5101:3-12-06 **Core home care services.**

(A) Nursing services

(1) "Nursing services" are those services ~~which~~ that require the skills of a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, and which are within the nurse's scope of practice in accordance with Chapter 4723. of the Revised Code.

(2) A "nursing visit" shall be defined as a face-to-face encounter rendered by a nurse for the purpose of providing nursing services.

(3) A "group nursing visit" shall be defined as a face-to-face encounter rendered by a nurse for the purpose of providing nursing services to two or three consumers at the same residential address or community setting on the same date, regardless of the payer source of each consumer. The ratio of consumers per nurse shall be no greater than three-to-one.

(4) Nursing visits covered in accordance with paragraph (A)(9) of this rule are limited to:

(a) Intermittent visits, which generally require less than two hours, not to exceed four hours for the performance of nursing duties specified in the plan of care; and

(b) Intermittent visits, ~~which~~ that generally require less than two hours, not to exceed four hours for the purpose of providing the nursing observations and assessments ~~which~~ that are required in accordance with paragraphs (A)(5) and (A)(6) of this rule.

(c) Continuous care visits, ~~which~~ that must last over four hours and may not exceed twelve hours per visit without a change in staff. Under certain circumstances, ODJFS or its designee may approve continuous care visits lasting up to sixteen hours.

(5) When core services are performed by medicare-certified home health agencies or nurses in independent practice, nursing observations and assessments must be performed by a registered nurse at least every sixty days for the recertification of the plan of care, but may occur as often as the severity of the consumer's condition requires.

(6) When core services are performed by other accredited home health agencies for the purpose of providing nursing observations and assessments must be

performed by a registered nurse as often as the severity of the consumer's condition requires.

(7) Reimbursable nursing visits do not include continuous care visits for the purpose of continuously monitoring medical conditions without the performance of other hands-on nursing services provided during the visit.

(8) Visits performed by a registered nurse for the sole purpose of meeting the supervisory requirements for the coverage of daily living services is not a covered nursing visit. When the supervision of a daily living worker is performed during a covered nursing visit as defined in paragraph (A)(4) of this rule, the supervisory services provided by the nurse during the nursing visits are reimbursable services.

(9) For a nursing service to be covered:

(a) The service must be provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse who is either:

(i) Employed by a medicare-certified or an other accredited home health agency and who is not the consumer's foster parent; or

(ii) An independent home care nurse or advanced practice nurse provider, and is not the consumer's spouse, parent, stepparent, foster parent or legal guardian of a minor consumer.

(b) For consumers enrolled in the core benefit package intermittent nursing visits must be provided by a medicare-certified home health agency.

(c) For consumers enrolled in the core plus benefit package, intermittent nursing visits must be provided by a medicare-certified home health agency. Continuous care nursing visits may be provided by a medicare-certified home health agency; or when continuous nursing is the only service required, an other accredited home health agency or an independent home care nurse.

(d) For consumers enrolled in the ODJFS administered waiver package, intermittent and continuous care visits may be provided by a medicare-certified home health agency, an other accredited home health agency, or an independent home care nurse.

(e) Providers must, at a minimum, maintain the following documentation

requirements for the provision of nursing services:

(i) Clinical records must be maintained at the provider's place of business. In addition, an independent provider must maintain a copy of the clinical records in the consumer's residence.

(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards of practice must be maintained for every consumer.

(b) Each clinical record must be signed and dated by the personnel who conducted the visit and rendered services for which a payment claim is made.

(c) Clinical records must clearly specify the nature of each nursing visit (e.g., changing of a wound dressing) and must contain the following:

(i) The current plan of care.

(ii) Consumer identifying information.

(iii) The name of the consumer's treating physician.

(iv) Pertinent medical history.

(v) Drug, dietary, treatment and activity orders.

(vi) Clinical progress notes ~~which~~ that specify the nature of each nursing visit and ~~which~~ that are signed and dated by the provider who conducted the visit and rendered the services for which a claim is being made.

(vii) Copies of communication with the treating physician and other members of the interdisciplinary team.

(viii) A discharge summary ~~which~~ that includes the consumer's medical and health status at the time services are terminated.

(ix) Initial and subsequent physician orders ~~which~~ that

specify the type, frequency, scope and duration of the nursing services to be provided.

(ii) Physician orders

Initial and subsequent orders from the consumer's treating physician must specify the type of nursing services to be provided to the consumer as well as the frequency, scope and duration of the services.

(iii) Use of oral (verbal) orders

When services are furnished based on the treating physician's oral order for initial or subsequent orders and/or the recertification of the plan of care, the orders may be accepted and put in writing by personnel authorized to do so by applicable state and federal laws and regulations, as well as by the medicare-certified or an other accredited home health agency's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse responsible for furnishing or supervising the ordered services. Oral orders must be countersigned and dated by the consumer's treating physician before the provider submits a claim to ODJFS for payment.

(f) For consumers receiving services under the core-plus and ODJFS-administered waiver benefits, the nursing services must be approved by ODJFS or its designee and be identified on the all services plan. Providers of core-plus and ODJFS-administered waiver benefits are responsible for providing services as approved on the all services plan. Services provided that have not been approved by ODJFS or its designee are noncovered services.

(10) Daily living services performed by registered nurses or licensed practical nurses under the supervision of a registered nurse during a covered nursing visit shall be considered incidental to the nursing service and reimbursed as part of the nursing service.

(11) Nursing services delegated in accordance with the Nurse Practice Act in Chapter 4723. of the Revised Code and performed by individuals who are not licensed nurses shall be reimbursed as a daily living service.

(B) Daily living service

(1) "Daily living services" are services ~~which~~ that assist consumers in carrying out activities of daily living and instrumental activities of daily living that they would typically self-perform if functional ability were present. Such services are synonymous with home health aide services when the services listed under paragraph (B)(4) of this rule are performed by a home health aide who has met the personnel requirements as set forth in 42 ~~CFR~~ C.F.R. 484 (2005), and who is employed by a medicare- certified home health agency enrolled under the Ohio medicaid program.

(2) A "daily living visit" shall be defined as a face-to-face encounter for the purpose of providing daily living services as defined in paragraph (B)(1) of the rule.

(3) A "group daily living visit" shall be defined as a face-to-face encounter for the purpose of providing daily living services to two or three consumers at the same residential address or community setting on the same date, regardless of the payer source of each consumer. The ratio of consumers per daily living service provider shall be no greater than three-to-one.

(4) Reimbursable daily living visits are limited to intermittent or continuous care visits to provide the following services:

(a) Personal care services that are needed to facilitate treatment or to prevent deterioration of the consumer's health unless the skills of a licensed nurse are required due to the consumer's condition. Such services include, and are not limited to: bathing; dressing; grooming; caring for hair, nail and oral hygiene; shaving; deodorant application; skin care with lotions and /or powders; foot care; ear care; feeding; assistance with elimination (including enemas, routine catheter care, and colostomy care); assistance with ambulation; changing position in bed and assistance with transfers;

(b) Assistance with activities that are directly supportive of skilled therapy services, but do not require the skills of a therapist or therapy assistant to be safely and effectively performed, (i.e., routine maintenance exercise and repetitive practice of functional communicating skills to support speech-language pathology services);

(c) Routine care of prosthetic and orthotic devices (i.e., care not considered the responsibility of the supplier of prosthetic and orthotic devices);

(d) Performance of general household activities that are essential to the consumer's health and safety, (i.e., preparation and clean-up of meals,

laundry, bed making, dusting, vacuuming, errands and other routine household chores);

(e) Short term relief for the primary caregivers of consumers enrolled on the ODJFS-administered waiver benefit; and

(f) Other services that are traditionally nursing services that may be delegated by nurses, in accordance with Chapter 4723. of the Revised Code, as long as the service provider is trained and qualified under Ohio law to perform the delegated service.

(5) Under the core and core plus benefits, homemaker services can only be provided if the homemaking services are incidental to daily living services. Under the ODJFS-administered waiver benefit, homemaking services may be provided as a separate service.

(6) For daily living services to be covered:

(a) The services must be provided by an individual who is not the consumer's spouse, parent, stepparent, foster parent or legal guardian of a minor consumer.:

(i) For consumers receiving services under the core or core-plus benefit packages the individual must be employed by a medicare-certified home health agency and meet the requirements of a home health aide as set forth in 42 ~~CFR~~ C.F.R. 484 (2005).

(ii) For consumers receiving services under the ODJFS-administered waiver benefit package, the individual must be:

(a) Employed by a medicare-certified or ~~JCAHO~~ joint commission on accreditation of healthcare organizations (JCAHO) accredited home health agency; or

(b) For consumers electing to participate in the consumer options described in paragraphs (A)(4) and (A)(5) of rule 5101:3-12-12 of the Administrative Code, be an ODJFS-administered ~~HCBS~~ home and community-based services (HCBS) waiver independent daily living aide or an ODJFS-administered HCBS waiver independent daily living non-aide.

(b) Providers must, at a minimum, maintain the following documentation requirements for the provision of daily living services:

(i) Clinical records must be maintained at the provider's place of business. In addition, an independent provider must maintain a copy of the clinical records in the consumer's residence.

(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards of practice must be maintained for every consumer.

(b) Each clinical record must be signed and dated by the personnel who conducted the visit and rendered services for which a payment claim is made.

(c) Clinical records must clearly specify the nature of each daily living service visit (e.g.~~,~~ bathing and dressing the consumer) and must contain the following:

(i) The current plan of care.

(ii) Consumer identifying information.

(iii) The name of the consumer's treating physician.

(iv) Pertinent medical history.

(v) Drug, dietary, treatment and activity orders.

(vi) Clinical progress notes ~~which~~ that specify the nature of each visit and ~~which~~ that are signed and dated by the provider who conducted the visit and rendered the services for which a claim is being made.

(vii) Copies of communication with the treating physician and other members of the interdisciplinary team.

(viii) A discharge summary ~~which~~ that includes the consumer's medical and health status at the time services are terminated.

(ix) Initial and subsequent physician orders ~~which~~ that specify the type, frequency, scope and duration of the services to be provided.

(ii) Physician orders

Initial and subsequent orders from the consumer's treating physician must specify the type of daily living service(s) to be provided to the consumer as well as the frequency, scope and duration of the services. Independent daily living aides and independent daily living non-aide providers shall not obtain physician orders. Physician orders shall be obtained by ODJFS or its designee for those consumers who receive services from independent daily living aides and independent daily living non-aides.

(iii) Use of oral (verbal) orders

When services are furnished based on the treating physician's oral order for initial or subsequent orders and/or the recertification of the plan of care, the orders may be accepted and put in writing by personnel authorized to do so by applicable state and federal laws and regulations, as well as by the medicare-certified or accredited home health agency's internal policies. The orders must be signed and dated with the date of receipt by the registered nurse responsible for furnishing or supervising the ordered services. Oral orders must be countersigned and dated by the consumer's treating physician before the provider submits a claim to ODJFS for payment.

(c) For consumers receiving core-plus or ODJFS-administered waiver benefits, the daily living services must be prior approved by ODJFS or its designee and be identified on the all services plan. Providers of core-plus and ODJFS-administered waiver services are responsible for providing services as approved on the all services plan. Services provided that have not been approved are noncovered services.

(C) Skilled therapy services

(1) "Skilled therapy services" are defined as those medically necessary services ~~which~~ that require the skills of a licensed physical therapist, occupational therapist, speech-language pathologist, or licensed physical therapy assistant (LPTA) under the direction of a physical therapist, or a certified occupational

therapy assistant (COTA) under the direction of a licensed occupational therapist. Physical, occupational, or speech-language pathology services provided to the consumer must be within the therapist's or therapy assistant's scope of practice pursuant to sections 4755.44, 4755.07, and 4753.07 of the Revised Code.

(2) Reimbursable therapy services include implementation and applicable supervision of the following:

(a) Physical therapy services as described in section 4755.40 of the Revised Code.

(b) Occupational therapy services as described in section 4755.01 of the Revised Code.

(c) Speech-language pathology services as described in section 4753.01 of the Revised Code.

(3) A therapy visit shall be defined as:

(a) For physical therapy, any face-to-face encounter with a consumer to provide a covered physical therapy service as defined in paragraph (C)(2)(a) of this rule;

(b) For occupational therapy, any face-to-face encounter with a consumer for the purpose of providing a covered occupational therapy service as defined in paragraph (C)(2)(b) of this rule;

(c) For speech-language pathology, any face-to-face encounter with an individual for the purpose of providing a covered speech-language pathology service as defined in paragraph (C)(2)(c) of this rule.

(4) A "group visit" shall be defined as a face-to-face encounter for the purpose of providing the same type of therapy services to two or three consumers provided at the same residential address or community setting on the same date of service, regardless of the payer source of the consumer. The ratio of consumers per skilled therapist shall be no greater than three-to-one.

(5) For a therapy service to be covered, the service must be provided by an individual who is employed by a medicare-certified home health agency and who is not the consumer's foster parent. Consumer's family members may provide skilled therapy services as long as they are employed by a

medicare-certified home health agency.

(6) The service of a physical therapist, occupational therapist, or speech-language pathologist is covered if the inherent complexity of the service is such that it must be performed by a licensed physical therapist, occupational therapist, or speech therapist or a licensed therapy assistant under the general supervision of a licensed therapist.

(7) Therapy services must be provided with the expectation that the consumer's condition will improve within a reasonable and predictable period of time. Such time limits shall be included in the consumer's plan of care.

(a) When it is the expectation that the consumer's condition will not improve within a reasonable and predictable period of time, the service will be covered and reimbursed in accordance with paragraph (C)(8) of this rule.

(b) When a therapist is needed to reevaluate and/or adjust services for the purpose of maintaining current functional levels, or to prevent or slow muscle atrophy or deterioration, such services shall be covered and reimbursed as a skilled therapy service.

(8) The following services do not constitute skilled therapy services, but may be covered as daily living services:

(a) Services involving activities for the general welfare of an individual, such as general exercise to promote overall physical fitness or flexibility and activities to provide diversion or general motivation, do not constitute skilled therapy; and

(b) Services for the purpose of maintaining current functional levels or to prevent or slow muscle atrophy or functional deterioration.

(9) For consumers receiving core-plus and ODJFS-administered waiver benefit packages therapy services must be approved by ODJFS or its designee and be identified on the all services plan. Providers are responsible for providing services as approved on the all services plan. Services provided that have not been approved are noncovered services.

(10) Providers must, at a minimum, maintain the following documentation requirements for the provision of skilled therapy services:

(a) Clinical records must be maintained at the provider's place of business.

(i) Clinical records containing pertinent past and current findings in accordance with accepted professional standards of practice must be maintained for every consumer.

(ii) Each clinical record must be signed and dated by the personnel who conducted the visit and rendered services for which a payment claim is made.

(iii) Clinical records must clearly specify the nature of each skilled therapy visit (e.g. gait training) and must contain the following:

(a) The current plan of care.

(b) Consumer identifying information.

(c) The name of the consumer's treating physician.

(d) Pertinent medical history.

(e) Drug, dietary, treatment and activity orders.

(f) Clinical progress notes ~~which~~ that specify the nature of each visit and ~~which~~ that are signed and dated by the provider who conducted the visit and rendered the services for which a claim is being made.

(g) Copies of communication with the treating physician and other members of the interdisciplinary team.

(h) A discharge summary ~~which~~ that includes the consumer's medical and health status at the time services are terminated.

(i) Initial and subsequent physician orders ~~which~~ that specify the type, frequency, scope and duration of the services to be provided.

(b) Physician orders

Initial and subsequent orders from the consumer's treating physician must specify the type of skilled therapy service(s) to be provided to the consumer as well as the frequency, scope and duration of the services.

(c) Use of oral (verbal) orders

When services are furnished based on the treating physician's oral order for initial or subsequent orders and/or the recertification of the plan of care, the orders may be accepted and put in writing by personnel authorized to do so by applicable state and federal laws and regulations, as well as by the medicare-certified home health agency's internal policies. The orders must be signed and dated with the date of receipt by the skilled therapist responsible for furnishing or supervising the ordered services. Oral orders must be countersigned and dated by the consumer's treating physician before the provider submits a claim to ODJFS for payment.

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