5123-9-27 **Home and community-based services waivers - health care assessment under the individual options, level one, and self-empowered life funding waivers.**

(A) Purpose

This rule defines health care assessment and sets forth provider qualifications, requirements for service delivery and documentation of services, and payment standards for the service. Health care assessment is intended to provide right-on-time health assessment to determine the best clinical course of action, often avoiding unnecessary emergency room visits and decreasing the need for inpatient admissions; health care assessment is not intended to replace services provided by an individual's primary care physician.

(B) Definitions

For the purposes of this rule, the following definitions apply:

(1) "Advanced practice nurse" has the same meaning as in section 4723.01 of the Revised Code.

(2) "Agency provider" means an entity that directly employs at least one person in addition to a director of operations for the purpose of providing services for which the entity is certified in accordance with rule 5123-2-08 of the Administrative Code.

(3) "Department" means the Ohio department of developmental disabilities.

(4) "Health care assessment" means using technology to facilitate real-time consultation and support provided by a physician, a physician assistant, or an advanced practice nurse to assist an individual and/or the individual's authorized caregivers to understand the individual's presenting health symptoms and identify appropriate next steps. Health care assessment:

(a) Is consultative in nature, reflects the presentations and treatments unique to individuals with developmental disabilities, and provides disability-specific guidance on when best to seek additional or in-person medical treatment.

(b) Includes support and consultation, which is based on expertise in developmental disabilities, to an individual and/or the individual's paid and unpaid caregivers and seeks to empower the individual and build the capacity of caregivers to better understand the best approach for supporting the individual based on the individual's symptom presentation.

(c) Includes clinical transition of care, conducted immediately after conclusion of the consultation, from the provider of health care assessment to the receiving provider to help guide care and provider coordination, when the provider of health care assessment refers the individual to the emergency room, urgent care facility, or primary care physician.

(d) Includes follow-up and aftercare, as needed, via a follow-up consultation with the treated individual and/or the individual's caregiver, within eighteen hours after the initial consultation.

(e) Will not duplicate or replace other home and community-based services.

(f) Is limited to additional services not otherwise covered under the medicaid state plan (such as the "Early and Periodic Screening, Diagnostic, and Treatment Program" or in-person medical examinations as needed) but consistent with waiver objectives of avoiding institutionalization.

(g) Will not be used for routine, ongoing care, thus replacing an individual's primary care physician.

(5) "Individual" means a person with a developmental disability or for the purposes of giving, refusing to give, or withdrawing consent for services, the person's guardian in accordance with section 5126.043 of the Revised Code or other person authorized to give consent.

(6) "Individual service plan" means the written description of services, supports, and activities to be provided to an individual.

(7) "Physician" means a person authorized by Chapter 4731. of the Revised Code and rules adopted thereunder to practice medicine and surgery or osteopathic medicine and surgery.

(8) "Physician Assistant" means a person authorized by Chapter 4730. of the Revised Code and rules adopted thereunder to practice as a physician assistant.

(9) "Plan of care" means the medical treatment plan that is established, approved, and signed by the treating physician, physician assistant, or advanced practice nurse.

(10) "Service documentation" means all records and information on one or more documents, including documents that may be created or maintained in electronic software programs, created and maintained contemporaneously with the delivery of services, and kept in a manner as to fully disclose the nature and

extent of services delivered that includes the items delineated in paragraph (E) of this rule to validate payment for medicaid services.

(C) Provider qualifications

(1) Health care assessment will be provided only by an agency provider that meets the requirements of this rule and that has a medicaid provider agreement with the Ohio department of medicaid.

(2) An applicant seeking approval to provide health care assessment will complete and submit an application and adhere to the requirements of rule 5123-2-08 of the Administrative Code except that paragraphs (G)(3), (G)(4), (G)(7), (J)(2), (J)(3), (K), (M), and (R) of that rule do not apply to providers of health care assessment. The application will include documented evidence of:

(a) The applicant's demonstration of at least four years of experience providing medical care to individuals with developmental disabilities as well as capability to address, and as necessary triage, medical needs of individuals with developmental disabilities.

(b) The applicant's achievement of positive outcomes for individuals with developmental disabilities served (e.g., reducing emergency room visits or individual/caregiver satisfaction with services provided).

(3) At the point of application for certification and upon request by the department, a provider of health care assessment will provide a certificate of a continuing policy of professional liability insurance in an amount of at least one million dollars.

(4) A provider of health care assessment will ensure the person providing health care assessment is a physician, a physician assistant, or an advanced practice nurse who:

(a) Is properly credentialed and in good standing in accordance with Ohio law or laws of other states that govern the person's practice.

(b) Has successfully completed, prior to delivering health care assessment, twenty-five hours of training specifically related to serving individuals with developmental disabilities.

(5) Failure of a provider of health care assessment to comply with this rule and rule 5123-2-08 of the Administrative Code may result in denial, suspension, or revocation of the provider's certification.

(D) Requirements for service delivery

(1) Health care assessment will be provided pursuant to an individual service plan that conforms to the requirements of rule 5123-4-02 of the Administrative Code.

(2) To receive health care assessment, an individual will:

(a) Be determined by the individual's team to have a need for health care assessment and subscribed with a certified provider of the service.

(b) Have access to a mobile smart device or webcam that has internet service and is capable of two-way audio and video interactions.

(c) Be able to operate the mobile smart device or webcam or be accompanied by a paid or unpaid caregiver who is able to operate the mobile smart device or webcam.

(3) A provider of health care assessment will:

(a) Be available to provide the service twenty-four hours a day, three hundred sixty-five days per year.

(b) Have capacity to participate in two-way audio and video interactions with individuals and caregivers and provide immediate evaluations, video-assisted examinations, and development of plans of care by professionals with extensive specialized expertise in supporting individuals with developmental disabilities.

(c) Ensure that persons providing health care assessment are located in a private location that guarantees the privacy of the individual being served.

(d) Ensure that communication with individuals and caregivers is secure and compliant with state and federal regulations governing health care assessment services, technology, and privacy, including the Health Insurance Portability and Accountability Act.

(e) Follow-up on each call that involves an individual being attended by a physician, physician assistant, or advanced practice nurse by contacting the individual and persons authorized by the individual within eighteen hours of the initial call.

(f) Follow-up on each call that involves an individual being referred to an emergency room, urgent care facility, or primary care physician, by

contacting the emergency room, urgent care facility, or primary care physician to coordinate care and ensure advance preparation.

(4) Health care assessment requires face-to-face evaluation by a treating physician, physician assistant, or advanced practice nurse who is directly engaged with the individual (and not merely engaged to authorize health care).

(5) Health care assessment will be provided on a one-to-one basis.

(E) Documentation of services

(1) Service documentation for health care assessment will include each of the following to validate payment for medicaid services:

(a) Type of service.

(b) Name of individual receiving service.

(c) Medicaid identification number of individual receiving service.

(d) Name of provider.

(e) Provider identifier/contract number.

(f) Calendar month and year during which individual is subscribed.

(g) A documentation sheet for each calendar month during which an individual is subscribed that includes the date, time, and description of consultation and support provided to the individual and/or the individual's caregiver or indicates no consultation or support were provided during the month. The documentation sheet will include written or electronic signature of the person delivering the service or initials of the person delivering the service if signatures and corresponding initials are on file with the provider.

(2) Providers of health care assessment will collect and submit service utilization data by county to the department on a monthly basis in the format prescribed by the department, including but not limited to:

(a) Dates and times consultation and support were provided to an individual or an individual's caregiver.

(b) Reasons individuals and/or their caregivers used the service.

(c) Service outcomes.

(3) Within forty-eight hours of providing support and consultation to an individual or an individual's caregiver, a provider of health care assessment will:

(a) Make available to the individual and persons authorized by the individual, formal documentation of the encounter and, when appropriate, written instructions regarding actions the individual and/or caregiver should take post-consultation.

(b) Send via secure fax or other means, documentation of the encounter to the individual's primary care physician as a means to coordinate care.

(F) Payment standards

(1) The billing unit, service codes, and payment rate for health care assessment are contained in the appendix to this rule.

(2) Health care assessment will be provided as a subscription service billed on a calendar month basis.

(3) Health care assessment may be billed for an individual who is available for services at least one day in the calendar month.

(4) Health care assessment will not be billed for an individual who is receiving services in a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.

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