TO BE RESCINDED

5101:3-12-01 **Ohio home care program - definitions.**

The following definitions are applicable to this chapter:

(A) "Activities of daily living" are personal or self-care skills performed, with or without the use of assistive devices, on a regular basis that enable the consumer to meet basic life needs for food, hygiene and appearance as defined in rule 5101:3-3-06 of the Administrative Code.

(B) "All services plan" is the document completed by ODJFS or its designee which identifies the services being received by consumers enrolled on the core-plus, Ohio home care waiver, or transitions waiver benefit package. The all services plan must identify the general expected outcomes, measurable goals and objectives, services being provided, frequency of visits, the estimated length of time of the visits and the individuals or agencies responsible for providing the services, along with the names and phone numbers of contact persons for each service. ODJFS or its designee is responsible for coordinating all of the services - from medicaid or nonmedicaid providers as well as paid and unpaid providers - on the all services plan and overseeing their delivery to the consumer.

(C) "CDJFS" is a county department of job and family services.

(D) "CHAP" is the community health accreditation program, an organization which evaluates and rates home health agencies. For the purpose of this chapter, CHAP accredited agencies may provide the services JCAHO accredited agencies are eligible to provide.

(E) "Clinical record" is written documentation which must be maintained by each individual, agency, or entity providing home care program services. Clinical record requirements are specified for each service.

(F) CMS" means the centers for medicare and medical services.

(G) "Consumer" is a person receiving Ohio home care services under Ohio's medical assistance program and in accordance with Chapter 5101:3-12 of the Administrative Code.

(H) "Continuous care visit" is a face to face encounter between a consumer and a home health care provider for the provision of Ohio home care program services. A continuous care visit is over four hours long and may not exceed twelve hours per visit. Under certain circumstances, ODJFS or its designee may approve continuous care visits lasting up to sixteen hours.

(I) "Core benefit package" is the home care benefit package which consists of the core home care services defined in paragraph (K)of this rule. It is designed to meet the needs of consumers eligible for medicaid who require no more than a combined total of fourteen hours of daily living and/or nursing services per week. Preapproval by ODJFS or its designee is not required before a consumer can access covered services.

(J) "Core-plus benefit package" is the home care benefit package which consists of the core home care services defined in paragraph (K)of this rule. It is designed to meet the needs of consumers eligible for medicaid who require a total of more than fourteen hours per week of daily living and/or nursing services combined. Preapproval by ODJFS or its designee is required before a consumer can access covered services.

(K) "Core home care services" are nursing services, daily living services and skilled therapy services as defined in rule 5101:3-12-06 of the Administrative Code.

(L) "Data collection" is the compilation and evaluation of data pertaining to the physical condition, functional abilities, living environment and support services/resources on every individual seeking core-plus or ODJFS-administered waiver benefits, and on a selected random sample of consumers who have received core benefits.

(M) "Daily living services" are home care services defined in paragraph (B) of rule 5101:3-12-06 of the Administrative Code. The scope and duration of these service differ among the benefit packages as defined in rule 5101:3-12-03 of the Administrative Code.

(N) "Episode of home care" means the period beginning with the first day of delivery of any combination of home care services through the last day of service delivery, and in which there has not been a lapse of more than sixty days between service delivery.

(O) "Family member" is a consumer's or provider's immediate relative or member of the family, including:

(1) Husband or wife;

(2) Natural or adoptive parent, child or sibling;

(3) Stepparent, stepchild, stepbrother, stepsister, half brother, or half sister;

(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law;

(5) Grandparent or grandchild; or

(6) Spouse of grandparent or grandchild.

(P) "Group visit" is a face to face encounter for the purpose of providing services to two or three consumers at the same residential address or community setting on the same date and during the same visit, regardless of the payer source of each consumer. The ratio of consumers to provider shall be no greater than three to one.

(Q) "Home care services" means the services defined in rules 5101:3-12-06 and 5101:3-12-07 of the Administrative Code.

(R) "Home services facilitation" is the administrative activity that identifies, links and coordinates all of the services and resources that are needed by a consumer eligible for the core-plus or an ODJFS-administered waiver benefit package. ODJFS or its designee shall carry out these duties.

(S) "Home services facilitator" is the individual employed by ODJFS or its designee and assigned to facilitate services for medicaid consumers.

(T) "Individual cost cap" is the monthly cost of services that is approved by ODJFS for a consumer enrolled in the core-plus or ODJFS-administered waiver benefit package. ODJFS or its designee oversees that the cost of medicaid covered services does not exceed the individual cost cap, determines when an increase or decrease of the current individual cost cap is required, and makes a recommendation with justification to ODJFS for approval for increasing or decreasing the individual cost cap.

(U) "Institutional level of care" means any of the levels of care defined in rules 5101:3-3-05, 5101:3-3-06 and 5101:3-3-07 of the Administrative Code.

(V) "Institutional setting" is any nursing facility (NF), intermediate care facility for the mentally retarded and/or developmentally disabled (ICF-MR) or hospital.

(W) "Instrumental activity of daily living" is a community living skill performed, with or without the use of assistive devices, on a regular basis that enables the consumer to independently manage his or her living arrangement, as defined in rule 5101:3-3-08 of the Administrative Code.

(X) "Interdisciplinary team" is a group of persons including the consumer, his or her family or authorized representative and/or primary care giver(s), any medicaid or nonmedicaid providers, any paid and unpaid providers and ODJFS or its designee, if applicable.

(Y) "Intermittent home care" means the receipt of nursing visits and/or daily living service visits which amount to no more than fourteen hours of services per week and which is usually provided during intermittent visits.

(Z) "Intermittent visit" means any visit for nursing services, daily living services or skilled therapy services which generally requires less than two hours, not to exceed four hours, of the provider's time to perform the duties specified in the plan of care. An intermittent visit occurs only from time to time with a lapse of time of more than two hours between any previous or subsequent visit for the provision of the same type of core home care service.

(AA) "JCAHO" is the joint commission on accreditation of healthcare organizations. For the purpose of this chapter, CHAP accredited agencies may provide the services JCAHO accredited agencies are eligible to provide.

(BB) "Medical necessity" or "medically necessary" has the same meaning as the concept defined in paragraph (A) of rule 5101:3-1-01 of the Administrative Code.

(CC) "Noninstitutional setting" is any setting that is not a nursing facility (NF), an intermediate care facility for the mentally retarded and/or developmentally disabled (ICF-MR) or hospital.

(DD) "Nursing services" are home care services defined in paragraph (A) of rule 5101:3-12-06 of the Administrative Code. The scope and duration of these service differ among the benefit packages as defined in rule 5101:3-12-03 of the Administrative Code.

(EE) "ODJFS" means the Ohio department of job and family services.

(FF) "ODJFS-administered home care benefit packages" are the four types of home care benefits administered by ODJFS. They include the core benefit package, the core-plus benefit package, the Ohio home care waiver benefit package, and the transitions waiver benefit package.

(GG) "ODJFS-administered waiver benefit package" is the home care benefit package designed to meet the needs of consumers enrolled in an ODJFS-administered

HCBS waiver. It consists of nursing services, daily living services, skilled therapy services and approved ODJFS-administered HCBS waiver services.

(HH) "ODJFS-administered HCBS waiver" means the ODJFS-administered medicaid home and community-based waiver programs which serve individuals who meet the criteria set forth in rule 5101:3-12-04 and in paragraph (OO) of rule 5101:3-12-01 of the Administrative Code. These programs are called the Ohio home care waiver and the transitions waiver.

(II) "Ohio home care waiver is one of the two home and community based services waiver programs administered by ODJFS. The waiver is designed to provide services to individuals with and intermediate or skilled level of care in accordance with eligibility criteria in paragraph (C) of rule 5101:3-12-03 of the Administrative Code.

(JJ) "Other accredited agency" means an agency that is JCAHO or CHAP accredited.

(KK) "Part-time home care" means no more than a combined total of eight hours of nursing visits and daily living visits, skilled therapy visits or center-based day health services on a single date of service.

(LL) "Plan of care" is the prepared documentation that includes, but is not limited to, the consumer's pertinent diagnoses (including mental status), types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral and any other information specifically required for consumers as set forth in Chapter 5101:3-12 of the Administrative Code. The HCFA 485 form may be used to document the plan of care, but it is not required.

(MM) "Residential address" means any physical dwelling with a unique mailing address where a consumer resides. For example, an apartment within an apartment complex would be a residential address; the entire apartment building or complex would not be a residential address.

(NN) "Skilled therapy services" are services which include physical therapy, occupational therapy, or speech-language pathology services as defined in paragraph (C) of rule 5101:3-12-06 of the Administrative Code.

(OO) "Transitions waiver" is one of the two home and community based services waiver programs administered by ODJFS. The transitions waiver is designed to provide services to individuals who are enrolled on the Ohio home care waiver and who are

determined by ODJFS or its designee to have an ICF-MR level of care in accordance with rule 5101:3-3-07 of the Administrative Code.

(PP) "Treating physician" is the physician who provides care and treatment to a consumer on an ongoing basis. Treating physician does not mean a physician retained by a home care provider whose sole function is to sign and authorize plans of care. It does not mean a physician who has no involvement in the consumer's care or treatment. For the purpose of reviewing and signing the plan of care, "treating physician" can mean a designated physician covering for the treating physician in his or her temporary absence or a physician who is a member of the same group practice as the consumer's treating physician and in which it is customary for the members of the practice to cross cover for each other.

(QQ) "Visit" and "home care visit" are defined as any face-to-face encounter with the consumer to perform the covered nursing services, daily living services or skilled therapy services outlined in the plan of care. Also see definitions for intermittent visit and continuous care visit.

Effective:

R.C. 119.032 review dates: 03/24/2006

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5111.02
Rule Amplifies:	5111.01, 5111.02, 5111.85
Prior Effective Dates:	5/1/98, 9/29/00, 3/1/02 (Emer), 5/30/02