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.

~~(4)~~

(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. <u>The residence of the provider is not excluded when the</u>

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.

(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 who is providing care and treatment to the individual. 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 individual. 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 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 must 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, as ordered by the treating physician, 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, 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-~~09~~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. ~~The U5 modifier may be used when billing in accordance with rule 5160-12-06 of the Administrative Code. The use of the U5 modifier indicates that all conditions of paragraph (I) of this rule were met, PDN authorization was obtained and the child continued to meet medical necessity criteria.~~

(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 (G)(5) of this rule , a~~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 ~~must~~ shall submit the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity ~~must~~ 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 ~~ODM or its designee~~ DODD. Any documentation required by ~~ODM or its designee~~DODD for the review of medical necessity ~~must~~ shall be provided by the provider of PDN services. ~~ODM or its designee~~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 ~~all~~ 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, as ordered by the treating physician, 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. ~~Providers must bill using the U6 modifier in accordance with rule 5160-12-06 of the Administrative Code. The use of the U6 modifier indicates that all conditions of paragraph (J) of this rule were met, PDN authorization was obtained and the adult continued to meet medical necessity criteria.~~

(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 (G)(5) of this rule , a~~A~~ request for additional PDN authorization is made as follows:

(a) For an adult not enrolled on a HCBS waiver, the provider of PDN ~~must~~ shall submit the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity ~~must~~ 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.

~~(b)~~(c) For an adult enrolled on ~~a DODD or~~ an ODA administered waiver, the provider of PDN ~~must~~ shall submit the request to the case manager of the ~~HCBS~~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.

~~(c)~~(d) For an adult enrolled on an ODM administered waiver, the case manager will authorize PDN services through the ~~all~~ 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.

Effective:

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Certification

Date

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