Ohio | Department of Medicaid

Mike DeWine, Governor
Jon Husted, Lt. Governor

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To: ALL CLEARANCE REVIEWERS

From: Jesse Wyatt, Chief, Bureau of Long-Term Services and Supports

Date:

Subject: Home health, PDN and waiver service rates

Attached for your review and comment is a proposed Ohio Administrative Code (OAC) Home and Community-based (HCBS) rule under the Ohio Department of Medicaid.

Rule 5160-1-06.1, entitled "Home and community-based service waivers: PASSPORT," sets forth the covered services and the maximum allowable rates for services furnished under the PASSPORT waiver. The planned proposed amendment includes an increase to the maximum allowable reimbursement for adult day, choices home care attendant, community integration, enhanced community living, home care attendant, home delivered meals, homemaker, personal care, and waiver nursing services set forth in Appendix A as a result of house bill 33.

Rule 5160-1-06.5, entitled “Home and community based services (HCBS) waivers: assisted living,” is the rule that sets forth the covered services and the maximum allowable rates for services furnished under the assisted living waiver. The planned proposed amendment includes an increase to the maximum allowable reimbursement for the assisted living service set forth in Appendix A as a result of house bill 33. In addition, Am. Sub. H. B. 166 (133rd G. A.) lists six terms that cause a rule to be deemed to contain regulatory restrictions: "shall," "shall not," "must," "may not," forms of "require," and forms of "prohibit." All of these terms have been removed and the passages in which they appeared have been recast. Additionally, in Appendix A, Tiers 1 and 2 will be collapsed into the same per diem rate and the former Tier 3 will represent a new memory care assisted living service tier for individuals who need additional support especially as it relates to higher personnel cost needed for support of individuals with a form of dementia.

Rule 5160-12-05, entitled “Reimbursement: home health services,” sets forth the definitions and billing procedures for providers of home health under Ohio's Medicaid State Plan. The planned proposed amendment includes an increase to the maximum allowable reimbursement for the home health services set forth in Appendix A and Appendix B as a result of house bill 33. In addition, Am. Sub. H. B. 166 (133rd G. A.) lists six terms that cause a rule to be deemed to contain regulatory restrictions: "shall," "shall not," "must," "may not," forms of "require,"

and forms of "prohibit." All of these terms have been removed and the passages in which they appeared have been recast.

Rule 5160-12-06, entitled “Reimbursement: private duty nursing services,” sets forth the definitions and billing procedures for providers of private duty nursing services under Ohio's Medicaid State Plan. The planned proposed amendment includes an increase to the maximum allowable reimbursement for the private duty nursing services set forth in Appendix A and Appendix B as a result of house bill 33. In addition, Am. Sub. H. B. 166 (133rd G. A.) lists six terms that cause a rule to be deemed to contain regulatory restrictions: "shall," "shall not," "must," "may not," forms of "require," and forms of "prohibit." All of these terms have been removed and the passages in which they appeared have been recast.

Rule 5160-46-06, entitled "Ohio home care waiver program: reimbursement rates and billing procedures," is the rule that sets forth the covered services and maximum allowable rates for services furnished under the Ohio home care waiver. The planned proposed amendment includes an increase to the maximum allowable reimbursement for waiver nursing, personal care, adult day, home delivered meal, supplemental transportation, and community integration services as a result of house bill 33. In addition, Am. Sub. H. B. 166 (133rd G. A.) lists six terms that cause a rule to be deemed to contain regulatory restrictions: "shall," "shall not," "must," "may not," forms of "require," and forms of "prohibit." All of these terms have been removed and the passages in which they appeared have been recast. An update to an effective date for a statutory citation is also being made.

Rule 5160-46-06.1, entitled “Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures,” is the rule that sets forth the maximum allowable rates for home care attendant services furnished under the Ohio home care waiver. The planned proposed amendment includes an increase to the maximum allowable reimbursement for home care attendant services as a result of house bill 33. In addition, Am. Sub. H. B. 166 (133rd G. A.) lists six terms that cause a rule to be deemed to contain regulatory restrictions: "shall," "shall not," "must," "may not," forms of "require," and forms of "prohibit." All of these terms have been removed and the passages in which they appeared have been recast.

Questions pertaining to this clearance should be sent to Rules@Medicaid.Ohio.gov.

To receive notification when ODM posts draft rules for public comment please register via the Common Sense Initiative eNotifications Sign-up: eNotifications Sign Up | Governor Mike DeWine (ohio.gov). The Ohio Department of Medicaid will use this list to notify subscribers when draft rules are posted for public comment.

To receive notification when ODM original, revise, refile, or final files a rule package please register for Joint Committee on Agency Rules Review's (JCARR) RuleWatch at www.rulewatchohio.gov where an account can be created to be notified of rule actions by the rule number or department.

The main Ohio Department of Medicaid (ODM) web page includes links to valuable information about its services, programs and rules; the address is http://www.medicaid.ohio.gov.

Thank you in advance for your review of these rules.

5160-1-06.1 **Home and community-based service waivers: PASSPORT.**

(A) The Ohio department of aging (ODA) is responsible for the daily administration of the preadmission screening system providing options and resources today (PASSPORT) medicaid waiver program. ODA will administer the waiver pursuant to an interagency agreement with the Ohio department of medicaid in accordance with section 5162.35 of the Revised Code.

(B) The PASSPORT waiver provides home and community based services (HCBS) to individuals enrolled in the waiver in accordance with rule 5160-31-04 of the Administrative Code.

(C) The PASSPORT HCBS waiver covered services and eligibility requirements are set forth in Chapter 5160-31 of the Administrative Code.

(D) The maximum allowable payment rates for PASSPORT HCBS waiver program services are listed in appendix A to this rule.

(E) PASSPORT HCBS payment will be provided in accordance with paragraphs (A) to (C) of rule 5160-1-60 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5166.02
Rule Amplifies:	173.52
Prior Effective Dates:	01/01/2004, 07/01/2006, 07/02/2007 (Emer.), 10/01/2007, 07/01/2008 (Emer.), 09/30/2008, 07/01/2011 (Emer.), 09/29/2011, 07/01/2013 (Emer.), 09/27/2013, 03/01/2014, 07/01/2014, 01/01/2017, 01/01/2019, 07/01/2019, 03/23/2020, 11/01/2021, 08/06/2023

Appendix A
5160-1-06.1

PASSPORT WAIVER RATES

WAIVER	UNIT	BILLING MAXIMUM
Adult Day: enhanced	1 day	~~$61.74~~ $80.94
Adult Day: enhanced	½ day	~~$30.88~~ $40.48
Adult Day: enhanced	15 minutes	~~$1.94~~ $2.54
Adult Day: intensive	1 day	~~$81.05~~ $106.26
Adult Day: intensive	½ day	~~$40.51~~ $53.11
Adult Day: intensive	15 minutes	~~$2.54~~ $3.33
Adult Day Transportation	1 mile	~~$2.78~~ $3.12
Adult Day Transportation	Round Trip	~~$25.50~~ $28.61
Adult Day Transportation	1 one-way Trip	~~$20.69~~ $23.21
Alternative Meals	1 meal	$31.35
Choices Home Care Attendant	15 minutes	~~$6.25~~ $7.73
Community Integration	15 minutes	~~$3.50~~ $3.93
Community Transition	1 completed job or deposit	$2,000
Enhanced Community Living	15 minutes	~~$5.83~~ $6.54
Home Care Attendant	Unit is established in OAC 5160-46-06.1	Billing maximum is established in OAC 5160-46-06.1
Home Delivered Meals: regular	1 meal	~~$7.20~~ $8.80
Home Delivered Meals: therapeutic and kosher	1 meal	~~$8.68~~ $10.61
Home Medical Equipment and Supplies	1 item	$5,224.93
Home Maintenance and Chore	1 completed job	$10,000 per calendar year

Home Modification	1 completed job	$10,000 per calendar year
Homemaker	15 minutes	~~$4.07~~ $5.99
Non-medical Transportation	1 round trip	$1,306.24
Non-medical Transportation	1 one-way trip	$653.11
Nutritional Consultation	15 minutes	$13.34
Out-of-Home Respite	Unit is established in OAC 5160-46-06	Billing maximum is established in OAC 5160-46-06
Personal Care: agency	15 minutes	~~$4.92~~ $7.24
Personal Care: participant-directed individual provider	15 minutes	$3.44
Personal Emergency Response System: installation	1 completed installation	$32.95
Personal Emergency Response System: ongoing	1 monthly rental	$32.95
Social Work Counseling	15 minutes	$16.26
Waiver Nursing	Unit is established in OAC 5160-46-06	Billing maximum is established in OAC 5160-46-06

5160-1-06.5 **Home and community based services (HCBS) waivers: assisted living.**

(A) The Ohio department of aging (ODA) is responsible for the daily administration of the assisted living HCBS waiver. ODA will administer this waiver pursuant to an interagency agreement with the Ohio department of medicaid (ODM), in accordance with section 5162.35 of the Revised Code.

(B) The assisted living HCBS waiver is an alternative to nursing facility placement for persons age twenty-one and over who require an intermediate level of care or a skilled level of care as set forth in rule 5160-3-08 of the Administrative Code and are enrolled in the waiver.

(1) The assisted living HCBS waiver's services and program eligibility criteria are set forth in Chapter 5160-33 of the Administrative Code.

(2) The maximum allowable reimbursement rates for assisted living HCBS waiver program services are listed in appendix A to this rule.

(3) Assisted living HCBS reimbursement ~~shall be~~ are provided in accordance with rule 5160-1-60 of the Administrative Code.

(4) The billing maximum for the community transition service listed in appendix A to this rule represents the cumulative maximum for the items purchased or deposits made through the community transition service as set forth in rule 173-39-02.17 of the Administrative Code.

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Appendix A
5160-1-06.5

ASSISTED LIVING WAIVER RATES

WAIVER SERVICE	UNIT	BILLING MAXIMUM
~~Assisted Living Service: Tier 1~~	~~1 day~~	~~$54.76~~
~~Assisted Living Service: Tier 2~~	~~1 day~~	~~$65.73~~
~~Assisted Living Service: Tier 3~~	~~1 day~~	~~$76.67~~
Base Assisted Living Service	1 day	$130.00
Memory Care Assisted Living Service	1 day	$155.00
Community Transition Service	Completed Job Order or Deposit Made	$2000.00

5160-12-05 **Reimbursement: home health services.**

(A) Definitions of terms used for billing home health services rates set forth in appendix A to this rule are:

(1) "Base rate," as used in this rule and appendix A to this rule, means the amount reimbursed by Ohio medicaid:

(a) For the initial thirty-five to sixty minutes of home health aide service delivered;

(b) For the initial thirty-five to sixty minutes of home health nursing service delivered; or

(c) Up to the first four units of initial home health skilled therapy service delivered.

(2) "Unit rate," as used in this rule and appendix A to this rule, means the amount reimbursed by Ohio medicaid for each fifteen minutes of service delivered when the initial visit is:

(a) Greater than sixty minutes in length for any home health service delivered; or

(b) Less than or equal to thirty-four minutes in length for home health aide and/or home health nursing service delivered.

(B) Home health services are delivered and billed in accordance with this chapter by medicare certified home health agencies (MCHHA).

(C) The amount of reimbursement for a home health visit ~~shall~~ will be the lesser of the provider's billed charge or the medicaid maximum rate. The medicaid maximum rate is determined by using a combination of the base rate and/or unit rate found in appendix A as applicable to this rule using the number of units of service that were provided during a visit in accordance with this chapter as follows:

(1) Each visit ~~must~~ will be less than or equal to four hours.

(2) For a home health aide and/or a home health nursing visit that is less than thirty-five minutes in total, Ohio medicaid will reimburse a maximum of only one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(3) For a home health aide and/or a home health nursing visit thirty-five minutes to one hour in length in total, the medicaid maximum is the amount of the base rate.

(4) For a home health aide, home health nursing, or home health skilled therapy visit in length beyond the initial hour of service, the base rate plus the rate amount for each unit over the initial one hour may be claimed, not to exceed four hours.

(D) The amount of reimbursement for a visit ~~shall~~ will be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (C) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with rule 5160-12-04 of the Administrative Code.

(E) The modifiers set forth in appendix B to this rule ~~must~~ will be used to provide additional information in accordance with this chapter. A visit made for the purpose of home infusion therapy in accordance with 5160-12-01 of the Administrative Code ~~must~~ will be billed using the U1 modifier.

(F) The "place of service" code "02" will be used to indicate a visit was completed using telehealth.

(G) A visit conducted by a registered nurse (RN) for the provision of home health nursing services ~~must~~ will be billed to Ohio medicaid using the billing code G0299 as found in appendix A to this rule. A visit conducted by a licensed practical nurse (LPN) for the provision of home health nursing services ~~must~~ will be billed to Ohio medicaid using the billing code G0300 as found in appendix A to this rule.

(H) An MCHHA will not be reimbursed for home health services provided to an individual that duplicates same or similar services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplement recipient or individual receiving medicaid resides, such as an adult foster home, adult family home, adult group home, residential care facility, or other facility is paid to provide personal care or nursing services, home health services are not reimbursable by medicaid.

(I) An MCHHA may be reimbursed for home health services provided to an individual residing in a facility/home if the provider has written documentation from the facility/ home stating that it is not responsible for providing the same or similar home health services to the individual.

(J) Home health services provided to an individual enrolled on an assisted living home and community based services waiver in accordance with rule 5160-1-06 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

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Appendix A
5160-12-05

ODM codes and billing rates for home health service(s) provided on and after January 1, 2024. ~~November 1, 2021.~~

Code	Description	Base Rate	Unit Rate *
G0151	Physical Therapy	$74.21	$4.77
G0152	Occupational Therapy	$74.21	$4.77
G0153	Speech-Language Pathology	$74.21	$4.77
G0156	Home Health Aide	~~$25.01~~ $38.27	$4.16
G0299	Home Health Nursing-Registered Nurse (RN)	~~$50.29~~ $68.44	$9.25
G0300	Home Health Nursing-Licensed Practical Nurse (LPN)	~~$43.13~~ $58.72	$7.82

~~ODM codes and billing rates for home health service(s) provided on and after January 1, 2017 through October 31, 2021.~~

~~Code~~	~~Description~~	~~Base Rate~~	~~Unit Rate *~~
~~G0151~~	~~Physical Therapy~~	~~$69.94~~	~~$4.50~~
~~G0152~~	~~Occupational Therapy~~	~~$69.94~~	~~$4.50~~
~~G0153~~	~~Speech-Language Pathology~~	~~$69.94~~	~~$4.50~~
~~G0156~~	~~Home Health Aide~~	~~$23.57~~	~~$3.92~~
~~G0299~~	~~Home Health Nursing-Registered Nurse (RN)~~	~~$47.40~~	~~$8.72~~
~~G0300~~	~~Home Health Nursing-Licensed Practical Nurse (LPN)~~	~~$40.65~~	~~$7.37~~

*1 unit = 15 minutes

Appendix B
5160-12-05

Home Health Service Visit Modifiers Effective January 1, 2024. ~~January 1, 2017.~~

Billing Modifier	Description	Requirement
U1	Infusion Therapy	Must be used with code G0299 for the purpose of identifying home infusion therapy provided in accordance with rule 5160-12-01 of the Administrative Code.
U2	Second Visit	Must be used to identify the second visit for the same type of service made by a provider on a date of service per individual in accordance with rule 5160-12-04 of the Administrative Code.
U3	Third Visit	Must be used to identify the third or more visit for the same type of service made by a provider on a date of service per individual in accordance with rule 5160-12-04 of the Administrative Code.
U5	Healthchek	Must be used to identify the individual who meets the criteria in paragraph (H) of 5160-12-01.
U7	Over 14 hours	Must be used to identify the individuals age 21 whose physician has determined that medical necessity exists for more than a combined total of fourteen hours per week of home health nursing and home health aide services pursuant to paragraph (C)(2) of 5160-12-01.
HQ	Group Visit	Must be used to identify individual receiving services in accordance with rule 5160-12-04 of the Administrative.

5160-12-06 **Reimbursement: private duty nursing services.**

(A) Definitions of terms used for billing private duty nursing services (PDN) rates set forth in appendix A to this rule are:

(1) "Base rate," as used in this rule and appendix A to this rule, means the amount reimbursed by Ohio medicaid for the initial thirty-five to sixty minutes of service delivered.

(2) "Unit rate," as used in this rule and appendix A to this rule, means the amount reimbursed by Ohio medicaid for each fifteen minute units of service delivered when the initial visit is:

(a) Greater than sixty minutes in length; or

(b) Less than or equal to thirty-four minutes in length.

(B) PDN services are delivered and billed as PDN visits in accordance with rules 5160-12-02, 5160-12-2.3 and 5160-12-04 of the Administrative Code. The services ~~must~~ will be provided by medicare certified home health agencies, "otherwise accredited agencies," or "non-agency nurses." PDN service rates are identified in appendix A to this rule.

(C) The amount of reimbursement for a PDN visit ~~shall~~ will be the lesser of the provider's billed charge or the medicaid maximum rate. The medicaid maximum rate is determined by using a combination of the base rate and unit rate found in appendix A to this rule using the number of units of service that were provided during a visit in accordance with this chapter.

(D) The amount of reimbursement for a PDN visit ~~shall~~ will be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (C) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with rule 5160-12-04 of the Administrative Code.

(E) The modifiers set forth in appendix B to this rule ~~must~~ will be used to provide additional information in accordance with this chapter. A visit made for the purpose of home infusion therapy in accordance with 5160-12-02 of the Administrative Code ~~must~~ will be billed using the U1 modifier.

(F) A visit conducted by a registered nurse (RN) for the provision of PDN servcies ~~must~~ will be billed to Ohio medicaid using the TD modifier. A visit conducted by a licensed

practical nurse (LPN) for the provision of PDN ~~servcies~~ services ~~must~~ will be billed to Ohio medicaid using the TE modifier.

(G) Providers of PDN will not be reimbursed for PDN services provided to an individual that duplicate services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplemental recipient or individual receiving medicaid resides, such as an adult foster home, adult family home, adult group home, residential care facility, or other facility is paid to provide nursing services, PDN services are not reimbursable by medicaid.

(H) Providers of PDN may be reimbursed for PDN services provided to an individual who resides in a facility/home if the provider has written documentation from a facility/home stating that the facility/home is not responsible for providing the same or similar PDN services to the individual.

(I) PDN services provided to the individual enrolled in the assisted living home and community based services waiver in accordance with rule 5160-1-60 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

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Certification

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Date

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Appendix A
5160-12-06

ODM codes and billing rates for private duty nursing service(s) provided on and after January 1, 2024. ~~November 1, 2021.~~

Code	Description	Base Rate	Unit Rate
T1000	Private Duty Nursing, Agency Registered Nurse (RN) Provider	~~$50.29~~ $51.68	~~$9.25~~ $12.92
T1000	Private Duty Nursing, Non-Agency Registered Nurse (RN) Provider	~~$41.33~~ $46.00	~~$7.46~~ $11.50
T1000	Private Duty Nursing, each 15 minutes Agency Licensed Practical Nurse (LPN) Provider	~~$43.13~~ $43.60	~~$7.82~~ $10.90
T1000	Private Duty Nursing, Non-Agency Licensed Practical Nurse (LPN) Provider	~~$35.23~~ $38.88	~~$6.24~~ $9.72
T1000	Private Duty Nursing, Non-Agency Registered Nurse (RN) Provider - Overtime	~~$53.92~~ $69.00	~~$10.62~~ $17.25
T1000	Private Duty Nursing, Non-Agency Licensed Practical Nurse (LPN) Provider - Overtime	~~$45.62~~ $58.32	~~$8.84~~ $14.58

*1 unit = 15 minutes

Appendix B
5160-12-06

Private Duty Nursing Service

Modifier Descriptions Effective January 1, 2024.
~~January 1, 2017.~~

Billing Modifier	Description	Requirement
U1	Infusion Therapy	Must be used with code T1000-TD for the purpose of identifying home infusion therapy provided by an Registered Nurse (RN) in accordance with rule 5160- 12-02 of the Administrative Code.
U2	Second Visit	Must be used to identify the second visit for the same type of service made by a provider on a date of service per individual in accordance with rule 5160-12-04 of the Administrative Code.
U3	Third Visit	Must be used to identify the third or more visit for the same type of service made by a provider on a date of service per individual in accordance with rule 5160-12-04 of the Administrative Code.
U4	12 hours to 16 hours per visit	Must be used when a visit is more than twelve hours but does not exceed sixteen hours in accordance with rule 5160-12-02 of the Administrative Code.
U5	Healthchek	Must be used to identify the individual who meets the criteria in paragraph (I) of 5160-12-02.
HQ	Group Visit	Must be used to identify individual receiving services in accordance with rule 5160-12-04 of the Administrative.
TD	RN Visit	Must be used to identify a visit conducted by a registered nurse (RN) for the provision of a private duty nursing service billed to Ohio Medicaid.
TE	LPN Visit	Must be used to identify a visit conducted by a licensed practical nurse (LPN) for the provision of a private duty nursing service billed to Ohio Medicaid.

TU	Non-agency RN or LPN Visit	Must be used to indicate that the entire PDN visit conducted by the non-agency RN or LPN is being billed as overtime.
UA	Non-agency RN or LPN Visit	Must be used to indicate that a portion of the PDN visit conducted by the non-agency RN or LPN is being billed as overtime.

5160-46-06 **Ohio home care waiver program: reimbursement rates and billing procedures.**

(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 reimbursed by the Ohio department of medicaid (ODM) for the first thirty-five to sixty minutes of service delivered.

(2) "Bid rate," as used in table B, column 3 of paragraph (B) of this rule, means the per job bid rate negotiated between the provider and the individual's case manager.

(3) "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.).

(4) "Caretaker relative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(5) "Group rate," as used in paragraph (D)(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.

(6) "Group setting" means a setting in which:

(a) A 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 ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(b) A waiver nursing service provider furnishes the same type of services to either:

(i) Two or three individuals at the same address. The services provided in the group setting can be either the same type of ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(ii) Two to four individuals at the same address if all of the individuals receiving ODM-administered waiver nursing services are:

(a) Medically fragile children, and

(b) Siblings, and

(c) Residing together in the home of their caretaker relative. The services provided in the group setting ~~must~~ will be ODM-administered waiver nursing services.

(7) "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, or

(iii) The unit rate as defined in paragraph (A)(7)(b) of this rule.

(8) "Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of the "Social Security Act," (42 U.S.C. 1382c(a)(2) or (3)) (as in effect on January 1, ~~2021~~2024).

(9) "Modifier," as used in paragraph (D) 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.

(10) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount reimbursed by ODM for each fifteen minutes of service delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. ODM will reimburse a maximum of only one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(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 agency RN	~~$50.29~~$68.44	$9.25
T1002	Waiver nursing services provided by a non-agency RN	~~$41.33~~$56.26	$7.46
T1002	Waiver nursing services provided by a non-agency RN (overtime)	~~$53.92~~$84.39	~~$10.62~~$11.19
T1003	Waiver nursing services provided by an agency LPN	~~$43.13~~$58.72	$7.82
T1003	Waiver nursing services provided by a non-agency LPN	~~$35.23~~$48.00	$6.24
T1003	Waiver nursing services provided by a non-agency LPN (overtime)	~~$45.62~~$72.00	~~$8.84~~$9.36
T1019	Personal care aide services provided by an agency personal care aide	~~$25.34~~$28.96	~~$4.21~~$7.24
T1019	Personal care aide services provided by a non-agency personal care aide	~~$20.42~~$22.32	~~$3.24~~$5.58
T1019	Personal care aide services provided by a non-agency personal care aide (overtime)	~~$24.75~~$33.48	~~$4.56~~$8.37

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~~$0.48
S5101	Adult day health center services	Per half day	~~$40.60~~$53.11
S5102	Adult day health center services	Per day	~~$81.18~~$106.26
S5160	Personal emergency response systems	Per installation and testing	$32.95
S5161	Personal emergency response systems	Per monthly fee	$32.95
S5165	Home modification services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
S5170	Home delivered meal services - standard meal	Per meal	~~$7.20~~$8.80
S5170	Home delivered meal services - therapeutic or kosher meal	Per meal	~~$8.68~~$10.61
S5135	Community integration services	Per fifteen-minute unit	~~$3.50~~$3.93

T2038	Community transition services	Per job	$2,000 per waiver enrollment
S5121	Home maintenance and chore services	Per job	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year

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

(D) Required modifiers.

(1) The "HQ" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002, T1003 or T1019 if the service was delivered in a group setting. Reimbursement as a group rate ~~shall~~ will be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.

(2) The "TU" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002, T1003 or T1019 and the entire claim is being billed as overtime.

(3) The "UA" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002, T1003 or T1019 and only a portion of the claim is being billed as overtime.

(4) The "U1" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002 and the individual enrolled on the Ohio home care waiver is receiving infusion therapy.

(5) The "U2" modifier ~~must~~ will be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U3" modifier ~~must~~ will be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(7) The "U4" modifier ~~must~~ will 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.

(8) The "U6" modifier ~~must~~ will be used when a provider submits a claim for billing code S5170 for a therapeutic or kosher home delivered meal.

(E) Claims ~~shall~~ will be submitted to, and reimbursement ~~shall~~ will be provided by, ODM in accordance with Chapter 5160-1 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

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5160-46-06.1 **Ohio home care waiver program: home care attendant services reimbursement rates and billing procedures.**

(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 reimbursed by Ohio medicaid for the first thirty-five to sixty minutes 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 service tasks as described in paragraph (A)(1) of rule 5160-46-04 of the Administrative Code may be provided incidental to nursing services.

(3) "Group rate" means the amount that HCAS providers ~~shall~~ will 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 5160-44-27 of the Administrative Code, and as authorized by the Ohio department of medicaid (ODM), 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 5160-44-27 of the Administrative Code. An HCAS visit ~~shall~~ will 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~~ will 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", as set forth in column 4 of table A of this rule and column 4 of table B of this rule, means the additional two-alpha-numeric-digit billing code as set forth in paragraph (G) of this rule that HCAS providers ~~shall~~ will use to provide additional information regarding service delivery.

(9) "Unit rate," as set forth in column 5 of table A of this rule and column 5 of table B of this rule, means the amount reimbursed by Ohio medicaid for each fifteen minutes of HCAS delivered when the visit is:

(a) Greater than sixty minutes in length.

(b) Less than or equal to thirty-four minutes in length. Ohio medicaid will reimburse a maximum of only one unit if HCAS is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(B) Providers ~~shall~~ will 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	Column 5
Billing code	Home care attendant service description	Base rate	Modifier	Unit rate
S5125	Assistance with self-administration of medications and/or the performance of nursing tasks (HCAS/N)	$27.53	N/A	~~$4.70~~$6.39 per fifteen minute unit of HCAS/N delivered during visit
S5125	HCAS/N (overtime)	$35.11	TU or UA	~~$6.60~~$9.81

(C) Providers ~~shall~~ will 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~~ will 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~~ will be billed at the HCAS/N unit rate; and personal care aide service tasks (HCAS/PC) ~~shall~~ will be billed at the HCAS/PC unit rate using

the U8 modifier. There is no base rate for HCAS/PC. The HCAS/PC service can only be rendered in conjunction with an HCAS/N service.

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	$27.53	N/A	~~$4.70~~$6.39 per fifteen minute unit of HCAS/N delivered during the visit
S5125	HCAS/PC	N/A	U8	~~$3.24~~$4.70 per fifteen minute unit of HCAS/PC delivered during the visit
S5125	HCAS/N (overtime)	$35.11	TU or UA	~~$6.60~~$9.81
S5125	HCAS/PC (overtime)	N/A	either TU or UA, and U8	~~$4.56~~$7.05

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

(E) When HCAS/N and HCAS/PC are provided during an uninterrupted period of time, the visit ~~shall~~ will be considered a single HCAS visit. An HCAS provider is entitled to only one base rate during an HCAS visit.

(F) HCAS providers ~~shall~~ will 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 individuals enrolled on an ODM-administered waiver who are served.

(G) Required modifiers.

(1) The "HQ" modifier ~~must~~ will be used when a provider submits a claim if HCAS was delivered in a group setting. Reimbursement at a group rate ~~shall~~ will be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum rate.

(2) The "TU" modifier ~~must~~ will be used when a provider submits a claim for billing code S5125 and the entire visit is being billed as overtime.

(3) The "UA" modifier ~~must~~ will be used when a provider submits a claim for billing code S5125 and only a portion of the visit is being billed as overtime.

(4) The "U2" modifier ~~must~~ will be used when a provider submits a claim for a second HCAS visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(5) The "U3" modifier ~~must~~ will be used when the same provider submits a claim for three or more HCAS visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U8" modifier ~~must~~ will 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.

(H) Claims ~~shall~~ will be submitted to, and reimbursement ~~shall~~ will be provided by, the ODM in accordance with Chapter 5160-1 of the Administrative Code.

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