5101:3-46-06 **Ohio home care waiver: 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 paid for up to the first four units of service delivered.

(2) "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.).

(3) "Group rate," as used in paragraph (E)(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.

(4) "Group setting" is a situation where a waiver nursing and/or 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 ODJFS-administered waiver service, or a combination of ODJFS-administered waiver services and similar non-ODJFS-administered waiver services.

(5) "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.

(6) "Modifier," as used in paragraph (E) 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.

(7) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service provided.

(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 RN	$55.00	$5.70
T1003	Waiver nursing services provided by an LPN	$55.00	$5.70
T1019	Personal care aide services	$24.00	$3.00

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	$200.00
S0215	Supplemental transportation services	Per mile	$0.38
S5101	Adult day health center services	Per half day	$32.50
S5102	Adult day health center services	Per day	$65.00
S5160	Emergency response services	Per installation and testing	$45.00
S5161	Emergency response services	Per monthly fee	$45.00
S5165	Home modification services	Per item	Amount prior-authorized on the all services plan
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the all services plan
S5170	Home delivered meal services	Per meal	$7.00

(C) In order for a provider to submit a claim for Ohio home care waiver services, the services must be provided in accordance with rules 5101:3-12-08 to 5101:3-12-30 of the Administrative Code, and Chapters 5101:3-45 and 5101:3-46 of the Administrative Code.

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

(E) Required modifiers.

(1) The "HQ" modifier must 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 be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.

(2) The "U1" modifier must be used when a provider submits a claim for billing code T1002 and the consumer is receiving infusion therapy.

(3) The "U2" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to a consumer for the same date of service.

(4) The "U3" modifier must be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to a consumer for the same date of service.

(5) The "U4" modifier must 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.

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

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