

5101:3-47-04

**Transitions MR/DD waiver: definitions of the covered services and provider requirements and specifications.**

This rule sets forth the definitions of the services covered by the transitions MR/DD waiver. This rule also sets forth the provider requirements and specifications for the delivery of transitions MR/DD waiver services. The services are reimbursed in accordance with rule 5101:3-47-06 of the Administrative Code.

(A) Waiver nursing services.

(1) "Waiver nursing services" are defined as services provided to transitions MR/DD waiver consumers that require the skills of a registered nurse (RN) or licensed practical nurse (LPN) at the direction of an RN. All nurses providing waiver nursing to consumers on the transitions MR/DD waiver shall provide services within the nurse's scope of practice as set forth in Chapter 4723. of the Revised Code and Administrative Code rules adopted there under, and they shall possess a current and valid license in good standing with the Ohio board of nursing.

(2) "Personal care aide services" as defined in paragraph (B) of this rule may be reimbursed as waiver nursing services when provided incidental to waiver nursing services as defined in paragraph (A)(1) of this rule and performed during the authorized waiver nursing visit.

(3) Waiver nursing services do not include:

(a) Services delegated in accordance with Chapter 4723. of the Revised Code and rules to be adopted there under, and to be performed by individuals who are not licensed nurses in accordance with Chapter 4723. of the Revised Code;

(b) Services that require the skills of a psychiatric nurse;

(c) Visits performed for the sole purpose of meeting the supervisory requirements as set forth in paragraphs (B)(6)(c) and (B)(6)(d) of this rule; and

(d) Services performed in excess of the number of hours approved pursuant to the all services plan.

(4) In order to submit a claim for reimbursement of waiver nursing services, the RN, or LPN at the direction of the RN, delivering the service must:

(a) Be employed by a medicare-certified, or otherwise-accredited home health agency, or be a non-agency home care nurse provider;

(b) Not be the consumer's family member as that term is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code, unless the family

member is employed by a medicare-certified, or otherwise-accredited home health agency;

- (c) Not be the foster caregiver of the consumer;
- (d) Be identified as the provider on the all services plan that is prior-approved by the designated case management agency (CMA);
- (e) Be performing nursing services pursuant to signed and dated written orders from the treating physician; and
- (f) Be providing the service for one individual, or for up to three individuals in a group setting, during a face-to-face nursing visit.

(5) Non-agency LPNs, at the direction of an RN, must:

- (a) Conduct a face-to-face visit with the directing RN at least every sixty days after the initial visit to evaluate the provision of waiver nursing services and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care; and
- (b) Conduct a face-to-face visit with the consumer and the directing RN no less than every one hundred twenty days for the purpose of evaluating the provision of waiver nursing services, the consumer's satisfaction with care delivery, and LPN performance, and to assure that waiver nursing services are being provided in accordance with the approved plan of care.

(6) All waiver nursing service providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. Medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency waiver nursing service providers must maintain the clinical records at their place of business, and maintain a copy in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (k) of this paragraph.

- (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
- (b) Consumer medical history.
- (c) Name of consumer's treating physician.
- (d) A copy of the initial and all subsequent all services plans.

- (e) A copy of the initial and all subsequent plans of care, specifying the type, frequency, scope and duration of the nursing services being performed. When services are performed by an LPN at the direction of an RN, the clinical record shall include documentation that the RN has reviewed the plans of care with the LPN. The plan of care must be recertified by the treating physician every sixty days, or more frequently if there is a significant change in the consumer's condition.
- (f) In all instances when the treating physician gives verbal orders to the nurse, the nurse must document, in writing, the physician's orders, the date and time the orders were given, and sign the entry in the clinical record. The nurse must subsequently secure documentation of the verbal orders, signed and dated by the treating physician.
- (g) In all instances when a non-agency LPN is providing waiver nursing services, the LPN must provide clinical notes, signed and dated by the LPN, documenting the face-to-face visit between the LPN and the directing RN, and documenting the face-to-face visits between the LPN, the consumer and the directing RN. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- (h) A copy of the "do not resuscitate" (DNR) order, if one exists.
- (i) Clinical notes, signed and dated by the nurse, documenting the services performed during, and outcomes resulting from, each nursing visit. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.
- (j) Clinical notes, signed and dated by the nurse, documenting all communications with the treating physician and other members of the multidisciplinary team.
- (k) A discharge summary, signed and dated by the departing nurse, at the point the nurse is no longer going to provide services to the consumer, or when the consumer no longer needs nursing services.

(B) Personal care aide services.

- (1) "Personal care aide services" are defined as services provided pursuant to the transitions MR/DD waiver's all services plan that assist the consumer with activities of daily living (ADL) and instrumental activities of daily living (IADL) impairments. If the all services plan states that the service provided is to be personal care aide services, the service shall never be billed as a nursing service. Personal care aide services consists of services listed in subparagraphs (a) to (e) of this paragraph. Personal care aide service

providers may elect not to furnish one or more of the listed services. If the provider so elects, the provider must notify the designated CMA, in writing, of the services the provider elects not to furnish.

(a) Bathing, dressing, grooming, nail care, hair care, oral hygiene, shaving, deodorant application, skin care, foot care, feeding, toileting, assisting with ambulation, positioning in bed, transferring, range of motion exercises, and monitoring intake and output;

(b) General homemaking activities, including but not limited to: meal preparation and cleanup, laundry, bed-making, dusting, vacuuming, and waste disposal;

(c) Household chores, including but not limited to washing floors, windows and walls, tacking down loose rugs and tiles; and moving heavy items to provide safe access and exit;

(d) Paying bills and assisting with personal correspondence as directed by the consumer; and

(e) Accompanying or transporting the consumer to transitions MR/DD waiver services, medical appointments, other community services, or running errands on behalf of the consumer.

(2) Personal care aide services do not include services performed in excess of the number of hours approved pursuant to the all services plan.

(3) Personal care aides shall not administer prescribed or over-the-counter medications to the consumer, but may, pursuant to paragraph (B) of rule 4723-13-04 of the Administrative Code, help the consumer self-administer medications by:

(a) Reminding the consumer when to take the medication, and observing to ensure the consumer follows the directions on the container;

(b) Assisting the consumer by taking the medication in its container from where it is stored and handing the container to the consumer;

(c) Opening the container for a consumer who is physically unable to open the container;

(d) Assisting a consumer who is physically-impaired, but mentally alert, in removing oral or topical medication from the container and in taking or applying the medication; and

(e) Assisting a consumer who is physically unable to place a dose of medication in his or her mouth without spilling or dropping it by

placing the dose in another container and placing that container to the mouth of the consumer.

(4) Personal care aide services shall be delivered by one of the following:

- (a) An employee of a medicare-certified, or otherwise-accredited home health agency; or
- (b) A non-agency personal care aide.

(5) In order to submit a claim for reimbursement, all individuals providing personal care aide services must meet the following:

- (a) Be at least eighteen years of age;
- (b) Be identified as the provider on the all services plan that is prior-approved by the designated CMA;
- (c) Have a valid social security number, and one of the following forms of identification:
  - (i) Alien identification,
  - (ii) State of Ohio identification,
  - (iii) A valid driver's license, or
  - (iv) Other government-issued photo identification;
- (d) Not be the consumer's family member as that term family is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code, unless the family member is employed by a medicare-certified or otherwise accredited home health agency, and the consumer is the provider's adult child;
- (e) Not be the foster caregiver of the consumer;
- (f) Be providing personal care aide services for one individual, or for up to three individuals in a group setting during a face-to-face visit; and
- (g) Comply with the additional applicable provider-specific requirements as specified in paragraph (B)(6) or (B)(7) of this rule.

(6) Medicare-certified and otherwise-accredited home health agencies must assure that personal care aides meet the following requirements:

- (a) Prior to commencing service delivery, the personal care aide must:

- (i) Obtain a certificate of completion of either the nurse aide competency evaluation program conducted by the Ohio department of health under section 3721.31 of the Revised Code, or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005), and
    - (ii) Obtain and maintain first aid certification.
  - (b) Maintain evidence of the completion of eight hours of in-service continuing education within a twelve-month period, excluding agency and program-specific orientation. Continuing education must be initiated immediately after the personal care aide's first anniversary of employment with the agency, and must be completed annually thereafter.
  - (c) Receive supervision from an Ohio-licensed RN, or an Ohio-licensed LPN, at the direction of an RN in accordance with section 4723.01 of the Revised Code. The supervising RN, or LPN at the direction of an RN, must:
    - (i) Conduct a face-to-face consumer home visit explaining the expected activities of the personal care aide, and identifying the consumer's personal care aide services.
    - (ii) Conduct a face-to-face consumer home visit at least every sixty days after the initial visit to evaluate the provision of personal care aide services, the consumer's satisfaction with care delivery, personal care aide performance.
    - (iii) Conduct a face-to-face consumer home visit at least every one hundred twenty days while the personal care aide is present and providing care. The visit must be documented in the consumer's record.
    - (iv) Discuss the evaluation of personal care aide services with the case manager.
  - (d) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the transitions MR/DD waiver.
  - (e) Be able to effectively communicate with the consumer.
- (7) Non-agency personal care aides must meet the following requirements:
- (a) Prior to commencing service delivery personal care aides must have:

- (i) Obtained a certificate of completion within the last twenty-four months for either the nurse aide competency evaluation program conducted by the Ohio department of health in accordance with section 3721.31 of the Revised Code; or the medicare competency evaluation program for home health aides as specified in 47 C.F.R. 484 (2005); or other equivalent training program. The program must include training in the following areas:

  - (a) Personal care aide services as defined in paragraph (B)(1) of this rule;
  - (b) Basic home safety; and
  - (c) Universal precautions for infection control, including hand-washing and proper disposal of bodily waste.
- (ii) Obtained and maintain first aid certification.
- (b) Complete eight hours of in-service continuing education annually that must occur on or before the anniversary date of their enrollment as a medicaid personal care aide provider. Continuing education topics include, but are not limited to consumer health and safety, cardiopulmonary resuscitation (CPR), patient rights, emergency preparedness, communication skills, aging sensitivity, developmental stages, nutrition, transfer techniques, disease-specific trainings, and mental health issues.
- (c) Comply with the consumer's or the consumer's authorized representative's specific personal care aide service instructions, and perform a return demonstration upon request of the consumer or the case manager.
- (d) Comply with ODJFS monitoring requirements in accordance with rule 5101:3-12-30 of the Administrative Code.
- (e) Be able to read, write and understand English at a level that enables the provider to comply with all requirements set forth in the administrative rules governing the transitions MR/DD waiver.
- (f) Be able to effectively communicate with the consumer.
- (8) All personal care aide providers must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. medicare-certified, or otherwise-accredited home health agencies, must maintain the clinical records at their place of business. Non-agency personal care aides must maintain the clinical records at their place of business in a manner that protects the confidentiality of these records, and maintain a copy

in the consumer's residence. For the purposes of this rule, the place of business must be a location other than the consumer's residence. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

(a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) Documentation of drug allergies and dietary restrictions.

(f) A copy of the "do not resuscitate" (DNR) order, if one exists.

(g) Documentation that clearly shows the date of service delivery, the personal care aide service tasks performed or not performed, the arrival and departure times, and the signatures of the personal care aide and consumer or authorized representative upon completion of service delivery. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) Progress notes signed and dated by the personal care aide, documenting all communications with the CM, treating physician, other members of the multidisciplinary team, and documenting any unusual events occurring during the visit, and the general condition of the consumer.

(i) A discharge summary, signed and dated by the departing non-agency personal care aide or RN supervisor of an agency personal care aide, at the point the personal care aide is no longer going to provide services to the consumer, or when the consumer no longer needs personal care aide services.

(C) Adult day health center services.

(1) "Adult day health center services (ADHCS)" are regularly scheduled services delivered at an adult day health center to consumers age eighteen or older. A qualifying adult day health center must be a freestanding building or a space within another building that is used solely for the provision of ADHCS.

(a) The services the adult day health center must make available are the following:

- (i) Waiver nursing services as set forth in paragraph (A) of this rule, or personal care aide services as set forth in paragraph (B)(1) of this rule;
    - (ii) Recreational and educational activities; and
    - (iii) No more than two meals per day that meet the consumer's dietary requirements.
  - (b) The services the adult day health center may also make available include the following:
    - (i) Skilled therapy services as set forth in rule 5101:3-12-01 of the Administrative Code;
    - (ii) Transportation of the consumer to and from ADHCS.
  - (c) ADHCS are reimbursable at a full-day rate when five or more hours are provided to a consumer in a day. ADHCS are reimbursable at a half-day rate when less than five hours are provided to a consumer on a day.
  - (d) All of the services set forth in paragraphs (C)(1)(a) and (C)(1)(b) of this rule and delivered by an adult day health center shall not be reimbursed as separate services.
- (2) ADHCS do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, providers of ADHCS must:
- (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA; and
  - (b) Operate the adult day health center in compliance with all applicable federal, state and local laws, rules and regulations.
- (4) All providers of ADHCS must:
- (a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).
  - (b) Provide for replacement coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.

- (c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.
- (d) Assure that any waiver nursing services provided are within the nurse's scope of practice as limited in paragraph (A)(1) of this rule.
- (e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.
- (f) Maintain, at all times, a paid staff to consumer ratio of 1:6.
- (5) Providers of ADHCS must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

  - (a) Consumer identifying information, including but not limited to: name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.
  - (b) Consumer medical history.
  - (c) Name of consumer's treating physician.
  - (d) A copy of the initial and all subsequent all services plans.
  - (e) A copy of the "do not resuscitate" (DNR) order, if one exists.
  - (f) Documentation of drug allergies and dietary restrictions.
  - (g) Documentation that clearly shows the date of ADHCS delivery, including tasks performed or not performed, and the consumer's arrival and departure times. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by the paragraph.
  - (h) A discharge summary, signed and dated by the departing ADHCS provider, at the point the ADHCS provider is no longer going to provide services to the consumer, or when the consumer no longer needs ADHCS.
  - (i) Documentation of the information set forth in paragraphs (A)(6)(e),

(A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing and/or skilled therapy services.

(D) Home delivered meal services.

- (1) "Home delivered meal services" are defined as the provision of individual meals to consumers. The service includes the provider's preparation and home delivery of safe and nutritious meals. The meals must be planned by a dietician, taking into consideration the consumer's cultural and ethnic background, and dietary preferences and/or restrictions. The provider must be in compliance with all applicable federal, state, county and local laws and regulations concerning the preparation, handling and transportation of food.
- (2) Home delivered meals do not include services performed in excess of what is approved pursuant to the all services plan.
- (3) In order to submit a claim for reimbursement, all providers of home delivered meal services must:
  - (a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;
  - (b) Possess a valid food vendor's license;
  - (c) Assure that all meals are prepared and delivered as identified on the all services plan; and
  - (d) Only submit a claim for up to two meals per day per consumer.
- (4) Home delivered meal service providers must maintain the documentation identified in subparagraphs (a) to (d) of this paragraph.
  - (a) Daily route logs, signed and dated by the home delivered meal service provider, with consumer names appearing on the log in order of delivery with the time of first and last meal delivered, number of meals at each visit, initials of person delivering the meal and initials of the consumer or authorized representative receiving the meal(s).
  - (b) A record for each consumer served that contains a copy of the initial and all subsequent all service plans, all dietary instructions prepared by the dietician and any additional information supporting meal delivery as specified on the all services plan.
  - (c) All appropriate food vendor's licenses.
  - (d) Evidence of a time/temperature monitoring system for food preparation, handling and delivery.

- (5) Upon request, home delivered meal service providers shall make available to ODJFS or its designated CMA a copy of any local health department inspection reports.
- (6) Home delivered meal service providers cited for critical items during their local health department inspection shall make available a copy of that inspection report and the follow-up report to ODJFS or its designated CMA within five working days of receipt from the inspecting agent.
- (7) Home delivered meal service providers cited by the Ohio department of agriculture shall make available to ODJFS or its designated CMA a copy of the findings and corresponding plans of correction within five working days of receipt from the regulatory agent.

(E) Home modification services.

- (1) "Home modification services" are environmental accessibility adaptations to structural elements of the interior or exterior of a consumer's home that enable the consumer to function with greater independence in the home and remain in the community. Home modification services shall not exceed ten thousand dollars within a twelve-month period per consumer.
  - (a) The property owner must give written consent for the home modification that indicates an understanding that the transitions MR/DD waiver will not pay to have the property returned to its prior condition.
  - (b) The need for home modification services must be identified in an evaluation completed by an occupational therapist or physical therapist as licensed pursuant to sections 4755.07 and 4755.44 of the Revised Code.
- (2) Home modification services do not include:
  - (a) Changes to a home that are of general utility and are not directly related to the environmental accessibility needs of the consumer (i.e., carpeting, roof repair, central air conditioning, etc.);
  - (b) Adaptations that add to the total square footage of the home; and
  - (c) Services performed in excess of what is approved pursuant to the all services plan.
- (3) Home modification service providers shall be reimbursed for the actual cost of material and/or labor for the home modification as identified in the bid specification. The reimbursement may only be adjusted if the job specifications are modified in writing by the designated CMA and the

adjustment is warranted. Family members and volunteers will only be reimbursed for the cost of materials.

(4) In order to submit a claim for reimbursement, providers of home modification services must:

(a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;

(b) Assure that the home modification was completed in accordance with the agreed upon specifications using all of the materials and equipment cited in the bid;

(c) Assure that the home modification was tested and in proper working order;

(d) Assure that the home modification met all applicable state and local building codes and complies with the Americans with Disabilities Act (ADA);

(e) Maintain insurance and bonding for general contracting services and provide proof to the designated CMA upon request. Family members and volunteers are exempt from this requirement when they deliver home modification services to the consumer; and

(f) Obtain a final written approval from the consumer and the designated CMA after completion of the home modification service.

(5) Selection of home modification service providers.

(a) The designated CMA shall develop job specifications in consultation with the consumer, authorized representative, and/or caregiver(s) to meet the consumer's environmental accessibility needs with the lowest cost alternative.

(b) The designated CMA shall send the home modification specifications to every home modification service provider in the consumer's region and invite the submission of competitive bids. The following must be submitted with all bids:

(i) A drawing or diagram of the home modification;

(ii) An itemized list of all materials needed for the home modification;

(iii) An itemized list of the cost of the materials needed for the home modification;

(iv) An itemized list of the labor costs;

(v) A written statement of all warranties provided; and

(vi) A written attestation that the provider, all employees and/or all subcontractors to be used to perform the job specifications have the necessary experience and skills.

(c) The designated CMA shall review all submitted bids and the home modification service will be awarded to the lowest responsive and most responsible bidder, with price and other relevant factors being considered in the selection process.

(F) Supplemental transportation services.

(1) "Supplemental transportation services" are transportation services not otherwise covered by the Ohio medicaid program that enable a consumer to access waiver services and other community resources specified on the all services plan. Supplemental transportation services include assistance in transferring the consumer from the point of pick-up to the vehicle and from the vehicle to the destination point.

(2) Supplemental transportation services do not include services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for supplemental transportation services, the provider must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.

(4) Agency supplemental transportation service providers must:

(a) Maintain a current list of drivers;

(b) Assure that all drivers providing supplemental transportation services are age eighteen or older;

(c) Maintain a copy of the valid driver's license for each driver;

(d) Maintain collision and liability insurance for each vehicle and driver used to provide supplemental transportation services;

(e) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;

(f) Assure that drivers are not the consumers' family members as that term is

defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code; and

(g) Assure that drivers are not the consumers' foster caregivers.

(5) Non-agency supplemental transportation service providers must:

(a) Be age eighteen or older;

(b) Possess a valid driver's license;

(c) Maintain collision and liability insurance for each vehicle used to provide supplemental transportation services;

(d) Obtain and exhibit evidence of a valid motor vehicle inspection from the Ohio highway patrol for each vehicle used in the provision of supplemental transportation services;

(e) Not be the consumer's family member as that term is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code; and

(f) Not be the consumer's foster caregiver.

(6) All supplemental transportation service providers must maintain documentation that includes a log identifying the consumer transported, the date of service, pick-up point, destination point, mileage for each trip and the signature of the consumer receiving supplemental transportation services, or his or her authorized representative.

(G) Supplemental adaptive and assistive device services.

(1) "Supplemental adaptive and assistive device services" are medical equipment, supplies and devices, and vehicle modifications to a vehicle owned by the consumer, or the consumer's family member as that term is defined in paragraph (R) of rule 5101:3-45-01 of the Administrative Code, that are not otherwise available through any other funding source and that are suitable to enable the consumer to function with greater independence, avoid institutionalization, and reduce the need for human assistance. The designated CMA shall only approve the lowest cost alternative that meets the consumer's needs.

(a) Reimbursement for medical equipment and supplies shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of medical equipment, supplies and devices for the same consumer for a one-year period unless there is a documented need for ongoing medical supplies or a documented change in the consumer's medical and/or physical

condition requiring the replacement.

(b) Reimbursement for vehicle modifications shall not exceed ten thousand dollars within a twelve-month period per consumer. The designated CMA shall not approve the same type of vehicle modification for the consumer for a three-year period unless there is a documented change in the consumer's medical and/or physical condition requiring the replacement.

(2) Reimbursable vehicle modifications include operating aids, raised and lowered floors, raised doors, raised roofs, portable ramps, scooter/wheelchair handling devices, transfer seats, remote devices, lifts, equipment repairs and/or replacements, and transfers of equipment from one vehicle to another for use by the same consumer. Prior to the authorization of a vehicle modification, the consumer and, if applicable, any other person(s) who will operate the vehicle must provide the designated CMA with documentation of:

(a) Evidence of a valid driver's license, with appropriate restrictions;

(b) Evidence of the successful completion of driver training from a qualified driver rehabilitation specialist or a written statement from a driver's rehabilitation specialist attesting to the driving ability and competency of the consumer and/or other persons operating the vehicle;

(c) Evidence of the vehicle owner's collision and liability insurance for the vehicle being modified; and

(d) A written statement from a certified mechanic stating the vehicle is in good operating condition.

(3) Supplemental adaptive and assistive device services do not include:

(a) Items considered by the federal food and drug administration as experimental or investigational;

(b) Funding of down payments toward the purchase or lease of any supplemental adaptive and assistive device services;

(c) Payment toward the purchase or lease of a vehicle;

(d) Routine care and maintenance of vehicle modifications and devices;

(e) Permanent modification of leased vehicles;

(f) Vehicle inspection costs;

(g) Vehicle insurance costs; and

(h) Services performed in excess of what is approved pursuant to the all services plan.

(4) In order to submit a claim for supplemental adaptive and assistive device services, the provider must:

(a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA;

(b) Assure that all manufacturer's rebates have been deducted before requesting reimbursement for supplemental adaptive and assistive device services; and

(c) Assure that the supplemental adaptive and assistive device was tested and is in proper working order, and is subject to warranty in accordance with industry standards.

(5) Providers of supplemental adaptive and assistive device services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (d) of this paragraph.

(a) Consumer identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers, and health insurance identification numbers.

(b) Name of consumer's treating physician.

(c) A copy of the initial and all subsequent all services plans.

(d) Documentation that clearly shows the date the supplemental adaptive and assistive device service was provided. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(H) Out-of-home respite services.

(1) "Out-of-home respite services" are services delivered to a consumer in an out-of-home setting in order to allow respite for caregivers normally providing care. The service must include an overnight stay.

(a) The services the out-of-home respite provider must make available are:

(i) Waiver nursing services as set forth in paragraph (A) of this rule;

(ii) Personal care aide services as set forth in paragraph (B)(1) of this

rule; and

(iii) Three meals per day that meet the consumer's dietary requirements.

(b) All services set forth in paragraph (H)(1)(a) of this rule and delivered during the provision of out-of-home respite services shall not be reimbursed as separate services.

(2) Out-of-home respite services do not include services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for reimbursement, providers of out-of-home respite services must:

(a) Be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.

(b) Be either:

(i) An intermediate care facility for the mentally retarded and developmentally disabled (ICF-MR) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(ii) A nursing facility (NF) licensed and certified in accordance with rules 5101:3-3-02 and 5101:3-3-02.3 of the Administrative Code; or

(iii) Another institutional setting approved by the designated CMA.

(c) Be providing out-of-home respite services for one individual, or for up to three individuals in a group setting on the same date.

(4) All providers of out-of-home respite services must:

(a) Comply with federal nondiscrimination regulations as set forth in 42 C.F.R. 80 (1964).

(b) Provide for coverage of a consumer's loss due to theft, property damage, and/or personal injury; and maintain a written procedure identifying the steps a consumer takes to file a liability claim. Upon request, provide documentation to ODJFS or its designated CMA verifying the coverage.

(c) Maintain evidence of non-licensed direct care staff's completion of eight hours of in-service training within a twelve-month period, excluding agency and program-specific orientation. In-service training must be

initiated immediately after the non-licensed direct care staff's first anniversary of employment with the provider, and must be completed annually thereafter.

(d) Assure that any waiver nursing services provided are within the nurse's scope of practice as set forth in paragraph (A)(1) of this rule.

(e) Provide task-based instruction to direct care staff providing personal care aide services as defined in paragraph (B)(1) of this rule.

(5) Providers of out-of-home respite services must maintain a clinical record for each consumer served in a manner that protects the confidentiality of these records. The clinical record must contain the information listed in subparagraphs (a) to (i) of this paragraph.

(a) Consumer's identifying information, including but not limited to name, address, age, date of birth, sex, race, marital status, significant phone numbers and health insurance identification numbers.

(b) Consumer medical history.

(c) Name of consumer's treating physician.

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

(e) A copy of the "do not resuscitate" (DNR) order, if one exists.

(f) Documentation of drug allergies and dietary restrictions.

(g) Documentation that clearly shows the date of out-of-home respite service delivery, including tasks performed or not performed. Nothing shall prohibit the use of technology-based systems in collecting and maintaining the documentation required by this paragraph.

(h) A discharge summary, signed and dated by the departing out-of-home respite service provider, at the point the service provider is no longer going to provide services to the consumer, or when the consumer no longer needs out-of-home respite services.

(i) Documentation of the information set forth in paragraphs (A)(6)(e), (A)(6)(f), (A)(6)(i) and (A)(6)(j) of this rule when the consumer is provided waiver nursing.

(I) Emergency response services.

(1) "Emergency response services (ERS)" are in-home, twenty-four-hour communication connection systems that enable a consumer at high risk of

institutionalization to secure immediate assistance during a medical, physical, emotional, or environmental emergency. Consumers who live alone, are alone for significant parts of the day, or have no regular caregiver for extended periods of time and would otherwise require extensive routine supervision are considered to be high risk for the purposes of this service.

(2) ERS do not include:

(a) In-home communication connection systems used to supplant routine supervision of consumers under the age of eighteen; and

(b) Services performed in excess of what is approved pursuant to the all services plan.

(3) In order to submit a claim for ERS, all providers must be identified as the provider on the consumer's all services plan that is prior-approved by the designated CMA.

(4) Providers of ERS must:

(a) Permit consumers to select from a variety of remote activation devices;

(b) Assure that consumers have systems that meet their specific needs;

(c) Assure that emergency response systems meet all applicable quality assurance/quality control industry standards;

(d) Conduct monthly testing of emergency response systems to assure proper operation;

(e) Provide consumers, their authorized representatives, and caregivers with initial and ongoing training and assistance regarding the use of the emergency response system;

(f) Assure that the installation includes seize line circuitry guaranteeing that the emergency response system has priority over the telephone when the system is activated;

(g) Operate an emergency response center that is staffed twenty-four hours a day, three hundred sixty-five days a year to receive and respond to emergency signals;

(h) Assure that the emergency response center has back-up monitoring capacity to handle all monitoring functions and incoming emergency signals in the event the primary system malfunctions;

(i) Assure that emergency response center staff respond to alarm messages

within sixty seconds of receipt; and

(j) Furnish a replacement emergency response system or an activation device to the consumer within twenty-four hours of notification of a malfunction.

(5) Providers of ERS must maintain the following documentation:

(a) A log containing the names and contact information of each consumer and their authorized representatives' names and contact information;

(b) A written record of the date of delivery and installation of the emergency response system, with the consumer's or authorized representative's signature verifying delivery and installation;

(c) A record of the monthly test conducted on each consumer's emergency response system, including the date, time and results of the test; and

(d) A record documenting the date and time a consumer's emergency response system is activated and a summary of the incident and the action taken by the provider.

Replaces: Part of 5101:3-12-07

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Certification

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