Ohio Administrative Code

Rule 5123-9-39 Home and community-based services waivers - waiver nursing under the individual options waiver.

Effective: July 1, 2025

(A) Purpose

This rule defines waiver nursing and sets forth provider qualifications, requirements for service delivery and documentation of services, and payment standards for the service.

(B) Definitions

For the purposes of this rule, the following definitions apply:

(1) "Adult day support" has the same meaning as in rule 5123-9-17 of the Administrative Code.

(2) "Advanced practice registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(3) "Agency provider" means an entity that directly employs at least one person in addition to a director of operations for the purpose of providing services for which the entity is certified in accordance with rule 5123-2-08 of the Administrative Code.

(4) "Community respite" has the same meaning as in rule 5123-9-22 of the Administrative Code.

(5) "County board" means a county board of developmental disabilities.

(6) "Department" means the Ohio department of developmental disabilities.

(7) "Homemaker/personal care" has the same meaning as in rule 5123-9-30 of the Administrative Code.

(8) "Independent provider" means a self-employed person who provides services for which the

person is certified in accordance with rule 5123-2-09 of the Administrative Code and does not employ, either directly or through contract, anyone else to provide the services.

(9) "Individual" means a person with a developmental disability or for the purposes of giving, refusing to give, or withdrawing consent for services, the person's guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.

(10) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.

(11) "Intermediate care facility for individuals with intellectual disabilities" has the same meaning as in section 5124.01 of the Revised Code.

(12) "Licensed practical nurse" has the same meaning as in section 4723.01 of the Revised Code.

(13) "Medically necessary" has the same meaning as "medical necessity" described in rule 5160-1-01 of the Administrative Code.

(14) "Nursing task inventory" means the form used by a county board to identify the nursing tasks to be performed, the frequency and duration of each nursing task to be performed, and the current method by which each nursing task is performed.

(15) "Physician" means a person who is authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery.

(16) "Physician assistant" means a person who is licensed to practice as a physician assistant pursuant to Chapter 4730. of the Revised Code.

(17) "Plan of care" means the medical treatment plan that is established, approved, and signed by the treating physician, physician assistant, or advanced practice registered nurse. The plan of care is not the same as the individual service plan and includes:

(a) Individual's name, address, date of birth, sex, and medicaid number;

(b) Provider's name, address, telephone number, and medicaid provider number;

(c) Certification period;

(d) Start of care date;

(e) All pertinent diagnoses;

(f) All medications and treatments;

(g) Functional limitations and activities permitted;

(h) Mental, psychosocial, and cognitive status;

(i) Allergies;

(j) Nutritional requirements;

(k) The types of services, supplies, and equipment required;

(l) Safety measures;

(m) Prognosis;

(n) Orders for discipline and treatments including the amount, frequency, and duration of nursing services;

(o) Goals and discharge plans;

(p) Information related to any advanced directives;

(q) Physician's name and address;

(r) Physician's signature and date; and

(s) Nurse's signature and the date the nurse received the plan of care.

(18) "Registered nurse" has the same meaning as in section 4723.01 of the Revised Code.

(19) "Residential respite" has the same meaning as in rule 5123-9-34 of the Administrative Code.

(20) "Service documentation" means all records and information on one or more documents that:

(a) Are created and maintained as services are provided, and completed prior to billing for services;

(b) Are kept in a manner that fully discloses the extent of services delivered;

(c) Include the items delineated in paragraph (H) of this rule; and

(d) May be created or maintained in electronic software programs.

(21) "Significant change" means a change experienced by an individual including but not limited to, a change in health status, caregiver status, or location/residence; referral to or active involvement on the part of a protective services agency; or institutionalization.

(22) "Vocational habilitation" has the same meaning as in rule 5123-9-14 of the Administrative Code.

(23) "Waiver eligibility span" means the twelve-month period following either an individual's initial waiver enrollment date or a subsequent eligibility re-determination date.

(24) "Waiver nursing" means services provided to an individual with interventions of care which require the skills of, and are performed by, either a registered nurse or a licensed practical nurse working at the direction of a registered nurse. A service is not considered waiver nursing merely because it is performed by a licensed practical nurse.

(C) Provider qualifications

(1) Waiver nursing will be provided by an agency provider or an independent provider that meets the requirements of this rule.

(2) A provider of waiver nursing will obtain and maintain a medicaid provider agreement with the Ohio department of medicaid.

(3) Waiver nursing will be provided by a registered nurse or by a licensed practical nurse working at the direction of a registered nurse who:

(a) Possesses current valid licensure in good standing to practice nursing in Ohio pursuant to Chapter 4723. of the Revised Code; and

(b) Is working within the scope of practice as set forth in Chapter 4723. of the Revised Code and rules adopted thereunder.

(4) A provider of waiver nursing will meet the conditions of participation in rule 5160-44-31 of the Administrative Code.

(5) Waiver nursing will not be provided by an independent provider who is:

(a) The parent, stepparent, foster parent, or legal guardian of the individual receiving waiver nursing when the individual is under the age of eighteen; or

(b) The spouse of the individual receiving waiver nursing.

(6) Failure of a provider to comply with this rule and as applicable, rule 5123-2-08 or 5123-2-09 of the Administrative Code, may result in denial, suspension, or revocation of the provider's certification.

(D) Waiver nursing coverage requirements

For waiver nursing to be covered, the services must be determined to be necessary and:

(1) Performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.

(2) Performed only by a registered nurse when the task includes:

(a) Intravenous insertion, removal, or discontinuation;

(b) Intravenous medication administration;

(c) Programming of a pump to deliver medication including but not limited to, epidural, subcutaneous, and intravenous (except routine doses of insulin through a programmed pump);

(d) Insertion or initiation of infusion therapies;

(e) Central line dressing changes; or

(f) Blood product administration.

(3) Provided in accordance with the individual's plan of care.

(4) Appropriate given the individual's diagnosis, prognosis, functional limitations, and medical conditions as documented by the individual's treating physician, physician assistant, or advanced practice registered nurse.

(5) Documented in the individual service plan.

(6) Medically necessary in accordance with rule 5160-1-01 of the Administrative Code.

(7) Provided in person in the individual's residence unless it is medically necessary for the nurse to accompany the individual in the community. The individual's residence is where the individual lives

whether the residence is owned by the individual, a relative's home, an assisted living facility, or other type of living arrangement. The place of service cannot include the business location or residence of the provider unless the provider resides with the individual.

(8) Authorized only when an individual's needs cannot be met by medicaid state plan nursing services, as described in Chapter 5160-12 of the Administrative Code, by developmental disabilities personnel holding medication administration certification issued in accordance with rule 5123-6-06 of the Administrative Code, or through nursing delegation in accordance with rules adopted by the Ohio board of nursing pursuant to Chapter 4723. of the Revised Code.

(E) Waiver nursing exclusions

Waiver nursing does not include:

(1) Services delegated in accordance with Chapter 4723. of the Revised Code and rules adopted thereunder, and performed by persons who are not licensed nurses in accordance with Chapter 4723. of the Revised Code.

(2) Services that require the skills of a psychiatric nurse.

(3) Visits performed for the purpose of conducting a registered nurse assessment as set forth in rule 5160-12-08 of the Administrative Code.

(4) Registered nurse consultations as set forth in rule 5160-12-08 of the Administrative Code.

(5) Services performed in excess of the number of hours approved pursuant to, and as specified in, the individual service plan.

(6) Services performed that meet the definition of waiver nursing delegation/assessment or waiver nursing delegation/consultation set forth in rule 5123-9-37 of the Administrative Code.

(F) Service authorization process

(1) An individual or the individual's parent or guardian, hospital, physician, service provider, or member of the individual's care team may contact the county board to request waiver nursing.

(2) A county board or its contracted agent will submit a complete service authorization request for waiver nursing to the department for review and approval:

(a) For all initial requests for waiver nursing.

(b) When there is a significant change resulting in an increase, decrease, or termination of waiver nursing.

(c) At least annually for redetermination of waiver nursing. Annual redetermination requests may be submitted to the department ninety calendar days prior to the new waiver eligibility span.

(3) Each service authorization request will include:

(a) A plan of care, plan of care addendum order, and/or physician's orders, as applicable.

(b) A proposed weekly schedule with corresponding budget.

(c) A nursing task inventory.

(d) The three previous months of nursing notes, when available.

(e) Medication administration records.

(f) All other documentation requested by the department to assess the individual's need for waiver nursing.

(4) The department will complete a comprehensive review of all submitted documentation to determine if the requested services are medically necessary and are:

(a) Appropriate for the individual's health and welfare needs, living arrangement, circumstances, and

expected outcomes; and

(b) Of an appropriate type, amount, duration, scope, and intensity; and

(c) The most efficient, effective, and lowest cost alternative that, when combined with non-waiver services, ensure the health and welfare of the individual receiving the services; and

(d) In accordance with rule 5123-9-02 of the Administrative Code, not otherwise available through other resources.

(5) The department will notify the county board in writing of its decision to approve or deny waiver nursing.

(a) Upon receipt of the written approval, the county board will notify the waiver nursing provider and individual of the authorized amount, scope, and duration of approved services. The waiver nursing provider may begin services only after the county board provides written approval. Waiver nursing may be authorized for up to three hundred sixty-five days.

(b) If the department determines the individual does not have skilled nursing interventions that require waiver nursing, or the services are not medically necessary, the department will deny the waiver nursing request. A service authorization request may be denied only after an in-person assessment or video conference and desk review by a registered nurse to confirm the services are not medically necessary.

(6) Waiver nursing complements, and does not replace, similar services available under the medicaid state plan provided by the Ohio department of medicaid or a managed care organization. Medicaid fee-for-service or the individual's managed care organization covers medically necessary nursing services.

(7) An individual will be afforded notice and hearing rights regarding service authorizations in accordance with section 5101.35 of the Revised Code. Providers have no standing in appeals under this paragraph. A change in staffing ratios does not necessarily result in a change in the level of services received by an individual which would affect the annual service authorization.

(G) Requirements and limitations for service delivery

(1) Waiver nursing will be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code. The provider's name and number of hours will be specified in the individual service plan.

(2) Waiver nursing will not be provided to an individual during the same time the individual is receiving adult day support, community respite, residential respite being provided at an intermediate care facility for individuals with intellectual disabilities, or vocational habilitation.

(3) A registered nurse or licensed practical nurse working at the direction of a registered nurse may provide services for no more than three individuals in a group setting during a face-to-face waiver nursing visit.

(4) A waiver nursing visit by a registered nurse or a licensed practical nurse working at the direction of a registered nurse will not exceed twelve hours in length during a twenty-four hour period unless an unforeseen event causes a medically necessary scheduled visit to extend beyond twelve hours, in which case the visit will not exceed sixteen hours.

(5) A provider of waiver nursing who is a licensed practical nurse working at the direction of a registered nurse will conduct a face-to-face visit with the individual and the directing registered nurse prior to initiating services and at least once every one hundred twenty days for the purpose of evaluating the provision of waiver nursing, the individual's satisfaction with care delivery and performance of the licensed practical nurse, and to ensure that waiver nursing is being provided in accordance with the approved plan of care.

(6) When an independent provider who is a licensed practical nurse working at the direction of a registered nurse is providing waiver nursing, the licensed practical nurse will provide clinical notes, signed and dated by the licensed practical nurse, documenting all consultations between the licensed practical nurse and the directing registered nurse, documenting the face-to-face visits between the licensed practical nurse and the directing registered nurse, and documenting the face-to-face visits between the licensed practical nurse, the individual receiving waiver nursing, and the directing

registered nurse.

(7) Individuals who receive waiver nursing must be under the supervision of a treating physician, physician assistant, or advanced practice registered nurse who is enrolled with the Ohio department of medicaid, and is directly providing care and treatment to the individual (and not merely engaged to authorize plans of care for waiver nursing).

(8) In all instances, when a treating physician, physician assistant, or advanced practice registered nurse gives verbal orders to the registered nurse or licensed practical nurse working at the direction of a registered nurse, the nurse will record in writing, the orders, the date and time the orders were given, and sign the entry in the service documentation. The nurse will subsequently secure documentation of the verbal orders signed and dated by the treating physician, physician assistant, or advanced practice registered nurse.

(9) Waiver nursing may be provided on the same day as, but not concurrently with, a registered nurse assessment and/or registered nurse consultation as set forth in rule 5160-12-08 of the Administrative Code.

(10) A provider of waiver nursing will utilize electronic visit verification in accordance with Chapter 5160-32 of the Administrative Code.

(H) Documentation of services

(1) Service documentation for waiver nursing will include each of the following to validate payment for medicaid services:

(a) Type of service.

(b) Date of service.

(c) Place of service.

(d) Name of individual receiving service.

(e) Medicaid identification number of individual receiving service.

(f) Name of provider.

(g) Provider identifier/contract number.

(h) Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.

(i) Group size in which the service was provided.

(j) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan, including the individual's response to each medication, treatment, or procedure performed.

(k) Begin and end times of the delivered service.

(2) A provider of waiver nursing will also maintain a clinical record for each individual which includes:

(a) Individual's medical history.

(b) Name and national provider identifier number of individual's treating physician, physician assistant, or advanced practice registered nurse.

(c) A copy of all individual service plans in effect at the time of services.

(d) A copy of the initial and all subsequent plans of care.

(e) Documentation of verbal orders from the treating physician, physician assistant, or advanced practice registered nurse in accordance with paragraph (G)(8) of this rule.

(f) The clinical notes of an independent provider who is a licensed practical nurse working at the direction of a registered nurse in accordance with paragraph (G)(6) of this rule.

(g) A copy of any advance directives including, but not limited to, a "do not resuscitate" order or medical power of attorney, if they exist.

(h) Clinical notes signed and dated by the nurse provider documenting all communications with the treating physician, physician assistant, or advanced practice registered nurse and other members of the multidisciplinary team.

(3) Providers of waiver nursing will maintain, in a confidential manner for at least thirty calendar days at the individual's residence, a current plan of care with any addendum orders, the current individual service plan, a copy of the nurse's notes, and medication administration records.

(4) A provider of waiver nursing will maintain the records necessary and in such form to fully disclose the extent of waiver nursing provided, for a period of six years from the date of receipt of payment or until an initiated audit is resolved whichever is longer.

(I) Monitoring and oversight

A provider of waiver nursing services is subject to monitoring and oversight by the department. A provider of waiver nursing will cooperate with the department or its designee during provider monitoring and oversight activities by being available to answer questions during reviews and by ensuring the availability and confidentiality of individual information and other documents that may be requested as part of provider monitoring and oversight activities.

(J) Payment standards

(1) The billing units, service codes, payment rates, and billing modifier codes for waiver nursing are contained in the appendix to this rule.

(2) A registered nurse or licensed practical nurse working at the direction of a registered nurse may provide services for up to three individuals in a group setting during a face-to-face waiver nursing

visit.

(a) The entire visit is considered a group visit even if two or more individuals were present for only a portion of the visit.

(b) The "HQ" billing modifier code is used with each group visit billed.

(3) When waiver nursing provided by an independent provider is being billed as overtime:

(a) The "TU" billing modifier code is used to indicate that the entire visit is being billed as overtime.

(b) The "UA" billing modifier code is used to indicate that a portion of the visit is being billed as overtime.

(4) When the provision of waiver nursing by the same provider occurs on the same date of service for the same individual, the visits will be separated by a lapse of at least two hours. Documentation supporting the need for multiple visits is required. After the initial visit, multiple visits are billed with a "U2" billing modifier code for the second visit or a "U3" billing modifier code for any subsequent visit thereafter.

(5) When a waiver nursing visit exceeds twelve hours in length during a twenty-four hour period due to an unforeseen event, the "U4" billing modifier code is used to indicate that the service and support administrator has been notified of and approved the extension of hours.

(6) Waiver nursing is billed to and reimbursed by the Ohio department of medicaid in accordance with rule 5160-1-19 of the Administrative Code.