Ohio Administrative Code

Rule 5160-12-08 Registered nurse assessment and registered nurse consultation services.

Effective: November 28, 2021

(A) For the purpose of this rule:

(1) A "plan of care" is the medical treatment plan that is established, approved, and signed by a treating physician, advance practice nurse or physician's assistant in accordance with the Coronavirus Aid, Relief, and Economic Security (CARES) Act, S.3548 (2020), prior to a provider requesting reimbursement for a service. The plan of care has the same meaning as set forth in rule 5160-51-01 of the Administrative Code and is not the same as an all services plan, individual service plan, or helping Ohioans move expanding choice (HOME choice) service plan.

(2) A "registered nurse (RN) assessment" is the medicaid service performed by an RN pursuant to paragraphs (B) and (D) of this rule. It may include a recommendation subject to orders written by the treating physician, but not a determination of the amount or duration of nursing services. The RN assessment may be completed using telehealth.

(3) An "RN consultation" is a face-to-face or telephone contact between a directing RN and a licensed practical nurse (LPN) pursuant to paragraphs (C) and (D) of this rule, when an individual experiences a significant change that necessitates a change in the existing interventions the LPN must perform during a nursing service visit, and that will result in a change in the individual's plan of care. RN consultation does not replace routine direction and supervision provided by an RN to an LPN where evidence of significant change does not exist and/or does not necessitate a change in the LPN's intervention or the individual's plan of care.

(4) A "significant change" is a change experienced by an individual that warrants an RN assessment. Significant changes may include, but are not limited to, a change in health status, caregiver status, location/residence, referral to or active involvement on the part of a protective service agency, and/or institutionalization.

(5) A "nursing service visit" is the duration of time that a nurse provides covered medicaid services,

face to face, to an individual at the individual's residence on the same date during the same time period.

(B) RN assessment service.

(1) An RN assessment service shall be performed on an individual participating in the medicaid program prior to the individual receiving the following services for the first time, prior to any change being made to an individual's current package of the following services, and any time the RN is informed that the individual receiving the following services has experienced a significant change, including an improvement or a decline in condition:

(a) State plan home health services as set forth in rule 5160-12-01 of the Administrative Code;

(b) Private duty nursing services as set forth in rule 5160-12-02 of the Administrative Code;

(c) Waiver nursing services as set forth in rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code;

(d) Personal care aide services furnished by a medicare-certified home health agency or an otherwise accredited agency as set forth in rules 5160-46-04, 5160-50-04, and 5123:2-9-56 of the Administrative Code; and/or

(e) HOME choice nursing services as set forth in rule 5160-51-04 of the Administrative Code.

(2) An RN performing an RN assessment service shall:

(a) Possess a current, valid and unrestricted license with the Ohio board of nursing.

(b) Only provide services within the RN's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted thereunder.

(c) Be an active medicaid provider or be employed by an entity that is an active medicaid provider.

(d) Be either:

(i) Employed by a medicare-certified home health agency when identifying an individual's need for state plan home health services as set forth in rule 5160-12-01 of the Administrative Code;

(ii) Employed by medicare-certified home health agency or an otherwise accredited agency when identifying an individual's need for personal care aide services as set forth in rules 5160-46-04, 5160-50-04, and 5123:2-9-56 of the Administrative Code;

(iii) Employed by a medicare-certified home health agency or an otherwise accredited agency, or be an non-agency RN when identifying an individual's need for private duty nursing services as set forth in rule 5160-12-02 of the Administrative Code;

(iv) Employed by a medicare-certified home health agency or an otherwise accredited agency, or be a non-agency RN when identifying an individual's need for waiver nursing services as set forth in rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code; or

(v) Employed by a medicare-certified home health agency or an otherwise accredited agency, or be a non-agency RN when identifying an individual's need for HOME choice nursing services as set forth in rule 5160-51-04 of the Administrative Code.

(3) The RN assessment service shall:

(a) Provide the basis for the RN to make independent decisions and nursing diagnoses, plan nursing interventions and evaluate the need for other interventions, develop the plan of care and assess the need to communicate and, as applicable, consult with other team members as defined in rule 5160-45-01 of the Administrative Code.

(b) Include a face-to-face interview with, and observation of, the individual in his or her place of residence or through telehealth. Place of residence has the same meaning as defined in rule 5160-12-01 of the Administrative Code. During the interview, the RN will assess the individual's verbal and nonverbal communication abilities, medical and social history, medications, living arrangements, supportive assistance equipment needs, and any other information available and relevant to the

development of the individual's plan of care. At a minimum, the RN should capture the following information relative to the individual's health status:

(i) The physical condition of the individual including vital signs, skin color and condition, motor and sensory nerve function, cognitive status, respiratory status, and the nutritional, rest, sleep, activity, elimination habits and consciousness of the individual; and

(ii) The social and emotional condition of the individual, including religious preference, if any, occupation, mood, emotional state, and family ties and responsibilities.

(c) Serve as the guide for the directing RN when:

(i) An LPN and/or home health aide is providing state plan home health services pursuant to rule 5160-12-01 of the Administrative Code;

(ii) An LPN is providing private duty nursing services pursuant to rule 5160-12-02 of the Administrative Code;

(iii) An LPN is providing waiver nursing services pursuant to rules 5160-46-04, 5160-50-04, 5123:2-9-59 and 173-39-02.22 of the Administrative Code;

(iv) An LPN is providing HOME choice nursing services pursuant to rule 5160-51-04 of the Administrative Code;

(v) A home health aide is providing state plan home health services pursuant to rule 5160-12-01 of the Administrative Code;

(4) Reimbursement for an RN assessment service.

(a) RN assessment services shall be reimbursed in accordance with the rates set forth in appendix A to this rule.

(b) The non-agency provider's, medicare-certified home health agency's or otherwise accredited

agency's name and national provider identifier (NPI) number must be identified on the claim.

(c) When an individual is enrolled on an ODM-administered waiver, RN assessment services performed by a non-agency RN, or a medicare-certified home health agency or otherwise accredited agency must be prior-approved by ODM and be specified on the individual's service plan.

(d) When an individual is participating in the HOME choice program, RN assessment services performed by a non-agency RN or a medicare-certified home health agency or otherwise accredited agency must be prior-approved and be specified on the individual"s HOME choice service plan.

(e) An RN may be reimbursed for an RN assessment service no more than once every sixty days per individual receiving services unless the RN is informed that the individual receiving services experienced a significant change, including an improvement or a decline in condition, and therefore a subsequent RN assessment is required.

(f) RN assessments are reimbursable when sequentially, but not concurrently, performed with any other service during a visit in which the RN is furnishing billable home health, PDN, waiver nursing, or any other service that is reimbursable through the Ohio medicaid program.

(5) The RN assessment service code may be billed by an RN when the RN is performing a home care attendant service (HCAS) RN visit required by rules 5160-46-04.1, 5160-50-04.1 and 173-39-02.24, as applicable, and pursuant to rules 5160-46-06.1, 5160-50-06.1 and 173-39-02.24 of the Administrative Code as applicable.

(6) RN assessment services are not reimbursable when performed in conjunction with nursing delegation tasks as set forth in Chapter 4723-13 of the Administrative Code.

(7) RN assessments must be verified using an ODM-approved electronic visit verification (EVV) system in accordance with rule 5160-1-40 of the Administrative Code.

(C) RN consultation services.

(1) An RN consultation service shall be performed as required by rule 5160-12-01 of the

Administrative Code for state plan home health nursing services, rule 5160-12-02 of the Administrative Code for PDN services, rules 5160-46-04, 5160-50-04, 173-39-02.22 and 5123:2-9-59 of the Administrative Code for waiver nursing services and rule 5160-51-04 of the Administrative Code for HOME choice nursing services.

(2) An LPN shall seek the guidance of the directing RN when the individual receiving services from the LPN experiences a significant change in condition that may necessitate a change in the individual's plan of care and the interventions being provided by the LPN.

(3) An RN consultation service must be conducted between the directing RN and LPN either face-to-face or over the telephone.

(4) RN consultation services shall be reimbursed in accordance with the rates set forth in appendix A to this rule.

(5) RN consultation services are not reimbursable when performed in conjunction with nursing delegation services provided under a DODD-administered waiver program, or for consultations between RNs.

(D) If an individual selects multiple non-agency LPNs to furnish PDN services, waiver nursing, or HOME choice nursing services, the individual may designate a single RN to provide RN assessment and/or RN consultation services. Such designation shall be identified on the individual's service plan, as applicable, or the case manager, if one is assigned to the individual, shall develop a plan for the coordination of non-agency nursing services.

(E) Record keeping for RN assessment and RN consultation services.

(1) All RNs providing RN assessment and RN consultation services must maintain a clinical record for each individual receiving the medicaid covered services.

(2) Maintenance of the record shall be in a manner that protects the confidentiality of the record.

(3) Agency providers must maintain the clinical records at their place of business. The provider shall

also maintain a file in the individual's place of residence containing a copy of the individual's medication profile, if one exists. The file may also include, but not be limited to the individual's medication administration record, treatment administration record, aide assignment, all services plan and plans of care. The individual shall identify a location in his or her residence where a copy of the clinical record will be safely maintained. Storage shall be in the manner that protects the confidentiality of the file, and for the purpose of contributing to the continuity of the individual's care.

(4) Non-agency providers must maintain the clinical records at their place of business and a copy at the home of the individual receiving the services. The individual shall identify a location in his or her residence where a copy of the clinical record will be safely maintained. Storage shall be a manner that protects the confidentiality of the record, and for the purpose of contributing to the continuity of the individual's care.

(5) At a minimum, the record must contain the following information:

(a) The name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers of the individual receiving the services;

(b) The medical history of the individual receiving the services;

(c) If the RN performing RN assessment services and/or RN consultation services is employed by an agency, the RN's name and contact information, the agency's contact information, and the agency's national provider identifier (NPI) number and medicaid provider number;

(d) If the RN performing RN assessment services and/or RN consultation services is a non-agency provider, his or her name, contact information, medicaid provider number and NPI number;

(e) If an LPN, being directed by an RN, is providing services and is employed by an agency, the LPN's name and contact information and the agency's NPI number and medicaid provider number;

(f) If an LPN, being directed by an RN, is providing services and is a non-agency provider, the LPN's name, contact information, NPI number and medicaid provider number;

(g) The name of and contact information for the treating physician of the individual receiving the services;

(h) A copy of the initial and all subsequent all services plans, individual service plans or HOME choice service plans, as applicable, for the individual receiving the services;

(i) A copy of the initial and all subsequent plans of care for the individual receiving the services;

(j) Documentation that the RN has reviewed the plans of care with the LPN when services are performed by an LPN at the direction of an RN;

(k) Documentation that the plan of care was recertified by the treating physician at least every sixty days;

(l) Documentation of any change of orders by the treating physician subsequent to the certified plan of care that altered the plan of care;

(m) Documentation of each instance in which the treating physician gave verbal orders to the RN or LPN, including what the physician ordered and the date and time the orders were given by the physician to the RN or LPN nurse, followed by the nurse's signature;

(n) A copy of the treating physician's signed and dated written verification of the verbal orders given to the nurse;

(o) In all instances in which a non-agency LPN has provided services, clinical notes that are signed and dated by the LPN, documentation of all RN consultation services occurring between the LPN and the directing RN, documentation of all face-to-face visits between the LPN and the directing RN, and documentation of the face-to-face visits between the LPN, the directing RN, and the individual receiving the services;

(p) A copy of all advance directives, including a "do not resuscitate" (DNR) order or medical power of attorney, if they exist;

(q) Documentation of all drug and food interactions, allergies and dietary restrictions;

(r) Clinical notes and other documentation of tasks performed or not performed;

(s) Documentation of the arrival and departure times of the RN assessment service provider with the dated signatures of the provider and the individual receiving the services verifying the service delivery upon completion of the service delivery and verifying the arrival and departure times. The signature method of choice of the individual receiving the services shall be documented in the clinical record. The signature method of choice shall include, but not be limited to any of the following: a handwritten signature, initials, a stamp or mark, or an electronic signature;

(t) Documentation of the date, start time and end time of the RN consultation service including the RN consultation provider's dated signature upon completion of the service;

(u) Clinical notes signed and dated by the RN and LPN documenting all communications with the treating physician and other members of the team selected by the individual receiving the services if the individual has team members;

(v) Documentation of face-to-face HCAS RN visits that must occur, every ninety days pursuant to rules 5160-46-04.1, 5160-50-04.1 and 173-39-02.24 of the Administrative Code, and any resulting activities; and

(w) A discharge summary signed and dated by the directing RN, at the point the RN is no longer going to provide assessment and consultation services to the individual or when the individual no longer needs services from the supervising RN. The summary should include information regarding the progress made toward goal achievement and indicate any recommended follow-ups or referrals.