5101:3-46-06.1 **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 paid to a provider for up to four units of HCAS delivered. The base rate accounts for up to four units 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 tasks as described in paragraph (B)(1) of rule 5101:3-46-04 of the Administrative Code may be provided incidental to nursing services.

(3) "Group rate" means the amount that HCAS providers shall 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 5101:3-46-06.1 of the Administrative Code, and as authorized by the Ohio department of job and family services (ODJFS), 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 5101:3-46-04.1 of the Administrative Code. An HCAS visit shall 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 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" means the additional two-alpha-numeric-digit billing code set forth in paragraph (H) of this rule that HCAS providers shall use to provide additional information regarding service delivery.

(9) "Unit rate," as set forth in column 4 of table A of this rule and column 5 of table B of this rule, means the amount paid for each fifteen-minute unit of HCAS following the base rate paid for the first four units of HCAS provided.

(B) Providers shall 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
Billing code	Home care attendant service description	Base rate	Unit rate
S5125	Assistance with self-administration of medications and/or the performance of nursing tasks (HCAS/N)	$33.36	$4.17 per fifteen minute unit of HCAS/N delivered during visit (beginning with the fifth unit of service)

(C) Providers shall 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 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 be billed at the HCAS/N unit rate; and personal care tasks (HCAS/PC) shall be billed at the HCAS/PC unit rate using the U8 modifier.

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	$33.36	N/A	$4.17 per fifteen minute unit of HCAS/N delivered during the visit (beginning with the fifth unit of service)
S5125	HCAS/PC	N/A	U8	$3.00 per fifteen minute of HCAS/PC delivered during the visit

(D) In order for a provider to submit a claim for HCAS under the Ohio home care waiver, the services must be provided in accordance with Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

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

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

(G) HCAS providers shall 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 consumers served.

(H) Required modifiers.

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

(2) The "U2" modifier must be used when a provider submits a claim for a second HCAS visit to a consumer for the same date of service.

(3) The "U3" modifier must be used when the same provider submits a claim for three or more HCAS visits to a consumer for the same date of service.

(4) The "U8" modifier must 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.

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

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