3.15 AUTHORIZED NURSE VISITS – STATE PLAN (AGENCY MODEL)

INTRODUCTION

Authorized nurse visits are provided by Home and Community Based Services (HCBS) providers who are enrolled in the HCBS personal care agency model program. The nurse visits are for enhanced supervision of the personal care aide and maintenance or preventative services provided by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), or a Graduate Nurse (GN) under the direction of an RN or physician. The visits shall also include an assessment of the participant's health and the adequacy of the care plan to meet the participant's needs.

PURPOSE

Authorized nurse visits are funded through Medicaid State Plan. They are provided to participants with stable, chronic conditions and are NOT typically intended as a treatment for an acute health care condition as normally provided through home health services.

ELIGIBILITY

All participants authorized for nurse visits must meet the following eligibility criteria:

- At least 18 years of age
- Meet nursing facility level of care
- In active Medicaid status (Medicaid Eligibility)
  - Participants who are eligible for Medicaid on a spenddown basis may be authorized to receive nurse visits during periods when they meet their spenddown liability.
  - A participant is responsible for the cost of services received during periods of time when they have **not** met their spenddown liability.
  - Participants who receive Medicaid due to eligibility for Blind Pension (BP) may be authorized for nurse visits.
  - Participants in a 'Transfer of Property penalty' may be authorized for nurse visits.
  - The authorization of nurse visits does not meet the requirement for an individual to be eligible for Home and Community Based (HCB) Medicaid.
- Have an appropriate Medicaid Eligibility (ME) code

NOTE: Participants must be receiving other Personal Care Services (Agency Model) (PC) or Personal Care Assistance Consumer-Directed Model (CDS) to be eligible for nurse visits.

AUTHORIZATION OF NURSE VISITS

The following guidelines outline the process for authorizing nurse visits:

- Nurse visits shall be authorized by the visit, not in 15-minute increments. No minimum or maximum time is required to constitute a visit.
- The nurse is an employee of the HCBS provider and cannot be a member of the immediate family of the participant. An immediate family member is defined as a parent, sibling, child by blood, adoption, or marriage (stepchild); spouse; grandparent or grandchild.
- A **maximum** of 26 nurse visits will only be provided in a six-month authorization period.
- Authorized nurse visits shall **NOT** include services considered reimbursable as skilled nursing care under the home health program **or** when the visit is to determine whether an individual is eligible for HCBS.
  - Information shall be forwarded to the participant's physician by the provider any time a service need is detected which would require skilled nursing care. The physician may then issue home health orders as appropriate.
- Participants authorized for certain services through the Department of Mental Health (DMH) may not be eligible for services as outlined in this policy. DSDS staff shall refer to the DMH Service Coordination policy for guidance on coordinating services for participants authorized for DMH services.

NOTE: When a provider change occurs, the new provider shall only be authorized for any nurse visit(s) remaining within an existing authorization period.

COST MAXIMUM

Authorized nurse visits shall be included in the overall cost of care (HCBS Cost Maximums) for the participant with the following exceptions:

- The cost of authorized nurse visits is not included in the 60% monthly maximum cost for basic personal care.
- For participants who only receive authorized nurse visits for General Health Evaluations (GHE), the cost of two nurse visits shall be excluded from the calculation of a PCCP cost.

NOTE: The electronic case record system will automatically exclude the nurse visit(s) from the calculation of the PCCP.

- Nurse visits authorized together with other Medicaid State Plan HCBS, i.e., agency model PC, CDS, Advanced Personal Care (APC) **and** Aged and Disabled Waiver Services (ADW) shall not exceed 100% of the monthly cost for care in a nursing facility without prior approval from the Bureau of Federal Programs (BFP).
  - When the combination of State Plan and ADW services (excluding Adult Day Care) exceeds the 100% cost maximum:
    - The appropriate supervisor for the Division of Senior and Disability Services (DSDS) staff shall review all PCCP requests over the 100% cost cap to ensure the participant's unmet needs require the amount of service requested.
    - If documentation supports the request, the case shall be forwarded to BFP for consideration and approval prior to authorizing over 100% of the cost cap.
    - Pending the approval from BFP to exceed the cost cap, authorized nurse services in combination with other state plan or ADW services can be authorized up to 100% of the cost cap.

NOTE: When a PCCP includes Adult Day Care authorized through the ADW or the Adult Day Care Waiver (ADCW), the total cost of care **cannot** exceed 100% of the cost cap.

GENERAL HEALTH EVALUATIONS

All participants receiving agency model PC and APC shall be authorized a minimum of two (2) nurse visits annually to perform General Health Evaluations (GHE) as required by MO State Statute 192.2475.14 RSMo. The semi-annual nurse visits are necessary for the delivery and supervision of the individual providing the services to ensure quality of care, assessment of the participant's health and adequacy of the participant's PCCP.

GHEs shall be authorized when no other nursing need is identified as a task on separate lines in the 4th and 10th months following the (re)assessment as outlined in the General Health Evaluation Chart.

Month of Assessment	4th Month	10th Month
January	April	October
February	May	November
March	June	December
April	July	January
May	August	February
June	September	March
July	October	April
August	November	May
September	December	June
October	January	July
November	February	August
December	March	September

Excluded from the requirement for semi-annual nurse visits are those participants authorized for:

- Personal Care Services (Agency Model) in a Residential Care Facility (RCF) or Assisted Living Facility (ALF)
- Aged and Disabled Waiver services **only**
- Personal Care Assistance (Consumer-Directed Model) **only**
- Independent Living Waiver **only**

- Adult Day Care Waiver **only**
- Structured Family Caregiving Waiver

Participants with a documented need for other nurse tasks shall not be authorized for separate semi-annual nurse visits. The 4th and 10th months following a (re)assessment, during which the GHE is to be completed, shall be documented. DSDS or its designee shall communicate to the provider that the General Health Evaluation (GHE) and Level of Care Recommendation form is to be completed as part of a regularly scheduled nurse visit during those months. This directive shall be documented in the participant's electronic case record. GHEs shall not be selected as a task when a participant has a need for nursing tasks. When selecting nurse visits in the electronic case record, only enter the first month of the GHE. The second month will automatically populate.

DSDS or its designee shall be aware of and review documentation/information submitted by the provider nurse and take appropriate action. Information submitted includes:

- The General Health Evaluation and Level of Care Recommendation
- Notification that a participant has refused a General Health Evaluation and Level of Care Recommendation visit

NOTE: Critical issues identified during any provider nurse visit shall be communicated immediately to DSDS via telephone, email or fax as required by the Code of State Regulation(s). This notification may require an immediate care plan change.

REGULAR NURSE VISITS

For authorized nurse visits excluding the required semi-annual GHE visits, DSDS or its designee must establish and document that no other person is available who is willing and able to provide the service. Such documentation may include but is not limited to:

- Participant lives alone
- Incapability of available family members
- Unwillingness/incapability of other available individuals to provide the needed services
- Resident of RCF or ALF requires services beyond what is normally included in the monthly room and board reimbursement to the facility, RCF/ALF PC

In addition to increased supervision of the HCBS provider employee and assessment of the participant's health and adequacy of the care plan, authorized nurse visits may include the following:

- Medications
  - Filling insulin syringes **weekly** for diabetics who can self-inject the medication but cannot fill their own syringes.
    - Documentation must be sufficient to establish the participant has a diabetic condition impairment that prevents the participant from independently filling syringes.
  - Oral medication set-ups in divided daily compartments for participants who self-administer prescribed medications but need assistance and monitoring due to confusion or disorientation.
    - Documentation must be sufficient to establish the need for medication and that the participant is disoriented or confused. Although self-control of prescription and over-the-counter medications

may be allowed in an RCF or ALF with written permission from the resident's physician and allowed by facility policy, this task would not be applicable for RCF and ALF residents who are authorized for Personal Care in an RCF or ALF.

- Monitoring Skin Condition
  - Check for possible skin breakdown due to immobility, incontinence, or other needs as described below.
    - Unable to turn and position self
    - Limited ability to ambulate, with long periods of time sitting or lying in one position, or is documented to be incontinent
    - History of decubitus ulcers, poor circulation evidenced by edema or discolored extremities, and diabetes
      - Documentation must be sufficient to establish the participant is at risk of skin breakdown.
- Nail Care
  - Monthly visits to provide nail care for diabetic participants or participants with other medically contraindicating conditions, including but not limited to participants:
    - Taking anticoagulant medication, such as Coumadin
    - Diagnosed with peripheral vascular disease
    - Diagnosed with a compromised immune system (e.g. HIV and chemotherapy patients)
      - Documentation shall be sufficient to establish the participant has a medical condition such as diabetes AND is unable to perform this task.

OTHER NURSING CARE

Participants may be authorized for nurse visits for specific tasks when the needs of the participant cannot be met and are not reimbursable through the home health program. DSDS or its designee shall approve nurse visits for "other" non-routine nursing tasks after consultation with the participant, provider nurse, DSDS supervisor and, as necessary, the physician.

The "other" nursing tasks may include but are not limited to:

- Administration of injectable medications (other than insulin)
- Venipunctures
- Catheter changes
- Enemas (only when not utilizing a prepackaged enema)
- Wound dressing changes
- Central line dressing/flush/blood draws

Providers with written documentation should upload it to the participant's electronic case record and include documentation in case notes.

NOTE: It is not necessary for DSDS or its designee to obtain copies of physician's orders prior to the authorization of a nurse visit or adding a task to a nurse visit.

ADVANCED PERSONAL CARE

All APC participants shall be authorized for a monthly nurse visit to evaluate the adequacy of service delivery and ensure the participant's needs and conditions are met. During the visit, the nurse assesses the APC aide's ability to carry out the authorized services.

APC aides shall be trained on the APC tasks delivered. For participants not authorized for weekly nurse visits, an additional nurse visit shall be authorized through the first **full** month of the authorization for on-the-job training of the APC aide. DSDS staff or its designee shall select the Train APC task for those one-time visits.

The Train APC task shall not be selected for participants authorized for weekly nurse visits. In these circumstances, the Train APC should be authorized as an RN visit for the one-month authorization period. The task should be performed by the nurse during the regular nurse visit as needed.

The Train APC task is to be completed as follows:

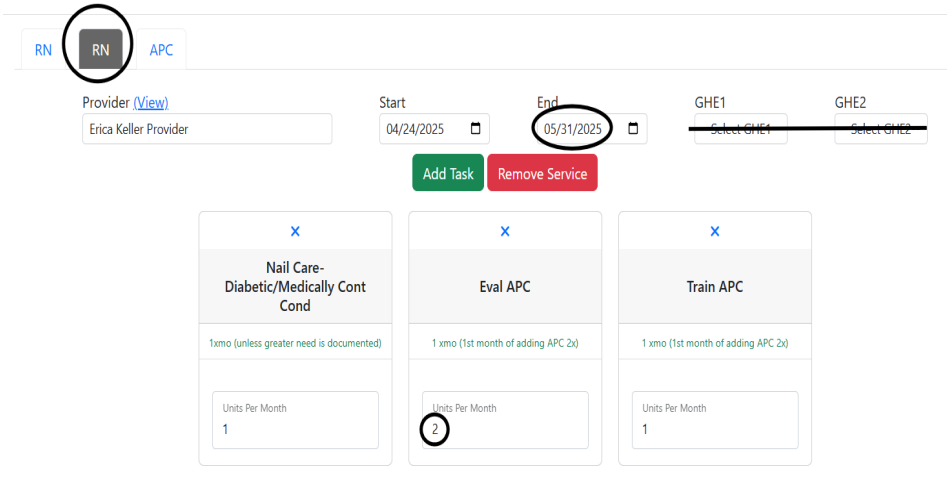
- Once during the first full month of an initial authorization of APC, following the addition of an APC task to the care plan
- At the time of an APC provider change
- When requested by the provider (such as when aides change) to provide on-the-job training of the APC aide.

When developing the PCCP two (2) RN visits will be added. One (1) unit will be entered for Train APC and two (2) units will be entered for Evaluate APC. Eval APC must be authorized for 2 units the first month in order for the provider to bill for both training and evaluating the APC aide later in the same month, as that will be 2 different visits.

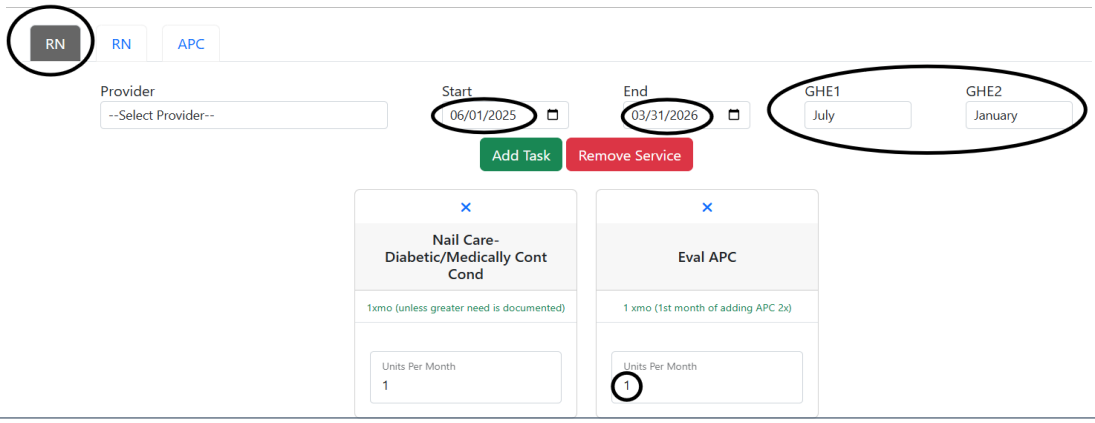
NOTE: To prevent duplicate prior authorizations, the end date and start date of each authorization must not overlap.

Example of APC authorization with a once-a-month RN task
(authorization would be the same if no other RN task was included)

1st RN Authorization

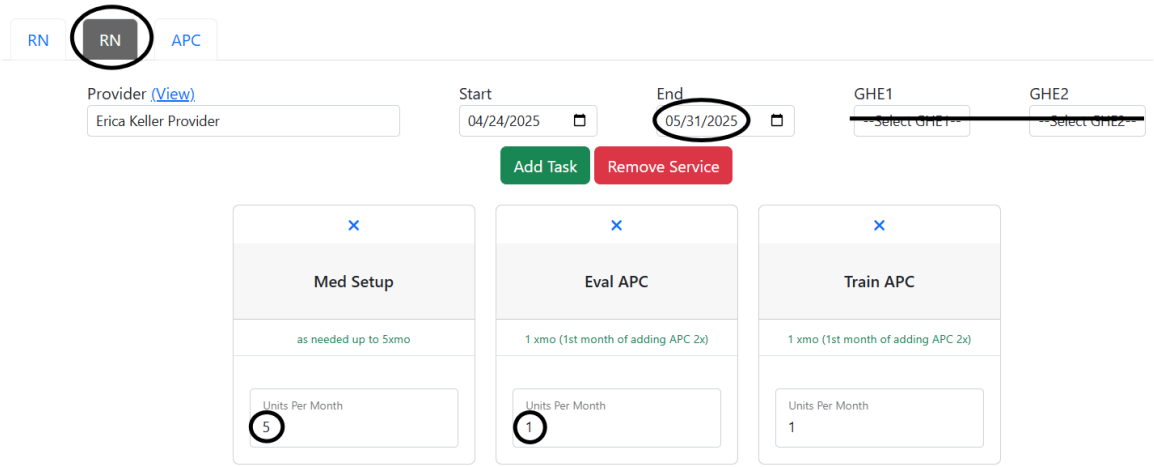


2nd RN Authorization



Example of APC authorization **with** weekly RN task included:

1st RN Authorization



2nd RN Authorization