OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

To: ALL CLEARANCE REVIEWERS
From: Sara Abbott, Chief, Bureau of Community Services Policy
Date: September 11, 2009
Subject: **ODJFS-Administered Waiver Programs: Waiver Service Provider Fee Decrease**

Attached for your review and comment are Rules 5101:3-46-06, 5101:3-47-06 and 5101:3-50-06 of the Administrative Code governing reimbursement of ODJFS-administered waiver services. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain Medicaid providers effective for dates of service on or after January 1, 2010.

Waiver nursing services provided by a registered nurse under the Ohio Home Care, Transitions MR/DD and Transitions Carve-Out Waivers are reimbursed using the T1002 HCPCS code. Waiver nursing services provided by a licensed practical nurse are reimbursed using the T1003 code. Effective January 1, 2010, the reimbursement amount for these codes is being reduced by three percent. The new reimbursement rate for these codes is $54.95 for the base rate and $5.69 for the fifteen-minute unit rate. Similarly, the base rate for Personal Care Aide Services (T1019) is being reduced to $23.98 and the unit rate is being reduced to $3.00.

Other ODJFS-administered waiver service rates will be as follows:

H0045	Out-of-home Respite Services	$199.82
S0215	Supplemental Transportation Services	$ 0.38
S5101	Adult Day Health Center Services (half-day)	$ 32.48
S5102	Adult Day Health Center Services (whole day)	$ 64.94
S5160	Emergency Response Services (installation/testing)	$ 44.96
S5161	Emergency Response Services (monthly fee)	$ 44.96
S5170	Home Delivered Meal Services	$ 6.99

These rules are also being amended to remove reference to Administrative Code rules that were previously rescinded.

Thank you in advance for your comments.

Attachments

Ohio | Department of Job and Family Services

Ted Strickland, Governor
Douglas E. Lumpkin, Director

Community Services Transmittal Letter (CSTL) No. XX-XX

TO: Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Director, Ohio Department of Mental Health
Director, Ohio Department of Alcohol and Drug Addiction Services
Providers, ODJFS-Administered Home and Community-Based Services
Providers, Home Health Agencies
Providers, Otherwise-accredited Agencies
Providers, Independent Private Duty Nursing
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
Directors, Area Agencies on Aging
Directors, County Boards of Mental Retardation and Developmental Disabilities
Directors, Centers for Independent Living
Ohio Long Term Care Ombudsmen
Director, Brain Injury Association of Ohio
Directors, Members, HOME Choice Planning and Advisory Group
Chairperson, Ohio Olmstead Task Force
Director, Ohio Council for Home Care
Director, Ohio Home Care Organization
Vice-President, SEIU District 1199, WV/KY/OH

FROM: Douglas E. Lumpkin, Director

SUBJECT: ODJFS-Administered Waiver Programs: Waiver Service Provider Fee Decrease

This letter provides information regarding the amendment of Rules 5101:3-46-06, 5101:3-47-06 and 5101:3-50-06 of the Administrative Code governing reimbursement of ODJFS-administered waiver services. These rules have been amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain Medicaid providers effective for dates of service on or after January 1, 2010.

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Columbus, Ohio 43215
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All ODJFS-administered waiver services that have Medicaid maximum rates established in rule have been reduced by three percent effective for services delivered on or after January 1, 2010. Therefore, the base rate for Waiver Nursing Services (T1002 and T1003) has been reduced to $54.95, and the unit rate has been reduced to $5.69. Similarly, the base rate for Personal Care Aide Services (T1019) has been reduced to $23.98 and the unit rate has been reduced to $3.00.

Other ODJFS-administered waiver service rates are as follows:

H0045	Out-of-home Respite Services	$199.82
S0215	Supplemental Transportation Services	$ 0.38
S5101	Adult Day Health Center Services (half-day)	$ 32.48
S5102	Adult Day Health Center Services (whole day)	$ 64.94
S5160	Emergency Response Services (installation/testing)	$ 44.96
S5161	Emergency Response Services (monthly fee)	$ 44.96
S5170	Home Delivered Meal Services	$ 6.99

These rules have also been amended to remove reference to Administrative Code rules that were previously rescinded.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-46-06 (effective 7/01/2008)	5101:3-46-06 (effective 1/01/2010)
5101:3-47-06 (effective 7/01/2008)	5101:3-47-06 (effective 1/01/2010)
5101:3-50-06 (effective 7/01/2008)	5101:3-50-06 (effective 1/01/2010)

Web Pages:
ODJFS maintains an "electronic manuals" web page for the department's rules, manuals and handbooks. The URL is as follows:

http://emanuals.odjfs.state.oh.us/emanuals/

This transmittal letter and attachments may be viewed as follows:
(1) Select "Ohio Health Plans – Provider" (right column).
(2) Select "Ohio Home Care" (left column).
(3) Select "Community Services Transmittal Letters" and "Ohio Home Care Rules" (in the "Table of Contents" dropdown).

Questions:
Questions about this CSTL should be addressed to:

Ohio Department of Job and Family Services
Bureau of Community Services Policy
P.O. Box 182709
Columbus, Ohio 43218-2709
http://jfs.ohio.gov/ohp
(614) 466-6742

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	~~$56.65~~$54.95	~~$5.87~~$5.69
T1003	Waiver nursing services provided by an LPN	~~$56.65~~$54.95	~~$5.87~~$5.69
T1019	Personal care aide services	~~$24.72~~ $23.98	~~$3.09~~ $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	~~$206.00~~ $199.82
S0215	Supplemental transportation services	Per mile	~~$0.39~~ $0.38
S5101	Adult day health center services	Per half day	~~$33.48~~ $32.48
S5102	Adult day health center services	Per day	~~$66.95~~ $64.94
S5160	Emergency response services	Per installation and testing	~~$46.35~~ $44.96
S5161	Emergency response services	Per monthly fee	~~$46.35~~ $44.96
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	~~$7.21~~ $6.99

(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.

5101:3-47-06 **Transitions MR/DD 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 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" means 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	~~$56.65~~$54.95	~~$5.87~~$5.69
T1003	Waiver nursing services provided by an LPN	~~$56.65~~$54.95	~~$5.87~~$5.69
T1019	Personal care aide services	~~$24.72~~ $23.98	~~$3.09~~ $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	~~$206.00~~ $199.82
S0215	Supplemental transportation services	Per mile	~~$0.39~~ $0.38
S5101	Adult day health center services	Per half day	~~$33.48~~ $32.48
S5102	Adult day health center services	Per day	~~$66.95~~ $64.94
S5160	Emergency response services	Per installation and testing	~~$46.35~~ $44.96
S5161	Emergency response services	Per monthly fee	~~$46.35~~ $44.96
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	~~$7.21~~ $6.99

(C) In order for a provider to submit a claim for transitions MR/DD 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 5101:3-47 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 at 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.

5101:3-50-06 Transitions carve-out 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 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.

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(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	~~$56.65~~$54.95	~~$5.87~~$5.69
T1003	Waiver nursing services provided by an LPN	~~$56.65~~$54.95	~~$5.87~~$5.69
T1019	Personal care aide services	~~$24.72~~ $23.98	~~$3.09~~ $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	~~$206.00~~ $199.82
S0215	Supplemental transportation services	Per mile	~~$0.39~~ $0.38
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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	~~$7.21~~ $6.99

(C) In order for a provider to submit a claim for transitions carve-out 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 5101:3-50 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 at a group rate shall be the lesser of the provider's billed charge or seventy-five per cent of the medicaid maximum.

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