

Home Health/Private Duty Nursing Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Medicaid Handbook Transmittal Letter (MHTL) No. 3336-11-01 / MAL 574 (Rule Changes Affecting Home Health Services and Hospice Services), is maintained in the General Information e-book.

[Click here to view MHTL 3336-11-01 / MAL 574, Rule Changes Affecting Home Health Services and Hospice Services](#)

MHTL 3334-10-02

Medicaid Handbook Transmittal Letter (MHTL) No. 3334-10-02 (New 2010 HCPCS and CPT Codes and Policy Updates), is maintained in the General Information e-book.

[Click here to view MHTL 3334-10-02, New 2010 HCPCS and CPT Codes and Policy Updates](#)

MHTL 3336-10-01

Medicaid Handbook Transmittal Letter (MHTL) No. 3336-10-01 (Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule), is maintained in the Physician Services e-book.

[Click here to view MHTL 3336-10-01, Addition of HPV Bivalent Vaccine and Appendices to Immunizations Rule](#)

Medical Assistance Letters

MAL 574 / MHTL 3336-11-01

Medical Assistance Letter MAL 574 / MHTL 3336-11-01 (Rule Changes Affecting Home Health Services and Hospice Services), is maintained in the General Information e-book.

[Click here to view MAL 574 / MHTL 3336-11-01, Rule Changes Affecting Home Health Services and Hospice Services](#)

MAL 563 (Community Provider Fee Decrease)

Medical Assistance Letter (MAL) 563

January 8, 2010

TO: All Eligible Home Health Agencies
All Eligible Home Health Nurses
All Eligible Home Health Nurse Aides
All Eligible Private Duty Nurses
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The

reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

Providers may view documents online by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
- (4) Selecting the desired document type;
- (5) Selecting the desired item from the "Table of Contents" pull-down menu.

Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MAL 558

Medical Assistance Letter (MAL) 558

Community Services Transmittal Letter (CSTL) No. 09-07

October 26, 2009

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: Rule Changes Affecting ODJFS-Administered Waiver Programs and Private Duty Nursing; and Changes in the JFS 02374 "Private Duty Nursing Services Request"

The Ohio Department of Job and Family Services (ODJFS) has amended rules 5101:3-45-01 and 5101:3-12-03.1 of the Administrative Code (OAC). These rules expand certain program-related definitions. A description of the amended rules follows below.

OAC rule [5101:3-45-01](#), ODJFS-administered Waiver Program: Definitions, contains key definitions associated with ODJFS-administered waivers. The definition of "otherwise-accredited agency" has been amended to include an agency that has and maintains accreditation by a national organization for the provision of home health services, private duty nursing, personal care services and support services upon execution of a Medicaid provider agreement in accordance with OAC rule 5101:3-1-17.2. The national accreditation organization must be approved by the Centers for Medicare and Medicaid Services (CMS), and shall include, but not be limited to, the Accreditation Commission for Health Care (ACHC), the Community Health Accreditation Program (CHAP) and the Joint Commission. OAC rule 5101:3-45-01 also includes a definition for ACHC, as well as modifications to the definitions of CHAP, Joint Commission, and a number of other definitions in order to update rule cites and offer additional clarity.

OAC rule [5101:3-12-03.1](#), **Non-Agency Nurses and Otherwise Accredited Agencies: Qualifications and Requirements**, sets forth the provider qualifications and requirements for non-agency nurses and otherwise-accredited agencies providing Private Duty Nursing services. Like OAC rule 5101:3-45-01, it is amending the definition of "otherwise-accredited agency."

In addition to the aforementioned rule changes, ODJFS has revised the [JFS 02374](#) "Private Duty Nursing (PDN) Services Request." Changes have been made in order to capture essential information that is necessary to process PDN requests on a timelier basis. Sister agency case managers and PDN providers submit the form to the ODJFS Bureau of Community Services Policy when requesting PDN services for consumers. This form is used in concert with OAC rules 5101:3-12-02 and 5101:3-12-02.3, however, no changes are being made to those rules at this time.

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-45-01 (effective 7/01/2006)	5101:3-45-01 (effective 10/26/2009)

Instructions:

Remove and File as Obsolete	Insert Replacement
5101:3-12-03.1 (effective 7/01/2006)	5101:3-12-03.1 (effective 10/26/2009)
ODJFS 2374 (5/2007)	JFS 02374 (6/2009)

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).

It may also be viewed as follows:

- (1) Select "Ohio Health Plans - Provider" (right column).
- (2) Select "Home Health-Private Duty Nursing" (left column).
- (3) Select "Medical Assistance Letters", "Home Health/Private Duty Nursing Rules" and "Forms" (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://ifs.ohio.gov/ohp>

(614) 466-6742

Questions about this MAL should be addressed to:

Ohio Department of Job and Family Services

Office of Ohio Health Plans

Bureau of Provider Services

P.O. Box 1461

Columbus, Ohio 43216-1461

(800) 686-1516

MAL 549

Medical Assistance Letter (MAL) 549

July 3, 2008

TO: Medicare Certified Home Health Agency
Other Accredited Home Health Agency
Non-Agency Nurses
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Rate Increases

The purpose of this Medical Assistance Letter (MAL) is to announce the updates to Ohio Administrative Code (OAC) rule [5101: 3-12-05](#) titled *Reimbursement: Home Health Services* and rule [5101: 3-12-06](#) titled *Reimbursement: Private Duty Nursing Services*.

The Department is pleased to announce that the home health and private duty nursing payment rates will increase by three percent (3%) as part of the Governor's biennial budget. The rates listed below will become effective for dates of service on and after July 1, 2008.

Home Health Care - July 1, 2008

Code	Description	Base Rate	Unit Rate
G0154	Home Health Nursing, each 15 minutes	\$56.65	\$5.87
G0156	Home Health Nursing Aide, each 15 minutes	\$24.72	\$3.09
G0151	Physical Therapy, each 15 minutes	\$72.10	\$4.64
G0152	Occupational Therapy, each 15 minutes	\$72.10	\$4.64
G0153	Speech-Language Pathology, each 15 minutes	\$72.10	\$4.64

Private Duty Nursing - July 1, 2008

Code	Description	Base Rate	Unit Rate
T1000	Private Duty Nursing, each 15 minutes	\$56.65	\$5.87

The full text of the rule amendments and the accompanying appendix A to the rules can be found on the Department's web site at <http://emanuals.odjfs.state.oh.us/emanuals> in the Home Health-Private Duty Nursing chapter.

These Medicaid changes are applicable to claims for consumers remaining in traditional Medicaid who have not transitioned to a Medicaid managed care plan (MCP). For claims for consumers in a Medicaid MCP, providers are reimbursed according to negotiated rates established between the MCP and the provider. MCP providers should refer to their contract with the MCP to determine how the Medicaid maximum updates and policy revisions in this MHTL and in the Medicaid reimbursement rule [5101: 3-12-05](#) and [5101: 3-12-06](#) will affect their MCP reimbursement. Contracting questions should be directed to the applicable MCP.

Web Page and Paper Distribution:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>

Providers may view documents and current reimbursement rates online by:

- (1) Selecting "Ohio Health Plans - Provider" folder;
- (2) Selecting " Home Health-Private Duty Nursing "; and
- (3) Selecting "5101:3-12-05 Reimbursement: Home Health Services and 5101:3-12-06 Reimbursement: Private Duty Nursing Services" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans
Provider Services Section
P.O. Box 1461
Columbus, OH 43216-1461
1-800-686-1516

MAL 540

Medical Assistance Letter (MAL) 540

November 7, 2007

TO: All Medicare Certified Home Health Agencies Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Home Health Requirement Changes

This Medical Assistance Letter (MAL) provides information regarding changes to Ohio Administrative Code (OAC) rule 5101:3-12-01 titled *Home health services: provision requirements, coverage, and service specification*, and rule 5101:3-12-03 titled *Medicare certified home health agencies (MCRHHA): qualifications and requirements*. These rule amendments become effective on November 8, 2007.

Ohio Administrative Code (OAC) rule 5101:3-12-01 is being amended at the request of stakeholders, including Ohio Department of Job and Family Services Bureau of Child Care and Development, consumers, and sister agencies, to enable children with medically-complex conditions to receive medical care in a licensed child day-care center and in a setting where the child receives early intervention services as indicated in the individualized family service plan are provided. This amendment is intended to reduce the isolation that homebound children may experience while at the same time allowing their parents to return to work or school. Also, this rule is being amended at the request of stakeholders to clarify language of paragraph (C) that only the treating physician can determine medical necessity. The JFS 07137 form linked to the clarification has been amended and is posted at the ODJFS electronic manuals web site.

Specific changes to the rule include the following:

- The place of service where Medicare certified home health agencies can provide services was expanded to include a licensed child day-care center and a setting where the child receives early intervention services as indicated in the individualized family service plan.
- Language was added that home health aides and skilled therapy providers can only provide services that are medically necessary in accordance with OAC rule 5101:3-1-01.
- Language was removed that allowed a hospital discharge planner or registered nurse to certify the consumer's medical need.
- The title of form JFS 07137 was changed to reflect the correct title.

Providers should note that all home health services, including those provided in a community setting, will continue to be reimbursed on a per visit basis. Also, as defined in rule 5101: 3-12-04, a group visit is a visit where services are provided to more than one person. The ratio of provider to client for a group visit must never exceed one to three. Additionally, the entire visit is considered a group visit which must always be billed with a HQ modifier to identify the group visit. For services provided in a licensed child day-care center or a setting where the child receives early intervention services as indicated in the individualized family service plan, the place of service must be designated as 99, in accordance with the BIN.1001.4 Instructions for Completing the New CMS 1500 08/05.

Ohio Administrative Code (OAC) rule 5101:3-12-03 is being amended to help streamline the transition from Medicaid fee-for-service to Medicaid managed care for both Medicare certified home health agencies and consumers. This rule sets forth provisions for eliminating Medicare certified home health agencies' (MCRHHAs) requirement to submit written notification to the consumer at least thirty days prior to the last date of service if the consumer has been enrolled in a Medicaid managed care plan. The title of JFS 07137 was also changed to reflect the correct title.

Web Page and Paper Distribution:

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Providers may view documents online by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "Home Health-Private Duty Nursing"; and
- (3) Selecting the desired item from the "Table of Contents" pull-down menu.

The Legal/Policy Central Calendar (<http://www.odjfs.state.oh.us/lpc/calendar>) site is a quick reference of documents recently published. The Legal/Policy Center Calendar site also provides a link to a listing of ODJFS Letters (<http://www.odjfs.state.oh.us/lpc/mtl>). The listing is categorized by letter number and subject and a link is provided to the easy print (PDF) document.

Providers will receive one printed copy of this letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, OH 43216-1461

Toll Free Telephone Number 1-800-686-1516

MAL 534

Medical Assistance Letter (MAL) 534

July 31, 2007

To: Medicare-Certified Home Health Agencies
Non-Agency Nurses
Otherwise Accredited Agencies
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Exceptions for Home Health and Private Duty Nursing (PDN) Services

This Medical Assistance Letter (MAL) announces rule 5101:3-12-07, Reimbursement: exceptions, which exempts certain provisions of the new home health and private duty nursing rules.

This rule, which becomes effective on July 23, 2007, is based on feedback from internal and external stakeholders to further define the reimbursement provisions of OAC Chapter 5101: 3-12 for home health and private duty nursing (PDN) services for the Ohio Medicaid program.

This rule sets forth exemptions to the requirement that services be documented on the all services plan when the consumer is enrolled in an ODJFS-administered waiver and on the services plan when the consumer is enrolled in an ODA- or ODMR/DD-administered waiver when the absence from the plan is due to circumstances outside the provider's control. In order for providers to be reimbursed for the services, the rule specifies documentation and verification requirements relative to a provider showing that the circumstances are beyond the provider's control. It also includes coverage and reimbursement provisions for home health and PDN services delivered in a facility/home or an assisted living facility.

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, forms and handbooks. The URL is as follows:

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

Providers will receive one hard copy of this medical assistance letter and the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family Services according to the instructions at the top of the form.

Questions pertaining to this letter should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43215-1461

Toll Free Telephone Number (800) 686-1516

MAL 533

Medical Assistance Letter (MAL) 533

June 7, 2007

To: Non-agency nurses
Trading Partners and Tape Intermediaries
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Re: Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid

NPI.....GET IT.....SHARE IT.....USE IT

The purpose of this Medical Assistance Letter (MAL) is to inform individual Non-agency nurses that are enrolled as providers in the Ohio Medicaid program and do business with ODJFS that they are required to obtain a National Provider Identifier (NPI) by May 23, 2007. An NPI for non-agency nurses is a unique, ten-digit, entity type 1 identifier that providers receive from the National Plan and Provider Enumeration System (NPPES). Upon receipt of their NPI and until January 1, 2008, non-agency nurses that conduct business with Medicaid in an electronic format (i.e., submit EDI claims, receive electronic remittance advices and/or communicate electronically with trading partners and payers) must submit both their individual NPI number and their current individual Medicaid provider number (now referred to as the Medicaid legacy number or Ohio Medicaid legacy number) in accordance with the Ohio Medicaid EDI companion guide and/or the instructions contained in this MAL.* This is to create an association between these two numbers.

Non-agency nurses **MUST** enumerate through NPPES, disclose their NPIs to ODJFS and bill using both the NPI and Medicaid legacy identifiers. This MAL provides direction to providers on enumerating through NPPES, disclosing your NPI to ODJFS, and billing ODJFS using your NPI.*

Claims received by ODJFS before January 1, 2008 that contain a valid Ohio Medicaid legacy number, or both a valid NPI and valid Ohio Medicaid legacy number in the required provider fields, will continue to be accepted and processed. Claims submitted without an Ohio Medicaid legacy number (i.e., submitted only with an NPI number) prior to January 1, 2008 will be rejected or denied.* Claims submitted to ODJFS on or after January 1, 2008 will be denied if the non-agency nurse's NPI number is not in the required field(s) on the claim. Claims submitted on or after May 23, 2008 will not require the Ohio Medicaid legacy number if ODJFS has a record of your NPI number and has linked the NPI to your Ohio Medicaid legacy number.

* *See special instructions for paper and tape claims (below in this MAL).*

I. How do I get an NPI?

Non-agency nurses can receive an NPI number by personally submitting an NPI application to NPPES. To obtain an NPI, non-agency nurses should contact NPPES directly at <http://nppes.cms.hhs.gov> or **by phone at 1-800-465-3203 (or 1-800-692-2326 (TTY))**. Providers can apply for an NPI electronically or by paper.

When you apply for your individual NPI, ODJFS encourages you to submit the following information with your NPI application:

- Ohio Medicare legacy (PIN) number,
- Ohio Medicaid legacy number,
- taxonomy number,
- social security number, and/or
- IRS individual tax identification number (TIN).

It is also important that you make it clear that you are applying for an NPI for an individual nurse (i.e., an entity type 1 NPI) by checking the box on the NPI application for "an individual who provides health care." A listing of taxonomy codes for Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) can be found at <http://www.wpc-edi.com/codes/taxonomy>.

II. How must my NPI relate to my Medicaid legacy number?

If your practice received this MAL, you/your practice submitted claim(s) as a non-agency nurse to ODJFS at least once during the last twelve months. When a non-agency nurse is doing business with ODJFS as an unincorporated or an incorporated individual, ODJFS only issues an individual Medicaid legacy number and expects the billing provider, the pay to provider and the rendering provider to be the same provider on any claim submitted to Medicaid.

A non-agency nurse may only submit claims for services personally rendered by them. Non-agency nurses must submit only the individual (entity type 1) NPI assigned to them with the Ohio Medicaid legacy number that was issued to them as a non-agency nurse. Only one NPI number may be associated with your non-agency nurse Medicaid legacy number. An NPI belonging to another nurse or another individual should never be submitted to ODJFS with your non-agency nurse Medicaid legacy number. Your individual NPI number should never be submitted on a Medicaid claim sent by another Medicaid provider (e.g., home health agency, other accredited home care agency, physician, APN). When a non-agency nurse is providing services as an employee of or an independent contractor of another provider or another health care entity, the services must be billed under provider identifiers belonging to that provider or entity.

III. How do I bill ODJFS using the NPI?

The billing instructions contained in this MAL are for non-agency nurses who provide private duty nursing services, waiver nursing services or other allowable waiver services under the Ohio Medicaid program.

Instructions for submitting the NPI by an individual non-agency nurse are also contained in the ODJFS EDI 837 Professional Companion Guide, which is available at:

<http://jfs.ohio.gov/OHP/providers/npi.stm> (see the box titled "Trading Partner").

Billing NPI on EDI 837 Professional Claims

The information in this section is technical but is intended to assist you in making the appropriate arrangements with your trading partner to receive your NPI number and to submit your NPI number on your EDI claims and other transactions. A copy of this MAL will also be issued to each EDI trading partner doing business with ODJFS.

The NPI number must be entered in the primary identifier field on ASCII X12 837 health care transactions. The non-agency nurse's NPI must be sent with the XX qualifier in the NM108 and the NPI in the NM109 of the 2010AB (for the pay to provider information) loop and/or 2010AA (for the billing provider information) loop. Prior to January 1, 2008, the non-agency nurse's Medicaid legacy provider number must also be sent with the 1D qualifier in the secondary identification qualifier location REF01 and the Medicaid legacy number in the secondary identification location REF02 of loops 2010AB and/or 2010AA. The EDI standard does not require the rendering provider loop to be completed if the rendering provider is the same as the pay to provider. For individual practices participating in Medicaid, the rendering and pay to provider are always the same. Do not send NPI information in the NM108 and NM109 nor the Medicaid legacy information in the REF01 and REF02 of the rendering provider loops (2310B or 2430B respectively).

Billing on Paper Claims or by Tape

** Special Instructions for Paper and Tape formats*

ODJFS is no longer accepting tape formats.

Beginning May 23, 2007, ODJFS will start to accept the Center for Medicare and Medicaid Services (CMS) 1500 (08/05) paper form (also referred to as the **new** CMS 1500). Providers may continue to send the CMS 1500 (12-90) paper form (also referred to as the **old** CMS 1500).

Providers using the old CMS 1500 must submit a Medicaid legacy number wherever a provider number (identifier) is required on the claim. Submitting an NPI number on the old CMS 1500 will cause the claim to reject or may cause the claim to pay inappropriately.

Providers submitting the new CMS 1500 must submit both the NPI and the Medicaid legacy number (identifier) in accordance with the ODJFS New CMS 1500 (08/05) Billing Instructions.

IV. If I am a non-agency nurse that is incorporated, do I still use my individual NPI number?

Yes, for Ohio Medicaid you must bill using NPI assigned to you as an individual nurse. The individual NPI issued to you will be linked to the Medicaid legacy number assigned to you as a non-agency nurse.

V. Why am I required to get an NPI?

The Code of Federal Regulations, CFR 45, Subpart D, Section 162.410 (a) (1) through (a) (6), requires non-agency nurses to obtain an NPI, to use it on all standard transactions where a provider identifier is required, and to disclose their NPI, when requested, to any entity that needs the NPI to identify that non-agency nurse in a standard transaction, including standard transactions sent to any health plan (i.e., Medicaid, Medicare or any other health plan). ODJFS must also comply with the federal regulations.

VI. Am I required to share my NPI number with ODJFS?

Yes, the non-agency nurse must disclose to ODJFS the NPI number that has been assigned to the individual nurse and associated with your social security number or tax identification number (TIN). If you do not disclose your NPI to ODJFS, ODJFS will not be able to recognize you as a valid Medicaid provider. This could cause your claims to deny.

Instructions on how to disclose your NPI information to ODJFS can be obtained under "SHARE IT!" from the following site: <http://ifs.ohio.gov/OHP/providers/npi.stm>.

VII. Am I required to share my NPI with other entities?

Yes, as stated in Section V above, you are required to disclose your NPI, when requested, to any entity that needs the NPI to identify the non-agency nurse in a standard transaction. This includes disclosing your NPI to Medicaid, Medicare, other health plans and other health care providers.

VIII. I heard that the date for NPI implementation has been extended. Is that true?

No, the law still requires providers of health care and health (except small) plans to be in compliance with the NPI regulations on May 23, 2007. However, for a 12 month period, CMS will not impose penalties on covered health plans that deploy contingency plans (in order to ensure the smooth flow of payments) if they have made reasonable efforts to become compliant and to facilitate the compliance of their providers and trading partners.

IX. Has ODJFS deployed a contingency plan?

Yes, ODJFS has deployed a contingency plan as detailed in this MAL.

X. What is meant by a dual identifier period?

A dual identifier period is the time period in which a health plan can require both the NPI and the plan's legacy (or proprietary) number on claim formats and may deny claims that are missing the plan's legacy number.

The purpose of the dual identifier period is to give health plans and providers the opportunity to assure the provider will get paid without interruption once NPI is fully implemented. It is in the provider's best interest to have a significant volume of claims that have both identifiers and have been submitted early

enough for ODJFS to assist the provider in correcting any NPI-related billing problems, prior to the end of the ODJFS dual identifier period.

As a part of ODJFS' NPI contingency plan, ODJFS has extended its dual identifier period to December 31, 2007. During this extended period, ODJFS requires both the Medicaid legacy identifier and the national provider identifier (NPI). Failure to continue to send the Medicaid legacy identifier during the ODJFS dual identifier period will result in non-payment or the rejection of claims.

Providers and trading partners will be notified in the event ODJFS believes the ODJFS dual identifier period can end sooner than December 31, 2007, or needs to be extended to the CMS approved date of May 23, 2008.

ODJFS appreciates the attention of the providers in this matter, and as a result of their cooperation anticipates a successful transition to NPI enumeration.

Questions pertaining to this MAL should be addressed to:

**Bureau of Plan Operations
The Provider Services Section
P.O. Box 1461
Columbus, Ohio 43216-1461**

Toll free telephone number 1-800-686-1516

You can also obtain information about NPI as it pertains to the Ohio Medicaid program at <http://ifs.ohio.gov/OHP/providers/npi.stm>

NPI.....GET IT.....SHARE IT.....USE IT

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 520

Medical Assistance Letter (MAL) No. 520

April 20, 2007

TO: All Medicare Certified Home Health Agencies
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Helen E. Jones-Kelley, Director

SUBJECT: Home Health and Private Duty Nursing Services: Billing Notes and Instructions

Several providers have experienced denials as a result of submitting inaccurate claims. As a reminder, this memorandum reiterates the Billing Notes and Instructions announced in the MAL No. 510 for the rules for Home Health and Private Duty Nursing Services (5101:3-12-01 through 5101:3-12-06 of the Administrative Code).

Billing Notes and Instructions

The CMS 1500 billing instructions were updated to accommodate the changes in the above-mentioned policies and to HIPAA compliant coding. Billing for Home Health and PDN may be made using either the CMS 1500 form, NSF tape or 837P EDI transaction.

Some items to note in the billing instructions include:

- Each line must represent a single visit. Multiple visits for the same service must be billed on separate lines but on the same claim. A visit for the provision of the same service, or service with the same scope of service, must be separated by two hours unless an agency requires a change in shift due to the length of a private duty nursing visit or waiver service.
- The following code groups must appear on separate claims.
 - G0151, G0152, G0153, G0154, G0156 (Home Health)
 - T1000 (Private Duty Nursing)
 - T1002, T1003, and T1019 (ODJFS-Admin. Waiver Nursing and Aide)
 - H0045, S0215, S5101, S5102, T2026, T2027, S5160, S5161, S5165,
 - S5170, S9127, S9470, and T2029 (ODJFS-Admin. Waiver Services)

Web Page

Providers may view Ohio Department of Job and Family Services transmittal letters, rules, manuals, forms and handbooks online at the ODJFS "electronic manuals" web page, <http://emanuals.odjfs.state.oh.us/emanuals/>.

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43216-1461

Toll Free Telephone Number 1-800-686-1516

MAL 519

Medical Assistance Letter (MAL) No. 519

Community Services Transmittal Letter (CSTL) No. 07-01

June 28, 2007

To: Medicare-Certified Home Health Agencies
Non-Agency Nurses
Otherwise Accredited Agencies
Case Managers and Administrators, CareStar
Directors, County Departments of Job and Family Services
ODJFS Medical Assistance Coordinators
Director, Ohio Department of Aging
Director, Ohio Department of Mental Retardation and Developmental Disabilities
Directors, Area Agencies on Aging
Superintendents/Executive Directors, County Boards of Mental Retardation and Developmental Disabilities
Executive Director, Ohio Board of Nursing
Executive Director, Ohio Nurses Association
Executive Director, Licensed Practical Nurse Association of Ohio
Co-Chairpersons, Ohio Olmstead Task Force
Executive Director, Ohio Council for Home Care
Vice President of Government Affairs, Ohio Home Care Organization
Hospital Discharge Planners

From: Helen E. Jones-Kelley, Director

Subject: Private duty nursing (PDN) service authorization

This Medical Assistance Letter (MAL) / Community Services Transmittal Letter (CSTL) transmits rule 5101:3-12-02.3, *Private duty nursing: procedures for service authorization*, which was previously emergency-filed with an effective date of September 1, 2006, and transmitted by [MAL 515](#).

This rule, which became effective on December 7, 2006, sets forth the procedures that must be followed by Medicaid providers and case managers when requesting prior authorization for PDN services for consumers who are not enrolled on a home- and community-based services (HCBS) waiver, consumers who are enrolled on an ODMR/DD- or ODA-administered waiver, and consumers who are enrolled on an ODJFS-administered waiver. It also sets forth the procedures to be followed when PDN services are required on an emergency basis. Specifically:

- 1) A PDN service provider must contact ODJFS to request PDN services when the consumer is not enrolled on an HCBS waiver.
- 2) An ODMR/DD or ODA case manager must assist a consumer and/or authorized representative in locating a PDN service provider when the consumer is enrolled on an ODMR/DD- or ODA-administered waiver.
- 3) A PDN service provider must contact an ODMR/DD or ODA case manager to request PDN services when the consumer is enrolled on an ODMR/DD- or ODA-administered waiver.

- 4) An ODJFS-designated case manager must assist an ODJFS-administered waiver consumer and/or authorized representative in locating a PDN service provider as part of the all services planning process.
- 5) ODJFS must notify the consumer and/or authorized representative, the PDN service provider, and/or the ODMR/DD or ODA case manager in writing of the authorized amount, scope, and duration of PDN services.
- 6) A consumer and/or authorized representative may request a hearing in the event of a disagreement about the authorized amount, scope, or duration of PDN services.

Providers will receive one printed copy of this transmittal letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a second printed copy of this letter with all attachments by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form. Or they may view ODJFS transmittal letters, rules, manuals, forms, and handbooks online at the ODJFS "electronic manuals" web page, <http://emanuals.odjfs.state.oh.us/emanuals/>.

Questions pertaining to this MAL / CSTL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216
In-state toll-free telephone number (800) 686-1516

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 515

Medical Assistance Letter (MAL) No. 515

November 1, 2006

TO: All Medicare Certified Home Health Agencies
Non-Agency Nurses
Otherwise Accredited Agencies
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators
Hospital Discharge Planners

FROM: Barbara E. Riley, Director

SUBJECT: Home Health Services, Private Duty Nursing (PDN) Service and Private Duty Nursing Authorization

This Medical Assistance Letter (MAL) transmits three rules and a form associated with the provision of PDN services. This MAL also transmits a revision to previous policy regarding the use of an appropriate signature.

Private Duty Nursing Service

This letter transmits the permanent Ohio Administrative Code (OAC) rules 5101:3-12-02, *Private duty nursing: services, provision requirements, coverage and service specification*, and OAC rule 5101:3-12-06, *Reimbursement: private duty nursing services*, which have an effective date of September 28, 2006. These rules continue the rules that were emergency filed. The only new policy in OAC rule 5101:3-12-02 is found in paragraph (A) regarding the length of visit as designated in the PDN authorization process.

Private Duty Nursing Authorization /JFS 02374

This letter transmits OAC rule 5101:3-12-02.3, *Private duty nursing: procedures for service authorization*, which was emergency filed with an effective date of September 1, 2006. This rule allowed providers on or after September 1, 2006 to request authorization of PDN services for dates of service on or after October 1, 2006 using two mechanisms:

1. For consumers who are either not enrolled on a waiver, or are enrolled on a waiver administered by the Ohio Department of Mental Retardation and Developmental Disabilities or the Ohio Department of Aging, providers will use the JFS 02374, "Private Duty Nursing (PDN) Services Request." The form is submitted to the Bureau of Home and Community Services as indicated on the form. Please refer to the rule for details regarding the authorization process.
2. For consumers who are enrolled on an ODJFS administered waiver, providers will receive authorization of PDN services as specified on the JFS 02375, "All Services Plan." Please refer to the rule for details regarding the authorization process.

JFS 07137 Appropriate Signature - Home Health/PDN

After the final rule filing of the home health and PDN rules, the department determined that the wording in paragraph (C) of OAC rule 5101:3-12-01 and paragraph (E) of OAC rule 5101:3-12-02 was ambiguous with respect to the person who could certify that the services are medically necessary. These two rules and the Home Care Certification Form (JFS 07137) will be amended to clarify that only a treating physician can certify the medical necessity of home health or PDN services. **The only acceptable signature on the JFS 07137 is the treating physician's signature.**

Interactive Voice Response System (IVR) Information

Providers may contact the IVR for 24-hour, 7-day a week access to information about client Medicaid and waiver eligibility status, claim status, payment status, prior authorization, drug and procedure codes, and

provider information. The IVR phone number is 1-800-686-1516. More information about the IVR may be found at: <http://jfs.ohio.gov/ohp/bpo/pnms/ivrs/index.stm>

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, forms and handbooks. The URL for this web page is:
<http://emanuals.odjfs.state.oh.us/emanuals/>

Providers will receive one hard copy of this MAL and the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the internet and wishes to request a paper copy of this transmittal letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family Services according to the instructions at the top of the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216

In-state toll free telephone number 1-800-686-1516

MAL 510

Medical Assistance Letter (MAL) No. 510

July 28, 2006

TO: All Medicare Certified Home Health Agencies
Non-Agency Nurses
Otherwise Accredited Agencies
Directors, County Department of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Home Health and Private Duty Nursing Services

Effective July 1, 2006

This memorandum announces the rules for Home Health and Private Duty Nursing Services (5101:3-12-01 through 5101:3-12-06 of the Administrative Code). These rules were revised as part of the five year rule review and the Ohio Home Care Waiver Redesign project and for HIPAA code compliance. Consumer and provider representatives were involved in the public process for these rules. These rules replace rules 5101:3-12-01 through 5101:3-12-06, 5101:3-12-10, and 5101:3-1-07 of the Administrative Code in effect before July 1, 2006. Note that rule 5101:3-1-39 of the Administrative Code effective April 1, 2005 is still in effect. Rules 5101:3-12-02 and 5101:3-12-06 were emergency filed on June 30, 2006 to accommodate comments made during the public process. These rules are in the process of a permanent filing for an effective date of September 28, 2006.

Home Health Services

(Providers are Medicare Certified Home Health Agencies (MCRHHAs) Only)

Provision requirements, coverage and service specifications (5101:3-12-01).

Reimbursement (5101:3-12-05 with Appendix A and B).

Home health services include home health nursing, home health aide and skilled therapies. The home health service, like the Core Benefit Package it replaced, requires part-time and intermittent services. However, the home health service allows consumers meeting specific criteria to access an increase in their hours per week for 60 days after a three day hospital stay.

Other highlights include: Services cannot be provided for the purpose of respite or habilitation. Skilled therapy services cannot be provided as maintenance care unless a home health aide provides routine and maintenance care within the scope of his or her duties. Home health services must be provided in the place of the consumer's residence. When a consumer is enrolled in a home and community based waiver, the consumer's service/all services plan must identify/document the services as provided in the consumer's plan of care.

The reimbursement rule covers the calculation of the Medicaid maximum from base rate and unit amounts and provides the applicable procedure codes and modifiers. The procedures codes and modifiers are repeated here for your reference.

New Procedure Code	Description	Valid Modifiers
G0151	Physical Therapy	U2, U3, U5, HQ
G0152	Occupational Therapy	U2, U3, U5, HQ
G0153	Speech Therapy	U2, U3, U5 HQ

G0154	Home Health Nursing	U1, U2, U3, U5, HQ
G0156	Home Health Aide	U2, U3, U5, HQ

Private Duty Nursing, PDN

(Providers are MCRHHAs, Non-Agency Nurses and Otherwise Accredited Agencies)

Provision requirements, coverage and service specifications (5101:3-12-02). Reimbursement (5101:3-12-06 with Appendix A and B).

PDN is a continuous nursing service that may be accessed in one of three ways. First, consumers meeting specific criteria in paragraph (E) of rule 5101:3-12-02 may access up to 56 hours per week of PDN for up to 60 days after a three day hospital stay. Second, children who meet the criteria in paragraph (F) of rule 5101:3-12-02 may qualify for PDN. Third, adults who meet the criteria in paragraph (G) of rule 5101:3-12-02 may receive PDN services. Providers should note that for dates of services on or after October 1, 2006 children and adults receiving PDN will need to be prior authorized. Additionally, new policy, effective for July 1, 2006, regarding PDN visits will be transmitted when the permanent rules are filed in September. Details of the prior authorization process and PDN visit policy will be announced in a later MAL.

The reimbursement rule covers the calculation of the Medicaid maximum from base rate and unit amounts and provides the applicable procedure code and modifiers. The procedures code and modifiers are repeated here for your reference.

New Procedure Code	Description	Valid Modifiers
T1000	Private Duty Nursing	U1, U2, U3, U4, U5, U6, HQ

Provider Qualifications and Requirements

Medicare certified home health agencies (MCRHHA) (5101:3-12-03).

Non-agency nurses and otherwise accredited agencies (5101:3-12-03.1).

Visit policy (5101:3-12-04).

These rules announce qualifications and requirements for Medicaid providers of home health and private duty nursing services. Many of the requirements reference the Code of Federal Regulations and/or the Medicare Benefit Policy Manual. Efforts were made to parallel the requirements from Medicare for administrative purposes. Non-agency nurses and otherwise accredited agencies are required to follow the same requirement as appropriate and specified in rule 5101:3-12-03. Additionally, non-agency nurses must meet additional conditions of participation, be in compliance with any applicable rules if their consumer is enrolled in a home and community base services waiver, and cannot be related to the consumer.

All Home Health and PDN services are reimbursed on a per visit basis. The policy addresses the definition of a visit, how visits should be billed, multiple visits and group visits. Providers should note the policy requiring the lapse of two or more hours between visits.

Consumers Previously Receiving Core Plus

Two new rules were filed that allowed those consumers receiving Core Plus services to be assessed for an ODJFS-administered waiver (5101:3-12-02.1 and 5101:3-45-15).

Billing Notes and Instructions

- The CMS 1500 [billing instructions](#) have been updated to accommodate the changes in policy and HIPPA compliant coding. Billing for Home Health and PDN may be made using either the CMS 1500 form, NSF tape or 837P EDI transaction.

Some items to note in the billing instructions include:

- Each line must represent a single visit. Multiple visits for the same service must be billed on separate lines but on the same claim. A visit for the provision of the same service, or service with the same scope of service, must be separated by two hours unless an agency requires a change in shift due to the length of a private duty nursing visit or waiver service.
- The following code groups must appear on separate claims.
 - G0151, G0152, G0153, G0154, G0156 (Home Health)
 - T1000 (Private Duty Nursing)
 - T1002, T1003, and T1019 (ODJFS-Admin. Waiver Nursing and Aide)
 - H0045, S0215, S5101, S5102, T2026, T2027, S5160, S5161, S5165, S5170, S9127, S9470, and T2029 (ODJFS-Admin. Waiver Services)

JFS 07137, Home Care Certification Form

This form is used by the treating physician, a hospital discharge planner or a registered nurse acting under the orders of the treating physician to certify the need for increased home health services and/or private duty nursing services for up to 60 consecutive days from the date of discharge from an inpatient hospital stay of three or more days in length.

Web Page and Paper Distribution

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page for the department's rules, manuals, forms and handbooks. The URL is as follows:

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

Providers will receive one hard copy of this medical assistance letter and the JFS 03400 "Ohio Department of Job and Family Services, Service Provider Update Request Form." If a provider does not have access to the Internet and wishes to request a paper copy of this transmittal letter with all attachments, the provider should complete the attached JFS 03400 and return it to the Ohio Department of Job and Family Services according to the instructions at the top of the form.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations

The Provider Network Management Section

P.O. Box 1461

Columbus, Ohio 43216

In-state toll free telephone number 1-800-686-1516

BIN.1001.2. Instructions for Completing the CMS 1500

[Click here to view the Instructions for Completing the CMS 1500.](#)

Home Health/Private Duty Nursing Rules

5160-1-39 **Verification of Home Care Service Provision to Home Care Dependent Adults**

***Formerly* 5101:3-1-39** **Verification of Home Care Service Provision to Home Care Dependent Adults**

[Click here to view OAC 5160-1-39 Verification of Home Care Service Provision to Home Care Dependent Adults](#)

This rule is maintained in the ODJFS Ohio Administrative Code eManual, located in the Legal Services collection.

[MAL 574](#) / [MHTL 3336-11-01](#)

Effective Date: February 1, 2011

Most Current Prior Effective Date: [November 8, 2007](#)

- (A) "Home health services" includes home health nursing, home health aide and skilled therapies as defined in paragraph ~~(F)~~(G) of this rule.
- (B) Home health services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the consumer within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code in which he or she performs that function or action. Advanced practice nurses in accordance with rule 5101:3-8-21 of the Administrative Code and in collaboration with the qualifying treating physician, or a physician assistant in accordance with rule [5101:3-4-03](#) of the Administrative Code and under the supervision of the qualifying treating physician, have the authority to conduct the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services. The face-to-face encounter with the consumer must occur independent of any provision of home health services to the consumer by the individual performing the face-to-face encounter. The face-to-face encounter must be documented:
- (1) For home health services unrelated to an inpatient hospital stay, the face-to-face encounter must be documented by the qualifying treating physician using:
 - (a) The [JFS 07137](#) "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) or
 - (b) The consumer's plan of care may be used to certify medical necessity for home health services if all of the data elements specified for home health services unrelated to an inpatient hospital stay in the [JFS 07137](#) "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) are included and the plan of care contains the physician's signature, physician's credentials and the date of the physician's signature.
 - (2) For post hospital home health services, the face-to-face encounter must be documented by the qualifying treating physician using the [JFS 07137](#) "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011).
 - (3) For a dual eligible consumer, if the face-to-face encounter date for medicare home health services falls within the ninety days prior to the medicaid home health services start of care date, or within thirty days following the medicaid start of care date inclusive of the medicaid start of care date, may be used on the [JFS 07137](#) "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) and the supporting documents attached to this form.
- ~~(B)~~(C) Home health services are covered only if provided on a part-time and intermittent basis, which means:
- (1) No more than a combined total of eight hours (thirty-two units) per day of home health nursing, home health aide, and skilled therapies except as specified in paragraph ~~(G)~~(H) of this rule;
 - (2) No more than a combined total of fourteen hours (fifty-six units) per week of home health nursing and home health aide services except as specified in paragraphs ~~(C)~~(D) and ~~(G)~~(H) of this rule; and

- (3) Visits are not more than four hours (sixteen units). Most visits are usually less than two hours (eight units). Nursing visits over four hours (sixteen units) may qualify for coverage in accordance with rule 5101:3-12-02 of the Administrative Code.

~~(C)~~(D) A combined total of twenty-eight hours (one hundred twelve units) per week of home health nursing and home health aide services is available to a consumer for up to sixty consecutive days from the date of discharge from an inpatient hospital stay of three or more covered days, if all of the following are met by the consumer as certified by the qualifying treating physician using the JFS 07137 "Certificate of Medical Necessity for Home ~~Care Certification~~ Health Services and Private Duty Nursing Services " (rev. ~~7/2006~~2/2011):

- (1) Consumer has a discharge date from an inpatient hospital stay of three or more covered days. For the purposes of this rule, a covered inpatient hospital stay is defined in rule [5101:3-2-03](#) of the Administrative Code and is considered one hospital stay when a consumer is transferred from one hospital to another hospital, either within the same building or to another location. The sixty days will begin once the consumer is discharged to the consumer's place of residence or to a nursing facility as defined in paragraph ~~(D)(3)~~(E)(4) of this rule, from the last inpatient stay whether or not the last inpatient stay was an inpatient hospital or inpatient rehabilitation unit of a hospital.
- (2) Consumer has a comparable level of care as evidenced by either:
 - (a) Enrollment in a home and community based services (HCBS) waiver; or
 - (b) Has a medical condition that temporarily meets the criteria for an institutional level of care which are any of the following rules defined in rule [5101:3-3-05](#) of the Administrative Code for skilled level of care (SLOC), or defined in rule [5101:3-3-06](#) of the Administrative Code for intermediate level of care, or defined in rule 5101:3-3-07 of the Administrative Code for ICF/MR level of care. In no instance does this requirement constitute the determination of a level of care for waiver eligibility status, or admission into a medicaid covered long term care institution.
- (3) Requires home health nursing or a combination of private duty nursing/home health nursing/waiver nursing/skilled therapy services at least once per week that is medically necessary in accordance with rule [5101:3-1-01](#) of the Administrative Code.
- (4) The consumer has had a covered inpatient hospital stay of three or more days, with the discharge date recorded on form JFS 07137 "Certificate of Medical Necessity for Home ~~Care Certification~~ Health Services and Private Duty Nursing Services" (rev. ~~7/2006~~2/2011).

~~(D)~~(E) The only provider of home health services is the MCRHHA (medicare certified home health agency) that meets the requirements in accordance with rule [5101:3-12-03](#) of the Administrative Code. In order for home health services to be covered, MCRHHAs must:

- (1) Provide home health services only if the qualifying treating physician has documented a face-to-face encounter with the consumer as specified in paragraph (B) of this rule.
- ~~(1)~~(2) Provide home health services that are appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as ordered by the consumer's treating physician for the treatment of the consumer's illness or injury.
- ~~(2)~~(3) Provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. Home health services not specified in a plan of care are not reimbursable. Additionally the MCRHHA's plan of care must provide the amount, scope, duration, and type of home health service as:
 - (a) Identified on the all services plan as defined in rule [5101:3-45-01](#) of the Administrative Code that is prior approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS-administered home and community based services (HCBS) waiver. Home health services that are not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when a consumer is enrolled in an ODA_ (Ohio department of aging) administered or ~~an~~ ~~ODMR/DD~~ ~~DODD~~- (Ohio department of ~~mental retardation and~~ developmental disabilities) administered HCBS waiver. Home health services that are not documented on the services plan are not reimbursable.

~~(3)~~(4) Provide home health services in the consumer's place of residence, in a licensed child day-care center, or for a child three years and under in a setting where the child receives early intervention services (EI) as indicated in the individualized family service plan (IFSP).

(a) "Consumer's place of residence" is wherever the consumer lives, whether the home is the consumer's own dwelling, an apartment, an assisted living residence, a relative's home, or an other type of living arrangement. The place of residence does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICR/MR).

(b) For the purposes of this chapter, "licensed child day-care center" means a "child day-care center" as defined in section 5104.01 of the Revised Code that is licensed pursuant to section 5104.03 of the Revised Code but does not include a licensed child day-care center that is the permanent residence of the licensee or administrator.

(c) "Setting" is the natural environment in which the services will appropriately be provided.

~~(4)~~(5) Not provide home health nursing and home health aide services for the provision of habilitative care, or respite care, and not provide skilled therapies for the provision of maintenance care, habilitative care or respite care.

(a) "Maintenance care" is the care given to a consumer for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the consumer is no longer making significant improvement in his or her medical condition.

(b) "Habilitative care" is in accordance with ~~Chapter 5101:3-1 of the Administrative Code~~ 42 U.S.C. 1396n(C)(5) (March 30, 2010).

(c) "Respite care" is the care provided to a consumer unable to care for himself or herself because of the absence or need for relief of those persons normally providing care.

~~(5)~~(6) Bill for provided home health services in accordance with the visit policy in rule 5101:3-12-04 of the Administrative Code.

~~(6)~~(7) Bill for provided home health services using the appropriate procedure code and applicable modifiers in accordance with rule 5101:3-12-05 of the Administrative Code.

~~(7)~~(8) Bill after all documentation is completed for the services rendered during a visit in accordance with rule 5101:3-12-03 of the Administrative Code.

~~(E)~~(F) Consumers who receive home health services must:

(1) Participate in a face-to-face encounter as specified in paragraph (B) of this rule for the purpose of certifying their medical need for home health services.

~~(4)~~(2) Be under the supervision of a treating physician who is providing care and treatment to the consumer. The treating physician cannot be a physician whose sole purpose is to sign and authorize plans of care or who does not have direct involvement in the care or treatment of the consumer. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.

~~(2)~~(3) Participate in the development of a plan of care along with the treating physician and the MCRHHA. An authorized representative may participate in the development of a plan of care in lieu of the consumer.

~~(3)~~(4) Access home health services in accordance with the program for the all-inclusive care of the elderly (PACE) when the consumer participates in the PACE program.

~~(4)~~(5) Access home health services in accordance with the consumer's provider of hospice services when the consumer has elected the hospice benefit.

~~(5)~~(6) Access home health services in accordance with the consumer's managed care plan when the consumer is enrolled in a medicaid managed care plan.

~~(F)~~(G) Covered home health services are:

- (1) "Home health nursing" is a nursing service that requires the skills of and is performed by a registered nurse, or a licensed practical nurse at the direction of a registered nurse. The nurse performing the service must be employed or contracted by the MCRHHA providing the service. A service is not considered a nursing service merely because it is performed by a licensed nurse. Home health nursing services:
 - (a) Must be performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted there under.
 - (b) Must be provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.
 - (c) Must be provided in a face-to-face encounter.
 - (d) Must be medically necessary in accordance with rule [5101:3-1-01](#) of the Administrative Code to care for the consumer's illness or injury.
 - (e) Are not covered when the visit is solely for the supervision of the home health aide.
 - (f) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously, or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-05 of the Administrative Code.
- (2) "Home health aide" is a service that requires the skills of and is performed by a home health aide employed or contracted by the MCRHHA providing the service. Home health aide services:
 - (a) Are performed within the home health aide's scope of practice as defined in 42 C.F.R. 484.36 ~~(October 1, 2005)~~(June 18, 2001). The home health aide cannot be the parent, step-parent, foster parent or legal guardian of a consumer who is under eighteen years of age, or the consumer's spouse.
 - (b) Are provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.
 - (c) Must be provided in a face-to-face encounter.
 - (d) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.
 - (e) Must be necessary to facilitate the nurse or therapist in the care of the consumer's illness or injury, or help the consumer maintain a certain level of health in order to remain in the home setting. Health related services can include:
 - (i) Bathing, dressing, grooming, hygiene, including shaving, skin care, foot care, ear care, hair, nail and oral care, that are needed to facilitate care or prevent deterioration of the consumer's health, and including changing bed linens of an incontinent or immobile consumer.
 - (ii) Feeding, assistance with elimination including administering enemas (unless the skills of a home health nurse are required), routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers.

- (iii) Performing a selected nursing activity or task as delegated in accordance with Chapter 4723-13 of the Administrative Code, and performed as specified in the plan of care.
 - (iv) Assistance with activities such as routine maintenance exercises and passive range of motion as specified in the plan of care. These activities are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed. The plan of care is developed by either a licensed nurse or therapist within their scope of practice.
 - (v) Performing routine care of prosthetic and orthotic devices.
 - (f) May also include incidental services along with health related services as listed in paragraph ~~(F)(2)(d)~~(G)(2)(e) of this rule, as long as they do not substantially extend the time of the visit.
 - (i) Incidental services are necessary household tasks that must be performed by anyone to maintain a home and can include light chores, consumer's laundry, light house cleaning, preparation of meals, and/or taking out the trash.
 - (ii) The main purpose of a home health aide visit cannot be solely to provide these incidental services since they are not health related services.
 - (iii) Incidental services are to be performed only for the consumer and not for other people in the consumer's covered place of residence.
- (3) "Skilled therapies" are defined as physical therapy, occupational therapy, and speech-language pathology services that require the skills of and are performed by skilled therapy providers to meet the consumer's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.
 - (a) "Skilled therapy providers" are licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants (LPTA) under the direction of a physical therapist, or certified occupational therapy assistants (COTA) under the direction of a licensed occupational therapist who are contracted or employed by a MCRHHA.
 - (b) "Rehabilitation" is the care of a consumer with the intent of curing the consumer's disease or improving the consumer's condition by the treatment of the consumer's illness or injury, or the restoration of a function affected by illness or injury.
 - (c) Skilled therapies:
 - (i) Must be provided to the consumer within the therapist's or therapy assistant's scope of practice in accordance with sections 4755.44, 4755.07, and 4753.07 of the Revised Code.
 - (ii) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.
 - (iii) Must be provided and documented in the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.
 - (iv) Must be reasonable in their amount, frequency, and duration. Treatment must be considered according to the accepted standards of medical practice to be safe and effective treatment for the consumer's condition.
 - (v) Must be provided with the expectation of the consumer's rehabilitation potential according to the treating physician's prognosis of illness or injury. The expectation of the consumer's rehabilitation potential is that the condition of the consumer will measurably improve within a reasonable period of time or the services are necessary to the establishment of a safe and effective maintenance program.

- (vi) May include treatments, assessments and/or therapeutic exercises but cannot include activities that are for the general welfare of the consumer, including motivational or general activities for the overall fitness of the consumer.

~~(G)~~(H) A consumer who meets the requirements in this paragraph may qualify for increased services. The MCRHHA must assure and document the consumer meets all requirements in this paragraph prior to increasing services. The U5 modifier must be used when billing in accordance to rule 5101:3-12-05 of the Administrative Code. The use of the U5 modifier indicates that all conditions of this paragraph were met. The consumer who meets the following requirements may receive an increase of home health services if he or she:

- (1) Is under age twenty-one and requires services for treatment in accordance with Chapter 5101:3-14 of the Administrative Code for the healthchek program.
- (2) Requires more than, as ordered by the treating physician:
 - (a) Eight hours (thirty two units) per day of any home health service, or a combined total of fourteen hours (fifty six units) per week of home health aide and home health nursing as specified in paragraph ~~(B)~~(C) of this rule; or
 - (b) A combined total of twenty-eight hours (one hundred twelve units) per week of home health nursing and home health aide for sixty days as specified in paragraph ~~(E)~~(D) of this rule.
- (3) Has a comparable level of care as evidenced by either:
 - (a) Enrollment in a HCBS waiver; or
 - (b) A level of care evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. In no instance does this constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long term care institution; and
- (4) Requires home health nursing or a combination of PDN/home health nursing/waiver nursing/skilled therapy visits at least once per week that is medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code as ordered by the treating physician.

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R.C. 119.032 review dates: 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

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MAL 515

Effective Date: September 28, 2006

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- (A) "Private duty nursing (PDN)" is a continuous nursing service that requires the skills of and is performed by either a registered nurse or a licensed practical nurse at the direction of a registered nurse and is provided in one or more PDN visits. A continuous nursing visit (or PDN visit) is defined as a medically necessary visit that is more than four hours (more than sixteen units) but less than or equal to twelve hours (forty-eight units) in length. A service is not considered a nursing service merely because it was performed by a licensed nurse. For dates of service on or after 7/01/06, a covered PDN visit must meet the definition of paragraph (A) in rule 5101-3-12-04 of the Administrative Code and be more than four hours (more than sixteen units) in length but less than or equal to twelve hours (forty-eight units) in length, unless:
- (1) An unusual, occasional circumstance requires a medically necessary visit of up to and including sixteen hours (sixty-four units); or
 - (2) Less than a two hour lapse between visits has occurred and the length of the PDN service requires an agency to provide a change in staff; or
 - (3) Less than a two hour lapse between visits has occurred and the PDN service is provided by more than one non-agency provider; or
 - (4) ODJFS or its designee has authorized PDN visits that are four hours or less length in accordance with rule 5101:3-12-02.3 of the Administrative Code.
- (B) For PDN to be covered, the service:
- (1) Must be performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.
 - (2) Must be provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.
 - (3) Must be provided in a face-to-face encounter.
 - (4) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.
 - (5) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-06 of the Administrative Code.
 - (6) Must be provided in the consumer's place of residence unless it is medically necessary for a nurse to accompany the consumer in the community. The consumer's place of residence is wherever the consumer lives, whether the residence is the consumer's own dwelling, an apartment, assisted living facility, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). The place of service in the community cannot include the residence or business location of the provider of PDN.
 - (7) Must not be provided for the provision of habilitative care. "Habilitative care" is referenced in Chapter 5101:3-1 of the Administrative Code.
 - (8) Must meet the criteria in accordance with this paragraph and paragraphs (A), (C) and (D) of this rule.

- (9) For "children" (consumers under the age of twenty-one), must also meet the criteria in accordance with either paragraph (E) or (F) of this rule.
- (10) For "adults" (consumers age twenty-one and older), must also meet the criteria in accordance with either paragraph (E) or (G) of this rule.

(C) The providers of PDN are: MCRHHAs (medicare certified home health agencies) that meet the requirements in accordance with rule 5101:3-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5101:3-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5101:3-12-03.1 of the Administrative Code. In order for PDN to be covered, these providers must:

- (1) Provide PDN that is appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as documented by the consumer's treating physician.
- (2) Provide PDN as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. PDN services not specified in a plan of care are not reimbursable. Additionally, for consumers enrolled on an HCBS waiver, the providers of PDN services must provide the amount, scope, duration, and type of PDN service within the plan of care as:
 - (a) Identified on the all services plan that is approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS administered home and community based services (HCBS) waiver. PDN services not identified on the all services plan are not reimbursable; or
 - (b) Documented on the services plan when a consumer is enrolled in an ODA (Ohio department of aging) administered or an ODMR/DD (Ohio department of mental retardation and developmental disabilities) administered HCBS waiver. PDN services not documented on the services plan are not reimbursable.
- (3) Bill for provided PDN services using the appropriate procedure code and applicable modifiers in accordance with rule 5101:3-12-06 of the Administrative Code.
- (4) Bill for provided PDN services in accordance with the visit policy in rule 5101:3-12-04 of the Administrative Code, except as provided for in paragraph (A) of this rule.
- (5) Bill after all documentation is completed for services rendered during a visit in accordance with rule 5101:3-12-03 of the Administrative Code.

(D) Consumers who receive PDN must:

- (1) Be under the supervision of a treating physician who is providing care and treatment to the consumer. The treating physician cannot be a physician whose sole purpose is to sign and authorize plans of care or who does not have direct involvement in the care or treatment of the consumer. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.
- (2) Participate in the development of a plan of care with the treating physician and the MCRHHA or other accredited agencies or non-agency registered nurse. An authorized representative may participate in the development of the plan of care in lieu of the consumer.
- (3) Access PDN in accordance with the program for the all-inclusive care of the elderly (PACE) if the consumer participates in the PACE program.
- (4) Access PDN in accordance with the consumer's provider of hospice services if the consumer has elected hospice.
- (5) Access PDN in accordance with the consumer's managed care plan if the consumer is enrolled in a medicaid managed care plan.

(E) Post hospital - PDN:

- (1) Any medicaid consumer, whether adult or child, may receive PDN services up to fifty-six hours (two hundred twenty-four units) per week, and up to sixty consecutive days from the date of

discharge from an inpatient hospital stay of three or more covered days in accordance with rule 5101:3-2-03 of the Administrative Code. For purposes of this rule, a covered inpatient hospital stay is considered one hospital stay when a consumer is transferred from one hospital to another hospital, either within the same building or to another location.

(a) The sixty days will begin once the consumer is discharged from the hospital to the consumer's place of residence as defined in paragraph (B)(6) of this rule, from the last inpatient stay whether or not the last inpatient stay was in an inpatient hospital or inpatient rehabilitation unit of a hospital.

(b) The sixty days will begin once the consumer is discharged from a hospital to a nursing facility. PDN is not available while residing in a nursing facility.

(2) The treating physician or a hospital discharge planner or a registered nurse acting under the orders of the treating physician certifies the medical necessity of PDN services using the [JFS 07137 "Home Care Physician Certification Form"](#) (rev. 7/2006). PDN is available to consumers only if they have a medical need comparable to a skilled level of care as evidenced by a medical condition that temporarily reflects the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code. In no instance do these requirements constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long-term care institution.

(3) The PDN service must not be for the provision of maintenance care. "Maintenance care" is the care given to a consumer for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the consumer is no longer making significant improvement in his or her medical condition.

(4) All requirements must be met in paragraph (E) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(5) Consumers who require additional PDN with or without a hospitalization may access PDN through either paragraph (F) or (G) of this rule.

(F) Child - PDN:

(1) A child may qualify for PDN services if he or she meets the requirements within paragraph (F) of this rule.

(a) Is under age twenty-one and requires services for treatment in accordance with Chapter 5101:3-14 of the Administrative Code for the healthchek program.

(b) Requires (as ordered by the treating physician) continuous nursing including the provision of on-going maintenance care. Services cannot be for habilitative care as defined in paragraph (B)(7) of this rule.

(c) Has a comparable level of care as evidenced by either:

(i) Enrollment in a HCBS waiver; or

(ii) A comparable institutional level of care as evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. In no instance do these criteria constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long-term care institution.

(2) The provider of PDN services must assure and document the consumer meets all requirements in paragraph (F) of this rule prior to requesting and billing for the PDN services.

- (3) The U5 modifier must be used when billing in accordance with rule 5101:3-12-06 of the Administrative Code. The use of the U5 modifier indicates that all conditions of paragraph (F) of this rule were met, PDN authorization was obtained and the consumer continued to meet medical necessity criteria.
- (4) The child must have a PDN authorization obtained in accordance with rule 5101:3-12-02.3 of the Administrative Code and approved by ODJFS or its designee to establish medical necessity and the consumer's comparable level of care. ODJFS or its designee will conduct a face-to-face encounter and/or review of documentation. In an emergency, PDN services may be delivered and PDN authorization obtained after the delivery of services when the services are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, and the services are required to protect the health and welfare of the consumer. A request for PDN authorization is made as follows:
- (a) For a child not enrolled in a HCBS waiver, the provider of PDN must submit the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider of the amount, scope and duration of services authorized.
- (b) For a child enrolled in an ODMR/DD or ODA-administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver, who will be forwarded to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.
- (c) For a child enrolled in an ODJFS-administered waiver, the case manager will authorize PDN services through the all services plan.
- (5) All requirements must be met in paragraph (F) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.
- (G) Adult - PDN: The adult consumer who meets the following requirements may receive PDN services.
- (1) The adult is age twenty-one or older.
- (2) The adult requires (as ordered by the treating physician) continuous nursing including the provision of on-going maintenance care. Services cannot be for habilitative care as defined in paragraph (B)(7) of this rule.
- (3) The adult has a comparable level of care as evidenced by either:
- (a) Enrollment in a HCBS waiver; or
- (b) A comparable institutional level of care as evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. In no instance does this constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long term care institution.
- (4) The provider of PDN services must assure and document the consumer meets all requirements in paragraph (G) of this rule prior to providing PDN. Providers must bill using the U6 modifier in accordance with rule 5101:3-12-06 of the Administrative Code. The use of the U6 modifier indicates that all conditions of paragraph (G) of this rule were met, PDN authorization was obtained and the consumer continued to meet medical necessity criteria.

- (5) The adult must have a PDN authorization obtained in accordance with rule 5101:3-12-02.3 of the Administrative Code and approved by ODJFS or its designee to establish medical necessity and the consumer's comparable level of care. ODJFS or its designee will conduct a face-to-face encounter and/or review of documentation. In an emergency, PDN services may be delivered and PDN authorization obtained after the delivery of services when the services are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, and the services are required to protect the health and welfare of the consumer. A request for PDN authorization is made as follows:
- (a) For an adult not enrolled in a HCBS waiver, the provider of PDN must submit the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider of the amount, scope and duration of services authorized.
- (b) For an adult enrolled in an ODMR/DD or ODA-administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver, who will forward the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.
- (c) For an adult enrolled in an ODJFS-administered waiver, the case manager will authorize PDN services through the all services plan.
- (6) All requirements must be met in paragraph (G) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(H) Consumers subject to medical determinations made by ODJFS or its designee pursuant to this rule will be afforded notice and hearing rights to the extent afforded in division 5101:6 of the Administrative Code.

Attachment

[Click here to view the JFS 07137.](#)

[Click here to view the Instructions for Completing the JFS 07137.](#)

Replaces: Part of 5101:3-12-01, 5101:3-12-02, 5101:3-12-03, 5101:3-12-04, 5101:3-12-05, 5101:3-12-06

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5160-12-02.1 Provision for Consumers Enrolled in and Providers who Provide the Core Plus Benefit Package Services

***Formerly* 5101:3-12-02.1 Provision for Consumers Enrolled in and Providers who Provide the Core Plus Benefit Package Services**

Effective Date: July 1, 2006

- (A) Core plus benefit package will no longer be available as of the effective date of this rule. The core plus benefit package was defined in Chapter 5101:3-12 of the Administrative Code prior to the effective date of this rule.
- (B) Consumers who were enrolled in the core plus benefit package, for any time period during the one hundred twenty days preceding the effective date of this rule, will have an eligibility determination made by ODJFS or its designated case management agency (CMA) in accordance with rule 5101:3-45-15 of the Administrative Code to determine if the consumer is eligible for an ODJFS-administered waiver.
- (C) If a consumer is determined ineligible for an ODJFS-administered waiver or the consumer chooses not to enroll in an ODJFS-administered waiver, the consumer will be afforded notice and hearing rights in accordance with division-level 5101:6 of the Administrative Code.

Effective: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2006

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.85

Most current prior effective date: [September 1, 2006 \(Emergency\)](#)

- (A) As a prerequisite to receiving private duty nursing (PDN) services,
- (1) A child must meet the requirements of rule 5101:3-12-02 of the Administrative Code, including paragraph (F)(4)(a) or (F)(4)(b), as applicable, which require the child receive PDN authorization from ODJFS or its designee; or
 - (2) An adult must meet the requirements of rule 5101:3-12-02 of the Administrative Code, including paragraph (G)(5)(a) or (G)(5)(b), as applicable, which require the adult receive PDN authorization from ODJFS or its designee.
- (B) The procedures set forth in this paragraph must be followed when securing a PDN authorization for children and adults who are not enrolled on a home and community-based services (HCBS) waiver. ODJFS shall specify the amount, scope and duration of PDN services to be authorized. The period for which PDN authorization applies shall not exceed one hundred eighty days.
- (1) The PDN provider shall submit a referral for PDN authorization to ODJFS on the JFS 02374, "Private Duty Nursing (PDN) Services Request" (9/06), and shall submit any additional supporting documentation requested by ODJFS.
 - (2) ODJFS shall conduct a face-to-face assessment and/or perform a desk review to determine if, in accordance with rule 5101:3-12-02 of the Administrative Code, the consumer has a medical condition that meets the criteria for an institutional level of care, and the services are medically necessary as set forth in rule 5101:3-1-01 of the Administrative Code.
 - (a) If ODJFS determines the consumer has a medical condition that meets the criteria for an institutional level of care, and PDN services are medically necessary as set forth in rule 5101:3-1-01 of the Administrative Code, ODJFS shall:
 - (i) Notify the PDN provider in writing of the authorized amount, scope and duration of PDN services and the PDN authorization number after conducting the face-to-face assessment and/or performing the desk review. The PDN provider shall begin furnishing PDN services to the consumer upon receipt of written PDN authorization and in accordance with all other requirements set forth in rule 5101:3-12-02 of the Administrative Code.
 - (ii) Inform the consumer and/or authorized representative of PDN authorization after conducting the face-to-face assessment and/or performing the desk review, and provide a written notice to the consumer and/or authorized representative specifying the authorized amount, scope and duration of PDN services.
 - (b) If the consumer and/or authorized representative disagrees with the authorized amount, scope and/or duration of PDN services, the consumer and/or authorized representative may request a hearing in accordance with division 5101:6 of the Administrative Code. PDN services shall be delivered according to the amount, scope and duration authorized pending the outcome of the hearing.
 - (c) If ODJFS determines the consumer does not have a medical condition that meets the criteria for an institutional level of care, and/or the services are not medically necessary as set forth in rule 5101:3-1-01 of the Administrative Code, ODJFS:
 - (i) Shall deny the PDN authorization request, and issue a denial notice and hearing rights to the consumer in accordance with division 5101:6 of the Administrative Code.
 - (ii) May conduct a review of the PDN authorization request that has been proposed for denial.

(iii) Shall notify the PDN provider in writing of the denial of the PDN authorization request.

(3) The provider shall notify ODJFS in writing on the JFS 02374, "Private Duty Nursing (PDN) Services Request," when there is any change in the consumer's condition that warrants a change in the amount, scope or duration of PDN services.

(C) The procedures set forth in this paragraph must be followed when securing a PDN authorization for children and adults enrolled on an HCBS waiver administered by the Ohio department of mental retardation and developmental disabilities (ODMR/DD) or the Ohio department of aging (ODA). ODJFS shall specify the amount, scope and duration of PDN services to be authorized. The period for which PDN authorization applies shall not exceed three hundred sixty-five days.

(1) The consumer and/or authorized representative, or PDN provider shall request that the ODMR/DD or ODA case manager submit a referral for PDN authorization to ODJFS on the JFS 02374, "Private Duty Nursing (PDN) Services Request," and shall submit any additional supporting documentation requested by ODJFS. The case manager shall assist the consumer and/or authorized representative in securing a potential PDN service provider.

(2) ODJFS shall conduct a face-to-face assessment and/or perform a desk review to confirm if, in accordance with rule 5101:3-12-02 of the Administrative Code, the consumer is enrolled in an ODMR/DD- or ODA-administered waiver, and has a medical condition that requires PDN services that are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code.

(a) If ODJFS confirms, in accordance with rule 5101:3-12-02 of the Administrative Code, the consumer is enrolled in an ODMR/DD- or ODA-administered waiver, and has a medical condition that requires PDN services that are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, ODJFS shall:

(i) Notify the ODMR/DD or ODA case manager, as applicable, in writing of the authorized amount, scope and duration of PDN services and the PDN authorization number after conducting the face-to-face assessment and/or performing the desk review. The ODMR/DD or ODA case manager shall notify the PDN provider of the authorized amount, scope and duration of PDN services and the PDN authorization number, and the PDN provider shall begin furnishing PDN services to the consumer upon receipt of written PDN authorization and in accordance with all other requirements set forth in rule 5101:3-12-02 of the Administrative Code.

(ii) Inform the consumer and/or authorized representative of PDN authorization after conducting the face-to-face assessment and/or performing the desk review, and provide a written notice to the consumer and/or authorized representative specifying the authorized amount, scope and duration of PDN services.

(b) If the consumer and/or authorized representative disagrees with the authorized amount, scope and/or duration of PDN services, the consumer and/or authorized representative may request a hearing in accordance with division 5101:6 of the Administrative Code. PDN services shall be delivered according to the amount, scope and duration authorized pending the outcome of the hearing.

(c) If ODJFS cannot confirm, in accordance with rule 5101:3-12-02 of the Administrative Code, the consumer is enrolled in an ODMR/DD- or ODA-administered waiver, and/or cannot confirm that the consumer has a medical condition that requires PDN services that are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, ODJFS shall:

(i) Deny the PDN authorization request and issue a denial notice and hearing rights to the consumer and/or authorized representative in accordance with division 5101:6 of the Administrative Code.

(ii) Notify the ODMR/DD or ODA case manager in writing of the denial of the PDN authorization request. The ODMR/DD or ODA case manager shall notify the PDN provider in writing of the denial.

(3) The provider shall notify ODJFS and the ODMR/DD or ODA case manager in writing on the JFS 02374, "Private Duty Nursing (PDN) Services Request," when there is any change in the consumer's condition that warrants a change in the amount, scope or duration of PDN services.

(4) The ODMR/DD or ODA case manager shall notify ODJFS in writing on the JFS 02374, "Private Duty Nursing (PDN) Services Request," when there is a change in the consumer's level of care.

(D) PDN services shall be approved for ODJFS-administered waiver consumers as a result of the face-to-face assessment or reassessment conducted by ODJFS or its designated case management agency (CMA) in accordance with rule 5101:3-46-02 of the Administrative Code, or the reassessment conducted in accordance with rule 5101:3-47-02 or 5101:3-50-02 of the Administrative Code, as appropriate. As set forth in rule 5101:3-12-02 of the Administrative Code, PDN services must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code.

(1) The case manager shall assist the consumer and/or authorized representative in securing a PDN service provider.

(2) If PDN services are approved, ODJFS or its designated CMA shall:

(a) Record the amount, scope and duration of approved PDN services on the all services plan.

(b) Notify the provider, in writing, of the amount, scope and duration of approved PDN services.

(c) Inform the consumer and/or authorized representative of PDN service approval after conducting the assessment or reassessment, and provide a written notice to the consumer and/or authorized representative specifying the approved amount, scope and duration of PDN services.

(3) If the consumer and/or authorized representative disagrees with the authorized amount, scope and/or duration of PDN services, the consumer and/or authorized representative may request a hearing in accordance with division 5101:6 of the Administrative Code. PDN services shall be delivered according to the approved amount, scope and duration pending the outcome of the hearing.

(4) If PDN services are denied, ODJFS or its designated CMA shall issue a denial notice and hearing rights to the consumer and/or authorized representative in accordance with division 5101:6 of the Administrative Code.

(5) Requests for a change in the amount, scope and/or duration of authorized PDN services shall be submitted to ODJFS or its designated CMA. ODJFS or its designated CMA shall conduct a face-to-face reassessment and/or perform a desk review to evaluate the request.

(E) PDN services may be provided to a consumer in an emergency when the provider has an existing PDN authorization to provide PDN services to that consumer. For the purposes of this rule, emergency services are provided outside of normal state of Ohio office hours when prior authorization cannot be obtained.

(1) PDN services may be delivered in an emergency and a new PDN authorization obtained after the delivery of services. The PDN services must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, and the services must be necessary to protect the health and welfare of the consumer.

(2) The provider shall notify ODJFS, or the ODMR/DD or ODA case manager, as applicable, in writing on the JFS 02374, "Private Duty Nursing (PDN) Services Request," when emergency PDN services are furnished. Notification shall be immediate, or no later than the first business day following the emergency provision of PDN services.

- (F) ODJFS may authorize the provision of PDN services by one or more provider(s) in visits of four hours or less during the authorized PDN service period in order to assure the health and welfare of the consumer. "PDN service period" means the length of time during which PDN services, which are more than four hours in length, are delivered without a two-hour lapse between visits.
- (G) Utilization of authorized PDN services is subject to monitoring by ODJFS.
- (H) ODJFS shall maintain all written records related to review of PDN service authorization for a period of six years following receipt of the request or until an initiated audit is resolved, whichever is longer.

Replaces: 5101:3-12-02.3

Effective: 12/07/2006

R.C. 119.032 review dates: 12/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 11/27/2006

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.85

Prior Effective Dates: 9/1/06 (Emer)

MAL 540

Effective Date: November 8, 2007

Most Current Prior Effective Date: July 1, 2006

- (A) A medicare certified home health agency (MCRHHA) that meets the requirements in accordance with this rule is eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code.
- (B) MCRHHAs are required:
- (1) To be certified for medicare participation by the Ohio department of health (ODH) in accordance with Chapter 3701-60 of the Administrative Code.
 - (2) To meet the conditions of participation in accordance with 42 C.F.R. 484 (October 1, 2005).
 - (3) To implement policy components for home health and private duty nursing as specified in the "Medicare Benefit Policy Manual, Chapter Seven: Home Health Services" (August 12, 2005) for the following sections:
 - (a) "Determination of Coverage" section 20;
 - (b) "Content of the Plan of Care" section 30.2 to "Under the Care of a Physician" section 30.3; and
 - (c) "Covered Services Under a Qualifying Home Health Plan of Care" section 40 to "Medical Social Services" section 50.3.
 - (4) To comply with all applicable requirements for medicaid providers in Chapter 5101:3-1 of the Administrative Code.
 - (5) To comply with all federal, state and local laws and regulations.
- (C) MCRHHAs are required:
- (1) To have back up staff available to provide services when the agency's regularly scheduled staff cannot or do not meet their obligation to provide services.
 - (2) To submit written notification to the consumer at least thirty days prior to the last date of service when terminating a service unless:
 - (a) The consumer's treating physician has discontinued home health services;
 - (b) The treating physician has been notified that goals have been met;
 - (c) The consumer is no longer at the consumer's place of residence;
 - (d) The consumer or another person has harmed or threatened to harm the MCRHHAs staff;
~~or~~
 - (e) The consumer requested that services be terminated; or
 - (f) The consumer has been enrolled in a medicaid managed care plan (MCP).
 - (3) To contact the consumer's medicaid MCP to request prior authorization for home health and PDN services.
 - ~~(3)~~(4) To maintain documentation on all aspects of services provided in accordance with this chapter. All documentation must be complete prior to billing for services provided in accordance with this chapter. This includes but is not limited to:
 - (a) Clinical records (including all signed orders) as specified in paragraph (B) of this rule.

- (b) Time keeping records that indicate the date and time span of the services provided during a visit, and the type of service provided.
- (c) To obtain the completed and signed JFS 07137 "Certificate of Medical Necessity Home Care Certification" "~~Home Care Physician Certification Form~~" (rev. 7/2006), which certifies the medical necessity for services in accordance with paragraph (C) of rule 5101:3-12-01 or paragraph (B) of rule 5101:3-12-02 of the Administrative Code.

Effective: 11/08/2007

R.C. 119.032 review dates: 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 10/29/2007

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021

Prior Effective Dates: 4/7/77, 5/1/87, 3/30/90 (Emer), 6/29/90, 7/1/90, 3/12/92 (Emer), 6/1/92, 7/31/92 (Emer) 10/30/92, 7/1/93 (Emer), 9/1/93, 1/1/96, 7/1/98, 9/29/00, 9/1/05, 7/1/06

5160-12-03.1 Non-Agency Nurses and Otherwise-Accredited Agencies: Qualifications and Requirements

~~*Formerly*~~ 5101:3-12-03.1 Non-Agency Nurses and Otherwise-Accredited Agencies: Qualifications and Requirements

[MAL 558](#) / [CSTL 09-07](#)

Effective Date: October 26, 2009

Most Current Prior Effective Date: [July 1, 2006](#)

"Non-agency nurses" and "~~otherwise accredited~~otherwise-accredited agencies" who meet the qualifications and requirements of this rule can provide private duty nursing (PDN) in accordance with rule [5101:3-12-02](#) of the Administrative Code.

- (A) A "non-agency nurse" that meets the requirements in accordance with this rule is eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule [5101:3-1-17.2](#) of the Administrative Code. A non-agency nurse is required:-
- (1) To be a registered nurse or licensed practical nurse at the direction of a registered nurse practicing within the scope of his or her nursing license pursuant to Chapter 4723. of the Revised Code as an independent provider.
 - (2) To comply with the requirements of an MCRHHA in accordance to rule [5101:3-12-03](#) of the Administrative Code except for paragraphs (A), (B)(1) and (C)(1) of rule 5101:3-12-03 of the Administrative Code.
 - (3) To not be related to the consumer.
 - (4) To meet all conditions of participation in paragraph (C) and (D) of rule [5101:3-45-10](#) of the Administrative Code.
- (B) ~~An "otherwise accredited agency" that meets the requirements in accordance with this rule is eligible to participate in the Ohio medicaid program upon execution of a provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. An other accredited agency is required:~~ "Otherwise-accredited agency" means an agency that has and maintains accreditation by a national accreditation organization for the provision of home health services, private duty nursing, personal care services and support services, and that has executed a medicaid provider agreement in accordance with rule 5101:3-1-17.2 of the Administrative Code. The accreditation shall be granted by a national accreditation organization approved by the centers for medicare and medicaid services (CMS), which may include, but is not limited to, one of the following: the accreditation commission for health care (ACHC), the community health accreditation program (CHAP) and the joint commission.~~(1) To have and maintain joint commission on accreditation of healthcare organizations (JCAHO) accreditation or community health accreditation program (CHAP) accreditation for private duty nursing services.~~
- ~~(2) To comply with the requirements of MCRHHA in accordance to rule 5101:3-12-03 of the Administrative Code except for paragraphs (A) and (B)(1) of rule 5101:3-12-03 of the Administrative Code.~~
- (C) Providers of PDN services who are also providers of waiver services to a waiver consumer enrolled in a home and community based services (HCBS) waiver must comply with all applicable requirements including those set forth by the HCBS waiver rule(s).

Effective: 10/26/2009

R.C. 119.032 review dates: 08/11/2009 and 10/01/2014

Certification: CERTIFIED ELECTRONICALLY

Date: 10/16/2009

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.021, 5111.85

Prior Effective Dates: 7/1/06

Effective Date: July 1, 2006

Reimbursement of home health services or private duty nursing (PDN) in accordance with this chapter is on a per visit basis.

- (A) A "visit" is the duration of time that a covered home health service or private duty nursing service is provided in a face to face encounter to one or more medicaid consumer(s) at the same residence on the same date during the same time period; and
- (1) Begins with the provision of a covered service and ends when the face to face encounter ends; and
 - (2) Must have a lapse of time of two or more hours between any previous or subsequent visit for the provision of the same covered service unless the length of a private duty nursing visit requires an agency to provide a change in staff; and
 - (3) Must have a lapse of two or more hours between the provision of home health nursing or private duty nursing service.
- (B) When a consumer is enrolled in a home and community based services (HCBS) waiver and is receiving consecutive home health or PDN service(s) with waiver service(s) that have the same scope of service, there must be a lapse of time of two or more hours between the services. A "scope" of a service includes the definition of the service and the conditions that apply to its provision and the provider who renders the service(s).
- (C) Each covered visit must be billed:
- (1) As a separate line item. The number of lines/procedure codes must reflect the number of visits provided with one line equaling one visit.
 - (2) To reflect the length of the visit where one unit equals fifteen minutes. Units must be rounded down if the number of minutes is seven or less and rounded up if over seven minutes.
- (D) A "group visit" is a visit where the service(s) is provided to more than one person. During a group visit:
- (1) The ratio of an individual provider or an employee of a provider to the people being served may never exceed one to three.
 - (2) An entire visit is considered a group visit even if only a portion of the visit met the definition of a group visit.
 - (3) A modifier HQ must be used when billing for a group visit to identify each group setting in accordance with rule 5101:3-12-05 of the Administrative Code.
- (E) A "multiple visit" is when the provision of the same home health service or PDN by the same provider occurs on the same date of service for the same consumer separated by a lapse of two hours. Multiple visits must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code due to the functional limitations and/or medical condition of the consumer as documented in the plan of care, and if the consumer is enrolled in HCBS waiver, the services plan or all services plan. Documentation must support the medical need for multiple visits. After the initial visit multiple visits must either be billed with a U2 modifier for the second visit or U3 for the third or any subsequent visit.

Replaces: Part of 5101:3-12-06, 5101:3-12-10

Effective: 07/01/2006

R.C. 119.032 review dates: 07/01/2011

Certification: CERTIFIED ELECTRONICALLY

Date: 06/20/2006

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02, 5111.85

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[LTCSTL 11-10](#)

Effective Date: October 1, 2011

Most Current Prior Effective Date: [January 1, 2010](#)

5101:3-12-05 [Appendix A](#)

5101:3-12-05 [Appendix B](#)

- ~~(A)~~ ~~Home health services are delivered and billed in accordance with this chapter by medicare certified home health agencies (MCRHHA). Home health service rates are identified in appendix A to this rule.~~
- (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 of service delivered.
 - (2) "Unit rate," as used in this rule and [appendix A](#) to this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service delivered.
- (B) Home health services are delivered and billed in accordance with this chapter by medicare certified home health agencies (MCRHHA).
- ~~(B)~~(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 unit rate found in appendix A 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 one hour (four units) the medicaid maximum is the amount of the base rate.
 - (3) For a visit that is over one hour (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).
- ~~(C)~~(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) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with [5101:3-12-04](#) of the Administrative Code.
- ~~(D)~~(E) The modifiers set forth in [appendix B](#) to this rule must be used to provide additional information in accordance with this chapter.
- ~~(E)~~(F) Reimbursement must be provided in accordance with paragraphs (A) to (D) of rule [5101:3-1-60](#) of the Administrative Code.
- ~~(F)~~(G) A MCRHHA will not be reimbursed for home health services provided to a consumer 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 recipient or 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.
- ~~(G)~~(H) A MCRHHA will be reimbursed for home health services provided to a consumer if the provider has written documentation from a 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 the facility/home is not responsible for providing the same or similar home health services to the consumer.

~~(H)~~(L) Home health services provided to the consumer enrolled in the assisted living HCBS waiver in accordance with rule [5101:3-1-06](#) and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

Effective: 10/01/2011

R.C. 119.032 review dates: 07/14/2011 and 10/01/2016

Certification: CERTIFIED ELECTRONICALLY

Date: 09/19/2011

Promulgated Under: 119.03

Statutory Authority: 5111.02, 5111.0213

Rule Amplifies: 5111.02, 5111.021, 5111.0213

Prior Effective Dates: 5/1/87, 4/1/88, 5/15/89, 7/1/98, 7/1/06, 7/1/08, 1/1/10

[LTCSTL 11-10](#)

Effective Date: October 1, 2011

Most Current Prior Effective Date: [January 1, 2010](#)

5101:3-12-06 [Appendix A](#)

5101:3-12-06 [Appendix B](#)

~~(A) Private duty nursing (PDN) services are delivered and billed as PDN visits in accordance with rules 5101:3-12-02, 5101:3-12-2.3 and 5101:3-12-04 of the Administrative Code. The services are provided by medicare certified home health agencies, "otherwise accredited agencies," or "non-agency nurses." PDN service rates are identified in appendix A to this rule.~~

(A) Definitions of terms used for billing private duty nursing services (PDN) 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 of service delivered.

(2) "Unit rate," as used in this rule and appendix A to this rule, means the amount paid for each fifteen minute unit following the base rate paid for the first four units of service delivered.

(B) PDN services are delivered and billed as PDN visits in accordance with rules [5101:3-12-02](#), [5101:3-12-2.3](#) and [5101:3-12-04](#) of the Administrative Code. The services are provided by medicare certified home health agencies, "otherwise accredited agencies," or "non-agency nurses." PDN service rates are identified in appendix A to this rule.

~~(B)~~(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 unit rate found in appendix A 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. ~~A~~The medicaid maximum rate for a private duty nursing visit is the amount of the base rate plus the unit rate amount for each unit over four units.

~~(C)~~(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) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with 5101:3-12-04 of the Administrative Code.

~~(D)~~(E) The modifiers set forth in [appendix B](#) to this rule must be used to provide additional information in accordance with this chapter.

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

~~(F)~~(G) Providers of PDN will not be reimbursed for PDN services provided to a consumer that duplicate services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplemental recipient or medicaid consumer resides, such as an adult foster home, adult family home, adult group home, ICF/MR, residential care facility, community alternative home, or other facility is paid to provide nursing services, then PDN services are not reimbursable by medicaid.

~~(G)~~(H) Providers of PDN will be reimbursed for PDN services provided to a consumer if the provider has written documentation from a 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 the facility/home is not responsible for providing the same or similar PDN services to the consumer.

~~(H)~~(L) PDN services provided to the consumer enrolled in the assisted living HCBS waiver in accordance with rule [5101:3-1-60](#) and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

Effective: 10/01/2011

R.C. 119.032 review dates: 07/14/2011 and 10/01/2016

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Statutory Authority: 5111.02, 5111.0213

Rule Amplifies: 5111.02, 5111.021, 5111.0213

Prior Effective Dates: 5/1/87, 4/1/88, 5/15/89, 7/1/98, 6/30/06 (Emer), 9/28/06, 7/1/08, 1/1/10

MAL 534

Effective Date: August 2, 2007

Home health and private duty nursing (PDN) service providers may be reimbursed when circumstances outside the provider's control result in any of the exceptions set forth in this rule. The provider shall maintain written documentation that includes the date, the time (if available), the content of the communication, the contact name, and the contact information (e.g., telephone number, fax number, email address, or mailing address).

- (A) Requirements of paragraphs (D)(2) of rule 5101:3-12-01 and (C)(2) of rule 5101:3-12-02 of the Administrative Code do not have to be met if either paragraph (A)(1), (A)(2), or (A)(3) of this rule applies:
- (1) Services are not identified on the all services plan when the consumer is enrolled in an ODJFS-administered waiver, and the provider has documented attempts to work with the case manager and the case manager's supervisors to identify the services on the all services plan. Documentation shall include written proof of the provider's attempts to obtain the all services plan that identifies the services. This exception does not extend to instances in which the provider disagrees with the amounts of service identified on the all services plan.
 - (2) Services are not documented on the services plan when the consumer is enrolled in an ODA- or ODMR/DD-administered waiver, and the provider has documented attempts to work with the case manager and the case manager's supervisors to identify the services on the services plan. Documentation shall include written proof of the provider's attempts to obtain the services plan that identifies the services. This exception does not extend to instances in which the provider disagrees with the amounts of service identified on the services plan.
 - (3) The provider verified and documented before providing services that either paragraph (A)(3)(a) or (A)(3)(b) of this rule applies.
 - (a) The consumer was not enrolled in a home and community-based services (HCBS) waiver at the initiation of services and every six months thereafter. And the case manager cannot produce documentation that the provider was notified that the consumer had become enrolled in an HCBS waiver.
 - (b) The consumer was not enrolled in an HBCS waiver and subsequently, at any point during, the delivery of services, the provider became aware of the consumer's enrollment and the provider notified the case manager and requested that the services be identified on the plan. And the case manager cannot produce documentation that the provider was notified that the consumer had become enrolled in an HCBS waiver.
- (B) Requirements of paragraphs (F) of rule 5101:3-12-05 and (F) of rule 5101:3-12-06 of the Administrative Code do not have to be met if either paragraph (B)(1) or (B)(2) of this rule applies.
- (1) The provider has written documentation from a 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 the facility/home is not responsible for providing the same or similar home health or PDN services to the consumer.
 - (2) Home health and/or PDN services provided to the consumer enrolled in the assisted living HCBS waiver in accordance with rule 5101:3-1-06 and Chapter 173-39 of the Administrative Code do not constitute a duplication of services.

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General Billing Instructions

Click [here](#) to view the Billing instructions eManual.

Forms

JFS 07137 Certificate of Medical Necessity Home Care Certification Form

[Click here to view the Certificate of Medical Necessity Home Care Certification Form \(JFS 07137\)](#)

JFS 02374 Private Duty Nursing Services Request

[Click here to view the Private Duty Nursing Services Request](#)