results of a fair hearing. This is why the form should not be faxed to the Office of AIDS prior to the end of the 10-day period. Once the Office of AIDS receives the form, the participant is disenrolled. If the participant appeals, the disenrollment cannot be reversed in the system. If the participant does not appeal the disenrollment decision, then the form is RightFaxed to the OA after the 10-day period has passed.

Refer to the *Share of Cost* section in the Part 1 manual for additional information about NOA requirements.

## Aid Paid Pending, Fair Hearing Requirement

MCWP participants have 90 days after the NOA to request a State Fair Hearing. If the participant requests a State Fair Hearing within the first 10 days, then the waiver agency must continue to provide services if the participant until a decision is rendered by an administrative law judge in favor of the waiver agency. If the administrative law judge rules in favor of the participant, services must be maintained as provided or modified as determined by the administrative law judge until subsequent assessment indicates the participant's status warrants further change in need for services. If the client was already disenrolled because they requested a hearing later than the 10 days, but the administrative law judge rules in favor of the participant, then the waiver agency must re-enroll the client.

# Provider Information

## Waiver Agencies

OA enters into agreements with agencies throughout California to administer the MCWP and provide case management services. These waiver agencies must subcontract with or employ (requires prior written authorization by OA), appropriately licensed providers for the remaining waiver services.

To participate in the MCWP, a waiver agency must be one of the following:

- A Home Health Agency licensed and certified by CDPH
- The outpatient department of a hospital licensed and certified by CDPH
- A county health department
- A community-based organization that meets certain CDPH/OA, standards and requirements, including the demonstrated organizational, administrative, and financial capabilities to carry out the contractual responsibilities of a waiver agency

## Waiver Agency Payment

Waiver agencies assume full financial risk for administering the MCWP, providing case management services, managing the provider/subcontractor billing process and disbursing payments to subcontractors for any authorized MCWP services that subcontractors provide to waiver participants.

The State pays waiver agencies for administrative and case management services on the basis of monthly administrative and case management flat fees per eligible, enrolled waiver participant. All other MCWP services are reimbursed at cost, but not in excess of the rates established in the *Medi-Cal Waiver Service Program Rate Schedule*.

All claims for payment of MCWP services are submitted by waiver agencies to the California Medicaid Management Information System Fiscal Intermediary. Providers must use procedure codes provided by the Department of Health Care Services, follow standard Medi-Cal procedures, and file all claims in accordance with the time frames identified in Medi-Cal policies and regulations.

Yearly Cost Limit

The maximum allowable reimbursement for each waiver participant is $33,937 per calendar year. This includes all MCWP service procedure codes, with the exception of administrative expenses (HCPCS code T2025).

CDPH/OA: Address/Phone Number

Agencies and organizations Interested in becoming waiver agencies, or people interested in learning more about the MCWP, should contact OA at (916) 449-5900, or write to:

Office of AIDS

HIV Care Branch

MS 7700

P.O. Box 997426

Sacramento, CA  95899-7426

# Waiver Services

## General Information

Medical records, including a copy of the most recent history and physical examination from the attending physician and a discharge summary from an acute hospital (if applicable), must be requested for all participants.

Individuals must have exhausted Other Health Coverage (OHC) for health care benefits similar to those available under the MCWP prior to using waiver services. Services rendered are in addition to, not in place of, services authorized according to the Medi-Cal State Plan or other resources. The case managers determine the total number of services needed by the participant in excess of services authorized under the State Plan or other resources.

## Case Management (HCPCS Code T2022)

Case management (HCPCS code T2022) consists of locating, coordinating and supervising services rendered to persons with a diagnosis of HIV disease or AIDS with symptoms or disabilities related to HIV disease or HIV disease treatment, in accordance with identified needs as set forth in a written service plan.

Case management includes an initial comprehensive nursing and psychosocial assessment and ongoing comprehensive reassessments that provide information about the participant's service needs and the development, implementation and periodic evaluation of the written service plan. Case management is a collaborative and interdisciplinary approach, performed by a team consisting of a nurse case manager, social worker or equivalent, foster childcare worker (if applicable), primary care provider, parent or guardian of a child with HIV/AIDS and participant or legal representative.

Case management is reimbursable at a flat calendar monthly cap rate of $363.23 per participant for the non-administrative portion of salary and benefits of nurse and social work case managers. HCPCS code T2022 cannot be block billed using the "from-through" method and is limited to one unit, per calendar month. If the participant received services for one day only, bill on a per-claim-line basis.

For participants who transfer care during the month, providers must use the date the participant was enrolled (not the first day of the month).

## Skilled Nursing by RN (HCPCS Code G0299) or LVN (HCPCS Code G0300)

Skilled nursing services, HCPCS code G0299 (direct skilled nursing services of a registered nurse [RN] in the home health or hospice setting, each 15 minutes) and HCPCS code G0300 (direct skilled nursing services of a licensed vocational nurse [LVN] in the home health or hospice setting, each 15 minutes), include the following:

- Assessing and evaluating participants' nursing needs related to specific skilled home care
- Developing and implementing the home health agency nursing plan of care
- Diagnosing and treating ailments and instituting preventive procedures that require the special skills of a nurse, as ordered by a physician and/or as authorized by the nurse case manager
- Performing rehabilitative procedures, as appropriate, that are required for the safety and care of the participant
- Monitoring participant symptoms and reporting changes/participant needs to treating physician and nurse case manager
- Counseling and instructing the participant and family about nursing and related needs
- Preparing clinical assessment and progress notes related to the above functions

Skilled nursing services by an RN are subject to a maximum payable amount of $19.27 per unit (15-minute increment). Providers must bill using HCPCS code G0299 and recommended revenue code 0552. Providers may bill up to 99 units per claim line using from and through dates.

Skilled nursing services by an LPN are subject to a maximum payable amount of $13.97 per unit (15-minute increment). Providers must bill using HCPCS code G0300 and recommended revenue code 0552. Providers may bill up to 99 units per claim line using from and through dates.

## Psychotherapy (CPT® code 90837) Family Psychotherapy (CPT code 90846), and Family Psychotherapy with Patient Present (CPT code 90847)

Psychotherapy (CPT codes 90837, 90846, and 90847) is a service in which appropriate assessments are made by a qualified individual who provides therapy with regard to the psychological adjustment of living with HIV/AIDS. Services may also include information and referral, as well as group and family therapy with the participant. Individuals providing psychotherapy may not be members of the case management team or perform waiver case management activities.

Psychotherapy CPT codes 90837, 90846 and 90847 are subject to a maximum payable amount of $98.02 per hour (unit) for each code. Providers may bill up to 99 units per claim line using from and through dates. When billing, providers should use the recommended revenue code 0562.

For group therapy, whether or not family is present, providers should use CPT code 90847 with the recommended revenue code 0562.

## Services of home health/hospice aide in home health or hospice settings (aka Attendant Care) (HCPCS Code G0156)

Attendant care services (HCPCS code G0156) are defined as hands-on care, of both a supportive and health-related nature, specific to the needs of a medically stable individual. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function. Attendant care services include, but are not limited to, planning and preparing nutritious meals, taking vital signs, reporting changes in the participant’s condition and needs, completing appropriate records and assisting the participant with the following:

- Getting into and out of bed with ambulation
- Bathing and care of the mouth, skin, and hair
- Dressing
- Eating
- Walking
- Prescribed exercises
- Using the bathroom and/or bedpan
- Medications that are ordinarily self-administered
- Housekeeping activities that are incidental to the performance of care (but may not be the major responsibilities of the attendant)

Attendant care services must be provided by a Certified Home Health Aide (CHHA), a person who has been recognized by the Department of Health Care Services (DHCS) as a Certified Nursing Assistant (CNA), or a person with DHCS Licensing and Certification Division's written approval of training equivalent to a CNA.

Attendant care services HCPCS code G0156 is subject to a maximum payable amount of $9.52 per unit (15-minute increment). Each unit represents 15 minutes of service. Providers may bill up to 99 units per claim line using from and through dates. When billing, providers should use recommended revenue code 0572.

## Homemaker Services (HCPCS Code S5130)

Homemaker services (HCOCS code S5130) consist of general household activities performed when the individual regularly responsible for these activities is temporarily absent or unable to manage the home care for himself or herself or others in the home.

Homemaker services include sweeping, vacuuming, washing and waxing floors, washing kitchen counters and sinks, cleaning the oven and stove, cleaning and defrosting the refrigerator, cleaning the bathroom, taking out garbage, dusting and picking up, changing bed linen, meal preparation and clean-up, laundry, ironing, folding and putting away laundry, shopping and errands, storing food and supplies, accompanying participants to medical appointments, boiling and storing tap water and other services necessary to allow participants to continue to live independently.

Services rendered are in addition to, not in place of, services authorized under the Medi-Cal State Plan, the In-Home Supportive Services (IHSS) Program and the Personal Care Services Program (PCSP).

Homemaker services HCPCS code S5130 is subject to a maximum payable amount of $7.07 per unit (15-minute increment). Each unit represents 15 minutes of service. Providers may bill up to 99 units per claim line using from and through dates. When billing, providers should use the recommended revenue code 0582.

## Medi-Cal Supplement for Infants and Children in Foster Care (HCPCS Code T2026)

The Medi-Cal supplement (HCPCS code T2026) is intended to facilitate placement efforts and compensate foster parents for increased costs and services when foster care funds are unavailable or insufficient. This includes intensive physical care in compliance with any special training (given to them or arranged by the nurse case manager), daily supervision, school supplies, personal and incidentals, special infection control measures, treatments or medications, and in some cases, costs for travel to the child's home for visitation and liability insurance.

The need for this supplement must be documented in the participant's progress notes. The foster home must be approved and licensed according to State law and regulation. The nurse case manager is responsible for obtaining documentation substantiating licensure. The cost of room and board is not included in this supplement. This service is subject to a $338.00 monthly cap rate per participant. This code must be billed using the "from-through" method if the participant received services for more than one day in the month. If the participant received services for one day only, bill on a per-claim-line basis.

Waiver agencies must access all other resources, including county funds (for example, foster family home basic rates and specialized care rate incentives and assistance programs), prior to billing MCWP for these services. The MCWP is the payer of last resort.

## "Specialized Supply, Specialized Medical Equipment" and "Physical Adaptations to the Home" (HCPCS Codes T2028, T2029 and S5165)

"Specialized medical equipment and supplies" and "minor physical adaptations to the home" (HCPCS codes T2028, T2029 and S5165) are reimbursable only when necessary to prevent institutionalization and must be immediately needed for participant care and safety beyond the allowable amount, duration, and scope provided for in the Medi-Cal State Plan.

Physical adaptations to the home (HCPCS code S5165) are subject to a $1,000.00 calendar year cap rate per participant. This code must be billed using the "from-through" method if the participant received services for more than one day in the month. If the participant received services for one day only, bill on a per-claim-line basis. Specialized medical equipment and supplies are billed "By Report" and are not subject to the $1,000 calendar year cap rate per participant

"Specialized medical equipment and supplies" includes devices controls or appliances specified in the plan of care that enable individuals to increase their abilities to perform daily activities or to perceive, control or communicate with the environment. This service includes items necessary for life support, ancillary supplies and equipment necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under Medi-Cal. Standard non-medical items routinely found in a home are not allowable.

Examples of Allowable Equipment and Supplies

Examples of allowable items include hospital beds, infusion pumps, dressing supplies, catheters, "egg crate" foam mattresses, shower chairs, protective goggles, disposable gloves, portable space heaters and fans (when household heating or cooling is inadequate and heating and/or cooling is necessary for the participant's welfare). Excluded items include those items that are not of direct medical or remedial benefit to the individual. Examples of excluded items include telephones, futons, microwave ovens, refrigerators, water heaters, bottled water, water filters or purification systems.

Examples of Home Adaptions

"Minor physical adaptations to the home" are those physical adaptations to the home required by the individual's service plan that are not provided by a landlord which are necessary to enable the individual to function with greater independence in the home and, without which, the individual would require institutionalization. For waiver purposes, "home" means a place of residence (owned or rented) where the participant spends the majority of time.

Such adaptations may include, but are not limited to, modification of bathroom facilities or installation of specialized electric or plumbing systems that are necessary for placement of life-sustaining medical equipment and supplies, wheelchair ramps, grab bars for bathrooms, doorway widening and handrails, ramp and sidewalk widening for the wheelchair-bound.

Excluded are those adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the participant, such as carpeting, roof repair, central air conditioning, water heaters, etc. Also excluded are adaptations that add to the total square footage of the home. This service is subject to a calendar year cap per participant. The progress note and Treatment Authorization Request (TAR) documentation requirements noted earlier in this section apply to this service.

Documentation Requirements

The participant's service plan and/or progress notes must document:

- Good faith efforts to obtain provision of medical equipment or supplies through the Medi-Cal State Plan or other available resources. TARs must be submitted when the participant's condition may meet the criteria for state plan coverage.

- TAR denials, including contacts with the local Medi-Cal field office and why approval is not possible, and actions taken to obtain TAR approval, must be documented.
- The principal and significant associated diagnosis necessitating the services/items.
- The date of onset of illness or injury.
- The specific type of equipment and/or supplies needed.
- A written physician certification of current medical condition or functional limitation necessitating the service/item.
- Specific type, number and frequency of services/items to be rendered.
- Proof that the item purchased was the most economical item available.

## Non -Medical Transportation; Encounters/Trips (HCPCS Code T2003)

Non- medical transportation (HCPCS code T2003) is reimbursable for a waiver participant or the participant's caregiver if the participant or caregiver has no personal transportation to obtain the health and/or social services (for example, counseling, support groups, methadone treatment or day care providers) stipulated in the waiver participant's service plan.

Medi-Cal reimburses for public mass transit and public or private carrier, used by the waiver participant with or without the caregiver. Reimbursement of taxi/shuttle vouchers, bus passes, gas, or reimbursement for vehicle mileage (not to exceed the state mileage rate per mile) are permissible when all community and family services have been exhausted, and the nurse case manager has determined that the participant is capable of traveling by privately owned vehicle, taxi, or shuttle.

This service is subject to a monthly cap rate per participant of up to $100. This code must be billed using the "from-through" method if the participant received services for more than one day in the month. If the participant received services for one day only, bill on a per-claim-line basis.

Documentation of the need, appropriateness, and good faith efforts to use community resources must be noted in the progress notes. A copy of the vehicle mileage log must be maintained on file at the waiver agency to document expenses.

MCWP participants under age 21 must receive the service via the state plan pursuant to Early and Periodic Screening, Diagnostic, and Treatment prior to utilizing transportation under the MCWP.

## Waiver Services (aka Administrative) Expenses (HCPCS Code T2025)

Administrative expenses (HCPCS code T2025) include program operating costs incurred while administering the MCWP, such as the administrative portion of the salary and benefits of the nurse case manager, social work case manager and support staff, indirect costs and the cost of billing Medi-Cal for reimbursement.

HCPCS code T2025 is reimbursed at a $246.91 flat calendar monthly rate per participant and cannot be billed using the “from-through” method. Code T2025 is limited to one unit per participant, per calendar month.

For participants who transfer care during the month, providers must use the date the participant was enrolled (not the first day of the month the participant was enrolled).

## Nutritional Counseling (HCPCS Code S9470)

Nutritional counseling (HCPCS Code S9470) provides participants and caregivers with guidance on eating habits and food choices. This counseling is offered to maximize nutritional opportunities for participants with disease symptoms such as bloating or gas, nausea or diarrhea and to prevent potential drug/food interactions. Food choices can be planned to meet ethnic and personal choices and financial constraints while promoting the participant’s nutritional goals. This service must be provided by a registered dietitian.

HCPCS code S9470 is subject to a maximum payable amount of $63.61 per hour. Providers may bill up to 99 units per claim line. When billing, providers should use the recommended revenue code 0562.

## Home Delivered Meals / Nutritional Supplements(HCPCS Code S5170)

Home-delivered meals and nutritional supplements (HCPCS code S5170) are provided to meet the nutritional needs of MCWP participants who are unable to prepare their own meals and do not have a caretaker at home to prepare meals for them. Nutritional supplements are based on the participant's medical condition and not solely on financial need. Documentation must be maintained in the participant chart indicating the medical condition and need for nutritional supplements.

Nutritional supplements may be considered for participants with any of the following conditions:

- Medications and the disease process producing symptoms such as pain, nausea, loss of appetite, bloating or gas, vomiting and diarrhea that become barriers to the participant trying to maintain a nutritional status
- Weight loss and muscle wasting
- Infections affecting the gastrointestinal system that prevent adequate absorption of food and make nutritional supplements necessary

Identification of the need for nutritional supplements will depend on service plan requirements. Nutritional supplements are intended to prevent institutionalization of participants. Nutritional supplements are prepackaged nutritionally fortified drinks (liquid or powder), health food bars, herbal therapy, vitamins and other food items that will contribute to the nutritional or caloric intake of the participant. They are, however, not intended to meet all nutritional needs of the participant or provide a full nutritional regimen (three meals a day).

Use of food vouchers and donated and purchased food combined and/or distributed together (for example, food bank, food bag) are permissible subject to OA policy and procedures. Bottled water is not considered to be a nutritional supplement and cannot be billed to the waiver program. MCWP is not to be billed for participants receiving donated food or food fully paid for by another funding source.

Home-delivered meals may be provided daily but may not meet all nutritional needs of the participant (three meals a day). The number and frequency of meals per day will depend on service plan requirements.

The number of units billed for HCPCS code S5170 is defined as follows and one unit equals one of the following:

- One meal voucher
- One individual meal (prepared)
- One nutritional supplement

For example, if a case of 24 cans of nutritional supplement is delivered to a participant, the units of service will be 24.

An individual may provide home-delivered meals when a “meals-on-wheels” vendor is not available. In these cases, the following documentation must be included in the participant’s progress notes:

- There is no “meals-on-wheels” or similar vendor available
- The amount being reimbursed for food and preparation cost is based on “usual and customary fees” charged by “meals-on-wheels” vendors
- There is a written agreement which outlines the details between the agency and the individual providing the service

HCPCS code S5170 is subject to a $150.00 calendar monthly cap rate, per participant.

# Special Billing Instructions

## Waiver Agencies Enrollment Procedures

To claim reimbursement, a waiver agency must first obtain a special Waiver identification number through the OA to confirm enrollment.

## Billing Tips

Providers should verify the following in the written confirmation they receive from OA.

- The recipient is currently enrolled in the Medi-Cal Waiver Program, and the provider is billing for dates of service on or after the enrollment date or on or before the disenrollment date.
- The Social Security Number, Waiver ID Number, and the Cognitive and Functional Ability score are correct.

- Claims submitted with date of service prior to July 1, 2010, should continue to provide the information in the *Patient Control Number* field (Box 3A). Waiver ID Number, and the Cognitive and Functional Ability score are entered correctly (see "Participant Waiver ID Number" in the AIDS Waiver program section of the appropriate Part 2 manual).
- "From-through" billing during the enrollment or disenrollment month is completed correctly. (For the enrollment month, the provider should use the enrollment date through the last day of the month. For the disenrollment month, the provider should use the first of the month through the disenrollment date.)

## Home Modifications (HCPCS Code S5165 HT)

When claims are submitted for the same person using HCPCS Level II codes S5165 (home modifications; per service) with modifier 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.

## HIV Diagnosis Code B20

Medi-Cal will only reimburse waiver program providers for claims billed with primary ICD-10-CM diagnosis code B20 (*human immunodeficiency virus [HIV] disease*). This code must appear in unlabeled Box 67 of the *UB-04* claim. All other diagnosis code fields must be left blank.

## "From-Through" Billing

"From-through" billing allows providers to bill several days of a continuous service without having to complete a separate claim line for each date of service. "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 (not to exceed 99) and the total service charge for the "from-through" period. If the quantity exceeds 99, providers bill any remaining services, either individually or with the "from-through" method, on separate lines.

Providers cannot block bill using "from-through" dates for case management (HCPCS code T2022), administrative expenses (HCPCS code T2025) and nutritional supplements/home delivered meals (HCPCS code S5170).

## Facility Type Codes

‹‹Waiver agencies must *enter facility type code "33" and the one-character claim frequency* code "1" as "331" in the *Type of Bill* field (Box 4) of the *UB-04* claim and in the *Place of Service* field of every claim line for ASC X12N 837 v.5010 claims.››

## Billing Examples

Refer to the *Medi-Cal Waiver Program Billing Examples* section in this manual for sample completed claims

# RAD Codes

## Common Denial Codes and Messages

The following Remittance Advice Details (RAD) codes and messages most commonly used to deny waiver agency claims are listed below in denial frequency order:

**Table of RAD Codes and Messages**

| Code | Message |
|---|---|
| 010 | This service is a duplicate of a previously paid claim. |
| 049 | Provider billing error. Claim line is invalid. Verify line charge, procedure code and other line information. |
| 9562 | Invalid Benefits Identification Card (BIC) identification/date of issue. A new BIC was issued. |
| 228 | Recipient was not an active waiver participant on the date(s) of service. |
| 252 | The recipient information does not match; verify claims input. Providers should reference the “Billing Tips” section above. |
| 175 | Cognitive and Functional Ability Scale Rating is not valid for MCWP. Rating must be 60 or lower. |
| 314 | Recipient is not eligible for the month of service billed. |
| 002 | The recipient is not eligible for benefits under the Medi-Cal program or other special programs. |
| 21 | This claim was received after the one-year maximum billing limitation. |
| 268 | The monthly capitation for this recipient has been exceeded for HCBS (Home and Community-Based Services) Model waiver services or MCWP yearly services. |

# 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. |