Ohio | Common Sense Initiative

Mike DeWine, Governor
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Business Impact Analysis

Agency, Board, or Commission Name: Ohio Department of Medicaid

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Regulation/Package Title (a general description of the rules' substantive content):

Home Health and Private Duty Nursing (the rules in this package establish the requirements for home health services, private duty nursing services, RN assessment, and RN consultation in the Medicaid program)

Rule Number(s): Ohio Administrative Code Rules 5160-12-01, 5160-12-02, 5160-12-04, and 5160-12-08

OAC Rule 5160-12-05 does not have an adverse impact and is included for reference purposes only

Date of Submission for CSI Review: 8/17/2020

Public Comment Period End Date: 8/24/2020

Rule Type/Number of Rules:

New/___ rules

No Change/____ rules (FYR? ___)

Amended/ 4 rules (FYR? Y)

Rescinded/____ rules (FYR? ___)

The Common Sense Initiative is established in R.C. 107.61 to eliminate excessive and duplicative rules and regulations that stand in the way of job creation. Under the Common Sense Initiative, agencies must balance the critical objectives of regulations that have an adverse impact on business with the costs of compliance by the regulated parties. Agencies

should promote transparency, responsiveness, predictability, and flexibility while developing regulations that are fair and easy to follow. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

Reason for Submission

1. **R.C. 106.03 and 106.031 require agencies, when reviewing a rule, to determine whether the rule has an adverse impact on businesses as defined by R.C. 107.52. If the agency determines that it does, it must complete a business impact analysis and submit the rule for CSI review.**

   Which adverse impact(s) to businesses has the agency determined the rule(s) create?

   The rule(s):

   a. ☒ **Requires a license, permit, or any other prior authorization to engage in or operate a line of business.**

   b. ☐ **Imposes a criminal penalty, a civil penalty, or another sanction, or creates a cause of action for failure to comply with its terms.**

   c. ☒ **Requires specific expenditures or the report of information as a condition of compliance.**

   d. ☐ **Is likely to directly reduce the revenue or increase the expenses of the lines of business to which it will apply or applies.**

Regulatory Intent

2. **Please briefly describe the draft regulation in plain language.**

   Ohio Administrative Code Rule 5160-12-01 outlines guidelines for coverage of home health services, including benefit limitations. Changes in the rule align Medicaid policy with changes in federal guidelines enacted in the Cares Act and provide opportunities to use telehealth when it is clinically appropriate.

   Ohio Administrative Code Rule 5160-12-02 outlines guidelines for coverage of private duty nursing services, including benefit limitations. Changes in the rule align private duty nursing changes with changes in federal guidelines enacted in the Cares Act and with proposed changes in home health policy.

Ohio Administrative Code Rule 5160-12-04 defines a visit and a group visit for purposes of Medicaid reimbursement of home health and private duty nursing services. The amendments allow home health services to be provided using telehealth when clinically appropriate.

Ohio Administrative Code 5160-12-05 provides for reimbursement of home health services. The amendment instructs providers to use a modifier if the service is provided using telehealth.

Ohio Administrative Code 5160-12-08 defines coverage and reimbursement for the RN consultation and RN assessment services. The amendments allow the RN assessment service to be providing using telehealth when clinically appropriate.

3. **Please list the Ohio statute(s) that authorize the agency, board or commission to adopt the rule(s) and the statute(s) that amplify that authority.**

4. Ohio Administrative Code Rules 5160-12-01, 5160-1-2-02, 5160-12-03, 5160-12-04 and 5160-12-08 is authorized by Ohio Revised Code Section 5164.02.

   Ohio Administrative Code Rule 5160-12-05 is authorized by Ohio Revised Code Sections 5164.70 and 5164.77.

   Ohio Administrative Code Rules 5160-12-01 and 5160-12-04 amplify Ohio Revised Code Sections 5162.03.

   Ohio Administrative Code Rule 5160-12-02 amplifies Ohio Revised Code Sections 5162.03, 5164.02, 5164.70. and 5166.02.

   Ohio Administrative Code Rule 5160-12-05 amplifies 5164.70 and 5164.77.

   Ohio Administrative Code Rule 5160-12-08 amplifies 5164.02.

5. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**

   Ohio Administrative Code Rules 5160-12-01 and 5160-12-02 are amended to aligned with the Cares Act which modifies the requirements related to ordering physicians to allow physicians, physician assistants, and advance practice nurses to order services provided by Medicare certified home health agencies and to sign the care plans.

6. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   Ohio Administrative Code Rules 5160-12-04, 5160-12-05, and 5160-12-08 align with federal guidelines related to the provision of home and community based services through the Medicaid program.

7. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Home health, private duty nursing, RN assessment and RN consultation are services that are integral to the home and community based service delivery system. These services support the desire of many Ohioans to receive services in their homes rather than institutions.

8. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The agency will use information submitted on claims to monitor the utilization of telehealth services. In addition, feedback from individuals receiving services and providers of those services will be reviewed to determine the impact of these changes on the delivery of services.

9. **Are any of the proposed rules contained in this rule package being submitted pursuant to R.C. 101.352, 101.353, 106.032, 121.93, or 121.931?**
   If yes, please specify the rule number(s), the specific R.C. section requiring this submission, and a detailed explanation.

   No.

Development of the Regulation

9. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**

   Policy changes included in these amendments were shared with Leading Age Ohio, the Ohio Council for Home Care and Hospice and the Ohio Health Care Association. They were also shared with other stakeholders, including the Ohio Nursing Coalition.

10. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

    Stakeholders approached the department when the Cares Act was enacted requesting the changes. The changes were initially implemented in emergency rules, and stakeholders have indicated that this had a significant impact on removing barriers to care and has enhanced access to home and community based services.

11. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

    Qualitative information from providers and individuals receiving services was used to develop the rule. Scientific data is not applicable to these rules.

12. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not** appropriate**? If none, why didn't the Agency consider regulatory alternatives?**

    The agency considered leaving existing policy in place, but chose to align with the federal provisions for Medicare certified home health agencies and to permit telehealth when clinically appropriate. These changes significantly improve access to care and avoid administrative complexity that is created when federal and state provider requirement are not aligned.

13. **Did the Agency specifically consider a performance-based regulation? Please explain.** ***Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.***

    Federal regulations governing Medicare certified home health agencies are specific. In order to avoid unnecessary administrative complexity, the rules are being updated to align with changes in those requirements.

14. **What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?**

    The amended rule was reviewed by Ohio Medicaid policy development staff, Office of Legal Services and the Office of Legislation to ensure there was no duplication.

15. **Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.**

    Information about the amended rules will be shared with the provider trade associations, stakeholder groups and partner agencies.

Adverse Impact to Business

16. **Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:**
    a. **Identify the scope of the impacted business community; and**
    The impacted business community includes all providers of home health services, private duty nursing services, RN assessment services and RN consultation services.

    b. **Identify the nature of all adverse impact (e.g., fees, fines, employer time for compliance,); and**

OAC Rule 5160-12-01 requires Medicare certification for agency providers who would like to be Medicaid providers of home health services. It further limits employees who can provide nursing services to LPNs and RNs and employees who can provider therapy services to licensed physical therapists, speech-language pathologists, physical therapy assistants and certified occupational therapy assistants.

OAC Rule 5160-12-02 limits individuals who can provide services to RNs and LPNs. In addition, OAC Rule 5160-12-02(I)(5) and (J)(5) require the report of information to obtain authorization for services.

OAC Rule 5160-12-04 requires the report of information using electronic visit verification.

OAC 5160-12-08 limits the individuals who can provide services to RNs and LPNs. In addition, the RN or LPN is required to be a non-agency Medicaid provider or be employed by either a Medicare certified home health agency or a home health agency accredited by another nationally recognized body.

c. Quantify the expected adverse impact from the regulation.

OAC Rule 5160-12-01 requires Medicare certification for home health agencies who want to be Medicaid providers of home health services. CMS charges home health agencies an application fee for the initial application, revalidation and the addition of a location. The application fee is $595. Note that this requirement is not a new requirement added with these amendments.

OAC Rules 5160-12-01, 5160-12-02 and 5160-12-08 require specific professional licensure for individuals providing some services. Staff costs vary widely based on specific job requirements, the needs of the clients served, the time of day services are provided and the agency business model. As a result, we are unable to provide an estimate of related costs. Note that this requirement is not a new requirement added with these amendments.

OAC Rule 5160-12-02 requires the report of information to obtain prior authorization of services for Medicaid reimbursement. This effort will take a minimal amount of staff time but there is no charge for requesting prior authorization. Note that this requirement is not a new requirement added with these amendments.

OAC Rule 5160-12-04 requires the report of information using electronic visit verification (EVV). The department offers providers of home health and private duty nursing services electronic visit verification systems at no cost. Administrative time to comply with EVV varies widely among providers; the cost of that administrative time

cannot be estimated. Note that this requirement is not a new requirement added with these amendments.

d. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

The requirements inf Ohio Administrative Code 5160-12-01 are intended to assure quality of care to individuals receiving home and community based services and to align with requirements establishing scope of practice for health care professionals in Ohio.

Regulatory Flexibility

17. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

No. The provisions in these rules are mandatory for all providers of home health, private duty nursing, RN assessment and RN consultation services.

18. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

Ohio Revised Code Section 119.14 does not apply to these rules.

19. What resources are available to assist small businesses with compliance of the regulation?

Providers in need of assistance may contact the Bureau of Long Term Care Services and Supports through the Provider Relations Hotline at (800)686-1516 and by email at HomeHealthPolicy@medicaid.ohio.gov.

5160-12-01 **Home health services: provision requirements, coverage and service specification.**

(A) "Home health services" includes home health nursing, home health aide services and skilled therapies.

(B) Home health services are reimbursable only if a qualifying treating physician, advance practice nurse or physician assistant certifying the need for home health services documents that he or she had a face-to-face encounter with the individual within ninety days prior to the start of care date, or within thirty days following the start of care date. To be a qualifying treating physician, the physician ~~must~~will be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code. Advanced practice registered nurses in accordance with rule 5160-4-04 of the Administrative Code ~~and in collaboration with the qualifying treating physician,~~ or a physician assistant in accordance with rule 5160-4-03 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 individual ~~must~~will occur independent of any provision of home health services to the individual. The face-to-face encounter may be completed using telehealth. The face-to-face encounter ~~must~~will be documented as follows:

(1) For home health services unrelated to an inpatient hospital stay, the face-to-face encounter ~~must~~will be documented by the qualifying treating physician, advance practice nurse or physician assistant using:

(a) The ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2016) or

(b) The individual's plan of care if all of the data elements specified for home health services unrelated to an inpatient hospital stay on the ODM 07137 are included and the plan of care contains the ~~physician's~~ signature, ~~physician's~~ credentials and the date of the ~~physician's~~ signature of the qualifying treating physician, advance practice nurse or physician assistant.

(2) For post hospital home health services, the face-to-face encounter ~~must~~will be documented by the clinician ~~qualifying treating physician~~ using the ODM 07137.

(3) For an individual dually eligible for medicare and medicaid, the face-to-face encounter ~~must~~will be documented by the treating ~~physician~~ clinician using the ODM 07137 if supporting documents are attached, or using the individual's plan of care pursuant to paragraph (B)(1)(b) of this rule when the face-to-face encounter date for medicare home health services falls within ninety days prior to the medicaid home health services start of care date, or within thirty days following the medicaid start of care date.

(C) Home health services are covered only if provided on a part-time or intermittent basis, which means:

(1) No more than a combined total of eight hours per day of home health nursing, home health aide, and skilled therapies except as specified in paragraph (H) of this rule;

(2) No more than a combined total of fourteen hours per week of home health nursing and home health aide services except as specified in paragraphs (D) and (H) of this rule or as prior authorized by ODM or its designee; and

(3) Visits are not more than four hours. Nursing visits over four hours may qualify for coverage in accordance with rule 5160-12-02 of the Administrative Code.

(D) A combined total of twenty-eight hours per week of home health nursing and home health aide services is available to an individual for up to sixty consecutive days from the date of discharge from an inpatient hospital stay if all of the following are met as certified by the qualifying treating ~~physician~~clinician using the ODM 07137:

(1) The individual is discharged from a covered inpatient hospital stay of three or more days, with the discharge date recorded on form ODM 07137. It is considered one inpatient hospital stay when an individual is transferred from one hospital to another hospital, either within the same building or to another location. The sixty days will begin once the individual is discharged to their place of residence or to a nursing facility from the last inpatient stay in an inpatient hospital or inpatient rehabilitation unit of a hospital.

(2) The individual has a comparable level of care as evidenced by either:

(a) Enrollment in a home and community based services (HCBS) waiver; or

(b) A medical condition that temporarily meets the criteria for an institutional level of care as described in rule 5160-3-08 of the Administrative Code or as defined in rule 5123:2-8-01 of the Administrative Code. 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) The individual requires home health nursing, or a combination of private duty nursing, home health nursing, or waiver nursing and/or skilled therapy services at least once per week and the services are medically necessary in accordance with rule 5160-1-01 of the Administrative Code.

(4) The individual has had a covered inpatient hospital stay of three or more days, with the discharge date recorded on form ODM 07137.

(E) Home health services may only be provided by a medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code. In order for home health services to be covered, MCHHAs must:

(1) Provide home health services only if the ~~qualifying treating physician~~clinician has documented a face-to-face encounter with the individual as specified in paragraph (B) of this rule.

(2) Provide home health services that are appropriate given the individual's diagnosis, prognosis, functional limitations and medical conditions as ordered by the individual's treating ~~physician~~clinician for the treatment of the individual's condition, illness or injury.

(3) Provide home health services as specified in the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code. Home health services not specified in a plan of care are not reimbursable. Additionally the plan of care must provide the amount, scope, duration, and type of home health service as:

(a) Documented on the person-centered services plan as defined in rule 5160-45-01 of the Administrative Code that is prior approved by the Ohio department of medicaid (ODM) or designee when an individual is enrolled on an ODM administered HCBS waiver. Home health services that are not identified on the person-centered services plan are not reimbursable; or

(b) Documented on the services plan when an individual is enrolled on an Ohio department of aging (ODA) or Ohio department of developmental disabilities (DODD) administered HCBS waiver. Home health services that are not documented on the services plan are not reimbursable.

(4) Provide the home health services in any setting in which normal life activities take place, other than a hospital, nursing facility; intermediate care facility for individuals with intellectual disabilities; or any setting in which payment is or could be made under Medicaid for inpatient services that include room and board.

(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 an individual 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 individual is no longer making significant improvement in his or her medical condition.

(b) "Habilitative care" is the care provided to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

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

(6) Bill for provided home health services in accordance with visit policy rule 5160-12-04 of the Administrative Code.

(7) Bill for provided home health services using the appropriate procedure code and applicable modifiers in accordance with rule 5160-12-05 of the Administrative Code.

(8) Bill after all documentation is completed for the services rendered during a visit in accordance with rule 5160-12-03 of the Administrative Code.

(F) Individuals who receive home health services ~~must~~will:

(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.

(2) Be under the supervision of a ~~treating physician~~clinician who is providing care and treatment to the individual. The ~~treating physician~~clinician ~~cannot~~will not be a ~~physician~~clinician 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

individual. A treating ~~physician~~ clinicianmay be a ~~physician~~clinician who is substituting temporarily on behalf of a treating ~~physician~~clinician.

(3) Participate in the development of a plan of care along with the treating ~~physician~~clinician and the MCHHA.

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

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

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

(G) Covered home health services:

(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 home health service must possess a current, valid and unrestricted license with the Ohio board of nursing and must be employed or contracted by a MCHHA that has an active medicaid provider agreement. A service is not considered a nursing service merely because it is performed by a licensed nurse.

(a) Nursing tasks and activities that shall only be performed by an RN include, but are not limited to, the following:

(i) Intravenous (IV) insertion, removal or discontinuation;

(ii) IV medication administration;

(iii) Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);

(iv) Insertion or initiation of infusion therapies;

(v) Central line dressing changes; and

(vi) Blood product administration.

(b) Home health nursing services performed by an RN and/or an LPN ~~must~~will be:

(i) Performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.

(ii) Provided and documented in accordance with the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code.

(iii) Provided during an in-person visit or using telehealth if clinically appropriate given the needs of the individual, the nature of the service, and the technology that is available.

(iv) Medically necessary in accordance with rule 5160-1-01 of the Administrative Code to care for the individual's illness or injury.

(c) Home health nursing services do not include:

(i) A visit when the sole purpose is for the supervision of the home health aide.

(ii) RN assessment services as defined in rule 5160-12-08 of the Administrative Code.

(iii) RN consultation services as defined in rule 5160-12-08 of the Administrative Code.

(2) "Home health aide services" are services that ~~requires~~use the skills of and are performed by a home health aide employed or contracted by the MCHHA 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, 2016). The home health aide cannot be the parent, step-parent, foster parent or legal guardian of an individual who is under eighteen years of age, or the individual's spouse.

(b) Are provided and documented in accordance with the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code.

(c) ~~Must be~~Are provided during an in-person visit or using telehealth if clinically appropriate given the needs of the individual, the nature of the service, and the technology that is available.

(d) Must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code to care for the individual's illness or injury.

(e) Must be necessary to assist the nurse or therapist in the care of the individual's illness or injury, or help the individual maintain a certain level of health in order to remain in a home and community based setting.

(f) Include health related services including but not limited to:

(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 individual's health, and including changing bed linens of an incontinent or immobile individual.

(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) Assisting 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 therapist or a licensed registered nurse within their scope of practice.

(v) Performing routine care of prosthetic and orthotic devices.

(g) May include incidental services, 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 someone to maintain a home and can include light chores, laundry, light house cleaning, preparation of meals, and 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 individual and not for other people in the individual's place of residence.

(3) "Skilled therapies" is 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 individual'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 MCHHA.

(b) "Rehabilitation" is the care of an individual with the intent of curing the individual's disease or improving the individual's condition by the treatment of the individual's illness or injury, or the restoration of a function affected by illness or injury.

(c) Skilled therapies:

(i) Must be provided to the individual 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 5160-1-01 of the Administrative Code to care for the individual's illness or injury.

(iii) Must be provided and documented in the individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code.

(iv) Must be reasonable in their amount, frequency, and duration. Treatment must be considered to be safe and effective treatment for the individual's condition according to the accepted standards of medical practice.

(v) ~~Must be~~Are provided with the expectation of the individual's rehabilitation potential according to the treating ~~physician's~~clinician's prognosis of illness or injury. The expectation of the individual's rehabilitation potential is that the condition of

the individual 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 individual, including motivational or general activities for the overall fitness of the individual.

(vii) Are provided during an in person visit or using telehealth if clinically appropriate given the needs of the individual, the nature of the service, and the technology that is available.

(H) An individual who meets the requirements in this paragraph may qualify for increased home health services. The MCHHA must assure and document that the individual meets all requirements in this paragraph prior to increasing services. The U5 modifier must be used when billing in accordance to rule 5160-12-05 of the Administrative Code. The use of the U5 modifier indicates that all conditions of this paragraph were met. The individual 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 5160-14 of the Administrative Code for the healthchek program.

(2) ~~Requires~~Needs more than, as ordered by the treating ~~physician~~clinician:

(a) Eight hours per day of any home health service, or a combined total of fourteen hours per week of home health aide and home health nursing as specified in paragraph (C) of this rule; or

(b) A combined total of twenty-eight hours per week of home health nursing and home health aide for sixty days as specified in paragraph (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 ODM or its designee for an individual not enrolled in a HCBS waiver. The criteria for an institutional level of care, including a nursing facility-based level of care as defined in rule 5160-3-08 of the Administrative Code or an ICF-IID level of care as defined in rule 5123:2-8-01 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~~Needs home health nursing or a combination of PDN, home health nursing, waiver nursing, and skilled therapy visits at least once per week that is medically necessary in accordance with rule 5160-1-01 of the Administrative Code as ordered by the treating ~~physician~~clinician.

(I) Individuals subject to decisions regarding home health services made by ODM 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.

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	Ohio Revised Code Section5164.02
Rule Amplifies:	Ohio Revised Code Sections 5164.02 and 5162.03
Prior Effective Dates:	04/04/1977, 04/07/1977, 12/21/1977, 06/01/1980, 05/01/1987, 04/01/1988, 05/15/1989, 03/30/1990 (Emer.), 06/29/1990, 07/01/1990, 03/12/1992 (Emer.), 06/01/1992, 07/31/1992 (Emer.), 10/30/1992, 04/30/1993 (Emer.), 07/01/1993 (Emer.), 07/30/1993, 09/01/1993, 01/01/1996, 05/01/1998, 07/01/1998, 09/29/2000, 03/01/2002 (Emer.), 05/30/2002, 01/31/2005, 09/01/2005, 07/01/2006, 11/08/2007, 02/01/2011, 07/01/2015, 07/01/2017

5160-12-02 **Private duty nursing services: provision requirements, coverage and service specification.**

(A) "Private duty nursing (PDN)" is a continuous nursing service that requires the skills of and is performed by either a registered nurse (RN) or a licensed practical nurse (LPN) at the direction of a registered nurse. A service is not considered a PDN service merely because it was performed by a licensed nurse. A covered PDN visit must meet the definition in paragraph (A) of rule 5160-12-04 of the Administrative Code and be more than four hours in length but less than or equal to twelve hours in length per nurse, on the same date or during a twenty-four hour time period, unless:

(1) An unforseen event causes a medically necessary scheduled visit to end at four or less hours, or extend beyond twelve hours, up to and including, but no more than sixteen hours; 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.

(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 individual's plan of care in accordance with rule 5160-12-03 of the Administrative Code;

(3) Must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code to care for the individual's condition, illness or injury; and

(4) Must be provided in person in the individual's place of residence unless it is medically necessary for a nurse to accompany the individual in the community. The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, 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 individuals with intellectual disabilities (ICF-IID). The place of service in the community cannot include the residence or business location of the provider of PDN. The residence of the provider is not excluded when the residence of the provider is

the same as the individual and all other requirements of Chapter 5160-12 of the Administrative Code are met.

(C) Nursing tasks and activities that shall only be performed by an RN include, but are not limited to, the following:

(1) Intravenous (IV) insertion, removal or discontinuation;

(2) IV medication administration;

(3) Programming of a pump to deliver medications including, but not limited to, epidural, subcutaneous and IV (except routine doses of insulin through a programmed pump);

(4) Insertion or initiation of infusion therapies;

(5) Central line dressing changes; and

(6) Blood product administration.

(D) PDN services do not include:

(1) Services provided for the provision of habilitative care in accordance with 42 U.S.C 1396n (c)(5).

(2) RN assessment services as defined in rule 5160-12-08 of the Administrative Code.

(3) RN consultation services as defined in rule 5160-12-08 of the Administrative Code.

(E) The providers of PDN include a medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code. In order for PDN to be covered, these providers must:

(1) Provide PDN that is appropriate given the individual's diagnosis, prognosis, functional limitations and medical conditions as documented by the individual's treating physician<u>, physician's assistant or advance practice nurse</u>.

(2) Provide PDN as specified in the plan of care in accordance with rule 5160-12-03 of the Administrative Code. PDN services not specified in a plan of care are not reimbursable. Additionally, for individuals enrolled on a home and community

based services (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) Documented on the all services plan that is approved by (ODM) or its designee when an individual is enrolled on an ODM administered HCBS waiver. PDN services not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when an individual is enrolled on an Ohio department of aging (ODA) administered or an Ohio department of developmental disabilities (DODD) 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 5160-12-06 of the Administrative Code.

(4) Bill for provided PDN services in accordance with the visit policy in rule 5160-12-04 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 5160-12-03 of the Administrative Code.

(F) In case of an emergency, PDN authorization may be requested and approved in accordance with paragraph (E) of rule 5160-12-02.3 of the Administrative Code, after the delivery of PDN services when:

(1) The provider has an existing prior authorization to provide PDN to the individual;

(2) PDN services are medically necessary in accordance with rule 5160-1-01 of the Administrative Code; and

(3) PDN services are deemed necessary to protect the health and welfare of the individual.

(G) Individuals who receive PDN must:

(1) Be under the supervision of a treating physician, physician's assistant or advance practice nurse who is providing care and treatment to the individual. The treating physician, physician's assistant or advance practice nurse ~~cannot be~~is not a ~~physician~~physician, physician's assistant or advance practice nurse 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 individual. A treating physician,

physician's assistant or advance practice nurse may be a physician, physician's assistant or advance practice nurse who is substituting temporarily on behalf of a treating physician.

(2) Participate in the development of a plan of care with the treating physician, physician's assistant or advance practice nurse and the MCHHA 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 individual.

(3) Access PDN in accordance with the program for the all-inclusive care of the elderly (PACE) if the individual participates in the PACE program.

(4) Access PDN in accordance with the individual's provider of hospice services if the individual has elected hospice.

(5) Access PDN in accordance with the individual's managed care plan's process if the individual is enrolled in a medicaid managed care plan.

(H) Post hospital PDN:

(1) Any individual receiving medicaid, whether adult or child, may receive PDN services up to fifty-six hours 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 5160-2-03 of the Administrative Code. For purposes of this rule, a covered inpatient hospital stay is considered one hospital stay when an individual is transferred from one hospital to another hospital, either within the same building or to another location.

(a) The sixty days will begin when the individual is discharged from the hospital to the individual's place of residence as defined in paragraph (B)(5) of this rule, from the most recent inpatient stay in an inpatient hospital or inpatient rehabilitation unit of a hospital.

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

(2) The treating physician, ohysician's assistant, or advance practice nurse ~~must~~will certify the medical necessity of PDN services using the ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 7/2014). PDN is available to individuals 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 as

defined in rule 5160-3-08 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 an individual 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 individual is no longer making significant improvement in his or her medical condition.

(4) Individuals who require additional PDN beyond the post hospitalization service may access PDN through either paragraph (I) or (J) of this rule.

(I) A child may qualify for additional PDN services if:

(1) The individual is under age twenty-one and requires services for treatment in accordance with Chapter 5160-14 of the Administrative Code for the healthchek program, and

(2) ~~Requires~~Needs, as ordered by the treating physician,physician's assistant, or advance practice nurse, continuous nursing services, including the provision of on-going maintenance care. Services ~~cannot be~~ for habilitative care as defined in paragraph (D)(1) of this rule are inappropriate, and

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

(a) Enrollment on a HCBS waiver; or

(b) For a child not enrolled on a HCBS waiver, a comparable institutional level of care, including a nursing facility-based level of care pursuant to rule 5160-3-08 of the Administrative Code, or an ICF-IID level of care pursuant to 5123:2-8-01 of the Administrative Code, as evaluated initially and annually by ODM or its designee. 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.

(4) The provider of PDN services ensures and documents the child meets all requirements in paragraph (I) of this rule prior to providing and billing for the PDN services.

(5) The child has a PDN authorization obtained in accordance with rule 5160-12-02.3 of the Administrative Code to establish medical necessity and the child's comparable level of care. Except as noted in paragraph (G)(5) of this rule, a

request for additional, recertification, and/or a change of PDN authorization is made as follows:

(a) For a child not enrolled on a HCBS waiver, the provider of PDN shall submit the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity shall be provided by the provider of PDN services. ODM or its designee will notify the provider of the amount, scope and duration of services authorized.

(b) For a child enrolled on a DODD administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver, who will forward the request to DODD. Any documentation required by DODD for the review of medical necessity shall be provided by the provider of PDN services. DODD will notify the provider and the case manager of the amount, scope and duration of services authorized.

(c) For a child enrolled on an ODM administered waiver, the ODM case manager will authorize PDN services through the person-centered services plan.

(J) An adult may qualify for additional PDN services if he or she meets the following requirements:

(1) The adult is age twenty-one or older;

(2) The adult ~~requires~~needs, as ordered by the treating physician, physician's assistant or advance practice nurse, continuous nursing including the provision of on-going maintenance care. Services cannot be for habilitative care;

(3) The adult has a comparable level of care as evidenced by either:

(a) Enrollment on a HCBS waiver; or

(b) A comparable institutional level of care, including a nursing facility-based level of care as evaluated initially and annually by ODM or its designee for an adult not enrolled on a HCBS waiver. The criteria for a nursing facility-based level of care are defined in rule 5160-3-08 of the Administrative Code or ICF-IID level of care as defined in rule 5123:2-8-01 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 ensures and documents the adult meets all requirements in paragraph (J) of this rule prior to providing PDN.

(5) The adult must have a PDN authorization obtained in accordance with rule 5160-12-02.3 of the Administrative Code and approved by ODM or its designee to establish medical necessity and the adult's level of care. ODM or its designee will conduct an in-person visit and/or review of documentation. In an emergency, PDN services may be delivered when the provider has an existing authorization to provide PDN services to the adult and PDN authorization obtained after the delivery of services when the services are medically necessary in accordance with rule 5160-1-01 of the Administrative Code, and the services are required to protect the health and welfare of the individual. Except as noted in paragraph (G)(5) of this rule, a request for additional PDN authorization is made as follows:

(a) For an adult not enrolled on a HCBS waiver, the provider of PDN shall submit the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity shall be provided by the provider of PDN services. ODM or its designee will notify the provider of the amount, scope and duration of services authorized.

(b) For an adult enrolled on a DODD administered waiver, the provider of PDN must submit the request to the county board of DD who will forward the request to DODD. Any documentation required by DODD for the review of medical necessity shall be provided by the provider of PDN services. DODD will notify the provider and the county board of DD of the amount, scope and duration of services authorized.

(c) For an adult enrolled on an ODA administered waiver, the provider of PDN shall submit the request to the case manager of the ODA waiver, who will forward the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity must be provided by the provider of PDN services. ODM or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.

(d) For an adult enrolled on an ODM administered waiver, the case manager will authorize PDN services through the person-centered services plan.

(K) Individuals subject to decisions regarding PDN services made by ODM 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.

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

(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.

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5160-12-05 **Reimbursement: home health services.**

(A) Definitions of terms used for billing home health services rates set forth in appendix A to this rule are:

(1) "Base rate", as used in this rule and appendix A to this rule, means the amount reimbursed by Ohio medicaid:

(a) For the initial thirty-five to sixty minutes of home health aide service delivered;

(b) For the initial thirty-five to sixty minutes of home health nursing service delivered; or

(c) Up to the first four units of initial home health skilled therapy service delivered.

(2) "Unit rate", as used in this rule and appendix A to this rule, means the amount reimbursed by Ohio medicaid for each fifteen minutes of service delivered when the initial visit is:

(a) Greater than sixty minutes in length for any home health service delivered; or

(b) Less than or equal to thirty-four minutes in length for home health aide and/or home health nursing service delivered.

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

(C) The amount of reimbursement for a home health visit shall be the lesser of the provider's billed charge or the medicaid maximum rate. The medicaid maximum rate is determined by using a combination of the base rate and/or unit rate found in appendix A as applicable to this rule using the number of units of service 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.

(2) For a home health aide and/or a home health nursing visit that is less than thirty-five minutes in total, Ohio medicaid will reimburse a maximum of only one unit if the service is equal to or less than fifteen minutes in length, and a maximum of two units if the service is sixteen through thirty-four minutes in length.

(3) For a home health aide and/or a home health nursing visit thirty-five minutes to one hour in length in total, the medicaid maximum is the amount of the base rate.

(4) For a home health aide, home health nursing, or home health skilled therapy visit in length beyond the initial hour of service, the base rate plus the rate amount for each unit over the initial one hour may be claimed, not to exceed four hours.

(D) The amount of reimbursement for a visit shall be the lesser of the provider's billed charge or seventy-five per cent of the total medicaid maximum as specified in paragraph (C) of this rule when billing with the modifier HQ "group setting" for group visits conducted in accordance with rule 5160-12-04 of the Administrative Code.

(E) The modifiers set forth in appendix B to this rule must be used to provide additional information in accordance with this chapter. A visit made for the purpose of home infusion therapy in accordance with 5160-12-01 of the Administrative Code must be billed using the U1 modifier.

(F) The "place of service" code "02" will be used to indicate a visit was completed using telehealth.

~~(F)~~(G) A visit conducted by a registered nurse (RN) for the provision of home health nursing services must be billed to Ohio medicaid using the billing code G0299 as found in appendix A to this rule. A visit conducted by a licensed practical nurse (LPN) for the provision of home health nursing services must be billed to Ohio medicaid using the billing code G0300 as found in appendix A to this rule.

~~(G)~~(H) An MCHHA will not be reimbursed for home health services provided to an individual that duplicates same or similar services already paid by medicaid or another funding source. For example, if the facility/home where a residential state supplement recipient or individual receiving medicaid resides, such as an adult foster home, adult family home, adult group home, residential care facility, or other facility is paid to provide personal care or nursing services, home health services are not reimbursable by medicaid.

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

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

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5160-12-08 **Registered nurse assessment and registered nurse consultation services.**

(A) For the purpose of this rule:

(1) A "plan of care" is the medical treatment plan that is established, approved, and signed by a treating physician, advance practice nurse or physician's assistant in accordance with the Coronavirus Aid, Relief, and Economic Security (CARES) Act, S.3548 (2020), prior to a provider requesting reimbursement for a service. The plan of care has the same meaning as set forth in rule 5160-51-01 of the Administrative Code and is not the same as an all services plan, individual service plan, or helping Ohioans move expanding choice (HOME choice) service plan.

(2) A "registered nurse (RN) assessment" is the medicaid service performed by an RN pursuant to paragraphs (B) and (D) of this rule. It may include a recommendation subject to orders written by the treating physician, but not a determination of the amount or duration of nursing services.The RN assessment may be completed using telehealth.

(3) An "RN consultation" is a face-to-face or telephone contact between a directing RN and a licensed practical nurse (LPN) pursuant to paragraphs (C) and (D) of this rule, when an individual experiences a significant change that necessitates a change in the existing interventions the LPN must perform during a nursing service visit, and that will result in a change in the individual's plan of care. RN consultation does not replace routine direction and supervision provided by an RN to an LPN where evidence of significant change does not exist and/or does not necessitate a change in the LPN's intervention or the individual's plan of care.

(4) A "significant change" is a change experienced by an individual that warrants an RN assessment. Significant changes may include, but are not limited to, a change in health status, caregiver status, location/residence, referral to or active involvement on the part of a protective service agency, and/or institutionalization.

(5) A "nursing service visit" is the duration of time that a nurse provides covered medicaid services, face to face, to an individual at the individual's residence on the same date during the same time period.

(B) RN assessment service.

(1) An RN assessment service shall be performed on an individual participating in the medicaid program prior to the individual receiving the following services for the first time, prior to any change being made to an individual's current package of the following services, and any time the RN is informed that the individual receiving the following services has experienced a significant change, including an improvement or a decline in condition:

(a) State plan home health services as set forth in rule 5160-12-01 of the Administrative Code;

(b) Private duty nursing services as set forth in rule 5160-12-02 of the Administrative Code;

(c) Waiver nursing services as set forth in rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code;

(d) Personal care aide services furnished by a medicare-certified home health agency or an otherwise accredited agency as set forth in rules 5160-46-04, 5160-50-04, and 5123:2-9-56 of the Administrative Code; and/or

(e) HOME choice nursing services as set forth in rule 5160-51-04 of the Administrative Code.

(2) An RN performing an RN assessment service shall:

(a) Possess a current, valid and unrestricted license with the Ohio board of nursing.

(b) Only provide services within the RN's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted thereunder.

(c) Be an active medicaid provider or be employed by an entity that is an active medicaid provider.

(d) Be either:

(i) Employed by a medicare-certified home health agency when identifying an individual's need for state plan home health services as set forth in rule 5160-12-01 of the Administrative Code;

(ii) Employed by medicare-certified home health agency or an otherwise accredited agency when identifying an individual's need for

personal care aide services as set forth in rules 5160-46-04, 5160-50-04, and 5123:2-9-56 of the Administrative Code;

(iii) Employed by a medicare-certified home health agency or an otherwise accredited agency, or be an non-agency RN when identifying an individual's need for private duty nursing services as set forth in rule 5160-12-02 of the Administrative Code;

(iv) Employed by a medicare-certified home health agency or an otherwise accredited agency, or be a non-agency RN when identifying an individual's need for waiver nursing services as set forth in rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code; or

(v) Employed by a medicare-certified home health agency or an otherwise accredited agency, or be a non-agency RN when identifying an individual's need for HOME choice nursing services as set forth in rule 5160-51-04 of the Administrative Code.

(3) The RN assessment service shall:

(a) Provide the basis for the RN to make independent decisions and nursing diagnoses, plan nursing interventions and evaluate the need for other interventions, develop the plan of care and assess the need to communicate and, as applicable, consult with other team members as defined in rule 5160-45-01 of the Administrative Code.

(b) Include a face-to-face interview with, and observation of, the individual in his or her place of residence or through telehealth. Place of residence has the same meaning as defined in rule 5160-12-01 of the Administrative Code. During the interview, the RN ~~shall~~will assess the individual's verbal and nonverbal communication abilities, medical and social history, medications, living arrangements, supportive assistance equipment needs, and any other information available and relevant to the development of the individual's plan of care. At a minimum, the RN should capture the following information relative to the individual's health status:

(i) The physical condition of the individual including vital signs, skin color and condition, motor and sensory nerve function, cognitive status, respiratory status, and the nutritional, rest, sleep, activity, elimination habits and consciousness of the individual; and

(ii) The social and emotional condition of the individual, including religious preference, if any, occupation, mood, emotional state, and family ties and responsibilities.

(c) Serve as the guide for the directing RN when:

(i) An LPN and/or home health aide is providing state plan home health services pursuant to rule 5160-12-01 of the Administrative Code;

(ii) An LPN is providing private duty nursing services pursuant to rule 5160-12-02 of the Administrative Code;

(iii) An LPN is providing waiver nursing services pursuant to rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code;

(iv) An LPN is providing HOME choice nursing services pursuant to rule 5160-51-04 of the Administrative Code;

(v) A home health aide is providing state plan home health services pursuant to rule 5160-12-01 of the Administrative Code;

(4) Reimbursement for an RN assessment service.

(a) RN assessment services shall be reimbursed in accordance with the rates set forth in appendix A to this rule.

(b) The non-agency provider's, medicare-certified home health agency's or otherwise accredited agency's name and national provider identifier (NPI) number must be identified on the claim.

(c) When an individual is enrolled on an ODM-administered waiver, RN assessment services performed by a non-agency RN, or a medicare-certified home health agency or otherwise accredited agency must be prior-approved by ODM and be specified on the individual's service plan.

(d) When an individual is participating in the HOME choice program, RN assessment services performed by a non-agency RN or a medicare-certified home health agency or otherwise accredited agency must be prior-approved and be specified on the individual"s HOME choice service plan.

(e) An RN may be reimbursed for an RN assessment service no more than once every sixty days per individual receiving services unless the RN is

informed that the individual receiving services experienced a significant change, including an improvement or a decline in condition, and therefore a subsequent RN assessment is required.

(f) RN assessments are reimbursable when sequentially, but not concurrently, performed with any other service during a visit in which the RN is furnishing billable home health, PDN, waiver nursing, or any other service that is reimbursable through the Ohio medicaid program.

(5) The RN assessment service code may be billed by an RN when the RN is performing a home care attendant service (HCAS) RN visit required by rules 5160-46-04.1, 5160-50-04.1 and 173-39-02.24, as applicable, and pursuant to rules 5160-46-06.1, 5160-50-06.1 and 173-39-02.24 of the Administrative Code as applicable.

(6) RN assessment services are not reimbursable when performed in conjunction with nursing delegation tasks as set forth in Chapter 4723-13 of the Administrative Code.

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

(C) RN consultation services.

(1) An RN consultation service shall be performed as required by rule 5160-12-01 of the Administrative Code for state plan home health nursing services, rule 5160-12-02 of the Administrative Code for PDN services, rules 5160-46-04, 5160-50-04, 173-39-02.22 and 5123:2-9-59 of the Administrative Code for waiver nursing services and rule 5160-51-04 of the Administrative Code for HOME choice nursing services.

(2) An LPN shall seek the guidance of the directing RN when the individual receiving services from the LPN experiences a significant change in condition that may necessitate a change in the individual's plan of care and the interventions being provided by the LPN.

(3) An RN consultation service must be conducted between the directing RN and LPN either face-to-face or over the telephone.

(4) RN consultation services shall be reimbursed in accordance with the rates set forth in appendix A to this rule.

(5) RN consultation services are not reimbursable when performed in conjunction with nursing delegation services provided under a DODD-administered waiver program, or for consultations between RNs.

(D) If an individual selects multiple non-agency LPNs to furnish PDN services, waiver nursing, or HOME choice nursing services, the individual may designate a single RN to provide RN assessment and/or RN consultation services. Such designation shall be identified on the individual's service plan, as applicable, or the case manager, if one is assigned to the individual, shall develop a plan for the coordination of non-agency nursing services.

(E) Record keeping for RN assessment and RN consultation services.

(1) All RNs providing RN assessment and RN consultation services must maintain a clinical record for each individual receiving the medicaid covered services.

(2) Maintenance of the record shall be in a manner that protects the confidentiality of the record.

(3) Agency providers must maintain the clinical records at their place of business. The provider shall also maintain a file in the individual's place of residence containing a copy of the individual's medication profile, if one exists. The file may also include, but not be limited to the individual's medication administration record, treatment administration record, aide assignment, all services plan and plans of care. The individual shall identify a location in his or her residence where a copy of the clinical record will be safely maintained. Storage shall be in the manner that protects the confidentiality of the file, and for the purpose of contributing to the continuity of the individual's care.

(4) Non-agency providers must maintain the clinical records at their place of business and a copy at the home of the individual receiving the services. The individual shall identify a location in his or her residence where a copy of the clinical record will be safely maintained. Storage shall be a manner that protects the confidentiality of the record, and for the purpose of contributing to the continuity of the individual's care.

(5) At a minimum, the record must contain the following information:

(a) The name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers of the individual receiving the services;

(b) The medical history of the individual receiving the services;

(c) If the RN performing RN assessment services and/or RN consultation services is employed by an agency, the RN's name and contact information, the agency's contact information, and the agency's national provider identifier (NPI) number and medicaid provider number;

(d) If the RN performing RN assessment services and/or RN consultation services is a non-agency provider, his or her name, contact information, medicaid provider number and NPI number;

(e) If an LPN, being directed by an RN, is providing services and is employed by an agency, the LPN's name and contact information and the agency's NPI number and medicaid provider number;

(f) If an LPN, being directed by an RN, is providing services and is a non-agency provider, the LPN's name, contact information, NPI number and medicaid provider number;

(g) The name of and contact information for the treating physician of the individual receiving the services;

(h) A copy of the initial and all subsequent all services plans, individual service plans or HOME choice service plans, as applicable, for the individual receiving the services;

(i) A copy of the initial and all subsequent plans of care for the individual receiving the services;

(j) Documentation that the RN has reviewed the plans of care with the LPN when services are performed by an LPN at the direction of an RN;

(k) Documentation that the plan of care was recertified by the treating physician at least every sixty days;

(l) Documentation of any change of orders by the treating physician subsequent to the certified plan of care that altered the plan of care;

(m) Documentation of each instance in which the treating physician gave verbal orders to the RN or LPN, including what the physician ordered and the date and time the orders were given by the physician to the RN or LPN nurse, followed by the nurse's signature;

(n) A copy of the treating physician's signed and dated written verification of the verbal orders given to the nurse;

(o) In all instances in which a non-agency LPN has provided services, clinical notes that are signed and dated by the LPN, documentation of all RN consultation services occurring between the LPN and the directing RN, documentation of all face-to-face visits between the LPN and the directing RN, and documentation of the face-to-face visits between the LPN, the directing RN, and the individual receiving the services;

(p) A copy of all advance directives, including a "do not resuscitate" (DNR) order or medical power of attorney, if they exist;

(q) Documentation of all drug and food interactions, allergies and dietary restrictions;

(r) Clinical notes and other documentation of tasks performed or not performed;

(s) Documentation of the arrival and departure times of the RN assessment service provider with the dated signatures of the provider and the individual receiving the services verifying the service delivery upon completion of the service delivery and verifying the arrival and departure times. The signature method of choice of the individual receiving the services shall be documented in the clinical record. The signature method of choice shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature;

(t) Documentation of the date, start time and end time of the RN consultation service including the RN consultation provider's dated signature upon completion of the service;

(u) Clinical notes signed and dated by the RN and LPN documenting all communications with the treating physician and other members of the team selected by the individual receiving the services if the individual has team members;

(v) Documentation of face-to-face HCAS RN visits that must occur, every ninety days pursuant to rules 5160-46-04.1, 5160-50-04.1 and 173-39-02.24 of the Administrative Code, and any resulting activities; and

(w) A discharge summary signed and dated by the directing RN, at the point the RN is no longer going to provide assessment and consultation services to the individual or when the individual no longer needs services from the supervising RN. The summary should include information regarding the

progress made toward goal achievement and indicate any recommended follow-ups or referrals.

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	Ohio Revised Code Section 5164.02
Rule Amplifies:	Ohio Revised Code Section 5164.02
Prior Effective Dates:	07/01/2015, 01/01/2018