5101:3-12-05 **Reimbursement: home health services.**

~~(A) Home health services are delivered and billed in accordance with this chapter by medicare certified home health agencies (MCRHHA). Home health service rates are identified in appendix A to this rule.~~

(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 paid for up to the first four units of service delivered.

(2) "Unit rate," as used in this rule and appendix A to this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service delivered.

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

~~(B)~~(C) The amount of reimbursement for a visit shall 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 (one unit equals fifteen minutes) that were provided during a visit in accordance with this chapter as follows:

(1) Each visit must be less than or equal to four hours (sixteen units).

(2) For a visit that is less than one hour (four units) the medicaid maximum is the amount of the base rate.

(3) For a visit that is over one hour (four units) the medicaid maximum is the amount of the base rate plus the unit rate amount for each unit over one hour (four units), but not to exceed four hours (sixteen units).

~~(C)~~(D) The amount of reimbursement for a visit shall be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (B) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with 5101:3-12-04 of the Administrative Code.

~~(D)~~(E) The modifiers set forth in appendix B to this rule must be used to provide additional information in accordance with this chapter.

~~(E)~~(F) Reimbursement must be provided in accordance with paragraphs (A) to (D) of rule 5101:3-1-60 of the Administrative Code.

~~(F)~~(G) A MCRHHA will not be reimbursed for home health services provided to a consumer that duplicates same or similar services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplemental recipient or medicaid consumer resides, such as an adult foster home, adult family home, adult group home, residential care facility, community alternative home, or other facility is paid to provide personal care or nursing services, then home health services are not reimbursable by medicaid.

~~(G)~~(H) A MCRHHA will be reimbursed for home health services provided to a consumer if the provider has written documentation from a facility/home (i.e., an adult foster home, adult family home, adult group home, residential care facility, community alternative home, or other facility) stating that the facility/home is not responsible for providing the same or similar home health services to the consumer.

~~(H)~~(I) Home health services provided to the consumer enrolled in the assisted living HCBS waiver in accordance with rule 5101:3-1-06 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

Effective:

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Certification

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