



Authorized Nurse Visits – (Agency Model) (RN) 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) under the direction of a RN or physician, in a private home. RN visits shall also include assessment of the participant's health and adequacy of the care plan to meet the participant's needs. **All** RN visit tasks are provided to persons with stable, chronic conditions, and are NOT intended as a treatment for an acute health care condition as normally provided through home health services. Authorization of RN services is funded through the Medicaid State Plan.

- ◆ Authorization of RN does not meet the requirement for an individual to be eligible for Home and Community Based (HCB) Medicaid.
- ◆ All RN participants must meet the following eligibility criteria:
 - At least 18 years of age;
 - In active Medicaid status (see [Policy 2.00](#));
 - Participants who are eligible for Medicaid on a spenddown basis may be authorized to receive RN services 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 RN.
 - Participants in a 'Transfer of Property penalty' may be authorized for RN.
 - Have an appropriate Medicaid Eligibility (ME) code (see Chapter 2 [Appendix 3](#));
 - Meet nursing facility level of care; and
 - Must be receiving other Personal Care Services (Agency Model) (PC) or Personal Care Assistance Consumer-Directed Model (CDS).
- ◆ RN services shall be authorized by the visit. No minimum or maximum time is required to constitute a visit.
- ◆ RN services shall be included in the overall cost of care (see [Appendix 2](#)) for the participant with the following exceptions:

NOTE: When a person centered care plan includes Adult Day Care authorized through the Aged and Disabled Waiver or the Adult Day Care Waiver, the total cost of care **cannot** exceed 100% of the cost cap.

- ◆ The cost of RN visits are not included in the 60% of the average statewide monthly cost for care in a nursing facility restriction for basic personal care.
- ◆ When the care plan includes an authorization for RN services, the cost of one RN visit shall be excluded from the calculation of a care plan's cost.
- ◆ For participants who receive RN visits for GHE only, the cost of two RN visits shall be excluded from the calculation of a care plan's cost.
- ◆ RN visits authorized together with other Medicaid State Plan HCBS [i.e. Personal Care Assistance Consumer-Directed Model (CDS), and Advanced Personal Care (APC)] **and** Aged and Disabled Waiver Services (ADW) shall not exceed 100% of the average statewide monthly cost for care in a nursing facility, without prior approval of the Bureau of Long Term Services and Supports (BLTSS).
 - When the combination of State Plan and ADW services (excluding Adult Day Care) exceed the 100% cost maximum:
 - The appropriate supervisor for the Division of Senior and Disability Services (DSDS) staff shall review all person centered care plan 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 the BLTSS for consideration and approval prior to authorization over 100% of the cost cap.
 - Pending the approval from BLTSS, to exceed the cost cap, RN 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 Aged and Disabled Waiver or the Adult Day Care Waiver, the total cost of care **cannot** exceed 100% of the cost cap.

- ◆ RN services are provided by Home and Community Based Services (HCBS) providers that are enrolled as a Personal Care-Agency Model provider with the Department of Social Services (DSS), Missouri Medicaid Audit and Compliance Unit (MMAC). Payment is made to the HCBS provider on behalf of the participant.
- ◆ The individual providing the service 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 (step-child); spouse; grandparent or grandchild.
- ◆ Restrictions:
 - A **MAXIMUM** of 26 RN visits shall be provided in a six-month authorization period.
 - Authorized RN visits shall **NOT** include services which would be reimbursable as skilled nursing care under the home health program **or** when the visit is to determine whether or not 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. Staff shall refer to the Service Coordination Policy for guidance on coordination of services for participants authorized for DMH services (See [Policy 4.35.](#))
- ◆ All participants who are authorized for PC and Advanced Personal Care (Agency Model) (APC) shall receive a **minimum** of two (2) RN visits annually (required by section 192.2475.1, RSMo). These nurse visits are to be authorized in the 4th and 10th months following the (re)assessment (see General Health Evaluation Chart below). These semi-annual RN visits, during which a General Health Evaluation and Level of Care Recommendation is completed, are necessary for the provision of enhanced supervision of the individual providing the services to ensure quality of care, assessment of the participant’s health, and assessment of the adequacy of the participant’s care plan to meet the participant’s needs.
 - Excluded from this requirement for semi-annual RN 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**; and

NOTE: Participants with a documented need for regular RN visits as described below *shall not* be authorized for separate semi-annual RN visits. DSOS 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 a part of a regularly scheduled visit during the 4th and 10th months following the (re)assessment. This directive shall be documented in the HCBS Web Tool Service Delivery Comment on the Prior Authorization Line Item Screen.

- ◆ For RN visit tasks, excluding the required semi-annual GHE visits, DSOS or its designee must establish and document that there is no other person 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; or
 - Resident of RCF or ALF requires services beyond what is normally included in the monthly room and board reimbursement to the facility (see [Policy 3.20](#)).
- ◆ RN visits may include, in addition to increased supervision of the HCBS provider employee and assessment of the participant’s health and the adequacy of the care plan, other tasks. Such tasks are as follows:

- 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 and an 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.
Documentation must be sufficient to establish the participant is at risk of skin breakdown including, but not limited to:
 - 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; or
 - History of decubitus ulcers, poor circulation evidenced by edema or discolored extremities, and diabetes.
 - 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; or
 - Diagnosed with a compromised immune system (.e.g. HIV and chemotherapy patients).
- NOTE:** Documentation shall be sufficient to establish the participant has a medical condition such as diabetes AND is unable to perform this task.
- Evaluate Advanced Personal Care Plan
 - All APC participants shall be authorized for a RN visit on a monthly basis to evaluate the adequacy of the authorized services to meet the needs and conditions of the participant. During the visit, the nurse assesses the APC aide's ability to carry out the authorized services.
 - Train APC Aide

- This task is to be completed 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, or when requested by the provider (such as when aides change) in order to provide on-the-job training of the APC aide.
 - ‘Train APC’ shall not be selected as a task for participants authorized for **weekly** RN visits. In these circumstances, the Task Detail Line Item shall identify only the tasks needed on a regular basis, and train APC shall be documented in the Service Delivery Comments section. The task should be performed by the nurse during the regular RN visit as needed.
 - ‘Train APC’ shall be selected as a task for participants authorized for less than weekly RN visits. An additional RN visit shall be authorized through the first **full** month of the authorization for on-the-job training of the APC aide.
 - In the example below the RN Visit for APC reflects two (2) units through the first full month of the authorization (12-7-16 through 1-31-17) to provide training and evaluation of the APC aide. In order for the Prior Authorization line to populate ‘#Units/Month’ with ‘2’, enter ‘2’ in the ‘# of Days/Month’ field in the Task Detail Line on the Prior Authorization Line Item screen for a selected nurse task. The authorization from 2-1-17 through 11-30-17 reflects only one (1) RN visits for the remainder of the authorization period for the ongoing evaluation of the APC services. The months for GHE are reflected in the Service Delivery Comment.

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

Line #	Service Type	Funding Code	Effective Date	EndDate	Provider	Total Units/Month	Status	PA #
1	Authorized Nurse Visit (per visit)	MD	02/01/2017	11/30/2017	A M Healthcare Enterprises, Ltd.	1	Posted	201634300
Line #	Task	# Min/Day	# Units/Day	# Days/Week	# Units/Month			
1	Eval APC Plan		1					
2	Authorized Nurse Visit (per visit)	MD	12/07/2016	01/31/2017	A M Healthcare Enterprises, Ltd.	2	Posted	201634300
Line #	Task	# Min/Day	# Units/Day	# Days/Week	# Units/Month			
1	Eval APC Plan		1					
2	Train APC		1					

- General Health Evaluation (GHE)
 - “General Health Evaluation” (for purposes of the semi-annual nurse visits) shall be selected as a task for HCBS participants when no other nursing need is identified. The GHE shall be authorized during the 4th and 10th months following the (re)assessment. The authorization for the semi-annual GHE visits shall be authorized on separate lines for the specific month.
 - ‘General Health Evaluation’ shall not be selected as a task when a participant has a need for other nursing tasks, the Task Detail Line Item shall identify only the tasks needed on a regular basis. The 4th and 10th months following the (re)assessment, during which the GHE is to be completed shall be documented in the Service Delivery Comment section of the Prior Authorization Line Item screen. The 4th and 10th month shall be determined using the following 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

- Other Nursing Care

- Participants may be authorized for RN 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 RN 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; and
 - Central line dressing/flush/blood draws.
- ◆ It is not necessary for DSDS or its designee to obtain copies of physician’s orders prior to the authorization of an RN visit or adding a task to an RN visit.

- ◆ Provider change:
 - A new provider shall only be authorized for any RN visit(s) remaining within that authorization period when a provider change has occurred within an existing authorization period.
- ◆ DSDS or its designee shall be aware of, 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 a provider nurse visit will be communicated immediately to DSDS or its designee via telephone or fax as required by the Code of State Regulation(s). This notification may require an immediate care plan change; and

Providers should upload written documentation to the participant’s electronic file in HCBS Web Tool and include notes in the HCBS Web Tool case notes.