5160-46-06 **Ohio home care waiver program: 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 reimbursed by the Ohio department of medicaid (ODM) for the first thirty-five to sixty minutes of service delivered.

(2) "Bid rate," as used in table B, column 3 of paragraph (B) of this rule, means the per job bid rate negotiated between the provider and the individual's case manager.

(3) "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.).

(4) "Caretaker relative" has the same meaning as in rule 5160:1-1-01 of the Administrative Code.

(5) "Group rate," as used in paragraph (D)(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.

(6) "Group setting" means a setting in which:

(a) A 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 ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(b) A waiver nursing service provider furnishes the same type of services to either:

(i) Two or three individuals at the same address. The services provided in the group setting can be either the same type of ODM-administered waiver service, or a combination of ODM-administered waiver services and similar non-ODM-administered waiver services.

(ii) Two to four individuals at the same address if all of the individuals receiving ODM-administered waiver nursing services are:

(a) Medically fragile children, and

(b) Siblings, and

(c) Residing together in the home of their caretaker relative. The services provided in the group setting ~~must~~ will be ODM-administered waiver nursing services.

(7) "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, or

(iii) The unit rate as defined in paragraph (A)(7)(b) of this rule.

(8) "Medically fragile child" means an individual who is under eighteen years of age, has intensive health care needs, and is considered blind or disabled under section 1614(a)(2) or (3) of the "Social Security Act," (42 U.S.C. 1382c(a)(2) or (3)) (as in effect on January 1, ~~2021~~2024).

(9) "Modifier," as used in paragraph (D) 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.

(10) "Unit rate," as used in table A, column 4 of paragraph (B) of this rule, means the amount reimbursed by ODM for each fifteen minutes of service delivered when the visit is:

(a) Greater than sixty minutes in length.

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

(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 agency RN	~~$50.29~~$68.44	$9.25
T1002	Waiver nursing services provided by a non-agency RN	~~$41.33~~$56.26	$7.46
T1002	Waiver nursing services provided by a non-agency RN (overtime)	~~$53.92~~$84.39	~~$10.62~~$11.19
T1003	Waiver nursing services provided by an agency LPN	~~$43.13~~$58.72	$7.82
T1003	Waiver nursing services provided by a non-agency LPN	~~$35.23~~$48.00	$6.24
T1003	Waiver nursing services provided by a non-agency LPN (overtime)	~~$45.62~~$72.00	~~$8.84~~$9.36
T1019	Personal care aide services provided by an agency personal care aide	~~$25.34~~$28.96	~~$4.21~~$7.24
T1019	Personal care aide services provided by a non-agency personal care aide	~~$20.42~~$22.32	~~$3.24~~$5.58
T1019	Personal care aide services provided by a non-agency personal care aide (overtime)	~~$24.75~~$33.48	~~$4.56~~$8.37

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	$199.82
S0215	Supplemental transportation services	Per mile	~~$0.38~~$0.48
S5101	Adult day health center services	Per half day	~~$40.60~~$53.11

S5102	Adult day health center services	Per day	~~$81.18~~$106.26
S5160	Personal emergency response systems	Per installation and testing	$32.95
S5161	Personal emergency response systems	Per monthly fee	$32.95
S5165	Home modification services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
T2029	Supplemental adaptive and assistive device services	Per item	Amount prior-authorized on the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year
S5170	Home delivered meal services - standard meal	Per meal	~~$7.20~~$8.80
S5170	Home delivered meal services - therapeutic or kosher meal	Per meal	~~$8.68~~$10.61
S5135	Community integration services	Per fifteen-minute unit	~~$3.50~~$3.93
T2038	Community transition services	Per job	$2,000 per waiver enrollment
S5121	Home maintenance and chore services	Per job	Amount prior-authorized on

			the person-centered services plan, not to exceed $10,000 in a twelve-month calendar year

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

(D) Required modifiers.

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

(2) The "TU" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002, T1003 or T1019 and the entire claim is being billed as overtime.

(3) The "UA" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002, T1003 or T1019 and only a portion of the claim is being billed as overtime.

(4) The "U1" modifier ~~must~~ will be used when a provider submits a claim for billing code T1002 and the individual enrolled on the Ohio home care waiver is receiving infusion therapy.

(5) The "U2" modifier ~~must~~ will be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for a second visit to an individual enrolled on the Ohio home care waiver for the same date of service.

(6) The "U3" modifier ~~must~~ will be used when the same provider submits a claim for billing code T1002, T1003 or T1019 for three or more visits to an individual enrolled on the Ohio home care waiver for the same date of service.

(7) The "U4" modifier ~~must~~ will 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.

(8) The "U6" modifier ~~must~~ will be used when a provider submits a claim for billing code S5170 for a therapeutic or kosher home delivered meal.

(E) Claims ~~shall~~ will be submitted to, and reimbursement ~~shall~~ will be provided by, ODM in accordance with Chapter 5160-1 of the Administrative Code.

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CERTIFIED ELECTRONICALLY

Certification

12/21/2023

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