

5101:3-12-01 Home health services: provision requirements, coverage and service specification.

(A) "Home health services" includes home health nursing, home health aide and skilled therapies as defined in paragraph (G) of this rule.

(B) Home health services are covered only if the qualifying treating physician certifying the need for home health services documents that he or she had a face-to-face encounter with the consumer within the ninety days prior to the home health care start of care date, or within thirty days following the start of care date inclusive of the start of care date. To be a qualifying treating physician, the physician must be a doctor of medicine or osteopathy legally authorized to practice medicine and surgery as authorized under Chapter 4731. of the Revised Code in which he or she performs that function or action. Advanced practice nurses in accordance with rule 5101:3-8-21 of the Administrative Code and in collaboration with the qualifying treating physician, or a physician assistant in accordance with rule 5101:3-4-03 of the Administrative Code and under the supervision of the qualifying treating physician, have the authority to conduct the face-to-face encounter for the purposes of the supervising physician certifying the need for home health services. The face-to-face encounter with the consumer must occur independent of any provision of home health services to the consumer by the individual performing the face-to-face encounter. The face-to-face encounter must be documented:

(1) For home health services unrelated to an inpatient hospital stay, the face-to-face encounter must be documented by the qualifying treating physician using:

(a) The JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) or

(b) The consumer's plan of care may be used to certify medical necessity for home health services if all of the data elements specified for home health services unrelated to an inpatient hospital stay in the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) are included and the plan of care contains the physician's signature, physician's credentials and the date of the physician's signature.

(2) For post hospital home health services, the face-to-face encounter must be documented by the qualifying treating physician using the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011).

(3) For a dual eligible consumer, if the face-to-face encounter date for medicare home health services falls within the ninety days prior to the medicare home health services start of care date, or within thirty days following the medicare start of care date inclusive of the medicare start of care date, may be used on the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011) and the supporting documents attached to this form.

(C) Home health services are covered only if provided on a part-time and intermittent basis, which means:

(1) No more than a combined total of eight hours (thirty-two units) per day of home health nursing,

home health aide, and skilled therapies except as specified in paragraph (H) of this rule;

(2) No more than a combined total of fourteen hours (fifty-six units) per week of home health nursing and home health aide services except as specified in paragraphs (D) and (H) of this rule; and

(3) Visits are not more than four hours (sixteen units). Most visits are usually less than two hours (eight units). Nursing visits over four hours (sixteen units) may qualify for coverage in accordance with rule 5101:3-12-02 of the Administrative Code.

(D) A combined total of twenty-eight hours (one hundred twelve units) per week of home health nursing and home health aide services is available to a consumer for up to sixty consecutive days from the date of discharge from an inpatient hospital stay of three or more covered days, if all of the following are met by the consumer as certified by the qualifying treating physician using the JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011):

(1) Consumer has a discharge date from an inpatient hospital stay of three or more covered days. For the purposes of this rule, a covered inpatient hospital stay is defined in rule 5101:3-2-03 of the Administrative Code and is considered one hospital stay when a consumer is transferred from one hospital to another hospital, either within the same building or to another location. The sixty days will begin once the consumer is discharged to the consumer's place of residence or to a nursing facility as defined in paragraph (E)(4) of this rule, from the last inpatient stay whether or not the last inpatient stay was an inpatient hospital or inpatient rehabilitation unit of a hospital.

(2) Consumer has a comparable level of care as evidenced by either:

(a) Enrollment in a home and community based services (HCBS) waiver; or

(b) Has a medical condition that temporarily meets the criteria for an institutional level of care which are any of the following rules defined in rule 5101:3-3-05 of the Administrative Code for skilled level of care (SLOC), or defined in rule 5101:3-3-06 of the Administrative Code for intermediate level of care, or defined in rule 5101:3-3-07 of the Administrative Code for ICF/MR level of care. In no instance does this requirement constitute the determination of a level of care for waiver eligibility status, or admission into a Medicaid covered long term care institution.

(3) Requires home health nursing or a combination of private duty nursing/home health nursing/waiver nursing/skilled therapy services at least once per week that is medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code.

(4) The consumer has had a covered inpatient hospital stay of three or more days, with the discharge date recorded on form JFS 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing Services" (rev. 2/2011).

(E) The only provider of home health services is the MCRHHA (Medicare certified home health agency) that meets the requirements in accordance with rule 5101:3-12-03 of the Administrative Code. In order for home health services to be covered, MCRHHAs must:

(1) Provide home health services only if the qualifying treating physician has documented a face-to-

face encounter with the consumer as specified in paragraph (B) of this rule.

(2) Provide home health services that are appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as ordered by the consumer's treating physician for the treatment of the consumer's illness or injury.

(3) Provide home health services as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. Home health services not specified in a plan of care are not reimbursable. Additionally the MCRHHA's plan of care must provide the amount, scope, duration, and type of home health service as:

(a) Identified on the all services plan as defined in rule 5101:3-45-01 of the Administrative Code that is prior approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS-administered home and community based services(HCBS) waiver. Home health services that are not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when a consumer is enrolled in an ODA- (Ohio department of aging) administered or a DODD- (Ohio department of developmental disabilities) administered HCBS waiver. Home health services that are not documented on the services plan are not reimbursable.

(4) Provide home health services in the consumer's place of residence, in a licensed child day-care center, or for a child three years and under in a setting where the child receives early intervention services (EI) as indicated in the individualized family service plan (IFSP).

(a) "Consumer's place of residence" is wherever the consumer lives, whether the home is the consumer's own dwelling, an apartment, an assisted living residence, a relative's home, or an other type of living arrangement. The place of residence does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICR/MR).

(b) For the purposes of this chapter, "licensed child day-care center" means a "child day-care center" as defined in section 5104.01 of the Revised Code that is licensed pursuant to section 5104.03 of the Revised Code but does not include a licensed child day-care center that is the permanent residence of the licensee or administrator.

(c) "Setting" is the natural environment in which the services will appropriately be provided.

(5) Not provide home health nursing and home health aide services for the provision of habilitative care, or respite care, and not provide skilled therapies for the provision of maintenance care, habilitative care or respite care.

(a) "Maintenance care" is the care given to a consumer 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 consumer is no longer making significant improvement in his or her medical condition.

(b) "Habilitative care" is in accordance with 42 U.S.C. 1396n(C)(5) (March 30, 2010).

(c) "Respite care" is the care provided to a consumer unable to care for himself or herself because of

the absence or need for relief of those persons normally providing care.

(6) Bill for provided home health services in accordance with the visit policy in rule 5101:3-12-04 of the Administrative Code.

(7) Bill for provided home health services using the appropriate procedure code and applicable modifiers in accordance with rule 5101:3-12-05 of the Administrative Code.

(8) Bill after all documentation is completed for the services rendered during a visit in accordance with rule 5101:3-12-03 of the Administrative Code.

(F) Consumers who receive home health services must:

(1) Participate in a face-to-face encounter as specified in paragraph (B) of this rule for the purpose of certifying their medical need for home health services.

(2) Be under the supervision of a treating physician who is providing care and treatment to the consumer. 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 consumer. A treating physician may be a physician who is substituting temporarily on behalf of a treating physician.

(3) Participate in the development of a plan of care along with the treating physician and the MCRHHA. An authorized representative may participate in the development of a plan of care in lieu of the consumer.

(4) Access home health services in accordance with the program for the all-inclusive care of the elderly (PACE) when the consumer participates in the PACE program.

(5) Access home health services in accordance with the consumer's provider of hospice services when the consumer has elected the hospice benefit.

(6) Access home health services in accordance with the consumer's managed care plan when the consumer is enrolled in a medical managed care plan.

(G) Covered home health services are:

(1) "Home health nursing" is a nursing service that requires the skills of and is performed by a registered nurse, or a licensed practical nurse at the direction of a registered nurse. The nurse performing the service must be employed or contracted by the MCRHHA providing the service. A service is not considered a nursing service merely because it is performed by a licensed nurse. Home health nursing services:

(a) Must be performed within the nurse's scope of practice as defined in Chapter 4723. of the Revised Code and rules adopted thereunder.

(b) Must be provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.

(c) Must be provided in a face-to-face encounter.

(d) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.

(e) Are not covered when the visit is solely for the supervision of the home health aide.

(f) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously, or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-05 of the Administrative Code.

(2) "Home health aide" is a service that requires the skills of and is performed by a home health aide employed or contracted by the MCRHHA providing the service. Home health aide services:

(a) Are performed within the home health aide's scope of practice as defined in 42 C.F.R. 484.36 (June 18, 2001). The home health aide cannot be the parent, step-parent, foster parent or legal guardian of a consumer who is under eighteen years of age, or the consumer's spouse.

(b) Are provided and documented in accordance with the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.

(c) Must be provided in a face-to-face encounter.

(d) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.

(e) Must be necessary to facilitate the nurse or therapist in the care of the consumer's illness or injury, or help the consumer maintain a certain level of health in order to remain in the home setting. Health related services can include:

(i) Bathing, dressing, grooming, hygiene, including shaving, skin care, foot care, ear care, hair, nail and oral care, that are needed to facilitate care or prevent deterioration of the consumer's health, and including changing bed linens of an incontinent or immobile consumer.

(ii) Feeding, assistance with elimination including administering enemas (unless the skills of a home health nurse are required), routine catheter care, routine colostomy care, assistance with ambulation, changing position in bed, and assistance with transfers.

(iii) Performing a selected nursing activity or task as delegated in accordance with Chapter 4723-13 of the Administrative Code, and performed as specified in the plan of care.

(iv) Assistance with activities such as routine maintenance exercises and passive range of motion as specified in the plan of care. These activities are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed. The plan of care is developed by either a licensed nurse or therapist within their scope of practice.

(v) Performing routine care of prosthetic and orthotic devices.

(f) May also include incidental services along with health related services as listed in paragraph (G)(2)(e) of this rule, as long as they do not substantially extend the time of the visit.

(i) Incidental services are necessary household tasks that must be performed by anyone to maintain a home and can include light chores, consumer's laundry, light house cleaning, preparation of meals, and/or taking out the trash.

(ii) The main purpose of a home health aide visit cannot be solely to provide these incidental services since they are not health related services.

(iii) Incidental services are to be performed only for the consumer and not for other people in the consumer's covered place of residence.

(3) "Skilled therapies" are defined as physical therapy, occupational therapy, and speech-language pathology services that require the skills of and are performed by skilled therapy providers to meet the consumer's medical needs, promote recovery, and ensure medical safety for the purpose of rehabilitation.

(a) "Skilled therapy providers" are licensed physical therapists, occupational therapists, speech-language pathologists, licensed physical therapy assistants (LPTA) under the direction of a physical therapist, or certified occupational therapy assistants (COTA) under the direction of a licensed occupational therapist who are contracted or employed by a MCRHHA.

(b) "Rehabilitation" is the care of a consumer with the intent of curing the consumer's disease or improving the consumer's condition by the treatment of the consumer's illness or injury, or the restoration of a function affected by illness or injury.

(c) Skilled therapies:

(i) Must be provided to the consumer within the therapist's or therapy assistant's scope of practice in accordance with sections 4755.44, 4755.07, and 4753.07 of the Revised Code.

(ii) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.

(iii) Must be provided and documented in the consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.

(iv) Must be reasonable in their amount, frequency, and duration. Treatment must be considered according to the accepted standards of medical practice to be safe and effective treatment for the consumer's condition.

(v) Must be provided with the expectation of the consumer's rehabilitation potential according to the treating physician's prognosis of illness or injury. The expectation of the consumer's rehabilitation potential is that the condition of the consumer will measurably improve within a reasonable period of time or the services are necessary to the establishment of a safe and effective maintenance program.

(vi) May include treatments, assessments and/or therapeutic exercises but cannot include activities

that are for the general welfare of the consumer, including motivational or general activities for the overall fitness of the consumer.

(H) A consumer who meets the requirements in this paragraph may qualify for increased services. The MCRHHA must assure and document the consumer meets all requirements in this paragraph prior to increasing services. The U5 modifier must be used when billing in accordance to rule 5101:3-12-05 of the Administrative Code. The use of the U5 modifier indicates that all conditions of this paragraph were met. The consumer who meets the following requirements may receive an increase of home health services if he or she:

(1) Is under age twenty-one and requires services for treatment in accordance with Chapter 5101:3-14 of the Administrative Code for the healthcheck program.

(2) Requires more than, as ordered by the treating physician:

(a) Eight hours (thirty two units) per day of any home health service, or a combined total of fourteen hours (fifty six units) per week of home health aide and home health nursing as specified in paragraph (C) of this rule; or

(b) A combined total of twenty-eight hours (one hundred twelve units) per week of home health nursing and home health aide for sixty days as specified in paragraph (D) of this rule.

(3) Has a comparable level of care as evidenced by either:

(a) Enrollment in a HCBS waiver; or

(b) A level of care evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 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 medical covered long term care institution; and

(4) Requires home health nursing or a combination of PDN/home health nursing/waiver nursing/skilled therapy visits at least once per week that is medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code as ordered by the treating physician.

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5101:3-12-02 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 or a licensed practical nurse at the direction of a registered nurse and is provided in one or more PDN visits. A continuous nursing visit (or PDN visit) is defined as a medically necessary visit that is more than four hours (more than sixteen units) but less than or equal to twelve hours (forty-eight units) in length. A service is not considered a nursing service merely because it was performed by a licensed nurse. For dates of service on or after 7/01/06, a covered PDN visit must meet the definition of paragraph (A) in rule 5101-3-12-04 of the Administrative Code and be more than four hours (more than sixteen units) in length but less than or equal to twelve hours (forty-eight units) in length, unless:

- (1) An unusual, occasional circumstance requires a medically necessary visit of up to and including sixteen hours (sixty-four units); 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; or
- (4) ODJFS or its designee has authorized PDN visits that are four hours or less length in accordance with rule 5101:3-12- 02.3 of the Administrative Code.

(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 consumer's plan of care in accordance with rule 5101:3-12-03 of the Administrative Code.
- (3) Must be provided in a face-to-face encounter.
- (4) Must be medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code to care for the consumer's illness or injury.
- (5) May include home infusion therapy for the administration of medications, nutrients or other solutions intravenously or enterally. A visit made for the purpose of home infusion therapy must be billed using the U1 modifier in accordance with rule 5101:3-12-06 of the Administrative Code.
- (6) Must be provided in the consumer's place of residence unless it is medically necessary for a nurse to accompany the consumer in the community. The consumer's place of residence is wherever the consumer lives, whether the residence is the consumer's own dwelling, an apartment, 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 the mentally retarded (ICF-MR). The place of service in the community cannot include the residence or business location of the provider of PDN.

(7) Must not be provided for the provision of habilitative care. "Habilitative care" is referenced in Chapter 5101:3-1 of the Administrative Code.

(8) Must meet the criteria in accordance with this paragraph and paragraphs (A), (C) and (D) of this rule.

(9) For "children" (consumers under the age of twenty-one), must also meet the criteria in accordance with either paragraph (E) or (F) of this rule.

(10) For "adults" (consumers age twenty-one and older), must also meet the criteria in accordance with either paragraph (E) or (G) of this rule.

(C) The providers of PDN are: MCRHHAs (medicare certified home health agencies) that meet the requirements in accordance with rule 5101:3-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5101:3-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5101:3-12-03.1 of the Administrative Code. In order for PDN to be covered, these providers must:

(1) Provide PDN that is appropriate given the consumer's diagnosis, prognosis, functional limitations and medical conditions as documented by the consumer's treating physician.

(2) Provide PDN as specified in the plan of care in accordance with rule 5101:3-12-03 of the Administrative Code. PDN services not specified in a plan of care are not reimbursable. Additionally, for consumers enrolled on an 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) Identified on the all services plan that is approved by ODJFS or the case management agency when a consumer is enrolled in an ODJFS administered home and community based services (HCBS) waiver. PDN services not identified on the all services plan are not reimbursable; or

(b) Documented on the services plan when a consumer is enrolled in an ODA (Ohio department of aging) administered or an ODMR/DD (Ohio department of mental retardation and developmental disabilities) 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 5101:3-12-06 of the Administrative Code.

(4) Bill for provided PDN services in accordance with the visit policy in rule 5101:3-12-04 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 5101:3-12-03 of the Administrative Code.

(D) Consumers who receive PDN must:

(1) Be under the supervision of a treating physician who is providing care and treatment to the consumer. 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 consumer. 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 MCRHHA 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 consumer.

(3) Access PDN in accordance with the program for the all-inclusive care of the elderly (PACE) if the consumer participates in the PACE program.

(4) Access PDN in accordance with the consumer's provider of hospice services if the consumer has elected hospice.

(5) Access PDN in accordance with the consumer's managed care plan if the consumer is enrolled in a medicaid managed care plan.

(E) Post hospital – PDN:

(1) Any medicaid consumer, whether adult or child, may receive PDN services up to fifty-six hours (two hundred twenty-four units) 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 5101:3-2-03 of the Administrative Code. For purposes of this rule, a covered inpatient hospital stay is considered one hospital stay when a consumer is transferred from one hospital to another hospital, either within the same building or to another location.

(a) The sixty days will begin once the consumer is discharged from the hospital to the consumer's place of residence as defined in paragraph (B)(6) of this rule, from the last inpatient stay whether or not the last inpatient stay was in an inpatient hospital or inpatient rehabilitation unit of a hospital.

(b) The sixty days will begin once the consumer is discharged from a hospital to a nursing facility. PDN is not available while residing in a nursing facility.

(2) The treating physician or a hospital discharge planner or a registered nurse acting under the orders of the treating physician certifies the medical necessity of PDN services using the JFS 07137 "Home Care Physician Certification Form" (rev. 7/2006). PDN is available to consumers 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 (SLOC) as defined in rule 5101:3-3-05 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 a consumer 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 consumer is no longer making significant improvement in his or her medical condition.

(4) All requirements must be met in paragraph (E) of this rule as well as all the requirements in

paragraphs (A), (B), (C) and (D) of this rule.

(5) Consumers who require additional PDN with or without a hospitalization may access PDN through either paragraph (F) or (G) of this rule.

(F) Child – PDN:

(1) A child may qualify for PDN services if he or she meets the requirements within paragraph (F) of this rule.

(a) Is under age twenty-one and requires services for treatment in accordance with Chapter 5101:3-14 of the Administrative Code for the healthcheck program.

(b) Requires (as ordered by the treating physician) continuous nursing including the provision of ongoing maintenance care. Services cannot be for habilitative care as defined in paragraph (B)(7) of this rule.

(c) Has a comparable level of care as evidenced by either:

(i) Enrollment in a HCBS waiver; or

(ii) A comparable institutional level of care as evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, Intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 of the Administrative Code. 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.

(2) The provider of PDN services must assure and document the consumer meets all requirements in paragraph (F) of this rule prior to requesting and billing for the PDN services.

(3) The U5 modifier must be used when billing in accordance with rule 5101:3-12-06 of the Administrative Code. The use of the U5 modifier indicates that all conditions of paragraph (F) of this rule were met, PDN authorization was obtained and the consumer continued to meet medical necessity criteria.

(4) The child must have a PDN authorization obtained in accordance with rule 5101:3-12-02.3 of the Administrative Code and approved by ODJFS or its designee to establish medical necessity and the consumer's comparable level of care. ODJFS or its designee will conduct a face-to-face encounter and/or review of documentation. In an emergency, PDN services may be delivered and PDN authorization obtained after the delivery of services when the services are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, and the services are required to protect the health and welfare of the consumer. A request for PDN authorization is made as follows:

(a) For a child not enrolled in a HCBS waiver, the provider of PDN must submit the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider of the

amount, scope and duration of services authorized.

(b) For a child enrolled in an ODMR/DD or ODA-administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver, who will be forwarded to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.

(c) For a child enrolled in an ODJFS-administered waiver, the case manager will authorize PDN services through the all services plan.

(5) All requirements must be met in paragraph (F) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(G) Adult – PDN: The adult consumer who meets the following requirements may receive PDN services.

(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 as defined in paragraph (B)(7) of this rule.

(3) The adult has a comparable level of care as evidenced by either:

(a) Enrollment in a HCBS waiver; or

(b) A comparable institutional level of care as evaluated initially and annually by ODJFS or its designee for a consumer not enrolled in a HCBS waiver. The criteria for an institutional level of care are any of the rules regarding the skilled level of care (SLOC) as defined in rule 5101:3-3-05 of the Administrative Code, intermediate level of care (ILOC) as defined in rule 5101:3-3-06 of the Administrative Code, or ICF/MR level of care as defined in rule 5101:3-3-07 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 medical covered long term care institution.

(4) The provider of PDN services must assure and document the consumer meets all requirements in paragraph (G) of this rule prior to providing PDN. Providers must bill using the U6 modifier in accordance with rule 5101:3-12-06 of the Administrative Code. The use of the U6 modifier indicates that all conditions of paragraph (G) of this rule were met, PDN authorization was obtained and the consumer continued to meet medical necessity criteria.

(5) The adult must have a PDN authorization obtained in accordance with rule 5101:3-12-02.3 of the Administrative Code and approved by ODJFS or its designee to establish medical necessity and the consumer's comparable level of care. ODJFS or its designee will conduct a face-to-face encounter and/or review of documentation. In an emergency, PDN services may be delivered and PDN authorization obtained after the delivery of services when the services are medically necessary in accordance with rule 5101:3-1-01 of the Administrative Code, and the services are required to protect the health and welfare of the consumer. A request for PDN authorization is made as follows:

(a) For an adult not enrolled in a HCBS waiver, the provider of PDN must submit the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider of the amount, scope and duration of services authorized.

(b) For an adult enrolled in an ODMR/DD or ODA-administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver, who will forward the request to ODJFS or its designee. Any documentation required by ODJFS or its designee for the review of medical necessity must be provided by the provider of PDN services. ODJFS or its designee will notify the provider and the case manager of the amount, scope and duration of services authorized.

(c) For an adult enrolled in an ODJFS-administered waiver, the case manager will authorize PDN services through the all services plan.

(6) All requirements must be met in paragraph (G) of this rule as well as all the requirements in paragraphs (A), (B), (C) and (D) of this rule.

(H) Consumers subject to medical determinations made by ODJFS 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.

Replaces: Part of 5101:3-12-01, 5101:3-12-02, 5101:3-12-03, 5101:3-12-04, 5101:3-12-05, 5101:3-12-06

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