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 ~~paid for up to the first four units~~ 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 ~~paid for~~ reimbursed by Ohio medicaid for each fifteen minutes of service delivered when the initial visit is: ~~unit following the base rate paid for the first four units of service delivered.~~

(a) Greater than sixty minutes in length; or

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

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

(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/or unit rate found in appendix A as applicable 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 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 ~~one hour (four units) the medicaid maximum is the amount of the base rate~~.

(3) For a visit ~~that is over~~ thirty-five minutes to one hour in length in total, ~~(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)~~.

(4) For a 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 be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (~~B~~C) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with rule ~~5101:3-12-04~~5160-12-04 of the Administrative Code.

(E) The modifiers set forth in appendix B to this rule must 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 be billed using the U1 modifier.

(F) A visit conducted by a registered nurse (RN) for the provision of home health services must be billed to Ohio medicaid using the TD modifier. A visit conducted by a licensed practical nurse (LPN) for the provision of home health services must be billed to Ohio medicaid using the TE modifier.

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

(G) An ~~MCRHHA~~MCHHA will not be reimbursed for home health services provided to ~~a consumer~~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 ~~supplemental~~ supplement recipient or individual receiving 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.

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

(I) Home health services provided to ~~the consumer~~ an individual enrolled ~~in the~~ on an assisted living home and community based services ~~HCBS~~ waiver in accordance with rule ~~5101:3-1-06~~5160-1-06 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

Effective:

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

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Certification

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Date

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