5101:3-12-02 **Private duty nursing: services, provision requirements, coverage and service specification.**

(A) "Private duty nursing (PDN)" as defined in paragraph (E) of this rule is a nursing service available up to sixty consecutive days, except as specified in paragraph (F) of this rule, from the date of discharge from an inpatient hospital stay of three or more covered days in accordance with rule 5101:3-2-03 of the Administrative Code. Consumers who require nursing on a continuous basis, which means:

(1) More than four hours (sixteen units) but less than or equal to twelve hours (forty eight units) per visit, unless an unusual circumstance requires a visit up to and including sixteen hours (sixty four units).

(2) Less than or equal to fifty-six hours (two hundred twenty-four units) a week of PDN except as specified in paragraph (F) of this rule.

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

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

(1) Provide PDN that is appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as ordered by the consumer's treating physician for the treatment of the consumer's illness or injury.

(2) Provide PDN as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. PDN services not specified in a plan of care are not reimbursable. Additionally the providers of PDN services' plan of care must provide the amount, scope, duration, and type of PDN service as:

(a) Identified on the all services plan that is prior approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS administered home and community based services (HCBS) waiver. PDN services not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when a consumer is enrolled in an ODA (Ohio department of aging) administered or a ODMR/DD (Ohio department of mental retardation and developmental disability) administered HCBS waiver. PDN services not documented on the services plan are not reimbursable.

(3) Provide PDN in the consumer's place of residence. The consumer's place of residence is wherever the consumer lives, whether the home is the consumer's own dwelling, an apartment, assisted living residence, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR). PDN may only be provided outside the place of residence if it is medically necessary for a nurse to accompany the consumer to a Medicaid covered service that is not any other residence. The place of service in the community cannot include the residence or business location of the provider of PDN.

(4) Not provide PDN for the provision of maintenance care, habilitative care or respite care.

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

(b) "Habilitative care" is in accordance with Chapter 5101:3-1 of the Administrative Code.

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

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

(6) Bill for provided PDN services using the appropriate procedure code and applicable modifiers in accordance with rule 5101:3-12-06 of the Administrative Code.

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

(D) Consumers who receive PDN must:

(1) Be under the supervision of a treating physician who is providing care and

treatment to the consumer. The treating physician cannot be a physician whose sole purpose is to sign and authorize plans of care or who does not have direct involvement in the care or treatment of the consumer. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.

(2) Participate in the development of a plan of care with the treating physician and the medicare certified home health agency (MCRHHA) or other accredited agencies or non-agency registered nurse. An authorized representative may participate in the development of the plan of care in lieu of the consumer.

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

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

(5) Access PDN in accordance with the consumer's managed care plan when the consumer is enrolled in a medicaid managed care plan.

(E) "Private duty nursing (PDN)" is a nursing service that requires the skills of and is performed by either a registered nurse or licensed practical nurse at the direction of a registered nurse. A service is not considered a nursing service merely because it was performed by, delegated by, or at the direction of a nurse. Covered PDN services:

(1) Must be performed within the nurse's scope of practice in accordance with Chapter 4723. of the Revised Code.

(2) Must be provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.

(3) Must be provided in a face-to-face encounter.

(4) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.

(5) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously, enterally, or by epidural. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance to rule 5101:3-12-06 of the Administrative Code.

(F) A consumer who meets the requirements in this paragraph may qualify for increased services. The provider of PDN services must assure and document the consumer meets all requirements in this paragraph prior to increasing services. The U5 modifier must be used when billing in accordance to rule 5101:3-12-06 of the Administrative Code. The use of the U5 modifier indicates that all conditions of

this paragraph were met. The consumer who meets the following requirements may receive an increase of PDN if he or she:

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

(2) Requires (as ordered by the treating physician) more than fifty-six hours (two hundred twenty-four units) of PDN service per week and/or longer than sixty days according to paragraph (A) 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 as assessed initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care, which are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. In no instance does this constitute the determination of a level of care for waiver eligibility purposes, or admission into a medicaid covered long term care institution, and

(4) Requires PDN or a combination of PDN/home health nursing/waiver nursing/skilled therapy services at least three times per week that is medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code as ordered by the treating physician.

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

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