Ohio Administrative Code

Rule 5160-12-04 Home health and private duty nursing: visit policy.

Effective: March 7, 2021

(A) Reimbursement of home health or private duty nursing (PDN) services in accordance with this chapter are on a per visit basis. A "visit" is the duration of time that a covered home health service or private duty nursing (PDN) service is provided during an in-person or telehealth encounter to one or more individuals receiving medicaid at the same residence on the same date during the same time period.

(1) A visit begins with the provision of a covered service and ends when the in-person or telehealth encounter ends.

(2) A visit 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.

(3) A visit must have a lapse of two or more hours between the provision of home health nursing and PDN service.

(4) A visit must be verified using an ODM-approved electronic visit verification (EVV) system in accordance with rule 5160-1-40 of the Administrative Code.

(B) When an individual 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 as a separate line item. The number of lines /procedure codes must reflect the number of visits provided with one line equaling one visit.

(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 provider to the individuals 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 to identify each group setting in accordance with rule 5160-12-05 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 individual separated by a lapse of two hours. Multiple visits must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code due to the functional limitations and/or medical condition of the individual as documented in the plan of care, and if the individual 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.