



Nursing Visit Definition

Cross-references: Medicare Conditions of Participation
Skilled and Maintenance nursing definition training

Purpose

To define nursing visits and differentiate between skilled and maintenance nursing visits in compliance with State/Federal guidelines. To offer the agency staff, physicians, and community guidelines for appropriate utilization of skilled and maintenance care services provided by the agency.

Policy

Agency will provide nursing service delineation in order to provide an improved understanding of services provided by the agency. All nursing services are provided by appropriately trained registered or licensed staff.

Procedure

1. **Skilled Nursing Services** will be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) under the supervision of an RN and in accordance with a medically approved Plan of Care (physician's orders) signed by a doctor of medicine, osteopathy, or podiatric medicine legally authorized to practice medicine.

Skilled Nursing Services can include, but are not limited to:

- a) Observation and assessment
- b) Management and evaluation of Care Plan
- c) Teaching and training activities.
- d) Skilled procedures may include, but are not limited to:
 - Injections
 - Insertion and irrigation of urinary catheters
 - New ostomy care and teaching
 - Dressings to wounds involving prescription medications and aseptic technique
 - Therapeutic activities
 - Veni-puncture

NOTE: Skilled services are defined using the Medicare Model.

2. **Maintenance Nursing Services** are provided to clients who do not meet the requirements of a skilled client. Generally, their level of service includes the following:
 - Medication Setup
 - Pre-filling syringes
 - Monitoring chronic conditions or routine monitoring of stable client.
 - Performing treatment/procedures that are not considered skilled (Example: simple dressing changes, blood glucose monitoring, etc.)
 - Simple observation to determine level of care necessary.

Resources:

Minnesota HomeCare Association's (MHCA) Skilled Visit definition
Medicare Conditions of Participation (COPs)

Skilled and Maintenance Nursing Visit Training Module

Definitions

Disease/Disability Care: is offered during acute, rehabilitation, chronic, unstable or stabilizing, or terminal stages of illness or injury. The patient's condition results in frequent hospitalization and/or requires frequent communication with physician resulting in a change in plan of care. A plan of care established by the nurse, patient and family in accordance with the physician's medical treatment plan. This adjustment, to seek out and utilize other resources, to establish altered patterns of family living, exercise, diet, work, recreation and to perform technical nursing procedures. Goal is to improve the health status, through healing, rehabilitation, or to assess terminal condition. The services required in the disease/disability care level are considered skilled in nature due to services required and patient's condition. The RN or other health professional; P.T., O.T., or S.T. will make an on site to the client's home to provide HHA supervision either directly or indirectly no less frequently than every 2 weeks when patient is receiving disease/ disability care. Usually requires more than one nursing visit each month for observation, assessment, teaching or treatments.

Maintenance Care: is offered to patients whose health is chronic disease or disabilities, stable, require less frequent hospitalization and/or less frequent communication with the physician and is need of supportive services. The plan of care remains unchanged. The goal of this service is to maintain a patient's current condition by coordinating community resources and to keep patient in community setting, with a plan of care that remains stable. Usually does not require more than one nursing visit each month for monitoring condition and management of supportive services being provided. The services provided in maintenance care level are considered unskilled or maintenance based on services requiring and patient's condition.

Indefinite duration of services can be provided as long as maintenance care meets the needs of the client. If the client's condition changes or becomes unstable, client will be placed under "disease/disability care" as defined above. Patients receiving maintenance level service and have home health aide as part of the plan of treatment will have an RN make home visit to patient to provide direct supervision of home health aide service at least every 60 days.

Skilled Nursing Visits

A. General Principles

- ❑ Must be provided by a registered nurse, or a licensed practical nurse under supervision of a registered nurse, to be safe and effective. Consider both the complexity of service and the overall condition of the patient.
 1. Services must be reasonable and necessary (physician has determined the services ordered are reasonable and necessary).
 2. The reasonable and necessary determination of whether a patient needs skilled nursing care should be based upon the patient's unique condition and individuals needs, without regard to whether the illness or injury is acute,

chronic, terminal or expected to extend over a long period of time. In addition, skilled care may, dependent upon the unique condition of the patient, continue to be necessary for patients whose condition is stable.

- ❑ For further specific details of skilled nursing refer to Home Health Manual, CMS Publication 11, Chapter II - Coverage of Home Health Services in section 205 and 206.
- ❑ The primary nurse is responsible for providing care coordination of services for patient's assigned to caseload.

B. Skilled nursing may include but not limited to the following areas:

1. ***Observation and assessment:***

- ❑ Observation and assessment of the patient's medical condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures.
- ❑ The skilled observation services are covered for three weeks or as long as there remains a reasonable potential for such complications of further acute episode.
- ❑ Observation and assessment by a nurse is not reasonable and necessary to the treatment of illness or injury where such indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

2. ***Management and Evaluation of Care Plan:***

- ❑ Skilled nursing visits for management and evaluation of the patient's plan of care are reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure the essential non-skilled care is achieving its purpose.
- ❑ To be reasonable and necessary, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of licensed nurse to promote the patient's recovery and medical safety in view of the patient's overall condition.

3. ***Teaching and Training Activities:***

- ❑ Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family or caregivers how to manage his/her treatment regimen would constitute skilled nursing services.
- ❑ Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered.
- ❑ Determination regarding whether or not a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered.
- ❑ Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

- ❑ Where it becomes apparent after a reasonable period of time that the patient, family or caregiver will not or is not able to be trained, further teaching and training would cease to be reasonable and necessary.
- ❑ In determining the reasonable and necessary number of teaching and training visits, consider whether the teaching and training provided constitute a reinforcement of teaching provided previously in an institutional setting or in the home or whether it represents the initial instruction. In general, Medicare will not consider home visits reasonable and necessary if the teaching was provided in an institutional setting and the patient comprehended the teaching.
- ❑ There is no requirement that the patient, family or other caregiver be taught to provide a service if they cannot or choose not to provide the care.
- ❑ Teaching and training activities that require the skills of a licensed nurse include, but are not limited to, the following:
 - a. Teaching the self-administration of injectable medications or a complex range of medications
 - b. A newly-diagnosed diabetic or caregiver all aspects of diabetes management, including how to prepare and administer insulin injections, prepare and follow a diabetic diet, observe foot-care precautions, and observe for and understand signs of hyperglycemia and hypoglycemia
 - c. Self-administration of medical gases
 - d. Wound care where the complexity of the wound, the overall condition of the patient, or the ability of the caregiver makes teaching necessary
 - e. Care for a recent ostomy or where reinforcement of ostomy care is needed
 - f. Self-catheterization
 - g. Self-administration of gastrostomy or enteral feedings
 - h. Care for and maintenance of peripheral and central venous lines and administration of intravenous medications through such lines
 - i. Bowel or bladder training when bowel or bladder dysfunction exists
 - j. How to perform the activities of daily living when the patient or caregiver must use special techniques and adaptive devices due to a loss of function
 - k. Transfer techniques, e.g., from bed to chair, that are needed for safe transfer
 - l. Proper body alignment and positioning, and turning techniques of a bed-bound patient
 - m. Ambulation with prescribed assistive devices (such as crutches, walker, cane, etc.) that are needed due to a recent functional loss
 - n. Prosthesis care and gait training
 - o. The use and care of braces, splints and orthotics, and associated skin care
 - p. The proper care and application of any specialized dressings or skin treatments (for example, dressings or treatments needed by patients with severe or widespread fungal infections, active and severe psoriasis or eczema, or due to skin deterioration from radiation)

treatments)

- q. The preparation and maintenance of a therapeutic diet
- r. Proper administration of oral medications, including signs of side-effects and avoidance of interaction with other medications and food.

4. Direct Service/Skilled Procedures

- Examples of direct care or skilled procedure may include but not limited to injections, insertion of urinary and irrigation of catheters, ostomy care, wound care, tube feedings, nasopharyngeal and tracheostomy aspiration, rehabilitation nursing, venipuncture.
 - a. Wound Care for skilled nursing care to reasonable and necessary to treat a wound, the size, depth, nature of drainage (color, odor, consistency and quantity), condition and appearance of skin surrounding the wound must be documented in the clinical findings. Moreover, the plan of care must contain the specific instructions for treatment of the wound.
 - b. Venipuncture for the purpose of obtaining a blood sample can no longer be the sole reason for Medicare skilled nursing eligibility. If another skilled service (for example, wound care) determines the patient's eligibility for Medicare skilled care, venipuncture may be completed as a skilled nursing visit. Venipuncture must be reasonable and medically necessary based on physician order associated with specific symptoms or diagnosis or documentation as well as accepted standard of medical practice for continued monitoring of a diagnosis, medical problem or treatment regimen.

Level of Care Determination of Skilled Nursing and Maintenance Nursing

The level of nursing care is classified as skilled nursing or maintenance nursing based on the definition stated above. The level of care determination form has been developed to assist in the determination of level of care as defined above. Consider the following when determining the level of care (skilled nursing versus maintenance nursing):

1. What is the overall medical condition of the patient's unstable or stabilizing condition or stable? The unstable or stabilizing health would require skilled nurse intervention. The stable health condition requires maintenance nursing intervention.
2. What is the goal for patient care services? A goal to improve the patient's health status to a maximum functioning level requires skilled nursing intervention. Maintaining the level of health status would be maintenance level.
3. Determine the complexity of the service provided. Complex services such as intravenous therapy, intravenous and intramuscular injections, sterile insertion of catheters, and wound care requires skilled nursing intervention. In some cases, an alternate person (for example, a family member) may be willing and able to learn complex procedures. Nursing visits to teach that person how to perform the procedure and to have that person demonstrate competency would require skilled nursing intervention. However, once that person has been taught and demonstrates

competency, skilled nursing services would no longer be reasonable and necessary.

4. Plan of care should include orders for skilled nurse visits as defined above (disease/ disability nursing care) or for maintenance nursing visits as defined above (maintenance care).

OASIS Requirements

OASIS completion is required only for Medicare patients and for Skilled Medicaid patients. OASIS is not required for non-skilled (unskilled or maintenance) patients.

The table below, although not all-inclusive, provides examples of skilled and unskilled visits for Medicaid patients.

Service Provided	Unskilled	Skilled
Medication Set up	Patient/caregiver does.	When changes in the patient’s status warrant changes in meds and/or dosages until pt. stabilizes. Cannot be delegated to paraprofessional staff.
Protimes	Anticoagulant dose with no change 2 months	Anticoagulant dose adjusted one or more times in past two months; patient/caregiver unable to report complications
Diabetes	BS/ meds stable over 1-2 months. Pt/ caregiver is able to report complications to MD. Pt/ caregiver. Unable to fill own insulin syringes/perform test - can be delegated to trained unlicensed staff.	BS/meds changes over 1-2 months; Pt/ caregiver lack knowledge of how to perform test; lack knowledge of when to notify MD.
Foley Catheters	Pt able to get to clinic for routine change; able to report complications to MD.	Unable to get to clinic for routine change; lacks knowledge of when to notify MD.
Monitor Vital Signs	Pt mobile; no recent significant change in vital signs or other concerns; able to report complications to MD.	Recent, significant change in vital signs requiring medication change. Change in vital signs may be exacerbated by effort to go to clinic; lacks knowledge of when to notify MD. Cannot be delegated to paraprofessional staff due to unstable condition/need for interpretation/assessment.
Lab Draws	Pt can go to clinic; able to report complications to MD. Draws 1 time per month or less often.	Unable to get to clinic; Labs draws more frequently than 1x month; lacks knowledge of when to notify MD. Cannot

Service Provided	Unskilled	Skilled
		be delegated to paraprofessional staff due to interpretation of results and coordination needed with MD.
Injections	Pt/caregiver can draw up and administer injection; Pt able to go to outpatient setting for injection; able to report complications to MD.	Pt/caregiver unable/unwilling to administer injection; Lack of knowledge regarding when to notify MD. Unable to go to outpatient setting. Cannot be delegated to paraprofessional staff.
Wound Care	NA	When the skills of a licensed nurse are needed to provide safely and effectively the services necessary, including direct care, teaching, and monitoring is skilled.
Infusion therapy	NA	Require the skills of a nurse to be performed (or taught) safely and effectively; monitoring and dressing changes.

Skilled Therapy Services

A. General Principles

- The service of a physical therapist, speech-language pathologist or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist.
- To be covered, the skilled services must also be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration of maintenance of function affected by the patient's illness or injury
- For further specific details of skilled therapy services refer to Home Health Manual, CMS Publication 11, Chapter II - Coverage of Home Health Services in section 205 and 206.

B. Medical Assistance classifies therapy as Restorative Therapy or Specialized Maintenance Therapy.

- Rehabilitation services can not be covered when the recipient can reasonably access these services outside his/her residence, excluding the assessment, counseling, and education.
- A recipient who leaves the home at will, or a patient who can easily transport the child, must obtain these services at a rehabilitation center, and will not be eligible for home care therapies.

C. All therapy services are seen as disease/ disability level of care.

- A patient may still receive maintenance skilled nurse visits under the disease/ disability frame if a patient is receiving skilled therapy services.

- D. Complies with accepted professional standards and principles.
- A patient may still receive maintenance skilled nurse visits under the disease/ disability frame if a patient is receiving skilled therapy services.

Pay Sources Requirements

A. Medicare:

1. Must be a Medicare Part A participant.
2. Meets requirements of Home Health Manual, CMS Publication 11, Chapter II Conditions a patient must meet to qualify for home health services in section 204.
 - i. Confined to home (homebound),
 - ii. Under plan of care established and approved by physician
 - iii. Needs Skilled Nursing Care on an Intermittent Basis (*Other than Solely Venipuncture for the Purposes of Obtaining a Blood Sample*) or Physical Therapy or Speech-Language Pathology Services or Has Continued Need for Occupational Therapy.
3. Medicare does not reimburse for maintenance level of care services (see definitions above).
4. Follows OASIS comprehensive assessment requirements

B. Medical Assistance/ PMAP/ MinnesotaCare:

1. Must have Medical Assistance or PMAP.
2. Meets definition of Code of Federal Regulations 42, part 484.30, HIM Section 232.9, Minnesota Statutes, section 256B.0627.
3. Follow disease/ disability or maintenance level of care definitions.
4. Prior authorization required based on visits expected or required by health plan. Twice a day visit can be authorized if medically necessary.
5. Home visits are based on need for home services that are not easily accessible to patients outside of their home due to barriers, the reasonable and necessary services required and the complexity of patient's condition to manage in their homes.
6. Follow comprehensive assessment requirements.

C. Private Insurance:

1. Based on benefits of policy holder specifically and meets definition of policy.
2. Prior authorization may or may not be required.
3. Usually is disease/ disability, unless maintenance covered in policy.
4. No OASIS required.
5. Follow comprehensive assessment requirements

D. Alternative Care (AC):

1. Must be eligible for Alternative Care Program.
2. Prior authorization required by County Case Manager.
3. May be disease/ disability or maintenance.
4. Follow OASIS comprehensive assessment requirements if skilled services provided.
5. Follow comprehensive assessment requirements

E. Veterans Administration:

1. Must be eligible veteran for services required.
2. Prior authorization required

3. May be disease/ disability or maintenance.
 4. No OASIS required.
 5. Follow comprehensive assessment requirements
- F. Worker's Compensation/ Liability Insurance
1. Must validate injury and insurance information.
 2. Must get prior authorization for services.
 3. Must reflect in service agreement primary pay source of workman's compensation or liability insurance, secondary pay source of Medicare if applicable or other pay source, third pay source would be private pay by sliding fee to comply with requirements of denial process for primary payer responsible for the incident needing services for.
 4. May be disease/ disability or maintenance.
 5. No OASIS required.
 6. Follow comprehensive assessment requirements
- G. General Assistance Medical Care (GAMC):
1. Home care services are not covered.



On Which Patients Do You Have To Do Federal OASIS Data Collection?

**By Pat Nelson, RN
OASIS Coordinator/Minnesota Department of Health**

OASIS data collection is required on all Medicare/Medicaid patients receiving skilled services.

- OASIS is excluded for patients under 18 years of age; regardless of payer source
- OASIS is excluded for patients receiving pre & postpartum maternity services; regardless of payer source

The following sources provide clarifying information regarding when OASIS data collection is required:

Information Bulletin 03-2 on the MDH website addresses the definition of skilled services for Medicare and non-Medicare patients according to the Home Health Agency (HHA) Manual (CMS HM-11). The bulletin can be found at:

http://www.health.state.mn.us/divs/fpc/profinfo/ib03_2.htm

The Patient Classification Table is a helpful tool that identifies when a patient requires OASIS data collection, a comprehensive assessment or both. The table can be found at <http://www.cms.hhs.gov/OASIS/Downloads/patientclassificationtable.pdf>

The State Operations Manual (SOM) at Section 2202 – Outcome and Assessment Information Set (OASIS) Requirements states when OASIS data collection applies. MDH recommends the section be read in its entirety for complete understanding. The SOM states in part:

“2202.3B(page 161).....2. Medicaid Home Health Programs/Medicaid Waiver Programs

The comprehensive assessment regulations apply to HHAs that are required to meet the Medicare home health CoP (Conditions of Participation). An HHA that currently must meet the Medicare CoP under Federal and/or State law must meet the Medicare CoP related to OASIS and comprehensive assessment and reporting. If an HHA provides skilled services to individuals under Medicaid, then OASIS applies. If the patient is not receiving skilled nursing, physical therapy, occupational therapy, or speech language pathology services, then OASIS does not apply. The requirement to collect OASIS on patients receiving only personal care services has been delayed until further notice.”

“2202.8C(page 193).....3. Transmission of OASIS Data

.....**NOTE:** CMS requires the encoding and transmission of OASIS information only on patients who are receiving Medicare/Medicaid benefits. This means that for patients with payor source (1) Medicare (traditional fee-for-service), (2) Medicare

(HMO/Managed Care), (3) Medicaid (traditional fee-for-service), or (4) Medicaid (HMO/Managed Care) on OASIS item M0150, the HHA must collect, encode and transmit all required OASIS information to the SA. **If Medicare/Medicaid is contributing to the payment of the patient's episode of care, the patient is considered a Medicare/Medicaid patient.** The payor source for services provided as part of a Medicaid waiver or home and community-based waiver program by a Medicare-approved HHA are coded as (3) Medicaid (traditional fee-for-service) at item M0150.”

For non-Medicare/non-Medicaid patients (patients with only pay sources other than M0150 response 1, 2, 3, or 4, the HHA is not required to assess and collect OASIS as part of the comprehensive assessment and agency medical record..... Non-Medicare/non-Medicaid payer sources include private insurance, private HMO/Managed Care, self pay, programs funded under the Act: for example, Title III, V, XX, or other Government programs.

<http://www.cms.hhs.gov/manuals/downloads/som107c02.pdf>

Based on Section 704 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, data collection for non-Medicare/non-Medicaid (private pay patient) patients was temporarily suspended. This is noted in the S & C letter 04-12 which is found at:

<http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter04-12.pdf>

Pat Nelson has been with MDH since June of 1989. Pat was an HFE Nurse Specialist in the Survey and Compliance Program from June 1989 until October 1995, a Special Investigator with the Office of Health Facility Complaints from October 1995 – May 2005 and has been a Registered Nurse Senior in the Case Mix Review Program since May 2005. In August 2006 Pat assumed the duties of the Oasis Coordinator and remains with the Case Mix Review Program as well.

For more information contact oasis@health.state.mn.us