5160-12-01 **Home health services: provision requirements, coverage and service specification.**

(A) "Home health services" includes home health nursing, home health aide services and skilled therapies ~~as defined in paragraph (G) of this rule~~.

(B) Home health services are ~~covered~~reimbursable only if ~~the~~a qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the ~~consumer~~ individual within ~~the~~ ninety days prior to the ~~home health care~~ start of care date, or within thirty days following the start of care date ~~inclusive of the start of care date~~. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code ~~in which he or she performs that function or action~~. Advanced practice nurses in accordance with rule ~~5101:3-8-21~~5160-8-21 of the Administrative Code and in collaboration with the qualifying treating physician, or a physician assistant in accordance with rule ~~5101:3-4-03~~5160-4-03 of the Administrative Code and under the supervision of the qualifying treating physician, have the authority to conduct the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services. The face-to-face encounter with the ~~consumer~~ individual must occur independent of any provision of home health services to the ~~consumer~~ individual~~by the individual performing the face-to-face encounter~~. The face-to-face encounter must be documented as follows:

(1) For home health services unrelated to an inpatient hospital stay, the face-to-face encounter must be documented by the qualifying treating physician using:

(a) The ~~JFS~~ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. ~~2/2011~~7/2014) or

(b) The ~~consumer's~~ individual's plan of care ~~may be used to certify medical necessity for home health services~~ if all of the data elements specified for home health services unrelated to an inpatient hospital stay ~~in~~on the ~~JFS~~ODM 07137 ~~"Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011)~~ are included and the plan of care contains the physician's signature, physician's credentials and the date of the physician's signature.

(2) For post hospital home health services, the face-to-face encounter must be documented by the qualifying treating physician using the ~~JFS~~ODM 07137 ~~"Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011)~~.

(3) For ~~a dual eligible consumer~~an individual dually eligible for medicare and

medicaid, the face-to-face encounter must be documented by the treating physician using the ODM 07137 if supporting documents are attached, or using the individual's plan of care pursuant to paragraph (B)(1)(b) of this rule when~~, if~~ the face-to-face encounter date for medicare home health services falls within ~~the~~ ninety days prior to the medicaid home health services start of care date, or within thirty days following the medicaid start of care date ~~inclusive of the medicaid start of care date, may be used on the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) and the supporting documents attached to this form~~.

(C) Home health services are covered only if provided on a part-time ~~and~~or intermittent basis, which means:

(1) No more than a combined total of eight hours ~~(thirty-two units)~~ per day of home health nursing, home health aide, and skilled therapies except as specified in paragraph (H) of this rule;

(2) No more than a combined total of fourteen hours ~~(fifty-six units)~~ per week of home health nursing and home health aide services except as specified in paragraphs (D) and (H) of this rule or as prior authorized by ODM or its designee; and

(3) Visits are not more than four hours ~~(sixteen units)~~. ~~Most visits are usually less than two hours (eight units)~~. Nursing visits over four hours ~~(sixteen units)~~ may qualify for coverage in accordance with rule ~~5101:3-12-02~~5160-12-02 of the Administrative Code.

(D) A combined total of twenty-eight hours ~~(one hundred twelve units)~~ per week of home health nursing and home health aide services is available to ~~a consumer~~ an individual for up to sixty consecutive days from the date of discharge from an inpatient hospital stay ~~of three or more covered days,~~ if all of the following are met ~~by the consumer~~ as certified by the qualifying treating physician using the ~~JFS~~ODM 07137 ~~"Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services " (rev. 2/2011)~~:

(1) ~~Consumer has a discharge date from an inpatient hospital stay of three or more covered days. For the purposes of this rule, a~~ The individual is discharged from a covered inpatient hospital stay ~~is defined in rule 5101:3-2-03 of the Administrative Code~~ of three or more days, with the discharge date recorded on form ODM 07137. It ~~and~~ is considered one inpatient hospital stay when ~~a consumer~~ an individual is transferred from one hospital to another hospital, either within the same building or to another location. The sixty days will

begin once the ~~consumer~~ individual is discharged to ~~the consumer's~~their place of residence or to a nursing facility ~~as defined in paragraph (E)(4) of this rule,~~ from the last inpatient stay ~~whether or not the last inpatient stay was an~~ in an inpatient hospital or inpatient rehabilitation unit of a hospital.

(2) ~~Consumer~~ The individual has a comparable level of care as evidenced by either:

(a) Enrollment in a home and community based services (HCBS) waiver; or

(b) ~~Has a~~ A medical condition that temporarily meets the criteria for an institutional level of care ~~which are any of the following rules~~ as described ~~defined~~ in rule ~~5101:3-3-05~~ 5160-3-08 of the Administrative Code ~~for skilled level of care (SLOC), or defined in rule 5101:3-3-06 of the Administrative Code for intermediate level of care,~~ or as defined in rule ~~5101:3-3-07~~ 5160-3-07 of the Administrative Code ~~for ICF/MR level of care~~. In no instance does this requirement constitute the determination of a level of care for waiver eligibility status, or admission into a medicaid covered long term care institution.

(3) ~~Requires~~ The individual requires home health nursing, or a combination of private duty nursing~~/~~, home health nursing, ~~/~~or waiver nursing~~/~~ and/or skilled therapy services at least once per week ~~that~~ and the services ~~is~~ are medically necessary in accordance with rule ~~5101:3-1-01~~5160-1-01 of the Administrative Code.

(4) The ~~consumer~~ individual has had a covered inpatient hospital stay of three or more days, with the discharge date recorded on form ~~JFS~~ODM 07137. ~~"Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011).~~

(E) ~~The only provider of home~~ Home health services may only be provided by a ~~is the MCRHHA (~~medicare certified home health agency~~)~~ (MCHHA) that meets the requirements in accordance with rule ~~5101:3-12-03~~ 5160-12-03 of the Administrative Code. In order for home health services to be covered, ~~MCRHHAs~~MCHHAs must:

(1) Provide home health services only if the qualifying treating physician has documented a face-to-face encounter with the ~~consumer~~ individual as specified in paragraph (B) of this rule.

(2) Provide home health services that are appropriate given the ~~consumer's~~ individual's diagnosis, prognosis, functional limitations and medical

conditions as ordered by the ~~consumer's~~ individual's treating physician for the treatment of the ~~consumer's~~ individual's condition, illness or injury.

(3) Provide home health services as specified in the individual's plan of care in accordance with rule ~~5101:3-12-03~~5160-12-03 of the Administrative Code. Home health services not specified in a plan of care are not reimbursable. Additionally the ~~MCRHHA's~~ plan of care must provide the amount, scope, duration, and type of home health service as:

(a) ~~Identified~~Documented on the all services plan as defined in rule ~~5101:3-45-01~~ 5160-45-01 of the Administrative Code that is prior approved by ~~ODJFS~~ the Ohio department of medicaid (ODM) or designee ~~or the case management agency~~ when ~~a~~an ~~consumer~~ individual is enrolled ~~in~~ on an ~~ODJFS~~ODM~~-~~administered ~~home and community based services (~~HCBS~~)~~ waiver. Home health services that are not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when ~~a consumer~~ an individual is enrolled ~~in~~on an ~~ODA (~~Ohio department of aging~~)~~ (ODA) ~~administered~~ or ~~a DODD (~~Ohio department of developmental disabilities~~)~~ (DODD) administered HCBS waiver. Home health services that are not documented on the services plan are not reimbursable.

(4) Provide the home health services in the ~~consumer's~~ individual's place of residence, in a licensed child day-care center, or in the case of a child less than four years of age ~~for a child three years and under~~ in a setting where the child receives early intervention services ~~(EI)~~ as indicated in the individualized family service plan ~~(IFSP)~~.

(a) "~~C~~onsumer's Individual's place of residence" is wherever the ~~consumer~~ individual lives, whether the home is the ~~consumer's~~individual's own dwelling, an apartment, an assisted living residence, a relative's home, or an other type of living arrangement. The place of residence does not include a hospital, nursing facility, or intermediate care facility for ~~the mentally retarded~~individuals with intellectual disabilities (ICF-IID). ~~(ICR/MR).~~

(b) For the purposes of this chapter, "licensed child day-care center" means a "child day-care center" as defined in section 5104.01 of the Revised Code that is licensed pursuant to section 5104.03 of the Revised Code. ~~but does not include a licensed child day-care center that is the permanent residence of the licensee or administrator.~~

(c) "Setting" is the natural environment in which the services will appropriately be provided.

(5) Not provide home health nursing and home health aide services for the provision of habilitative care, or respite care, and not provide skilled therapies for the provision of maintenance care, habilitative care or respite care.

(a) "Maintenance care" is the care given to ~~a consumer~~an individual for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the ~~consumer~~ individual is no longer making significant improvement in his or her medical condition.

(b) "Habilitative care" ~~is in accordance with 42 U.S.C. 1396n(C)(5) (March 30, 2010)~~is the care provided to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

(c) "Respite care" is the care provided to ~~a consumer~~ an individual unable to care for himself or herself because of the absence or need for relief of those persons normally providing care.

(6) Bill for provided home health services in accordance with ~~the~~ visit policy ~~in~~ rule ~~5101:3-12-04~~ 5160-12-04 of the Administrative Code.

(7) Bill for provided home health services using the appropriate procedure code and applicable modifiers in accordance with rule ~~5101:3-12-05~~ 5160-12-05 of the Administrative Code.

(8) Bill after all documentation is completed for the services rendered during a visit in accordance with rule ~~5101:3-12-03~~ 5160-12-03 of the Administrative Code.

(F) ~~Consumers~~ Individuals who receive home health services must:

(1) Participate in a face-to-face encounter as specified in paragraph (B) of this rule for the purpose of certifying their medical need for home health services.

(2) Be under the supervision of a treating physician who is providing care and treatment to the ~~consumer~~individual. The treating physician cannot be a physician whose sole purpose is to sign and authorize plans of care or who

does not have direct involvement in the care or treatment of the ~~consumer~~individual. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.

(3) Participate in the development of a plan of care along with the treating physician and the ~~MCRHHA~~MCHHA. ~~An authorized representative may participate in the development of a plan of care in lieu of the consumer.~~

(4) Access home health services in accordance with the program for the all-inclusive care of the elderly (PACE) when the ~~consumer~~ individual participates in the PACE program.

(5) Access home health services in accordance with the ~~consumer's~~ individual's provider of hospice services when the ~~consumer~~ individual has elected the hospice benefit.

(6) Access home health services in accordance with the ~~consumer's~~ individual's managed care plan when the ~~consumer~~ individual is enrolled in a medicaid managed care plan.

(G) Covered home health services ~~are~~:

(1) "Home health nursing" is a nursing service that requires the skills of and is performed by a registered nurse, or a licensed practical nurse at the direction of a registered nurse. The nurse performing the home health service must possess a current, valid and unrestricted license with the Ohio board of nursing and must be employed or contracted by ~~the~~ a ~~MCRHHA~~MCHHA that has an active medicaid provider agreement. ~~providing the service.~~ A service is not considered a nursing service merely because it is performed by a licensed nurse. ~~Home health nursing services:~~

(a) Nursing tasks and activities that shall only be performed by an RN include, but are not limited to, the following:

(i) Intravenous (IV) insertion, removal or discontinuation;

(ii) IV medication administration;

(iii) Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);

(iv) Insertion or initiation of infusion therapies;

(v) Central line dressing changes; and

(vi) Blood product administration.

(b) Home health nursing services performed by an RN and/or an LPN must be:

~~(a)~~(i) ~~Must be performed~~ Performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.

~~(b)~~(ii) ~~Must be provided~~ Provided and documented in accordance with the ~~consumer's~~individual's plan of care in accordance with rule ~~5101:3-12-03~~ 5160-12-03 of the Administrative Code.

~~(c)~~(iii) ~~Must be provided in a face-to-face encounter.~~Provided during an in-person visit.

~~(d)~~(iv) ~~Must be medically~~ Medically necessary in accordance with rule ~~5101:3-1-01~~ 5160-1-01 of the Administrative Code to care for the ~~consumer's~~ individual's illness or injury.

(c) Home health nursing services do not include:

~~(e)~~(i) ~~Are not covered when the~~ A visit ~~is solely~~ when the sole purpose is for the supervision of the home health aide.

(ii) RN assessment services as defined in rule 5160-12-08 of the Administrative Code.

(iii) RN consultation services as defined in rule 5160-12-08 of the Administrative Code.

~~(f) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously, or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-05 of the Administrative Code.~~

(2) "Home health aide services" ~~is a service~~are services that requires the skills of and ~~is~~are performed by a home health aide employed or contracted by the ~~MCRHHA~~MCHHA providing the service. Home health aide services:

(a) Are performed within the home health aide's scope of practice as defined in 42 C.F.R. 484.36 (~~June 18, 2001~~October 1, 2014). The home health aide cannot be the parent, step-parent, foster parent or legal guardian of ~~a consumer~~ an individual who is under eighteen years of age, or the ~~consumer's~~ individual's spouse.

(b) Are provided and documented in accordance with the ~~consumer's~~ individual's plan of care in accordance with rule ~~5101:3-12-03~~ 5160-12-03 of the Administrative Code.

(c) Must be provided ~~in a face-to-face encounter.~~during an in-person visit.

(d) Must be medically necessary in accordance with rule ~~5101:3-1-01~~ 5160-1-01 of the Administrative Code to care for the ~~consumer's~~ individual'sillness or injury.

(e) Must be necessary to ~~facilitate~~ assist the nurse or therapist in the care of the ~~consumer's~~ individual's illness or injury, or help the ~~consumer~~ individual maintain a certain level of health in order to remain in ~~the~~ a home and community based setting. ~~Health related services can include:~~

(f) Include health related services including but not limited to:

(i) Bathing, dressing, grooming, hygiene, including shaving, skin care, foot care, ear care, hair, nail and oral care, that are needed to facilitate care or prevent deterioration of the individual's health, and including changing bed linens of an incontinent or immobile individual.

(ii) Feeding, assistance with elimination including administering enemas (unless the skills of a home health nurse are required), routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers.

(iii) Performing a selected nursing activity or task as delegated in accordance with Chapter 4723-13 of the Administrative Code, and performed as specified in the plan of care.

(iv) Assisting with activities such as routine maintenance exercises and passive range of motion as specified in the plan of care. These activities are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively

performed. The plan of care is developed by either a licensed therapist or a licensed registered nurse within their scope of practice.

(v) Performing routine care of prosthetic and orthotic devices.

~~(f)~~(g) May ~~also~~ include incidental services ~~along with health related services as listed in paragraph (G)(2)(e) of this rule~~, as long as they do not substantially extend the time of the visit.

(i) Incidental services are necessary household tasks that must be performed by someone ~~anyone~~ to maintain a home and can include light chores, ~~consumer's~~ laundry, light house cleaning, preparation of meals, and~~/or~~ taking out the trash.

(ii) The main purpose of a home health aide visit cannot be solely to provide these incidental services since they are not health related services.

(iii) Incidental services are to be performed only for the ~~consumer~~ individual and not for other people in the ~~consumer's~~ individual's ~~covered~~ place of residence.

(3) "Skilled therapies" ~~are~~ is defined as physical therapy, occupational therapy, and speech-language pathology services that require the skills of and are performed by skilled therapy providers to meet the ~~consumer's~~ individual's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

(a) "Skilled therapy providers" are licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants (LPTA) under the direction of a physical therapist, or certified occupational therapy assistants (COTA) under the direction of a licensed occupational therapist who are contracted or employed by a ~~MCRHHA.~~MCHHA.

(b) "Rehabilitation" is the care of ~~a consumer~~ an individual with the intent of curing the ~~consumer's~~ individual's disease or improving the ~~consumer's~~ individual's condition by the treatment of the ~~consumer's~~ individual's illness or injury, or the restoration of a function affected by illness or injury.

(c) Skilled therapies:

(i) Must be provided to the ~~consumer~~ individual within the therapist's or therapy assistant's scope of practice in accordance with sections 4755.44, 4755.07, and 4753.07 of the Revised Code.

(ii) Must be medically necessary in accordance with rule ~~5101:3-1-01~~ 5160-1-01 of the Administrative Code to care for the ~~consumer's~~individual's illness or injury.

(iii) Must be provided and documented in the ~~consumer's~~ individual's plan of care in accordance with rule ~~5101:3-12-03~~ 5160-12-03 of the Administrative Code.

(iv) Must be reasonable in their amount, frequency, and duration. Treatment must be considered ~~according to the accepted standards of medical practice~~ to be safe and effective treatment for the ~~consumer's~~ individual's condition according to the accepted standards of medical practice.

(v) Must be provided with the expectation of the ~~consumer's~~ individual's rehabilitation potential according to the treating physician's prognosis of illness or injury. The expectation of the ~~consumer's~~ individual's rehabilitation potential is that the condition of the ~~consumer~~ individual will measurably improve within a reasonable period of time or the services are necessary to the establishment of a safe and effective maintenance program.

(vi) May include treatments, assessments and/or therapeutic exercises but cannot include activities that are for the general welfare of the ~~consumer~~individual, including motivational or general activities for the overall fitness of the ~~consumer.~~individual.

(H) ~~A consumer~~ An individual who meets the requirements in this paragraph may qualify for increased home health services. The ~~MCRHHA~~MCHHA must assure and document that the ~~consumer~~ individual meets all requirements in this paragraph prior to increasing services. The U5 modifier must be used when billing in accordance to rule ~~5101:3-12-05~~5160-12-05 of the Administrative Code. The use of the U5 modifier indicates that all conditions of this paragraph were met. The ~~consumer~~individual who meets the following requirements may receive an increase of home health services if he or she:

(1) Is under age twenty-one and requires services for treatment in accordance with Chapter ~~5101:3-14~~ 5160-14 of the Administrative Code for the healthchek

program.

(2) Requires more than, as ordered by the treating physician:

(a) Eight hours ~~(thirty-two units)~~ per day of any home health service, or a combined total of fourteen hours ~~(fifty-six units)~~ per week of home health aide and home health nursing as specified in paragraph (C) of this rule; or

(b) A combined total of twenty-eight hours ~~(one hundred twelve units)~~ per week of home health nursing and home health aide for sixty days as specified in paragraph (D) of this rule.

(3) Has a comparable level of care as evidenced by either:

(a) Enrollment in a HCBS waiver; or

(b) A level of care evaluated initially and annually by ~~ODJFS~~ ODM or its designee for ~~a consumer~~ an individual not enrolled in a HCBS waiver. The criteria for an institutional level of care, including a nursing facility-based level of care ~~are any of the rules regarding the skilled level of care (SLOC)~~ as defined in rule ~~5101:3-3-05~~ 5160-3-08 of the Administrative Code~~, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code,~~ or an ~~ICF/MR~~ICF-IID level of care as defined in rule ~~5101:3-3-07~~5123:2-08-01 of the Administrative Code. In no instance does this constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long term care institution; and

(4) Requires home health nursing or a combination of PDN~~/~~, home health nursing~~/~~, waiver nursing~~/~~, and skilled therapy visits at least once per week that is medically necessary in accordance with rule ~~5101:3-1-01~~ 5160-1-01 of the Administrative Code as ordered by the treating physician.

(I) Individuals subject to decisions regarding home health services made by ODM or its designee pursuant to this rule will be afforded notice and hearing rights to the extent afforded in division 5101:6 of the Administrative Code.

Effective:

Five Year Review (FYR) Dates: 04/14/2015

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Certification

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Date

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