4123-6-38.1 **Payment for nursing and caregiver services provided by persons other than home health agency employees.**

(A) Nursing services provided prior to December 14, 1992.

(1) Registered nurses and licensed practical nurses who are not employed by ~~a medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited home health agency, or~~ a home health agency ~~accredited through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS)~~ a home health agency certified in accordance with rule 4123-6-02.2 of the Administrative Code may continue to provide authorized services to ~~a claimant~~ an injured worker if the services began prior to December 14, 1992.

(2) The need for nursing services must be the ~~direct~~ result of an allowed injury or occupational disease.

(3) In the event the registered nurse or licensed practical nurse is no longer able to provide approved services or if services are stopped and later restarted, nursing services shall be provided only by an employee of a ~~medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited~~ home health agency~~, or a home health agency accredited through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS)~~ certified in accordance with rule 4123-6-02.2 of the Administrative Code.

(B) Non-licensed caregiver services.

(1) Requests for extension of non-licensed caregiver services initially provided prior to December 14, 1992.

(a) Prior to December 14, 1992, caregiver services provided by a non-licensed person including ~~claimant's~~ injured worker's spouse, friend or family member were considered for reimbursement in cases where the ~~claimant~~injured worker, as a ~~direct~~ result of an allowed injury or occupational disease, was bedfast, confined to a wheelchair, had a disability of two or more extremities which prevented the ~~claimant~~ injured worker from caring for ~~his/her~~ their own body needs or was otherwise unable to take care of ~~his/her~~ their own bodily functions. Services include, but are not limited to, feeding, bathing, dressing, providing personal hygiene, and transferring from bed to chair. Household, personal or other duties related to maintaining a household, including but not limited to care or upkeep to the inside or outside of the residence, washing clothes, preparing meals, or running errands, are not

considered nursing services, and will not be reimbursed, except to the extent such services are incidental to care of the ~~claimant~~injured worker.

(b) Requests for an extension of caregiver services initially approved prior to December 14, 1992, delivered by a non-licensed person, other than an attendant, aide, or ~~claimant's~~ injured worker's spouse, but including other family members or friends, will be approved only if:

(i) The ~~claimant~~ injured worker does not have a spouse because the ~~claimant~~ injured worker is not married, or the ~~claimant's~~ injured worker's spouse is deceased, or the claimant's spouse is physically or mentally incapable of caring for the ~~claimant~~injured worker; and,

(ii) The approved home health agency is greater than thirty-five miles from the ~~claimant's~~ injured worker's location and the home health agency refuses to provide services to the ~~claimant~~injured worker.

(c) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a ~~medicare-certified, joint commission-accredited, or community health accreditation program (CHAP) accredited home health agency, or~~ a home health agency ~~accredited through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS)~~ certified in accordance with rule 4123-6-02.2 of the Administrative Code.

(2) Requests for extension of caregiver services initially provided on or after December 14, 1992 and prior to January 9, 1995.

(a) Requests for approval of caregiver services delivered by a non-licensed person, other than an attendant, aide, or ~~claimant's~~ injured worker's spouse were considered for reimbursement only if the ~~claimant~~ injured worker did not have a spouse or the spouse was physically or mentally incapable of caring for the ~~claimant~~injured worker, or an approved home health agency was greater than thirty-five miles from the ~~claimant's~~ injured worker's location and the home health agency refused to provide services to the claimant.

(b) Criteria for approval of caregiver services were as indicated in paragraph (B)(1)(a) of this rule.

(c) After January 9, 1995, persons who are not home health agency home health aides or attendants, but who are currently approved to provide

caregiver services to ~~a claimant~~an injured worker, may continue to do so until services are no longer medically necessary or unless services are not authorized. After January 9, 1995, approval of caregiver services shall only be considered when services are rendered by a home health agency home health aide or attendant.

(d) In the event the caregiver is no longer able to provide approved services or if services are stopped and later restarted, services shall be provided only by an employee of a ~~medicare certified, joint commission accredited, or community health accreditation program (CHAP) accredited home health agency, or a~~ home health agency ~~accredited through an organization that has been granted deeming authority by the centers for medicare and medicaid services (CMS)~~ certified in accordance with rule 4123-6-02.2 of the Administrative Code.

(C) All covered home health services must ~~be rendered on a part-time or intermittent care basis, in accordance with the written treatment plan and the bureau standard of care. Part-time or intermittent care means that services are generally rendered for no more than eight hours per day. Home health services rendered on a full time or continuous care basis are not covered. More appropriate alternative settings will be considered for claimants requiring more than eight hours per day of care, where medical necessity is documented. Exceptional cases may be reviewed by the bureau~~ comply with rule 4123-6-38 of the Administrative Code, except as otherwise provided in this rule.

(D) A review of the claim or assessment of the injured worker will be conducted at least annually to ensure that nursing or caregiver services are necessary as a ~~direct~~ result of the allowed injury or occupational disease.

Effective:

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Certification

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