Proposed New Rule - March 17, 2016

5123:2-9-39 Home and community-based services waivers - waiver nursing services under the individual options waiver.

(A) Purpose

This rule defines waiver nursing services under the individual options waiver and sets forth provider qualifications, requirements for service delivery and documentation of services, and payment standards for the service.

(B) Definitions

(1) "Adult day support" has the same meaning as in rule 5123:2-9-17 of the Administrative Code.

(2) "Adult family living" has the same meaning as in rule 5123:2-9-32 of the Administrative Code.

(3) "Adult foster care" has the same meaning as in rule 5123:2-9-33 of the Administrative Code.

(4) "Agency provider" means an entity that directly employs at least one person in addition to the chief executive officer for the purpose of providing services for which the entity must be certified in accordance with rule 5123:2-2-01 of the Administrative Code.

(5) "County board" means a county board of developmental disabilities.

(6) "Department" means the Ohio department of developmental disabilities.

(7) "Homemaker/personal care" has the same meaning as in rule 5123:2-9-30 of the Administrative Code.

(8) "Independent provider" means a self-employed person who provides services for which he or she must be certified in accordance with rule 5123:2-2-01 of the Administrative Code and does not employ, either directly or through contract, anyone else to provide the services.

(9) "Individual" means a person with a developmental disability or for the purposes of giving, refusing to give, or withdrawing consent for services, his or her guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.

(10) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.

(11) "Intermediate care facility for individuals with intellectual disabilities" has the same

meaning as in section 5124.01 of the Revised Code.

(12) "Licensed practical nurse" has the same meaning as in section 4723.01 of the Revised Code.

(13) "Plan of care" means the medical treatment plan that is established, approved, and signed by the treating physician. The plan of care must be signed and dated by the treating physician prior to requesting payment for a service. The plan of care is not the same as the individual service plan.

(14) "Registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(15) "Residential respite" has the same meaning as in rule 5123:2-9-34 of the Administrative Code.

(16) "Service documentation" means all records and information on one or more documents, including documents that may be created or maintained in electronic software programs, created and maintained contemporaneously with the delivery of services, and kept in a manner as to fully disclose the nature and extent of services delivered that shall include the items delineated in paragraph (F) of this rule to validate payment for medicaid services.

(17) "Significant change" means a change experienced by an individual that includes, but is not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective services agency; or institutionalization.

(18) "Vocational habilitation" has the same meaning as in rule 5123:2-9-14 of the Administrative Code.

(19) "Waiver nursing services" means services provided to an individual who requires the skills of a registered nurse or licensed practical nurse working at the direction of a registered nurse. Waiver nursing services shall not include:

(a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules adopted thereunder, and to be performed by persons who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;

(b) Services that require the skills of a psychiatric nurse;

(c) Visits performed for the purpose of conducting a registered nurse assessment as set forth in rule 5160-12-08 of the Administrative Code including but not limited to, an outcome and assessment information set or any other assessment;

(d) Registered nurse consultations as set forth in rule 5160-12-08 of the Administrative

Code including but not limited to, those performed by registered nurses for the sole purpose of directing licensed practical nurses in the performance of waiver nursing services or directing personal care aides or home health aides employed by a medicare-certified home health agency or otherwise accredited agency;

(e) Visits performed for the sole purpose of meeting the home care attendant service registered nurse visit requirements set forth in rules 173-39-02.24 and 5160-46-04.1 of the Administrative Code; or

(f) Services performed in excess of the number of hours approved pursuant to, and as specified in, the individual service plan.

(C) Provider qualifications

(1) Waiver nursing services shall be provided by an independent provider or an agency provider that meets the requirements of this rule and that has a medicaid provider agreement with the Ohio department of medicaid.

(2) Waiver nursing services shall be provided by a registered nurse or by a licensed practical nurse working at the direction of a registered nurse who:

(a) Possesses a current, valid, and unrestricted license issued by the Ohio board of nursing; and

(b) Is working within his or her scope of practice as set forth in Chapter 4723. of the Revised Code and administrative rules adopted thereunder.

(3) Nursing tasks and activities that shall be performed only by a registered nurse include, but are not limited to:

(a) Intravenous insertion, removal, or discontinuation;

(b) Intravenous medication administration;

(c) Programming of a pump to deliver medication including but not limited to, epidural, subcutaneous, and intravenous (except routine doses of insulin through a programmed pump);

(d) Insertion or initiation of infusion therapies;

(e) Central line dressing changes; and

(f) Blood product administration.

(4) Waiver nursing services shall not be provided by a county board or a regional council of

governments formed under section 5126.13 of the Revised Code by two or more county boards.

(5) An applicant seeking approval to provide waiver nursing services shall complete and submit an application through the department's website (http://dodd.ohio.gov/providers/becomeaprovider/pages/default.aspx) and adhere to the requirements of rule 5123:2-2-01 of the Administrative Code.

(6) Failure of a provider to comply with this rule and rule 5123:2-2-01 of the Administrative Code may result in denial, suspension, or revocation of the provider's certification.

(D) Service authorization

(1) A county board or its contracted agent shall complete and submit a service authorization request for waiver nursing services to the department for review and approval at least annually and upon identification of a significant change that affects a service authorization. Each service authorization request shall include:

(a) An assessment of resources available to address each skilled nursing task ordered by a physician; and

(b) A proposed weekly schedule with corresponding budget.

(2) Waiver nursing services shall be authorized only when an individual's needs cannot be met through medication administration and nursing delegation in accordance with Chapter 5123:2-6 of the Administrative Code and/or state plan nursing services as defined in Chapter 5160-12 of the Administrative Code.

(3) When reviewing a service authorization request, the department shall determine whether the waiver nursing services for which authorization is requested are medically necessary unless the requested services have been determined by the Ohio department of medicaid not to be medically necessary within a twelve-month period immediately preceding the service authorization request, in which case a medical necessity review under this paragraph shall not be required. The department shall determine the services to be medically necessary if the services:

(a) Are appropriate for the individual's health and welfare needs, living arrangement, circumstances, and expected outcomes; and

(b) Are of an appropriate type, amount, duration, scope, and intensity; and

(c) Are the most efficient, effective, and lowest cost alternative that, when combined with non-waiver services, ensure the health and welfare of the individual receiving the services; and

(d) In accordance with rule 5123:2-9-02 of the Administrative Code, are not otherwise available through other resources.

(4) Notwithstanding the procedures set forth in this rule, the department may approve a service authorization request in its entirety or may partially approve a service authorization request if it determines that the services are medically necessary.

(5) The individual shall be afforded notice and hearing rights regarding service authorizations in accordance with Chapter 5101:6 of the Administrative Code.

(a) Providers shall have no standing in appeals under this section.

(b) A change in staff-to-waiver-recipient service ratios does not necessarily result in a change in the level of services received by an individual which would affect the annual service authorization.

(E) Requirements for service delivery

(1) Waiver nursing services shall be provided pursuant to an individual service plan that conforms to the requirements of rule 5123:2-1-11 of the Administrative Code.

(2) Waiver nursing services shall not be provided to an individual during the same time the individual is receiving adult day support, adult family living, adult foster care, residential respite being provided at an intermediate care facility for individuals with intellectual disabilities, or vocational habilitation.

(3) A provider of waiver nursing services shall be identified as the provider and have specified in the individual service plan the number of hours for which the provider is authorized to furnish waiver nursing services.

(4) A registered nurse or licensed practical nurse working at the direction of a registered nurse may provide services for no more than three individuals in a group setting during a face-to-face nursing visit.

(5) A provider of waiver nursing services who is a licensed practical nurse working at the direction of a registered nurse shall conduct a face-to-face visit with the individual and the directing registered nurse prior to initiating services and at least once every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the individual's satisfaction with care delivery and performance of the licensed practical nurse, and to ensure that waiver nursing services are being provided in accordance with the approved plan of care.

(6) In all instances, when a treating physician gives verbal orders to the registered nurse or licensed practical nurse working at the direction of a registered nurse, the nurse shall record, in writing, the physician's orders, the date and time the orders were given, and

sign the entry in the service documentation. The nurse shall subsequently secure documentation of the verbal orders signed and dated by the treating physician.

(7) In all instances, when an independent provider who is a licensed practical nurse working at the direction of a registered nurse is providing waiver nursing services, the licensed practical nurse shall provide clinical notes, signed and dated by the licensed practical nurse, documenting all consultations between the licensed practical nurse and the directing registered nurse, documenting the face-to-face visits between the licensed practical nurse and the directing registered nurse, and documenting the face-to-face visits between the licensed practical nurse, the individual receiving waiver nursing services, and the directing registered nurse. The clinical notes may be collected and maintained in electronic software programs.

(8) Waiver nursing services may be provided on the same day as, but not concurrently with, a registered nurse assessment and/or registered nurse consultation as set forth in rule 5160-12-08 of the Administrative Code.

(F) Documentation of services

(1) Service documentation for waiver nursing services shall include each of the following to validate payment for medicaid services:

(a) Type of service.

(b) Date of service.

(c) Place of service.

(d) Name of individual receiving service.

(e) Medicaid identification number of individual receiving service.

(f) Name of provider.

(g) Provider identifier/contract number.

(h) Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.

(i) Group size in which the service was provided.

(j) Description and details of the service delivered that directly relate to the services specified in the approved individual service plan as the services to be provided, including the individual's response to each medication, treatment, or procedure

performed.

(k) Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.

(l) Begin and end times of the delivered service.

(2) In addition to service documentation specified in paragraph (F)(1) of this rule, providers of waiver nursing services shall maintain a clinical record for each individual which includes:

(a) Individual's medical history.

(b) Name and national provider identifier number of individual's treating physician.

(c) A copy of all individual service plans in effect when the provider provides services.

(d) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope, and duration of the waiver nursing services being performed. When waiver nursing services are performed by a licensed practical nurse working at the direction of a registered nurse, the record shall include documentation that the registered nurse has reviewed the plan of care with the licensed practical nurse. The plan of care shall be certified by the treating physician initially and recertified at least annually thereafter, or more frequently if there is a significant change in the individual's condition.

(e) Documentation of verbal orders from the treating physician in accordance with paragraph (E)(6) of this rule.

(f) The clinical notes of an independent provider who is a licensed practical nurse working at the direction of a registered nurse in accordance with paragraph (E)(7) of this rule.

(g) A copy of any advance directives including but not limited to, a "do not resuscitate" order or medical power of attorney, if they exist.

(h) Documentation of drug and food interactions, allergies, and dietary restrictions.

(i) Clinical notes signed and dated by the registered nurse or licensed practical nurse working at the direction of a registered nurse, documenting all communications with the treating physician and other members of the multidisciplinary team.

(G) Payment standards

(1) The billing units, service codes, and payment rates for waiver nursing services are

contained in the appendix to this rule.

(2) Homemaker/personal care may be reimbursed as waiver nursing services when provided incidental to waiver nursing services performed during an authorized waiver nursing services visit.

APPENDIX

BILLING UNITS, SERVICE CODES, AND PAYMENT RATES
FOR WAIVER NURSING SERVICES

Independent Provider Who is a Registered Nurse

Billing Unit	Service Code	Payment Rate
Base rate (the amount paid for the first thirty-five to sixty minutes of service delivered)	T1002	$38.60
Unit rate (the amount paid for each fifteen minutes of service delivered when the visit is greater than sixty minutes in length or less than or equal to thirty-four minutes in length)*	T1002	$6.96

Independent Provider Who is a Licensed Practical Nurse Working at the Direction of a Registered Nurse

Billing Unit	Service Code	Payment Rate
Base rate (the amount paid for the first thirty-five to sixty minutes of service delivered)	T1003	$31.65
Unit rate (the amount paid for each fifteen minutes of service delivered when the visit is greater than sixty minutes in length or less than or equal to thirty-four minutes in length)*	T1003	$5.57

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Employee of Agency Provider Who is a Registered Nurse

Billing Unit	Service Code	Payment Rate
Base rate (the amount paid for the first thirty-five to sixty minutes of service delivered)	T1002	$45.40
Unit rate (the amount paid for each fifteen minutes of service delivered when the visit is greater than sixty minutes in length or less than or equal to thirty-four minutes in length)*	T1002	$8.32

Employee of Agency Provider Who is a Licensed Practical Nurse Working at the Direction of a Registered Nurse

Billing Unit	Service Code	Payment Rate
Base rate (the amount paid for the first thirty-five to sixty minutes of service delivered)	T1003	$37.90
Unit rate (the amount paid for each fifteen minutes of service delivered when the visit is greater than sixty minutes in length or less than or equal to thirty-four minutes in length)*	T1003	$6.82

* The provider shall be paid a maximum of 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 to thirty-four minutes in length.