

Frequently Asked Questions - IO Waiver Nursing Webinar Families/Providers

Q: What is the contact information for Permedion?

A: This is the link to the Permedion website for PA of increased state plan services - www.hmspermedion.com The form and provider instructions are available on the website.

Q: What level would be needed for a child with a trach and ventilator?

A: There is not a prescribed 'level' for any particular condition or nursing task. The nursing task assessment form has classifications of tasks - '1' and '2' – meaning: a 'classification 1' is a task that nursing would be expected to deliver care. Nursing does not HAVE to be utilized, but DODD understands that the care required for these individuals may require licensed nursing personnel.

If 'classification 2' task - then the typical expectation is that the tasks could be met with medication certification with/without delegation. If nursing must be used to perform these tasks, then an explanation would be required to state the specific reason why nursing authorized rather than certification/delegation.

Q: We've gone through 3 caregiver provider companies who could not keep staff employed who were willing and able to learn how to suction and do cough assist treatments and learn how to understand the ventilator. We were told that under no circumstances could they learn how to change a trach tube. But Nursing hours are limited to 14 hours a day. Families like ours are exhausted.

A: Nursing authorization should be provided based upon the medical needs of the individual – regardless of the number of hours it requires. Waiver nursing can be used to supplement State Plan Nursing services.

In this particular example, you cite changing a tracheostomy tube. Typically, this procedure is ordered to be done at specific intervals, weekly/monthly/etc... and for those particular times that the tracheostomy tube is changed, then the expectation would be that nursing could/would be authorized to perform that service.

Q: Medicare COP's, don't they have rules regarding scope of practice?

A: Any actions related to nursing are ultimately based upon the rules provided by the Ohio Board of Nursing. With respect to nursing delegation, the particular rule is Ohio Administrative Code 4723-13-05 Criteria and standards for a licensed nurse delegating to an unlicensed person. This can be found at this website: <http://codes.ohio.gov/oac/4723-13-05v1>

Q: There is a difference between catheterization and sterile catheterization. We were told the only ones to do sterile catheterization is Nursing. What if agencies do not allow aides to do catheterization? Our agencies said they will allow only Nursing to do this. I have 2 agencies and both will not be responsible for this procedure if done by anyone but Nursing.

A: There are not particular duties that can, or cannot, be delegated. An agency may have their own particular policies/procedures which are not governed by DODD. However, if the task is able to be met with certification and/or delegation, then an appropriate provider should be sought. Delegation is based upon the stability of the individual, the competency of the provider and the RN determining which tasks are to be delegated.

Q: Can Nursing services overlap H/PC services? It wasn't mentioned along with ADS, adult family, etc.

A: They should not, but there are certain circumstances in which it cannot be avoided. For example, an HPC provider may be with the individual to perform bathing/dressing/grooming/all meal preparation/assistance with feeding/laundry/housekeeping/etc...but the individual has a specific treatment that must be performed at timed intervals. If the treatment must be performed by a nurse, then the nurse may have to interrupt the personal care time to perform the specific treatment. The HPC can be performing IADLs (like the laundry/housekeeping duties/etc.) while nurse performing the treatment.

Q: With waiver Nursing, did you say that you have to be certified to provide state plan Nursing as well as have DODD certification?

A: No. All IO Nursing providers are not required to have Medicaid agreements to deliver state plan home health and/or private duty nursing providers.

Q: What is the name of the form that is used to request for the increase of hours for the state plan services?

A: This is the link to the Permedion website for PA of increased state plan services - www.hmspermedion.com The form and provider instructions are available on the website.

Q: I provide Nursing through an agency that are transitioning from the TDD waiver to IO waiver. They have PDN hours already in place. My question are these individuals going to be switched to health aide hours? According to the speaker, she said just about anything can be performed by an aide under the delegation of a RN. Are these folks going to lose PDN hours?

A: The county board SSA will perform a home visit with individual, parent/guardian/family members and paid team members. A review of the plan of care will be done in order that the SSA knows what nursing tasks have been ordered, including their frequency and duration. The SSA, along with DODD, will determine if the nursing tasks can be met through medication certification and/or delegation or if nursing services will be required or a combination of all services – HPC/waiver nursing/state plan nursing. The determination is based upon the need if the individual.

Q: As a Medicare certified agency we were told our cert1 HHAs are not permitted to administer meds eve for IO waiver clients. Please clarify. We are aware they cannot administer meds for state plan hours.

A: Your agency will need to follow the policies of your organization in order to meet the requirements of your credentialing organization. If you are a Medicare-certified agency and you are not allowed to have your personal care aides administer medications, then we respect your credentialing board. However, there would still be the expectation that if the nursing task/medication administration – along with the stability of the individual + competency of the provider - could be met through certification/delegation, that would be put into place.

Q: Can you please repeat the rule number?

A: With respect to nursing delegation, the particular rule is [Ohio Administrative Code 4723-13-05](http://codes.ohio.gov/oac/4723-13-05) Criteria and standards for a licensed nurse delegating to an unlicensed person. This can be found at this website: <http://codes.ohio.gov/oac/4723-13-05v1>

Q: Level II – Have been told that staff does not need certified to administer only feeding through G-tube that does not include medications?

A: True. Medication Administration Certification Category 2 is only required for administration of medications via g/j tube. The presentation/instillation of nutrition or fluid via g/j tube is considered a nursing TASK and does not require medication administration certification. As a nursing task, it can be delegated if/when it meets the standards and provisions of OBNS Chapter 13 (OAD 4723-13).

Q: RN does not need certified to delegate services?

A: Delegation is a nursing action that is within the scope of a nurse's practice according to provisions and specifications in Ohio Revised Code 4723.01 and Ohio Administrative Code 4723-13. An RN only needs DODD RN Trainer Certification to provide for the DODD medication administration certification of unlicensed DD Personnel.

Q: What if a person hasn't been getting services through a TDD waiver due to a lack of providers and is now getting an IO waiver, how can we make a comparison for the nursing assessment?

A: We do not actually need a comparison. We need an accurate reflection of the current status and needs of the individual at the time of the team meeting when the services will be planned. What a person had earlier does not pertain because the individual may have had a change in condition (improving or declining) so previous services do not matter.

Q: What is an example of other accredited agency – Type 16?

A: CHAPS – Community Health Accreditation Program. Joint Commission Accreditation. ACHC Accreditation Commission for Health Care

The State of Ohio is an Equal Opportunity Employer and Provider of Services

The next questions are from the MSS – IO Waiver Nursing Webinar on 6/9/16

Q: Am I correct in saying that if this process is not followed, state plan will not be paid for? A provider will no longer be able to bill state plan unless this process is followed?

A: The authorization process must be followed. Although state plan services can be billed, if the services are not authorized on the Individual Support Plan, then the home care agency will be viewed as providing services without authorization which could result in an audited situation and potentially be responsible for repayment of services.

Q: What happens in the 30 days we are waiting for the nursing assessment to be approved? Do the services need to wait to start until this is approved?

A: The redetermination can be completed up to 90 days prior to the beginning of the new waiver span. There should not be an issue with review/approval in an appropriate time frame prior to the waiver span. If, for some reason, a review is delayed...the county board can contact DODD via EM to the TDDInbox@dodd.ohio.gov and request that the CPT/Nursing Task Assessment form be reviewed in a more expedited fashion.

Q: What about for kids?

A: The process for performing the home visit with individual/parents/family/paid care providers, completion of the Nursing Task Assessment form and CPT (annual budget) will be completed the same as for an adult.

Q: Can we enter Nursing services into the calendar and unscheduled for the same time span?

A: Yes

Q: Why don't you just get the engineers to design an upload docs area just like for Prior Authorizations?

A: At this point in time, this is planned as a future enhancement to the Medicaid Services System (MSS) application.

Q: If a Home Health agency (Medicare) is also DODD certified, what would we put them under in CPT?

A: You would associate a provider who is both a DODD certified provider and a Medicare certified home health care Agency under the Waiver Provider tab under the Manage Provider portion of Cost Projection Tool (CPT) in the Medicaid Services System (MSS) application.

Q: Can waiver Nursing be provided during non-medical transportation?

A: The place of service in the community cannot include the residence or business location of the provider of PDN. Waiver nursing – is allowable if there are nursing tasks to be performed during transport and documented accordingly. Nursing services cannot be authorized for the purposes of supervision only.

Q: If we currently have someone on an IO waiver who is getting State Plan Nursing services; do we need to add this into the CPT/MSS system after July 1 to go through the DODD process? Or do we continue to do the same procedure with the provider as we are doing now for the services provided through State Plan?

A: We hope to soon have all individuals receiving state plan services to have the services included on the CPT. Currently, the only ones *required* to be incorporated are those enrolled in the I/O Waiver (the TDD to I/O transitions + those already enrolled in I/O). Level I does not have to be incorporated now, but the day will soon come when the CPTs will include all services. Please remember to include the services on your ISP, even if not on the CPT.

Q: You stated the finalizations are separate, but are the Nursing authorizations CPT version specific and how does it impact ongoing separate HPC/ADS/NMT authorization CPT versions?

A: Finalizations for Nursing services are separate from the finalization of HPC/ADS/NMT costs. Finalization of nursing services create their own version separate from the versions created when HPC/ADS/NMT are finalized. Just like versioning for HPC/ADS/NMT, a Nursing services version contains only those details present at the time of finalization. So when nursing services are finalized, that version only contains those nursing details present at the time of finalization. There is no impact of nursing authorizations on ongoing HPC/ADS/NMT authorizations/CPT Versions.

Q: Can you repeat how many hours an individual can get in one day; all service hours combined?

A: State Plan Home Health: each visit must be less than, or equal to, 4 hours in duration, Total number of hours of service (nursing + aide) for an adult (21 years or older) cannot exceed 14 hours/week – unless specifically reviewed and approved per Permedion. State plan includes PT/OT/ST but these hours are not included in the 14 total hours/week – that limitation is for nursing + aide services only. You cannot have back to back services of the same scope unless you have a 2-hour break from the end of one visit to the beginning of the next. Same scope of service means (a) nurse visit followed by another nurse visit, or (b) aide visit followed by another aide visit.

State Plan Private Duty Nursing – must be a continual nursing visit. The shift must be longer than 4 hours in duration but should not exceed 12 hours for any singular provider of PDN services. In other words, Nurse A should not be assigned to work from 8 AM - 10 PM – except in an unforeseen, or unexpected, event.

Q: For individuals who just have state plan services, when do we begin entering these services; now or at the beginning of their span?

A: For those in I/O Waiver, you should add them as you complete an annual redetermination OR if you are requesting a budget adjustment...then all services should be added to the CPT.

Q: Is the Nursing budget then limited by the amount of hours, not dollars? More hours move it to PDN from waiver but is there an actual limit?

A: Funding is authorized for each provider type (PDN/Waiver) based upon the number of hours projected to be needed by the individual. If a provider delivers more service than authorized, claims may be rejected.

Q: Does this include being able to see state plan services/claims in data warehouse for those who aren't receiving IO waiver Nursing?

A: Yes, the Data Warehouse will be able to track state plan service costs for all individuals enrolled in DD waivers.

Q: When changing someone from TDD to IO we cannot enter them into the site until they transfer. How do we submit CPT without the ability to use active site?

A: MSS was updated six (6) month ago, to allow for the association of an individual with a waiver type of TDD. MSS simply "ignores" the TDD waiver type, and the user is able to assign a non-waiver span to the individual in order to enter service details into the Cost Projection Tool (CPT) portion of the MSS application. The user will still be unable to finalize nursing service costs until the individual's waiver status is updated to enrolled in the Waiver Management System (WMS) application.

Q: We have SSAs who have not accessed the TDDInbox before. IO waiver Nursing assessment and requests to look at change will only go through the TDDInbox?

A: Anyone can send EM communications, including the EM with the attached Nursing Task Assessment for to TDDInbox@DODD.Ohio.gov

Q: Waiver Nursing budget requests – the CPT must be finalized not authorized, is that correct?

A: Correct. The county board will 'Finalize' the CPT and DODD, following its review, will 'Authorize'

Q: PDN referrals for individuals on an IO waiver, but not transferring from TDD will still go to JFS; correct?

A: Yes. Any individual enrolled in a DD Waiver (not transitioning from the TDD Waiver) will continue the same process for requesting the initial and ongoing ODM assessments for PDN authorization using the PDN Authorization Request Form.

Q: What is the process for existing waiver recipients to be authorized waiver Nursing after 7/1/16?

A: Any individual enrolled in a DD Waiver (not transitioning from the TDD Waiver) will continue the same process for requesting the initial and ongoing ODM assessments for PDN authorization using the PDN Authorization Request Form. If waiver nursing is required for anyone enrolled in the I/O Waiver (only – no waiver nursing is allowed at this time in any other waiver save the I/O waiver), then the nursing task assessment form will be completed, the CPT will be completed and finalized, and then the Nursing Task Assessment form will be attached to an EM and sent to the TDDInbox@dodd.ohio.gov

Q: If there are more than one independent provider LPN providing services to a person (PDN); will we authorize services to the best of our knowledge as far as which IP Nurse will provide which hours but if they need to switch shifts, will this be allowed without having to change CPT; as long as same service, same provider type?

A: Any change in allocation of hours from one provider to another should be documented as a revision to the ISP for audit purposes.

Q: For other waivers we frequently use state plan services for medication administration because that saves funds for waiver. We would have to pay staff versus state plan for medication administration?

A: If you have an HPC in the home providing personal care services and the medication administration could be met through certification...then that is the method that should be used. If the need cannot be met, then state plan is then, of course, a potential alternative.

Q: If using an agency for Nursing; will we set up services/costs as if an RN is providing services so that funding is available if they will switch out using either RN or LPN?

A: Yes.

Q: We are to enter all state plan services for someone even if they do not receive waiver Nursing services at all? If so, do we enter them for the first time at their redetermination or 7/1/16?

A: It depends. We hope to soon have all individuals receiving state plan services to have the services included on the CPT. Currently, the only ones *required* to be incorporated are those enrolled in the I/O Waiver (the TDD to I/O transitions + those already enrolled in I/O).

Q: How do we check to ensure that a state plan provider is a Medicare certified agency or where do we find information for the area that offers this service?

A: You can always ask the agency. Soon the provider type will be included into PCW, but if you cannot get the information any other way...you can send an EM to the TDDInbox and request this information, DODD will attempt to help you get the provider type.

Q: How quickly should we expect a typical authorization or denial from the department once we finalize in MSS? (Assuming that we have the Nursing task assessment form submitted properly.)

A: We are allowed up to 30 days; however, we are hoping to have all requests reviewed and returned within a 7-10-day timeframe. If you are running short on waiver span time, you can send an EM to the TDD Inbox and request an expedited review and DODD will try to get reviewed and determination made as quickly as possible.

Q: Can we have a Health Check example?

A: An individual, under the age of 21, requires skilled nursing to complete a task that is not able to be delegated. The SN is ordered to have 3 visits/day, with each visit lasting 2 hours. This program allows the individual to have 42 hours of nursing care without authorization required from ODM or its contracted reviewing provider (Permedion). The care can only be provided by a Medicare certified agency and cannot be provided for Respite.

Q: Do we also complete the Nursing task assessment form for state plan services as well; or are we just doing the MSS system for state plan Nursing and the state plan home health agency will continue to do their assessment as they are doing now?

A: The Nursing Task Assessment Form must be completed for those individuals transitioning from TDD to I/O who will be receiving Waiver Nursing and/or State Plan Private Duty Nursing. It will also be required if the individual is receiving State Plan Home Health services IF the individual is also receiving Waiver Nursing and/or State Plan Private Duty Nursing

Q: Please explain how authorizations are added to MITS and eMBS. Will there be monthly dollar caps? Will specific providers be listed?

A: Nursing services (e.g. IO Waiver Nursing) will not be added to eMBS. Costs for IO Waiver Nursing services will be entered in CRM by DODD. There will still be a monthly dollar cap. No, specific provider(s) will not be listed in MITS. The individual's service plan will identify/serve as authorization for each provider.

Q: Five bed+ licensed homes receive local Nursing for delegated Nursing in some cases. Are these services eligible for waiver Nursing? (2 hours per month, some get 4 others may get 6 hours)

A: Anyone enrolled in an I/O Waiver, who has a need for nursing care, is eligible for waiver nursing services; however, the medical need will have to be established and the SSA will need to describe why the needs cannot be met through medication certification/delegation/state plan service(s). If medical need – waiver nursing can be authorized.

Q: Will authorization for waiver services show up in PAWS after approved or only MITS; and will our notification be the email?

A: Waiver nursing is only billed through MITS so there is nothing associated with PAWS. Funding levels will be set by DODD through Ohio Benefits. The person submitting the CPT will be sent an EM with the disposition of the CPT – Approves/Denied/Incomplete.

Q: Can state plan HHS or PDN be provided in a 24 hour IO congregate setting?

A: Generally speaking, 24-hour care is not authorized, but...there may be an individualized situation in which it may be approved so...I will just say that every case is reviewed individually and decided on a case-by-case basis.

Q: When we had the TDD waiver we had to carve out one waiver service per month for those with PDN services and other state plan services such as therapies. Will we still do that and indicate in MSS the one waiver Nursing service per month?

A: Every waiver enrollee must have at least one waiver service/month to maintain their waiver status. If the only services the individual is receiving is the nursing service, then 'yes' at least 1 visit/month should be assigned to waiver. Your CPT will allow you to assign 1 visit/month either in Scheduled or Unscheduled calendar.

Q: If there are questions regarding the Nursing task assessment, will the reviewer ask the SSA questions or will it just be denied?

A: It can happen either way. Initially, the reviewers are calling county boards and trying to get issues worked out. As we all become more proficient, there will be, probably, less talking and more EM communication – in order to keep disruptions to the county board/SSAs to a minimum.

Q: Is this for all waiver Nursing? Not just TDD?

A: Anyone enrolled in the IO Waiver is eligible to receive IO nursing, based upon assessed needs.

Q: Will a prior authorization still be available for individuals receiving waiver Nursing and HPCS/ATN services?

A: Prior Authorization, in the sense that the individual has a funding range determined by the Ohio Developmental Disability profile, does not apply to IO Waiver Nursing. Prior Authorization will still apply to the individual's HPC, Transportation, Home Modifications, Adaptive & Assistive Equipment, etc. budget. If the county board determines that an individual currently receiving IO Waiver Nursing requires a greater amount of service, the county board will need to submit a new Nursing Assessment along with an updated CPT for review and approval of those additional IO Waiver nursing costs.

Q: Will CPT ever be directly linked to MITS?

A: No.

Q: Can we use an “unknown” provider in CPT for state plan/PDN services?

A: No, that is not an option in the CPT.

Q: Individuals exiting an ICF or NF and in need of Nursing services; we cannot do an enrollment until after they move, so we can’t do the CPT until after they are in the new home; what about those cases?

A: For individuals currently living in an ICF or NF, the user can associate the individual with a Cost Projection Tool (CPT). The user is then able to assign a non-waiver span to the individual in order to enter service details into the (CPT) portion of the MSS application. The user will still be unable to finalize nursing service costs until the individual’s waiver status is updated to enrolled in the Waiver Management System (WMS) application.

Q: Is waiver in Nursing cost projection being deducted from waiver cost projection and in SPA?

A: IO Waiver Nursing costs are not subject to an individual’s Ohio Developmental Disabilities Profile (ODDP) funding range and are not included in the individual’s costs that are captured in the ODDP line in the Manage Cost Projection portion of Medicaid Services System (MSS) application.

Q: Are waiver Nursing services included in the cost of the DDP funding range?

A: No

Q: Can you share Nursing services?

A: Yes. A nurse can provide care up to 3 people, if appropriate in meeting the needs of the individuals.

Q: If there is a budget adjustment, how long to review? (No assessment needed, just change in provider type)

A: If the county board has a need for the review to be done ASAP, then EMERGENCY needs to be written in the subject line of the EM sent to the TDD Inbox. Otherwise...it will be put into order based upon the date received. The oldest will be at the top of the list and the newer ones submitted will be at the bottom.

Q: Where do we put providers who are waiver and Medicare agencies?

A: You would associate a provider who is both a DODD certified provider and a Medicare certified home health care Agency under the Waiver Provider tab under the Manage Provider portion of Cost Projection Tool (CPT) in the Medicaid Services System (MSS) application.

Q: Is there any other way to verify that an agency is Medicare certified vs other accredited?

A: You can ask the agency itself...or the provider types will be entered into PAWS. Be careful that you are selecting the correct agency that will actually be providing the care to your individual because a Medicare-certified agency in one location may not be a Medicare-certified agency in another. Same name of the company...but different provider type.

Q: If we enter a waiver agency in state plan by mistake will there be an error message?

A: After you select the provider, the application will restrict what services you can assign to that provider based either on their certification (providers associated under the waiver provider tab), or based on what provider designation the you assigned to that provider (i.e. Agency 60=Medicare certified, Agency 16=Other Accredited, etc. for providers associated under the state plan provider tab).

Q: Can we finalize the CPT prior to the Nursing services being reviewed by DODD?

A: You can finalize the costs of both waiver services (e.g. homemaker/personal care, non-medical transportation, adult day supports) as well as nursing services (e.g. state plan nursing, Private Duty Nursing, and IO Waiver Nursing) prior to being reviewed by DODD. Only waiver services (e.g. homemaker/person care, non-medical transportation, adult day services) can be authorized by the county board in the Service Payment Authorization (SPA) portion of the Medicaid Services System (MSS).

Q: What if a state plan agency claims they have more than one certification; such as 16, 45, etc.?

A: An agency can only have one provider type for a particular service. What you might be referring to is the same 'company' name having Medicare-certified offices in one area but 'other accredited' offices in another area of the state. Be careful that you are selecting the correct agency that will actually be providing the care to your individual. Same name of the company...but different provider type.

Q: Do state plan providers still receive the nursing reimbursement, if so where is that entered?

A: State Plan is paid based upon the requirements and restrictions of the provider type, procedure code, and service hours. Funding levels are not set by DODD.

Q: If the individual with Nursing needs attends a day program, how can Nursing be authorized?

A: Waiver nursing services shall not be provided to an individual during the same time the individual is receiving adult day support.

Q: Where do we send the email for the referral form?

A: TDDInbox@dodd.ohio.gov

Q: State plan authorizations will not go on a PAWS, correct? Does this mean that IO waiver Nursing services will also not be on PAWS?

A: Yes

Q: When do we start entering state plan supports into the MSS?

A: Nursing services may be reflected in MSS up to 90 days in advance of either someone enrolling in IO or in advance of the annual redetermination.

Q: Where will we find the Nursing assessment form?

A: The link is provided for you here.

<https://drive.google.com/file/d/0B5uAy0zzkGgoWVhsaEFBOFVCNIU/view?pref=2&pli=1>