
DEPARTMENT FOR MEDICAID SERVICES

ADVANCED REGISTERED NURSE PRACTITIONER SERVICES

Services by an Advanced Registered Nurse Practitioner shall be payable if the service provided is within the scope of licensure. These services shall include, however not be limited to, services provided by the certified nurse midwife (CNM), family nurse practitioner (FNP), and pediatric nurse practitioner (PNP).

AMBULATORY SURGICAL CENTER SERVICES

Medicaid covers medically necessary services provided in free-standing ambulatory surgical centers.

BIRTHING CENTER SERVICES

Covered birthing center services include an initial prenatal visit, follow-up prenatal visits, delivery and up to two (2) follow-up postnatal visits within four (4) to six (6) weeks of the delivery date.

DENTAL SERVICES

Coverage shall be limited but includes cleanings, oral examinations, X-rays, filling, extractions, palliative treatment of oral pain, hospital and emergency calls for recipients of all ages. Other preventive dental services (i.e. root canal therapy) and Comprehensive Orthodontics are also available to individuals under age twenty-one (21).

DURABLE MEDICAL EQUIPMENT

Certain medically-necessary items of durable medical equipment, orthotic and prosthetic devices shall be covered when ordered by a physician and provided by suppliers of durable medical equipment, orthotic and prosthetics. Most items require prior authorization.

DEPARTMENT FOR MEDICAID SERVICES

EARLY PERIODIC, DIAGNOSIS, AND TREATMENT (EPSDT)

Under the EPSDT program, Medicaid-eligible children, from birth through the birth month of their twenty-first birthday may receive the following tests and procedures as appropriate for age and health history when provided by participating providers:

- Medical History
- Physical Examination
- Growth and Development Assessment
- Hearing, Dental, and Vision Screenings
- Lab tests as indicated
- Assessment or Updating of Immunizations

(EPSDT) SPECIAL SERVICES PROGRAM

The EPSDT Special Services Program considers medically necessary items and services that are not routinely covered under the state plan. These services are for children from birth through the end of their birth month of their twenty-first year. All services shall be prior authorized by the Department for Medicaid Services.

FAMILY PLANNING SERVICES

Comprehensive family planning services shall be available to all eligible Medicaid recipients of childbearing age and those minors who can be considered sexually active. These services shall be offered through participating agencies such as local county health departments and independent agencies, i.e., Planned Parenthood Centers. Services also shall be available through private physicians.

A complete physical examination, counseling, contraceptive education and educational materials, as well as the prescribing of the appropriate contraceptive method, shall be available through the Family Planning Services element of the Kentucky Medicaid Program. Follow-up visits and emergency treatments also shall be provided.

DEPARTMENT FOR MEDICAID SERVICES

HEARING SERVICES

Hearing evaluations and single hearing aids, when indicated, shall be paid for by the program for eligible recipients, to the age of twenty-one (21). Follow-up visits, as well as check-up visits, shall be covered through the hearing services element. Certain hearing aid repairs shall also be paid through the program.

HOME HEALTH SERVICES

Skilled nursing services, physical therapy, speech therapy, occupational therapy, and aide services shall be covered when necessary to help the patient remain at home. Medical social worker services shall be covered when provided as part of these services. Home Health coverage also includes disposable medical supplies. Coverage for home health services shall not be limited by age.

HOSPICE

Medicaid benefits include reimbursement for hospice care for Medicaid recipients who meet the eligibility criteria for hospice care. Hospice care provides to the terminally ill relief of pain and symptoms. Supportive services and assistance shall also be provided to the patient and family in adjustment to the patient's illness and death. A Medicaid recipient who elects to receive hospice care waives all rights to certain separately available Medicaid services which shall also be included in the hospice care scope of benefits.

DEPARTMENT FOR MEDICAID SERVICES

HOSPITAL SERVICES

INPATIENT SERVICES

Kentucky Medicaid benefits include reimbursement for admissions to acute care hospitals for the management of an acute illness, an acute phase or complications of a chronic illness, injury, impairment, necessary diagnostic procedures, maternity care, and acute psychiatric care. All non-emergency hospital admissions shall be preauthorization by a Peer Review Organization. Certain surgical procedures shall not be covered on an inpatient basis, except when a life-threatening situation exists, there is another primary purpose for admission, or the physician certifies a medically necessity requiring admission to the hospital. Elective and cosmetic procedures shall be outside the scope of program benefits unless medically necessary or indicated. Reimbursement shall be limited to a maximum of fourteen (14) days per admission except for services provided to recipients under age six (6) in hospitals designated as disproportionate share hospitals by Kentucky Medicaid and services provided to recipients under age one (1) by all acute care hospitals.

OUTPATIENT SERVICES

Benefits of the program element include diagnostic, therapeutic, surgical and radiological services as ordered by a physician, clinic visits, pharmaceuticals, emergency room services in emergency situations as determined by a physician, and services of hospital-based emergency room physicians.

There shall be no limitations on the number of hospital outpatient visits or covered services available to Medicaid recipients.

KENTUCKY COMMISSION FOR HANDICAPPED CHILDREN

The Commission provides medical, preventive and remedial services to handicapped children under age twenty-one (21). Targeted Case Management Services are also provided. Recipients of all ages who have hemophilia may also qualify.

LABORATORY SERVICES

Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories includes procedures for which the laboratory is certified by Medicare.

DEPARTMENT FOR MEDICAID SERVICES

LONG TERM CARE FACILITY SERVICES

**INTERMEDIATE CARE FACILITY SERVICES FOR THE MENTALLY RETARDED AND
DEVELOPMENTALLY DISABLED (ICF/MR/DD)**

The Kentucky Medicaid Program shall make payment to intermediate care facilities for the mentally retarded and developmentally disabled for services provided to Medicaid recipients who are mentally retarded or developmentally disabled prior to age twenty-two (22), who because of their mental and physical condition require care and services which are not provided by community resources.

NURSING FACILITY SERVICES

The Department for Medicaid Services shall make payment for services provided to Kentucky Medicaid eligible residents of nursing facilities which have been certified for participation in the Kentucky Medicaid Program. The need for admission and continued stay shall be certified by the Kentucky Medicaid Peer Review Organization (PRO). The Department shall make payment for Medicare deductible and coinsurance amounts for those Medicaid residents who are also Medicare beneficiaries.

The need for the ICF/MR/DD level of care shall be certified by the Kentucky Medicaid Peer Review Organization (PRO).

DEPARTMENT FOR MEDICAID SERVICES

MENTAL HEALTH SERVICES

COMMUNITY MENTAL HEALTH CENTER SERVICES

Community mental health-mental retardation centers serve recipients of all ages in the community setting. From the center a patient may receive treatment through:

- Outpatient Services
- Psychosocial Rehabilitation
- Emergency Services
- Inpatient Services
- Personal Care Home Visits

Eligible Medicaid recipients needing psychiatric treatment may receive services from the community mental health centers and possibly avoid hospitalization. There are fourteen (14) major centers, with satellite centers available. The Kentucky Medicaid Program also reimburses psychiatrists for psychiatric services through the physician program.

MENTAL HOSPITAL SERVICES

Reimbursement for inpatient psychiatric services shall be provided to Medicaid recipients under the age of twenty-one (21) and age sixty-five (65) or older in a psychiatric hospital. There shall be no limit on length of stay; however, the need for inpatient psychiatric hospital services shall be verified through the utilization control mechanism.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Inpatient psychiatric residential treatment facility services are limited to residents age six (6) to twenty-one (21). Program benefits are limited to eligible recipients who require inpatient psychiatric residential treatment facility services on a continuous basis as a result of a severe mental or psychiatric illness. There is no limit on length of stay; however, the need for inpatient psychiatric residential treatment facility services must be verified through the utilization control mechanism.

DEPARTMENT FOR MEDICAID SERVICES

TARGETED CASE MANAGEMENT SERVICES

ADULTS Case management services are provided to recipients eighteen (18) years of age or older with chronic mental illness who need assistance in obtaining medical, educational, social, and other support services.

CHILDREN Case management services are provided to Severely Emotionally Disturbed (SED) children who need assistance in obtaining medical, educational, social, and other services.

NURSE ANESTHETIST SERVICES

Anesthesia services performed by a participating Advanced Registered Nurse Practitioner - Nurse Anesthetist shall be covered by the Kentucky Medicaid Program.

NURSE MIDWIFE SERVICES

Medicaid coverage shall be available for services performed by and within the scope of practice of certified registered nurse midwives through the Registered Nurse Practitioner Program.

DEPARTMENT FOR MEDICAID SERVICES

PHARMACY SERVICES

Legend and non-legend drugs from the approved Medical Assistance Outpatient Drug List when required in the treatment of chronic and acute illnesses shall be covered. The Department is advised regarding the outpatient drug coverage by a formulary subcommittee composed of persons from the medical and pharmacy professions. A Drug List is available to individual pharmacists and providers upon request and routinely sent to participating pharmacies and nursing facilities. The Drug List is distributed periodically with monthly updates. Certain other drugs which may enable a patient to be treated on an outpatient basis and avoid institutionalization shall be covered for payment through the Drug Preauthorization Program.

In addition, nursing facility residents may receive other drugs which may be prior authorized as a group only for nursing facility residents.

PHYSICIAN SERVICES

Covered services include:

Office visits, medically indicated surgeries, elective sterilizations*, deliveries, chemotherapy, selected vaccines and RhoGAM, radiology services, emergency room care, anesthesiology services, hysterectomy procedures*, consultations, second opinions prior to surgery, assistant surgeon services, oral surgeon services, psychiatric services.

*Appropriate consent forms shall be completed prior to coverage of these procedures.

Non-covered services include:

Most injections, supplies, drugs (except anti-neoplastic drugs), cosmetic procedures, package obstetrical care, IUDs, diaphragms, prosthetics, various administrative services, miscellaneous studies, post mortem examinations, surgery not medically necessary or indicated.

Limited coverage:

Certain types of office exams, e.g. new patient comprehensive office visits, shall be limited to one (1) per twelve (12) month period, per patient, per physician.

DEPARTMENT FOR MEDICAID SERVICES

PODIATRY SERVICES

Selected services provided by licensed podiatrists shall be covered by the Kentucky Medicaid Program. Routine foot care shall be covered only for certain medical conditions where the care requires professional supervision.

PREVENTIVE HEALTH SERVICES

Preventive Health Services shall be provided by health department or districts which have written agreements with the Department for Health Services to provide preventive and remedial health care to Medicaid recipients.

PRIMARY CARE SERVICES

A primary care center is a comprehensive ambulatory health care facility which emphasizes preventive and maintenance health care. Covered outpatient services provided by licensed, participating primary care centers include medical services rendered by advanced registered nurse practitioners as well as physician, dental and optometric services, family planning, EPSDT, laboratory and radiology procedures, pharmacy, nutritional counseling, social services and health education. Any limitations applicable to individual program benefits shall be generally applicable when the services are provided by a primary care center.

RENAL DIALYSIS CENTER SERVICES

Free-standing renal dialysis center benefits include renal dialysis, certain supplies and home equipment.

DEPARTMENT FOR MEDICAID SERVICES

RURAL HEALTH CLINIC SERVICES

Rural health clinics are ambulatory health care facilities located in rural, medically underserved areas. The program emphasized preventive and maintenance health care for people of all ages. The clinics, though physician directed, shall also be staffed by Advanced Registered Nurse Practitioners. The concept of rural health clinics is the utilization of mid-level practitioners to provide quality health care in areas where there are few physicians. Covered services include basic diagnostic and therapeutic services, basic laboratory services, emergency services, services provided through agreement or arrangements, visiting nurse services and other ambulatory services.

TRANSPORTATION SERVICES

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the patient's condition requires special transportation. Also covered shall be preauthorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

VISION SERVICES

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

ELIGIBILITY INFORMATION

Programs

The Department for Social Insurance, Division of Field Services local office staff have primary responsibility for accepting and processing applications for benefit programs administered by the Cabinet for Human Resources, Department for Social Insurance. These programs, which include eligibility for Medicaid, include:

- AFDC (Aid to Families with Dependent Children)
- AFDC Related Medical Assistance
- State Supplementation of the Aged, Blind or Disabled
- Aged, Blind, or Disabled Medical Assistance

Any individual has the right to apply for Medicaid and have eligibility determined. Persons wanting to apply for Medicaid benefits shall be referred to the local Department for Social Insurance, Division of Field Services office in the county in which they live. Persons unable to visit the local office may write or telephone the local office of information about making application. Form most program, a relative or other interested party may make application for a person unable to visit the office.

In addition to the program administered by the Department for Social Insurance, persons eligible for the federally administered Supplemental Security Income (SSI) programs also receive Medicaid through the Medicaid Program, Eligibility for SSI is determined by the Social Security Administration. Persons wanting to apply for SSI should be referred to the Social Security Administration office nearest to the county in which they live: The SSI program provides benefits to individuals who meet the federal definitions of age, blindness, or disability, in addition to other eligibility requirements.

ELIGIBILITY INFORMATION

MAID Cards

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period.

Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one (1) MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID cards may show a retroactive period eligibility. Depending on the individual circumstances of eligibility, the retroactive period may include several months.

Duplicate MAID cards may be issued for individuals who original card is lost or stolen. The recipient shall report the lost or stolen card to the local Department for Social Insurance, Division of Field Services worker responsible for the case.

Verifying Eligibility

The local Department for Social Insurance, Division of Field Services staff may provide eligibility to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 may also verify eligibility for providers.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	INS.
ELIGIBILITY PERIOD FROM: 08-01-90 TO: 07-01-90 CASE NUMBER 037 C 000123456		Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M
CASE NAME AND ADDRESS Jane Smith 400 Block Ave. Frankfort, KY 40601						
ISSUE DATE: 05-27-90						
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS						
SEE OTHER SIDE FOR SIGNATURE		MAP 530 REV 1/90				

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For Kentucky Medicaid Program Statistical Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for Kentucky Medicaid Program benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

WHITE CARD

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "Ins." block.

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES																		
<p>This card certifies that the person(s) listed herein is/are eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621-0001</p>	<ol style="list-style-type: none">1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services.2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.4. If you have questions, contact your eligibility worker at the county office.5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.																		
<p>Insurance Identification</p> <table><tbody><tr><td>A-Part A, Medicare Only</td><td>F-Private Medical Insurance</td></tr><tr><td>R-Part A, Medicare Premium Paid</td><td>G-Charitas</td></tr><tr><td>B-Part B Medicare Only</td><td>H-Health Maintenance Organization</td></tr><tr><td>C-Both Parts A & B Medicare</td><td>J-Unknown</td></tr><tr><td>S-Both Parts A & B Medicare Premium Paid</td><td>K-Other</td></tr><tr><td>D-Blue Cross Blue Shield</td><td>L-Absent Parent's Insurance</td></tr><tr><td>E-Blue Cross Blue Shield Major Medical</td><td>M-None</td></tr><tr><td></td><td>N-United Mine Workers</td></tr><tr><td></td><td>P-Black Lung</td></tr></tbody></table>	A-Part A, Medicare Only	F-Private Medical Insurance	R-Part A, Medicare Premium Paid	G-Charitas	B-Part B Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	J-Unknown	S-Both Parts A & B Medicare Premium Paid	K-Other	D-Blue Cross Blue Shield	L-Absent Parent's Insurance	E-Blue Cross Blue Shield Major Medical	M-None		N-United Mine Workers		P-Black Lung	<p>_____ Signature</p>
A-Part A, Medicare Only	F-Private Medical Insurance																		
R-Part A, Medicare Premium Paid	G-Charitas																		
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D-Blue Cross Blue Shield	L-Absent Parent's Insurance																		
E-Blue Cross Blue Shield Major Medical	M-None																		
	N-United Mine Workers																		
	P-Black Lung																		
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.424, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf. Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.</p>																			

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

II. THE REQUEST PROCEDURE

A. Initiating a Request

1. Requests for pre-authorization may be initiated by the prescribing physician or office personnel under his direct supervision. Requests from pharmacists and social workers who are working directly with the recipient's physician shall also be accepted.
2. The primary concern is that the caller have available the information necessary for staff to make an accurate determination.

B. Transmittal Methods

1. Written Requests

The drug pre-authorization may be made IN WRITING TO: EDS, PO BOX 2036, Frankfort, Kentucky 40602.

2. Telephone Requests

Or by PLACING A TELEPHONE CALL to the following toll-free number between 8:00 a.m. and 4:30 p.m. EST/EDST, on Monday through Friday (except during holidays):
Telephone Number: 1-800-756-7558
Out of State: (502) 227-9073

III. INFORMATION REQUIRED FOR A DETERMINATION

Persons requesting a pre-authorization of medications shall provide information, line for line from the Preauthorization Request Form. Special attention should be given to giving a specific statement, indicating the need for the requested drug as well as previous medications tried unsuccessfully.

IV. DISPOSITION OF REQUEST

- A. Nurses shall review each request and make determinations on the basis of established Program criteria. Extenuating circumstances shall be directed to the medical consultant.
- B. If the appropriate information is received and the medication meets the Program criteria, an approval shall be made. However, if the request does not meet the basic criteria or if insufficient or contradictory information is provided, the request shall be disapproved. Drug Preauthorization staff will NOT assume responsibility for calling physicians for more information.

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APPENDIX XII

- C. Unusual or unique situations shall be reviewed by consultant pharmacists, physicians, and recognized University staff.
- D. When the medication is not on the DMS Drug List and is disapproved for pre-authorization, the recipient shall assume responsibility for the cost or obtain an alternative source of payment.
- E. Determinations shall be made daily Monday through Friday, except on holidays.

V. NOTIFICATION OF DISPOSITION

- A. Notification regarding the disposition (approval or disapproval) of each pre-authorization request shall be made as follows:

- 1. **DISAPPROVALS:** When disapproved, the prescribing physician shall be notified by mail. The request and reason for disapproval shall be provided.
- 2. **APPROVALS:** When approved, notification shall be made by phone to the selected pharmacy. The pharmacist shall provide the pre-authorization staff with the NDC number and provider number.

NOTE: Pre-authorization shall not be guaranteed for any request until reviewed and approved by pre-authorization staff members. If any change should occur, i.e. NDC#, MAID#, quantity, etc., please notify pre-authorization staff immediately to assure Program payment.

- B. Period of Coverage

The effective date for Program coverage of preauthorized drugs shall begin on the date the request is postmarked or date received by phone. The pre-authorization shall remain in effect for the specified time on the "Authorization to Bill" or until the recipient becomes ineligible, whichever comes first.

CAUTION: Pre-authorization does not guarantee payment.
Recipient shall be eligible on date of service.
Verify by checking the recipient's Medicaid card.

VI. PHARMACY INFORMATION

A. Reimbursement for Preauthorized Drugs

1. Selected pharmacies shall be reimbursed at the lower of the MAC, if applicable, or Average Wholesale Price (AWP) minus ten (10) percent plus dispensing fee, or usual and customary charge to the general public.
2. Private insurance companies and Medicare, if applicable, SHALL BE BILLED PRIOR to submitting claims for payment.

B. Pharmacy Billing for Preauthorized Drugs

Preauthorized drugs shall be billed in the same manner as drugs on the Kentucky Medicaid Outpatient Drug List — utilizing regular pharmacy billing statements notating the pre-authorization number in the appropriate field.

C. Payment Inquiries

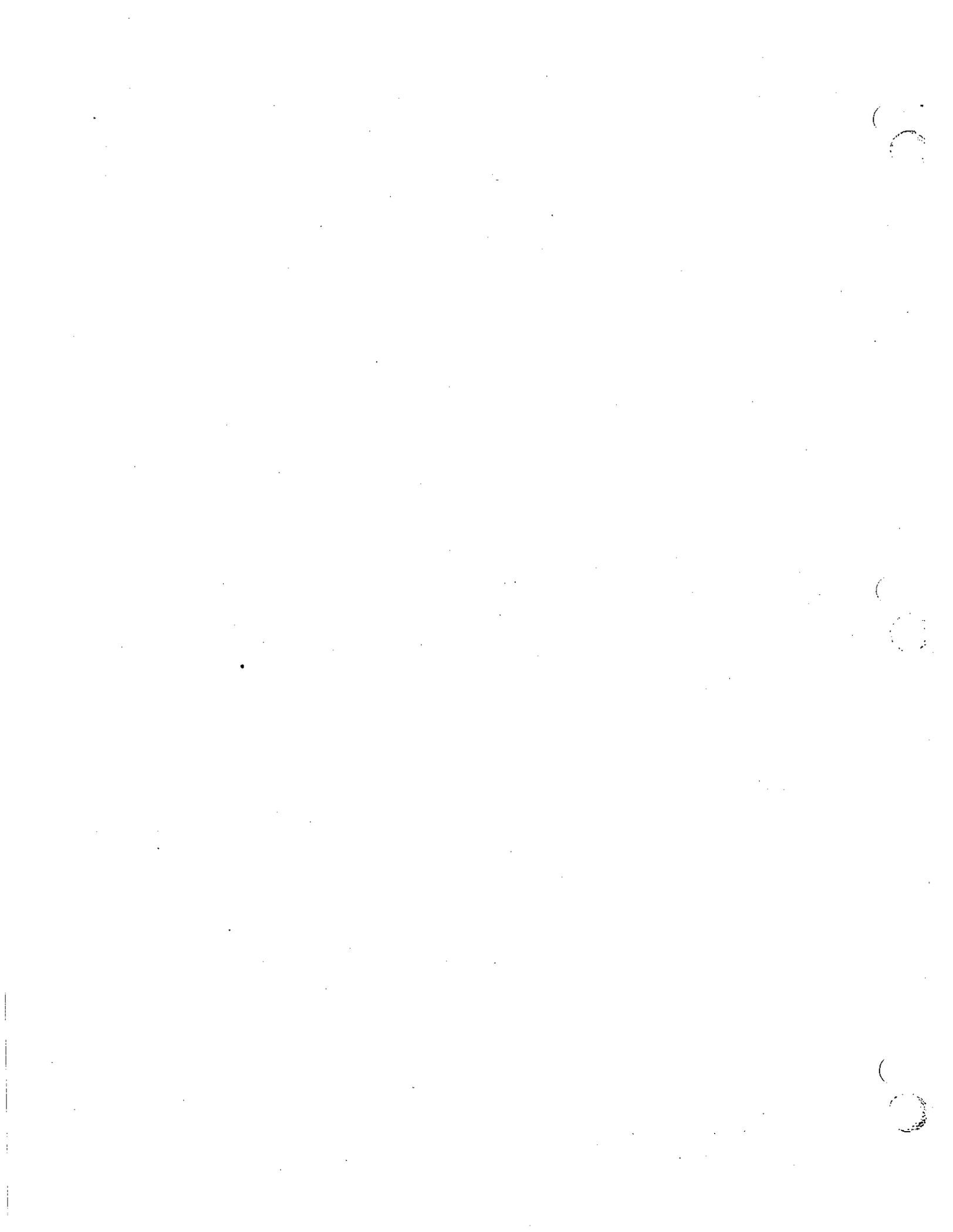
If pharmacies have any questions regarding payment for submitted preauthorized drugs, EDS should be contacted at 1-800-756-7557 or at EDS, PO BOX 2009, FRANKFORT KY 40602.

VII. ADDITIONAL INFORMATION

Any questions regarding the Drug Preauthorization Procedure shall be directed to:

EDS
PO BOX 2036
FRANKFORT KY 40602

Telephone Number: 1-800-756-7558



Requester: Please complete [outlined] fields.
Pharmacist: Please complete other fields marked by an asterisk. *

Date: _____

Kentucky Medical Assistance Program Drug Prior Authorization/Authorization To Bill

Mail to:
EDS
P.O. Box 2036
Frankfort, KY
40602

Patient's Name: _____

Pharmacy Name: _____

*** Address:** _____

*** City/St./Zip:** _____

*** Pharmacy Provider No.:** _____

Phone: () _____

MAID #: _____

Physician Name: _____

Address: _____

City/St./Zip: _____

Prescribing Physician License Number: _____

Phone: () _____

PA Number	Drug Name	NDC * _____ 0 _____
Strength	Quantity	Begin Date * _____
Diagnosis		End Date

~~Other Drugs Tried Without Positive Results~~

PA Number	Drug Name	NDC * _____ 0 _____
Strength	Quantity	Begin Date * _____
Diagnosis		End Date

~~Other Drugs Tried Without Positive Results~~

Notes

PA Number	Drug Name	NDC * _____ 0 _____
Strength	Quantity	Begin Date * _____
Diagnosis		End Date

~~Other Drugs Tried Without Positive Results~~

Notes

CAUTION: THE ABOVE RECIPIENT MUST BE ELIGIBLE ON THE DATE OF SERVICE. VERIFY BY CHECKING THE RECIPIENT'S MEDICAID CARD.

OFFICE USE ONLY

APPROVED

- _____ Drug is of type already covered on KMAP Formulary.
- _____ Drug is to be used in accordance with FDA standards and indications.
- _____ Drug is rated "possibly or less than effective" by the FDA.
- _____ Other

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COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

Home Health Program

Agency Name _____ Vendor # _____

Agency Address _____

CERTIFICATION FOR DISPOSABLE MEDICAL SUPPLIES

Patient's Name _____ MAID # _____

Address _____ Medicare # _____

_____ Birthdate _____

Other Insurance _____

Diagnosis _____

This is to certify that the following medical supplies are essential to meet the medical needs of this recipient.

Indicate Directions for Use of the Supplies) _____

Anticipated Duration of Need: _____ 0-30 days _____ 1-6 months

_____ Lifetime _____ Indefinite

_____ Date

_____ Physician's Signature

_____ Address

_____ License #

Must be signed and dated by the physician.

Case Management Protocol
Home Apnea Monitoring

Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

June 18, 1984

Michigan Department of Public Health
Case Management Protocol for Medical and Nursing Care
of the Home Apnea Monitored Child was used as a guide

REPORT
MEDICAL ASSISTANCE ADVISORY COUNCIL

Special Committee for
Home Apnea Monitoring

Attached is a final draft copy of the case management protocol for Home Apnea Monitoring.

The special committee to review the protocol related to apnea/bradycardia home monitoring met Tuesday, May 15, 1984, as requested by the Kentucky Medical Assistance Advisory Council at its regular meeting of March 7, 1984.

Ms. Janet Rodgers, L.P.T., with the Visiting Nurse Association of Louisville, Kentucky, served as chairperson for the committee. Also serving on the committee and in attendance at the meeting were the following people:

Doane Fischer, M.D., Department of Pediatrics, University of Kentucky Medical Center, Lexington, Kentucky
John Roberts, M.D., Neonatologist, Department of Pediatrics, Kosair-Childrens Hospital, Louisville, Kentucky
Patricia K. Nicol, M.D., Director, Division of Maternal and Child Health, Department for Health Services
Joy Davis, R.N., Continuity of Care Coordinator, Kosair-Childrens Hospital, Louisville, Kentucky
Maggie Murray, R.N., Administrator, St. Claire Medical Center Home Health Agency, Morehead; Kentucky
Ida Lyons, Program Coordinator, Sudden Infant Death Syndrome Program, Division of Maternal and Child Health

Additional people in attendance were:

Nileen Verbeten, Executive Director, Kentucky Home Health Association
Fletcher Lutcavish, Assistant Director, Division of Medical Assistance, Department for Social Insurance
Jean Farrisee, Supervisor, Alternate Care Section, Division of Medical Assistance
Peggy Nelson, R.N., Medical Policy Analyst, Electronic Data Systems Federal
Barbara Knox, Program Coordinator, Home Health Services, Division of Medical Assistance

In developing this protocol, the committee considered recent data available on home apnea monitoring as well as using the expertise of the members of the committee.

The committee recommended that the KMAP follow the guidelines of this protocol in determining reimbursement and approving home apnea monitoring. The committee would welcome the use of this protocol by groups associated with and interested in home apnea monitoring.

The committee felt strongly that home monitoring must be a) preceded by a 24-48 hour period of hospitalization for evaluation and diagnostic workup, b) coordinated prior to discharge, c) followed-up with criteria established, and d) discontinued when the monitor is no longer medically necessary.

The pneumogram testing could presently be reimbursed as a hospital inpatient or outpatient service.

The committee recognized that at the present time, however, there is no KMAP coverage for the pneumogram testing and evaluation provided in the patient's home. Since this may be necessary in determining the appropriateness of discontinuing the monitor, the committee strongly recommends that coverage be made available for the pneumogram and interpretation provided in the home. Timely discontinuation of the monitor has the potential of saving the KMAP money which would otherwise be billed as rental for a prolonged length of unnecessary service.

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The protocol is the product of a Special Committee convened in May 1984 at the request of the Kentucky Medical Assistance Advisory Council to provide advice and guidelines on the current state of knowledge and practice in the utilization of apnea monitors. The Committee was organized because the Home Health Technical Advisory Committee recognized the need to develop appropriate standards and policies regarding the utilization of Apnea/bradycardia monitors in order to assure quality and safe care to Medicaid recipients.

Case Management Protocol
Home Apnea Monitoring
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

THE PURPOSE OF THIS PROTOCOL is to communicate the optimal components of service for children suspected of having apnea. The protocol will be utilized by the Kentucky Medical Assistance Program (KMAP) in approving requests for financial reimbursement for apnea bradycardia monitors.

Protocol

I. MEDICAL CRITERIA FOR APNEA DIAGNOSTIC WORK-UP AND PLACEMENT OF HOME MONITORS

- A. Definition of Apnea: The American Academy of Pediatrics Task Force on Prolonged Apnea defines prolonged apnea as "cessation of breathing for 20 seconds or longer, or as a briefer episode associated with bradycardia, cyanosis or pallor."
- B. Etiology: Etiology includes but is not limited to seizure disorders, severe anemia, gastro-esophageal reflux, hypoglycemia, other metabolic disorders and impaired regulation of breathing.
- C. Population at Risk

- *Child with observed apneic episode (without demonstrable cause)
- *Child with history of apnea, cyanosis, birth asphyxia or hypoxia of any cause
- *Siblings of SIDS infant
- *Premature infant less than 1500 grams
- *Infant of drug dependent mother
- *Child with tracheostomy
- *Selected children with certain cardiac arrhythmias
- *Children with specific seizure disorders

D. Elements of Diagnostic Work-Up¹

1. REQUIRED elements of study

- *History and physical examination
- *Laboratory studies
 - CBC
 - Urinalysis
 - Chem 6 - (Sodium, Potassium, CO₂, BUN, Glucose, Chloride)
 - Calcium
 - Magnesium
 - Creatinine
- *Cardio-respiratory monitoring (inpatient) for 24-48 hour with close professional observation of child
- *Chest x-ray
- *EKG

¹If the capability for proper testing/analysis is unavailable, we recommend appropriate referral or consultation

2. Recommended further studies as indicated

- *Pneumogram
- *EEG
- *Blood/septic work-up
- *Upper GI
- *Spinal tap/lumbar puncture
- *CT Scan

E. Criteria for Monitor Placement

1. Presence of one or more

- *Documented episode(s) of apnea with no treatable cause or an inadequate response to treatment
- *Documented episode of apnea with bradycardia, cyanosis or pallor
- *History of apnea described by parent or caretaker based on physician's best informed judgement and evaluation of testing
- *Abnormal ventilatory pattern on pneumogram
- *SIDS sibling
- *Multiple-birth SIDS survivor(s)
- *Potential for airway obstruction

2. Monitor order and need for monitor must be included as part of physician's order/information on Home Health Plan of Treatment recertification

F. Criteria for Continuation

- *Child should be seen at least every 2 months by the primary care physician or apnea consultant after monitor placement for medical evaluation and recertification for continuing need of monitor or discontinuation
- *The physician ordering and recertifying the need for the monitor must not be affiliated with the company supplying the monitor

G. Criteria for Discontinuation of the Monitor

- *No clinical apnea for 2 months unless sibling of SIDS. For sibling of SIDS should leave monitor for 2 months longer than number of months of life of SIDS
- *Parent preparation and readiness
- *Clinical judgement

II. HOSPITAL DISCHARGE PLANNING

The following items are the responsibility of the hospital staff under the direction of the physician ordering the monitor. All activities must be completed and documented in the child's record prior to discharge.

A. Assessment

- *Parent(s)² ability, acceptance and understanding of the purposes, responsibilities, risks and benefits of home monitoring
- *Appropriateness of home environment
- *Family support systems and coping abilities
- *Financial ability to support home care costs, including utilities

B. Equipment (supplied to parents prior to discharge)

- *Apnea and bradycardia monitor³ which has been used by the infant for a minimum of 24 hours prior to hospital discharge
- *Two sets of connecting equipment appropriate for the monitor (leads, belts, tabs, etc.)
- *Power failure alarm (if not incorporated into monitor)
- *Observation and incident record sheets

C. Teaching (includes instruction, discussion, demonstration of and the return demonstration by parents)

- *Placement of equipment
- *Attachment of monitor to child
- *Operation of monitor, including setting alarm sensitivity
- *Reading and interpretation of alarm
- *Response sequence to monitor alarm
- *Infant resuscitation techniques (use of mouth-to-mouth and CPR)
- *Recording of necessary information on forms
- *Emergency support plan, including names and phone numbers for:
 - Hospital emergency room
 - Key hospital staff
 - Physicians
 - Emergency squad or ambulance
 - Power company
 - Medical equipment company for monitor malfunction or failure
 - Home health agency nurse
 - Child care person
 - Transportation to hospital
- *Safety measures
 - Proper grounding
 - Access to telephone
 - Available flashlight
 - Noise control
 - Close supervision of young siblings
 - Instruction to older siblings
 - Secure placement of monitor

²Parent(s) refers throughout to parent or caretaker.

³This excludes the use of pad type monitors.

- D. Written Instructions (to be sent home with parents and to be attached to all home health agency referrals)

*All items in II-C (Teaching and Instruction) above

- E. Physician referral

*The physician must contact the Home Health Agency and establish a Home Health Plan of Treatment to order the monitor and nursing visit(s).⁴ The Home Health Agency should work in close collaboration with the physician and hospital personnel in contacting the medical equipment company and making arrangements for the equipment.⁵
*Primary care physician (unless already the ordering physician).

- F. Community Referrals

*Financial aid
*Social services
*Parent support groups
*Mental health

III. COMMUNITY SERVICES

- A. Responsibilities of Home Health Agency Nurse

1. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home
2. Contact with child and family within 24 hours of hospital discharge
3. Assess, review and reinforce all items in II-A through D page 5-7
4. Review physical care needs of child with parent(s)
5. Assist in identifying additional resources (especially for relief) as needed
6. Review and support the child's normal growth and development with special emphasis on incorporating the child into the normal family structure
7. Review plans for follow-up care and coordinate community referrals

⁴Every child discharged with a monitor will be referred to a home health agency prior to discharge. Contact should occur between the home health agency and the hospital discharge planner to discuss specific patient care needs.

⁵Equipment should be delivered and appropriate aspects of the emergency plan reviewed with the parent(s) prior to discharge.

8. Review and report pertinent findings to the primary care physician or apnea physician consultant at a minimum of every 2 months, i.e. number of spells of apnea; how long lasted; description of spell; condition of patient during spell; was CPR/gentle shaking required, how long since last spell, etc.
9. Prepare family for eventual discontinuation of monitor
10. Offer emotional support to family and be cognizant of typical parental reactions

B. Responsibilities of Medical Equipment Suppliers

1. Collaborate with hospital staff and home health agency to assure continuity of services between hospital and home
2. Provide appropriate equipment and related supplies
3. Machine operation
 - a. Review machine operation with parent(s) and supply written instructions
 - b. Evaluate equipment in home within first week, i.e. written report to physician and home health nurse
4. Maintain equipment
5. Review appropriate aspects of emergency plan with parent(s)
6. 24 hour answering service and respond to calls regarding monitor malfunction or failure in timely manner

C. Responsibilities of Primary Care Physicians/Apnea Physician Consultants

1. Initiate necessary referrals
2. Primary care physician and apnea physician consultant (if applicable) should coordinate patient's care.
3. Provide ongoing education to parents regarding the pathology underlying the child's apnea and regarding eventual discontinuation of monitor
4. Provide emotional support
5. Child's progress should be evaluated by consultant or primary care physician at a minimum of every 2 months after placement of monitor
6. Review the history of apnea and daily log of the child's status
7. Review laboratory results

8. Evaluate blood levels of prescribed medication (i.e. Theophylline, Phenobarbital, etc.)
9. Discontinuation of monitor with appropriate explanation to family

**Case Management Protocol
for Care of the
Home Ventilation Patient**

**Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources**

The protocol is the product of a Special Committee convened at the request of the Kentucky Medical Assistance Advisory Council to provide advice and guidelines on the current state of knowledge and practice in the care of the home ventilation patient. The Committee was organized because the Home Health Technical Advisory Committee recognized the need to develop appropriate standards and policies regarding the care of the home ventilation patient in order to assure quality and safe care to Medicaid recipients.

Case Management Protocol
for Care of the
Home Ventilation Patient
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

THE PURPOSE OF THIS PROTOCOL is to communicate the optimal components of managing the ventilator dependent patient at home. The protocol will be utilized by the Kentucky Medical Assistance Program (KMAP) in approving requests for financial reimbursement for mechanical ventilators.

The placement and care of the ventilator dependent patient involves a partnership among the physician, hospital, home health agency and equipment supplier. Because of the importance of ongoing patient care in the home setting and necessity of reliable response systems, the referring hospital/physician shall consult with the home health agency prior to any selection of equipment supplier.

I. Eligibility Criteria

The following criteria must be met for a patient to be considered for a home ventilation program. If all criteria are not met, a home ventilator shall not be installed.

A. Medical

Candidates to be considered for a home ventilation program shall be medically stable, possess a permanent tracheostomy (for positive pressure ventilation), and be generally included in, but not limited to, the following categories:

1. Injuries of the spinal cord
2. Irreversible neuromuscular disease
3. Sleep disorders
4. Chronic pulmonary disorders
5. Other neurological disorders

A person trained in the care of patients who require mechanical ventilation, (e.g., pulmonologist, neonatologist, intensivist, cardio thoracic surgeon, internist) should review the need for at home mechanical ventilation before institution.

B. Social - Environmental

1. The patient's family/primary caregiver must be capable of comprehension and performance of duties and responsibilities relative to ventilatory dependent patient care.
2. There shall be documentation of caregiver's competence in performance of patient care.
3. There shall be documentation of acceptable dwelling and physical facilities.

C. Community Resources

1. Emergency Medical Service.
2. Local physician to accept patient when applicable.
3. Home Health Agency (with staff trained in care of ventilator dependent patients).
4. Medical equipment supplier (with staff trained in care of ventilator dependent patients).

II. Home Ventilator Plan

The following are activities necessary for adequate ventilator dependent care. When specific behavioral objectives are stated, they must be met during the course of orientation, instruction, and treatment (unless indicated as optional by an *). The responsibilities for performance of duties to the left according to the following:

- HO - hospital from which patient will be discharged to home;
- HH - home health agency operating within county of patient's residence;
- D - durable medical equipment supplier.

In case of dual responsibilities, the agency listed first shall assume responsibility for implementation.

A. Assessment

- HO/HH 1. Primary caregivers shall possess the ability to accept and understand the purposes, responsibilities, risks, and benefits of home ventilator therapy.
- D/HH 2. Documented assessment of an adequate home environment shall be made prior to discharge to evaluate the following:
 - a. Electrical capability
 - b. Size of doorways and rooms
 - c. Accessibility (steps, ramps, etc.)
 - d. Bathroom location
 - e. Availability of telephone
 - f. Adequate heating and cooling
 - g. Adequate refuse disposal
 - h. Acceptable area for supplies, equipment, and exercise
- HO/HH 3. Adequate family support systems and coping mechanisms shall be evaluated.
- HO/HH 4. There shall be adequate financial resources to support medical, home care, nutritional, utilities, and continued family living costs.

B. Implementation

- HO 1. The physician shall write the orders for home ventilation.

- HO 2. The caregiver shall be instructed in the following:
- HO a. Anatomy and Physiology
 - HO/HH b. Nutrition and Hydration
 - HO/HH c. Personal Care
 - HO/HH d. Tracheostomy Care
 - site care
 - dressing/ties/changing
 - tube cleaning/changing/insertion
 - emergency care
 - HO/D e. Suction Procedures
 - hyperinflation/hyperoxygenation with manual ventilator (e.g., ambu bag)
 - proper tracheal and nasopharyngeal suction techniques (to include sterile technique)
 - installation of bland or medicated solution for secretion removal
 - HO f. Chest Physiotherapy
 - percussion/postural drainage
 - breathing retraining
 - HO g. Physical Therapy
 - musculoskeletal exercise program
 - aerobic retraining program
 - D/HH/HO h. Ventilator Operation
 - circuit change
 - equipment cleaning/disinfection
 - checking and changing parameters
 - checking alarm system
 - safety precautions
 - checking and charging electrical back-up
 - trouble shooting
 - HO/D i. Tracheostomy Collar
 - humidifier/nebulizer operation
 - cleaning/disinfection
 - proper FIO₂ setting
 - over hydration precautions
 - tubing changes
 - maintenance of sterile/clean system

- HO j. Cardiopulmonary Resuscitation
- HO/D k. Safety Precautions
- adequate grounding
 - response to alarms
 - response to power failure
 - response to machine failure
 - recognition of early signs of respiratory distress
 - response to airway occlusion
 - prevention of barotrauma
 - prevention of infection
 - noise control
 - recognition of gastric distention
 - supervision of small children

- HO/HH l. Medications
- name
 - dosages
 - frequencies
 - actions
 - common side effects and rationale for notification of M.C. or home health agency
 - contraindications

Note: All instructions given to caregiver and patient shall be accompanied by a written procedure statement, and attached to home health referral.

C. Specific Duties

In addition to the above, those agencies and individuals shall have the following specific responsibilities:

1. Home Health Agency
- a. Collaborate with hospital staff and equipment suppliers to assure continuity of coordinated care between hospital and home.
 - b. Organize one site visit with patient and family/ caregiver prior to discharge.
 - c. Be physically present upon arrival at home.
 - d. Assess, review, and reinforce all items included in II - A and B after discharge.
 - e. Assess and assist in identifying additional resources (especially respite) as needed.

- f. Encourage incorporation of patient into routine family structure and lifestyle as much as possible.
- g. Review follow-up plans and coordinate community referrals.
- h. Assist caregivers/family in arranging six month reevaluation by discharging physician or his designee.
- i. Have in place twenty-four hour call system.
- j. Report all pertinent findings to primary care physician as needed or every two months.
- k. Assist with arranging transportation as needed and medically necessary.
- l. Make changes in ventilator parameters as ordered, with immediate notification to the medical equipment suppliers.
- m. Provide other supplies not available from supplier or included in ventilator units.

2. Medical Equipment Supplier

- a. Supply a ventilator available for patient to use 7 to 14 days prior to discharge.
- b. Maintain accurate documentation of ventilator parameters.
- c. Make changes in ventilator parameters as ordered with immediate verbal and written notification to the home health agency.
- d. Provide supplies necessary as ventilator adjuncts to assure complete ventilator operation.
- e. Provide twenty-four hour call with one hour response for equipment repair or replacement.
- f. Maintain available services of a respiratory therapist or respiratory therapy technician as identified by the National Board of Respiratory Care.
- g. Provide twenty-four hour electrical source.
- h. Provide manual ventilator source (with or without supplemental oxygen as ordered).
- i. Perform routine maintenance as specified by manufacturer or company protocol and assure proper equipment function.

- j. Provide functionally safe alarm systems.
- k. Provide personnel and equipment for transport of patient from hospital.
- l. Visit patient a minimum of every week during the first month and monthly after the initial month.
- m. Review cleaning/sterilization techniques with caregiver.
- n. Provide home health patient with written instructions/trouble shooting guide.
- o. Reinforce knowledge of generator operations with caregiver and provide written guide for patient.
- p. Provide written notification of presence of ventilator patient to area electric, fire and telephone services.

3. Physician

- a. The discharging physician shall write all ventilator orders and discharge orders. These shall be communicated to the primary care (community) physician where applicable.
- b. The discharging physician will provide period six month case review (or assign to another physician, e.g., primary care physician).
- c. The primary care physician may assume total patient care which may include or exclude six month care review, at the discretion of the discharging physician.

Appendix XVII

Case Management Protocol
In-Home IV Therapy
Kentucky Medical Assistance Program
Department for Social Insurance
Division of Medical Assistance

Case Management Protocol
In-Home IV Therapy
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

THE PURPOSE OF THIS PROTOCOL is to communicate the optimal components of managing the patient receiving IV Therapy at home. The placement and care of the patient involves a partnership among the physician; hospital, home health agency, pharmacist and supplier. Because of the importance of ongoing patient care in the home setting and necessity of reliable response systems, the referring hospital/physician shall consult with the home health agency prior to any selection of supplier.

Case Management Protocol
In-Home IV Therapy
Kentucky Medical Assistance Program
Department for Social Insurance
Cabinet for Human Resources

Introduction

The purpose of this protocol is to identify the basic components of intravenous therapy and to establish criteria and guidelines for safe institution, maintenance and termination of IV Therapy in the home setting.

I. DEFINITION

Intravenous therapy is the administration of fluids, medication and/or nutritional products via the venous route and all those processes involved with its institution, maintenance and termination.

SECTION A

II. IV FLUID REPLACEMENT IN THE HOME

A. Medical Criteria

1. Inability of patient to take adequate nutritional products orally.
2. Physical signs of dehydration.
3. Baseline laboratory data with appropriate periodic evaluation and laboratory screening. Baseline laboratory data should include: WBC and differential, Hgb and/or Hct, BUN, Glucose and electrolytes. Other tests are to be done as indicated by the patients condition or diagnosis.
4. Safety of the IV fluids for home administration.
5. Patient in clinically stable condition; exception for terminal illness with voluntary consent of patient and/or caregiver.
6. Approved by a physician and seen by his/her agent (i.e. home health nurse) in the preceding 24 hours. Arrangements made for physician follow-up during therapy and after its termination.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home IV Therapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment.

- a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering IV therapy.
- b. Patient and/or primary caregiver acceptance and understanding of the purposes, responsibilities, risks, and benefits of home IV Therapy.
- c. Mutual consent of caregiver and/or patient and physician. Consent form for home IV Therapy signed by responsible person prior to discharge with signed copy of form to home health agency. For non-hospitalized patient, consent form signed in the home by patient or other legally responsible person prior to institution of IV Therapy. A sample of a consent form has been included. (Appendix I)
- d. Availability of medical supply delivery system.
- e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of intravenous therapy.
- f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)
- g. Availability of nursing personnel on a 24-hour basis.
- h. Age of patient. (Children under 5 years are not deemed as appropriate candidates for fluid replacement home IV Therapy, however, exceptions can be considered in specific cases. The opinions of all members of the health team, including the family must be taken into consideration before a final decision is made.)
- i. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

- Standards for teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)
- Nursing personnel teaching IV Therapy should have specialized IV skills.
- Teaching should be done using simplified terms at the patient's and/or caregiver's level of understanding.

a. Specifics of Teaching:

- (1) aseptic technique
- (2) proper administration of IV fluids; i.e., priming IV tubing, etc
- (3) signs/symptoms of complications and their specific interventions
 - (a) phlebitis
 - (b) infiltration
 - (c) leakage of fluid
 - (d) separation of line
 - (e) air in line
 - (f) contamination
 - (g) fluid overload
 - (h) occlusion
- (4) procedure for 24 hour problem reporting
- (5) type, amount and rate of fluids
- (6) delivery system (pump, etc.)
- (7) maintenance of patent IV line
- (8) appropriate storage and rotation of supplies
- (9) appropriate area for IV fluid administration
- (10) safe discarding of disposable equipment

(11) addition of medications if ordered (i.e. vitamins, KCl)

(12) interpretation of labels on IV fluid containers to include expiration dates

(13) assessment of IV fluid for contamination

b. Written instructions (to be sent home with patient/caregiver and to be attached to all home health agency referrals).

3. Physician Referral

a. The physician is to work in close collaboration with hospital personnel in making the necessary arrangements for discharge of the patient.

b. The physician or his representative are to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for the IV Therapy and nursing visit(s).

c. Notification of primary care physician if other than the physician ordering the IV therapy.

d. Specifics:

(1) I.V. fluids are to be ordered according to type, amount, rate, additives, duration, route and method of delivery.

C. Community Services

1. Responsibilities of Home Health Agency Nurse^{1/}

a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician medical suppliers, pharmacists and other health professionals as indicated.

b. Contact with patient/caregiver same day as discharge from hospital.

c. Assess patient's condition.

d. Assess home environment and if found to be unsuitable, contact the physician.

e. Assess, review and reinforce all items in 2a above.

^{1/} Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

- f. Return demonstration by responsible person of procedures taught in the hospital. (Refer to NITA standards in Appendix II.)
- g. Assist in identifying additional resources (especially for relief) as needed.
- h. Review plans for follow-up care and coordinate community referrals as necessary.
- i. Assure consent form is signed.
- j. Assure that all supplies are in the home to render IV Therapy.
- k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier and availability of 24-hour services.
- l. Visit patient on a regular and appropriate basis when on continuous IV fluid therapy as deemed necessary by the physician and/or patient's condition.
- m. Maintain regular contact with physician and other disciplines as indicated.
- n. Adhere to the following standards specific to nursing activities for IV Therapy:
 - (1) Check IV fluids for contamination and expiration dates
 - (2) Use of povidone/iodine or other approved topical anti-microbial prep for IV site (for iodine allergies use 70% alcohol prep)
 - (3) Change IV site every 72 hours^{2/}
 - (4) Apply sterile occlusive dressing to IV site
 - (5) Remove plastic cannulas at termination of IV Therapy with proper inspection
 - (6) Assure that a volume limiting device is attached to IV fluid containers for pediatric patients and others where fluid overload is a potential problem

^{2/} Venous access sometimes dictates frequency of site changes. Above guideline is to be used as a norm.

- o. Use of Heparin lock recommended for peripheral IV therapy.
- p. Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

SECTION 8

III. IV ANTIBIOTIC THERAPY IN THE HOME

A. Medical Criteria

1. Documentation of infection including any available culture and sensitivity reports.
2. Infectious process that can best be treated with IV antibiotics, i.e., antibiotic not available in oral form or therapeutic objectives not achieved via oral route.
3. Initiation of IV antibiotic in hospital or other medical facility.
4. Safety of IV antibiotic for home administration.
5. Patients seen by physician in preceding 48 hours before discharge.
6. Patient in clinically stable condition; exception for terminal illness with voluntary consent of patient and/or caregiver.
7. Dependable IV route.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home IV Therapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment

- a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering IV therapy.
- b. Patient's and/or primary caregiver's acceptance and understanding of the purposes, responsibilities, risks, and benefits of home IV Antibiotic Therapy.
- c. Mutual consent of caregiver and/or patient and physician. Consent form for home IV Therapy signed by patient or other legally responsible person prior to discharge with signed copy of form to home health agency. A sample of a consent form has been included. (Appendix I)
- d. Availability of medical supply delivery system.

- e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of intravenous therapy.
- f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)
- g. Availability of nursing personnel on a 24-hour basis.
- h. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of IV techniques and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

- Standards for teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)
- Nursing personnel teaching IV Antibiotic Therapy should have specialized IV skills. Nurse to be knowledgeable about the specific IV antibiotic ordered (may refer to pharmacist, manufacturer's instructions, etc.).
- Teaching should be done using simplified terms at the patient and/or caregivers level of understanding.

a. Specifics of Teaching:

- (1) aseptic technique
- (2) proper administration of IV antibiotics
 - (a) appropriate "thaw time" for premixed refrigerated or frozen antibiotics
 - (b) antibiotics should not be given IV push. (Refers to rate)
- (3) signs/symptoms of complications and their specific interventions
 - (a) phlebitis
 - (b) cellulitis
 - (c) infiltration

- (d) break and leaks in administration set or catheters
- (e) separation of line
- (f) air in line
- (g) air embolism
- (h) contamination
- (i) bleeding
- (j) allergic reaction
- (k) occlusion

- (4) procedure for 24 hour problem reporting
- (5) type, amount and rate of IV antibiotics (rate of administration important, especially with aminoglycosides)
- (6) delivery system (volutrol if indicated, etc.)
- (7) maintenance of patent IV line
- (8) checking of bag for pin hole leaks
- (9) appropriate storage and rotation of supplies (refrigeration or freezing will be necessary for premixed antibiotics)
- (10) appropriate area for IV fluids administration
- (11) safe discarding of disposable equipment
- (12) interpretation of labels on IV antibiotics to include expiration dates
- (13) assessment of IV fluid for contamination
- (14) preparation of IV antibiotic if not delivered premixed
- (15) appropriate intervals for administration of IV antibiotics if more than one is ordered
- (16) side effects for specific antibiotic or class of antibiotics; i.e., aminoglycosides (ototoxicity:

b. Written instructions (to be sent home with patient/caregiver and to be attached to all home health agency referrals).

3. Physician Responsibilities

a. The physician is to work in close collaboration with the pharmacist and hospital personnel in making the necessary arrangements for discharge of the patient.

- b. The physician or his representative is to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for antibiotic IV Therapy and nursing visit(s).
- c. Notification of primary care physician if other than the physician ordering the IV therapy.
- d. Specifics:
 - (1) I.V. antibiotics are to be ordered according to type, amount, rate, additives, duration, route and method of delivery
 - (2) Appropriate laboratory studies for:
 - (a) toxicity (i.e., weekly BUN, creatinine, urinalysis; hearing and vestibular testing on a regular basis for aminoglycoside therapy)
 - (b) therapeutic efficacy (peak and trough serum levels)
 - (3) Arrangements made for prompt notification of physician regarding lab values
 - (4) Periodic personal followup/clinical assessment by physician

4. Pharmacist Responsibilities

- a. Communicate with the physician, hospital personnel and HHA to coordinate resources necessary for discharge.
- b. Verify/evaluate physician's orders.
- c. Evaluate for reimbursement sources.
- d. Assist nurse and/or patient in teaching process as needed.
- e. Assure proper preparation of IV antibiotics.
- f. Prepare appropriate labels for parenteral container to include:
 - (1) patient's name
 - (2) physician's name
 - (3) date
 - (4) drug(s)

- (5) dosages (strength)
- (6) expiration date
- (7) diluent
- (8) administration rate
- (9) require a Federal labeling
- (10) other precautionary statement(s) if indicated
- g. Act as resource person for HHA nurse in regards to antibiotic ordered.
 - (1) storage of antibiotic
 - (2) stability
 - (3) compatibility
 - (4) reconstitution of antibiotic if not premixed
 - (5) rate
 - (6) necessary supplies
 - (7) other information specific to antibiotic ordered

D. Community Services

1. Responsibilities of Home Health Agency Nurse^{1/}

- a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician, medical supplier, pharmacist and other health professionals as indicated.
- b. Contact with patient/caregiver same day as discharge from hospital.
- c. Assess patient's condition.
- d. Assess home environment and if found to be unsuitable, contact the physician.
- e. Assess, review and reinforce all items under Hospital Discharge Planning #2 (Teaching).

^{1/}Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

- f. Return demonstration by responsible person of procedures taught in the hospital. (Refer to NITA standards in Appendix II.)
- g. Assist in identifying additional resources (especially for relief) as needed.
- h. Review plans for follow-up care and coordinate community referrals as necessary.
- i. Assure consent form is signed.
- j. Assure that all supplies are in the home to render IV Therapy.
- k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier, and availability of 24-hour services.
- l. Visit patient on a regular and appropriate basis when on antibiotic therapy as deemed necessary by the physician and/or patient's condition.
- m. Assess for appropriate laboratory monitoring.
- n. Maintain regular contact with physician and other disciplines as indicated. Physician to receive prompt notification of lab results.
- o. Adhere to the following standards specific to nursing activities for Antibiotic IV Therapy:
 - (1) Check IV antibiotic containers for contamination and proper labeling
 - (2) Use of povidone/iodine or other approved topical anti-microbial prep for IV site prep (for iodine allergies use 70% alcohol prep)
 - (3) Use Heparin lock
 - (4) Change IV site every 72 hours^{2/}
 - (5) Apply sterile occlusive dressing to IV site
 - (6) Remove plastic cannulas at termination of IV Therapy with proper inspection
- p. Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

^{2/} Venous access sometimes dictates frequency of site changes. Above guideline is to be used as a norm.

SECTION C

IV. TOTAL PARENTERAL NUTRITION (TPN) IN THE HOME

A. Medical Criteria

1. Inability of patient to take nourishment by any other route.
2. Medical condition warrants ongoing need for TPN according to physician's assessment.
3. Initiation of TPN in hospital or other medical facility.
4. TPN formula has been consistent for a 3 to 4 day period.
5. Patient stabilized on TPN regimen which will be given in the home (continuous or cyclic).
6. Monitoring of lab values on regular basis (at least weekly) with stabilization of values prior to discharge.
7. Patients seen by physician in preceding 24 hours before discharge.
8. Patient in clinically stable condition; exception for terminal illness with voluntary consent of patient and/or caregiver.
9. Intact central line.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home TPN Therapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment

- a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering TPN therapy.
- b. Patient's and/or primary caregiver's acceptance and understanding of the purposes, responsibilities, risks, and benefits of home TPN Therapy.
- c. Mutual consent of caregiver and/or patient and physician. Consent form for home TPN Therapy signed by patient or other legally responsible person prior to discharge with signed copy of form to home health agency. A sample of a consent form has been included. (Appendix I)

- d. Availability of medical supply delivery system.
- e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of TPN therapy.
- f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)
- g. Availability of nursing and pharmacy personnel on a 24-hour basis.
- h. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of TPN techniques and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

-Standards for teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)

-Nursing personnel teaching TPN Therapy should have specialized IV skills and be knowledgeable in the specifics of TPN Therapy (may refer to pharmacist, manufacturer's instructions, etc.).

-Teaching should be done using simplified terms at the patient and/or caregivers level of understanding.

a. Specifics of Teaching:

(1) aseptic technique

(2) proper administration of TPN

(a) infusion controller device necessary (recommend simplified pump with alarm system)

(b) warming of refrigerated TPN solution for approximately 18 - 24 hours at room temperature

- (c) use of filter (.22 micron) - lipid solutions to be infused below filter as close to catheter as possible
 - (d) ordered additives (vitamins, etc.) to be added to TPN solution just prior to administration
- (3) signs/symptoms of complications and their specific interventions
- (a) hypo/hyperglycemia
 - (b) fluid overload
 - (c) dehydration
 - (d) local and systemic infections
 - (e) electrolyte imbalances
 - (f) breaks and leaks in administration set, catheter line, solution container
 - (g) thrombophlebitis
 - (h) air embolism
 - (i) bleeding
 - (j) fatty embolism
 - (k) occlusion
 - (l) separation of line
 - (m) infiltration
 - (n) pump problems
- (4) procedure for 24 hour problem reporting
- (a) physician
 - (b) HHA nurse
 - (c) supply company (vendor)
 - (d) ambulance
 - (e) pharmacist
- (5) notification of utility companies
- (6) list of composition of TPN solution to include amount and rate
- (7) cyclic or continuous administration
- (a) tapering schedule for cyclic administration as ordered
- (8) maintenance of patent central line-heparinization
- (9) use of approved central catheter clamps
- (a) proper clamping
 - (b) weekly rotation of clamp site
- (10) assessment of TPN containers for leaks, contamination and proper labeling

- (11) appropriate storage and rotation of supplies
- (12) recorded inventory checks on regular basis
- (13) appropriate refrigeration of TPN solutions
- (14) appropriate work area for preparation, initiation and discontinuation of TPN
- (15) safe discard of disposables
- (16) monitoring of urine sugar/acetone on a regular basis during and after TPN administration
- (17) daily monitoring of temperature
- (18) daily weights if practical
- (19) intake and output if ordered by physician
- (20) ongoing assessment for complications with notification of physician, HHA nurse if they occur
- (21) care of central catheter site (clean/sterile) (with Hickman/Broviac Catheters, use sterile technique first month, then may use clean technique)
 - (a) use of povidone/iodine prep at catheter site
 - (b) sterile occlusive dressing to be changed on a regular basis and prn
 - (c) percutaneous catheter-must use sterile technique
- (22) securing all catheter junctions and taping of catheter to body
- (23) daily changing of luer-lock catheter caps using sterile technique
 - (a) for multiple lumen catheter, change cap of active lumen
 - (b) use of Valsalva maneuver when changing caps of percutaneous line
- (24) TPN line should not to be used for other medical purposes (except where there are no other alternatives, terminal patients - no other venous access)
- (25) changing of administration set every 24 hours
- (26) TPN solution to hang no more than 24 hours

(27) lipid solution to hang no more than 12 hours

(28) oral hygiene bid

(29) promotion of active physical exercise in accordance with patient's capabilities

b. Written instructions (to be sent home with patient/caregiver and to be attached to all home health agency referrals).

3. Physician Responsibilities

a. The physician is to work in close collaboration with the pharmacist and hospital personnel in making the necessary arrangements for discharge of the patient.

b. The physician or his representative is to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for TPN Therapy and nursing visit(s).

c. Notification of primary care physician if other than the physician ordering the IV therapy.

d. Specifics:

(1) TPN therapy is to be ordered according to concentration of glucose/amino acid mixture, amount, rate, additives, duration, route and method of delivery

(2) Appropriate laboratory studies should include:

(a) SMA-18 or equivalent battery of tests, mg⁺ level 1 - 2 times per month after patient is stabilized

(3) Arrangements made for prompt notification of physician regarding lab values

(4) Periodic personal followup/clinical assessment by physician

(5) Determination as to discontinuation of TPN (specify tapering schedule)

4. Pharmacist Responsibilities

a. Communicate with the physician, hospital personnel and HHA to coordinate resources necessary for discharge.

- b. Verify/evaluate physician's orders.
 - (1) Advise/counsel physician regarding availability and selection of TPN products
- c. Evaluate for reimbursement sources.
- d. Assist nurse and/or patient in teaching process as needed.
- e. Assure proper preparation of TPN solution.
 - (1) sterile technique required
 - (2) follow manufacturer instructions for preparation
 - (3) prepared by pharmacist or trained technician under direct supervision of pharmacist
- f. Prepare labels for TPN container to include:
 - (1) patient's name
 - (2) date
 - (3) physician
 - (4) concentration of glucose/amino acid mixture
 - (5) additives
 - (6) dosages
 - (7) expiration date
 - (8) required Federal labeling
 - (9) other precautionary statements if indicated
- g. Act as resource person for HHA nurse in regards to TPN solutions.
 - (1) storage of TPN
 - (2) stability
 - (3) compatibility
 - (4) preparation of TPN in home if not premixed
 - (5) rate
 - (6) necessary supplies
 - (7) administration
 - (8) complications
 - (9) other information specific to TPN

D. Community Services

1. Responsibilities of Home Health Agency Nurse^{1/}

- a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician, medical suppliers, pharmacist and other health professionals as indicated.

^{1/}Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

- b. Contact with patient/caregiver same day as discharge from hospital.
- c. Assess patient's condition.
- d. Assess home environment and if found to be unsuitable, contact the physician.
- e. Assess, review and reinforce all items under Hospital Discharge Planning #2 (Teaching).
- f. Return demonstration by responsible person of procedures taught in the hospital.
- g. Assist in identifying additional resources (especially for relief) as needed.
- h. Review plans for follow-up care and coordinate community referrals as necessary.
- i. Assure consent form is signed.
- j. Assure that all supplies are in the home to render TPN Therapy.
- k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier, and availability of 24-hour services.
- l. Visit patient on a regular and appropriate basis when on TPN therapy as deemed necessary by the physician and/or patient's condition.
- m. Assess for appropriate laboratory monitoring.
- n. Maintain regular contact with physician and other disciplines as indicated. Physician to receive prompt notification of lab results.
- o. Addition of extension set to percutaneous catheter if indicated.

Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

E. Special Considerations

- 1. Self-Mixing of TPN Solutions in the Home.
 - a. Careful assessment of patient's or primary caregiver's willingness and physical and mental capability in self-mixing and administering TPN.

- b. Appropriate well-ventilated work area identified specifically for self-mixing.
 - c. Proper procedures for preparing work area just prior to self-mixing.
 - d. Sterile gloves to be worn during preparation (mask to be worn if deemed necessary - upper respiratory infection).
 - e. Sterile technique.
 - f. Demonstration at home by person preparing TPN.
 - g. Written instructions of step-by-step procedure for self-mixing.
 - h. Preparation to be done just prior to administration; therefore, refrigeration not required.
 - i. Agitation of TPN container after each additive.
 - j. Addition of additives in proper sequence (see manufacturer's instructions).
 - k. Follow other guidelines specified for pre-mixed TPN solutions.
2. Implantable Venous Access Devices (IVAD's) in TPN Therapy.
- a. Use of #19G Huber needle (right angle) with extension set. Needle to be changed weekly and prn.
 - b. Heparinization of IVAD with at least 9 cc Heparin (due to extension set).
 - c. Weekly dressing change to coincide with needle change (use transparent sterile dressing).
 - d. Keep record of number of punctures and gauge needle used.
 - e. Discourage use of IVAD for obtaining blood specimens.
 - f. Person with IVAD should carry ID regarding IVAD and its location.
 - g. Follow other guidelines for TPN specified in this protocol.

SECTION D

V. IV CANCER CHEMOTHERAPY IN THE HOME

Introduction

The following protocol reflects current, accepted practice in the administration of IV chemotherapy. Much research is being done in the field of IV chemotherapy which will result in new methods of treatment. Therefore, the guidelines contained herein are stated in general terms. Professional health personnel involved with home IV chemotherapy need to be aware of the rapid changes occurring in this type of therapy which will require that they contact knowledgeable medical personnel to obtain up-to-date information and guidance in the proper procedures necessary for safe administration of IV cancer chemotherapy in the home.

A. Medical Criteria

1. Initial doses of IV chemotherapy given in medical facility (hospital, outpatient clinic or other location where physician in attendance).
2. IV chemotherapy can be safely administered in the home.
3. Patient has difficulty accessing medical facility and desires chemotherapy in the home.
4. Acceptable lab values (blood counts and chemistries as indicated) with periodic evaluations.
5. Assessment of patient's physical and mental status by physician to determine candidacy for home IV chemotherapy.
6. Approved and seen by physician in preceding 24-48 hours with arrangements made.
7. Provision made for local physician to follow if patient has more than 2 hour drive to location where chemotherapy was instituted. Arrangements should include written correspondence, discharge summaries and lab and x-ray reports as a minimum.

B. Hospital Discharge Planning

The following items are the responsibility of the hospital staff under the direction of the physician ordering the home IV chemotherapy. All activities must be completed and documented in the patient's record prior to discharge.

1. Assessment
 - a. Patient's and/or primary caregiver's willingness and mental and physical capability in administering IV chemotherapy.

- b. Patient's and/or primary caregiver's acceptance and understanding of the purposes, responsibilities, risks, and benefits of home IV chemotherapy.
- c. Mutual consent of caregiver and/or patient and physician. Consent form for home IV chemotherapy signed by patient or other legally responsible person prior to discharge with signed copy of form to home health agency. A sample of a consent form has been included. (Appendix I)
- d. Availability of medical supply delivery system.
- e. Physical facilities of the patient's residence should be appropriately equipped and conducive to the safe administration of IV chemotherapy.
- f. Accessibility of the home to health professionals. (Consideration of travel time as opposed to actual mileage.)
- g. Availability of nursing and pharmacy personnel on a 24-hour basis.
- h. The illness or condition should be amenable to care at home including reasonable expectation that the patient's medical, nursing and social needs can be met adequately in the home including a plan to meet medical emergencies.

2. Teaching

Teaching (includes instruction, discussion, demonstration of IV chemotherapy techniques and return demonstration by patient and/or primary caregiver) until person taught is competent in procedures to be followed at home.

Recommendations:

- Standards of teaching should be those of the National Intravenous Therapy Association (NITA). (Appendix II)
- Nursing personnel teaching IV chemotherapy should have specialized IV skills and be knowledgeable in the specifics of IV chemotherapy (may refer to pharmacist, manufacturer's instructions, etc.).
- Teaching should be done using simplified terms at the patient and/or caregivers level of understanding.

a. Specifics of Teaching:

- (1) aseptic technique

(2) proper administration of IV chemotherapy

- (a) refrigeration of chemotherapy solutions in a separate compartment in refrigerator (sealed in plastic container)
- (b) warming of chemotherapy solution according to pharmacists' instructions
- (c) use of .22 micron filter (Exception: No filter with actinomycin-D)
- (d) use of appropriate infusion device (small volume with alarm)

(3) complications

(a) drug-related (depends on type chemotherapy agent being administered)

- (1) oral lesions
- (2) G-I disturbances
- (3) alopecia
- (4) neurological disturbances
- (5) anemia
- (6) hematological side effects
- (7) electrolyte imbalances
- (8) cardiac toxicity
- (9) pulmonary toxicity
- (10) vascular disturbances
- (11) flu-like syndrome (malaise)
- (12) genitourinary disturbances
- (13) anaphylaxis
 - aa. specify procedures for treating/transporting

(b) prompt notification of physician when complications/side effects occur

(c) other complications

- (1) sepsis
- (2) breaks and leaks in administration set, catheter line, solution container
- (3) thrombophlebitis
- (4) air embolism
- (5) bleeding
- (6) occlusion
- (7) separation of line
- (8) extravasation
 - aa. specify procedures to use for extravasation
- (9) pump problems

- (4) procedure for 24 hour problem reporting
 - (a) physician
 - (b) HHA nurse
 - (c) supply company (vendor)
 - (d) ambulance
 - (e) pharmacist
 - (5) notification of utility companies
 - (6) list of composition of chemotherapy solution to include amount, rate and expiration date
 - (7) short or long term administration (depends on drug ordered)
 - (8) maintenance of patent central line-heparinization
 - (9) use of approved central catheter clamps
 - (a) proper clamping
 - (b) weekly rotation of clamp site
 - (10) assessment of chemotherapy containers for leaks, contamination and proper labeling (do not squeeze bag)
 - (11) appropriate storage and rotation of supplies
 - (12) recorded inventory checks on regular basis
 - (13) appropriate work area for initiation and discontinuation of chemotherapy solution
- Note: Strongly recommend that chemotherapy solutions not be mixed in the home.
- (14) disposable gown, latex gloves and mask to be worn during initiation and discontinuation of chemotherapy solution - use double gloves for cleaning spills
 - (15) discard all disposables in contact with chemotherapy solution in leak and puncture proof containers marked hazardous wastes and place in sealed container - transport to medical facility for disposal
 - (16) procedure to be used if accidents occur - accidental needlestick, spills
 - (17) daily monitoring of temperature
 - (18) daily weights if practical

- (19) ongoing assessment for complications with notification of physician, HHA nurse if they occur
- (20) care of central catheter if patient has one (clean/sterile-with Hickman/Broviac Catheters, use sterile technique first month, then may use clean technique)
 - (a) use of povidone/iodine prep at catheter site
 - (b) sterile occlusive dressing to be changed on a regular basis and prn
 - (c) percutaneous catheter-must use sterile technique
- (21) securing all catheter junctions and taping of catheter to body
- (22) changing of luer-lock catheter caps using sterile technique after each dose chemotherapy; twice per week when not receiving chemotherapy
 - (a) for multiple lumen catheter, change cap of active lumen
 - (b) use of Valsalva maneuver when changing caps of percutaneous line
- (23) chemotherapy line should not be used for other medical purposes (except where there are no other alternatives, terminal patients - no other venous access)

Note: Strongly recommend that home IV chemotherapy be administered via central line, especially vesicants.
- (24) change IV tubing with each dose of chemotherapy (for a 3-5 day continuous infusion, do not change tubing). All tubing to be primed with chemotherapy solution prior to infusion
- (25) chemotherapy solution to hang for as long as ordered
- (26) all connecting sites on IV apparatus are to have luer-lock devices and be taped
- (27) oral hygiene bid
- (28) promotion of active physical exercise in accordance with patient's capabilities

- b. Written instructions to be sent home with patient/ caregiver and to be attached to all home health agency referrals.

3. Physician Responsibilities

- a. The physician is to work in close collaboration with the pharmacist and hospital personnel in making the necessary arrangements for discharge of the patient.
- b. The physician or his representative is to contact the Home Health Agency (HHA) and establish a Home Health Plan of Treatment for chemotherapy and nursing visit(s).
- c. Notification of primary care physician if other than the physician ordering the chemotherapy.
- d. Specifics:
 - (1) chemotherapy orders to include:
 - (a) name of drug
 - (b) dose
 - (c) rate
 - (d) duration
 - (e) route
 - (f) method of delivery
 - (2) periodic lab studies required and ordered according to drug being given
 - (3) periodic assessments of patient by physician and/or representative
 - (4) automatic stop orders for IV chemotherapy for particular lab values and/or physical findings

4. Pharmacist Responsibilities

Introduction

Pharmacists involved in the preparation of IV chemotherapy agents should possess adequate knowledge and skills related to the specific requirements of ordering, storing, preparing, handling and disposing of chemotherapy drugs and supplies. They should also be knowledgeable regarding proper dilutions, administration guidelines and special precautions. It is recommended that these pharmacists possess up-to-date reference materials and develop good working relationships with personnel who are experts in the field of chemotherapy.

- a. Communicate with the physician, hospital personnel and HHA to coordinate resources necessary for discharge.
- b. Verify/evaluate physician's orders according to compatibility with other drugs/fluids, dose levels, administration rates.
- c. Evaluate for reimbursement sources.
- d. Assist nurse and/or patient in teaching process.
- e. Assure proper preparation of chemotherapy solution.

Note: Recommend that Type II, Class B3 vertical flow hood be used for preparation.

- (1) sterile technique required
 - (2) follow manufacturer's instructions for preparation
 - (3) prepared by pharmacist or trained technician under direct supervision of pharmacist using proper attire as indicated
- f. Prepare labels for chemotherapy container to include:
 - (1) patient's name
 - (2) date
 - (3) physician
 - (4) concentration of chemotherapy agent
 - (5) dosages
 - (6) expiration date
 - (7) required Federal labeling
 - (8) other precautionary statements
 - g. Act as resource person for HHA nurse in regards to chemotherapy agents.
 - (1) storage
 - (2) stability
 - (3) compatibility
 - (4) rate
 - (5) necessary supplies
 - (6) administration
 - (7) complications
 - (8) other information specific to chemotherapy agent being used
 - (9) proper disposal of supplies used in administration of chemotherapy
 - h. Maintain patient profile including cumulative doses of chemotherapy agent.

D. Community Services

1. Responsibilities of Home Health Agency Nurse^{1/}

- a. Collaborate with hospital staff to assure continuity of coordinated care between hospital and home to include communication with physician, medical suppliers, pharmacist and other health professionals as indicated.
- b. Contact with patient/caregiver same day as discharge from hospital.
- c. Assess patient's condition.
- d. Assess home environment prior to patient discharge and, if found to be unsuitable, contact the physician.
- e. Assess, review and reinforce all items under Hospital Discharge Planning #2 (Teaching).
- f. Return demonstration by responsible person of procedures taught in the hospital.
- g. Assist in identifying additional resources (especially for relief) as needed.
- h. Review plans for follow-up care and coordinate community referrals as necessary.
- i. Assure consent form is signed.
- j. Assure that all supplies are in the home to render chemotherapy.
- k. Notify the patient/caregiver of emergency numbers; home health agency, physician, medical supplier, and availability of 24-hour services.
- l. Visit patient on a regular and appropriate basis when on chemotherapy as deemed necessary by the physician and/or patient's condition.
- m. Assure periodic laboratory monitoring specific to the chemotherapy being ordered.
- n. Maintain regular contact with physician and other disciplines as indicated. Physician to receive prompt notification of lab results and physical assessment findings.

^{1/} Refer to Appendix III for opinion statement of the Kentucky Board of Nursing (July 1984) regarding L.P.N. practice in IV Therapy.

- o. Strict adherence to proper disposal of chemotherapy supplies.
- p. Maintain close contact with pharmacist regarding chemotherapy agent being used.
- q. If patient on 3-5 day concentrated infusion, at termination of infusion, withdraw remaining chemotherapy agent out of central line (volume will depend on type of central catheter), flush with saline and heparinize.
- r. Carefully assess for extravasation if IVAD (implantable venous access device) is being used.

Refer to NITA standards, specifically recommendations of practice listed under heading #32, Home IV Therapy Programs. (Appendix II)

APPENDIX I

Patient's Consent For Non-Nurse Administered
Intravenous Therapy In The Home

I, _____ consent to
(Patient's Full Name)
_____, who is my _____ having
(Full Name) (Relationship)
responsibility for administering intravenous medications/fluids prescribed
by my physician and needed by me at my home.

I understand that _____ will be administering
(Full Name)
and monitoring the intravenous therapy in the absence of the visiting
nurse.

I understand that _____ has received instruction,
(Full Name)
but that the instruction is not as complete as the training of the nurse.

I understand that only specially trained nurses will be assigned to
provide home care to me and that precautions will be taken to avoid
complications. However, I realize that at times complications occur
despite meticulous attention.

I understand that a visiting nurse service is an intermittent
service and the nurse may not be present at the time of the therapy or
when complications/emergencies could arise.

I agree to release _____
(Name of Home Health Agency)
and any of its agents, servants or employees from any and all claims or
causes of action which I, or any of my heirs, successors, or assigns may
have arising out of the administering of my intravenous therapy whether
or not it is related to the instruction which _____
(Full Name)
received or any other reason.

I have the right to discontinue home intravenous therapy upon
notification of my doctor.

My signature certifies that I have read and understand and consent
to the administration of intravenous therapy in the home.

(Date) Signed: _____
(Patient)

(Witness) Or: _____
(Responsible Adult)

(Relationship to Patient)

... all possible complications associated with I.V. therapy and the ability to recognize the occurrence of such reactions, make clinical judgements and initiate proper nursing intervention.

l. Blood Component Therapy

To provide the registered professional nurse with knowledge of immunohematology, blood grouping, blood and blood components, equipment and reactions. The registered professional nurse shall be knowledgeable of the selection and protection of blood donors, the fractionation of blood into its components and the laboratory testing required for determining compatibility. Emphasis shall be placed on the administration of blood and its components and the recognition and management of any adverse reactions which the patient may experience.

m. Parenteral Nutrition

To provide the registered professional nurse with the knowledge in clinical application of parenteral nutrition including assessment, initiation, maintenance and termination of the therapy. Emphasis should be placed on metabolic processes, potential complications and preventive measures to insure the desired therapeutic effect.

n. Chemotherapy

To provide the registered professional nurse knowledge and understanding of the basic principles of cancer therapy and administration of I.V. antineoplastic agents.

2. Clinical

All clinical aspects of I.V. therapy shall be supervised until proficiency is demonstrated acceptable by observation and approval of returned demonstrations and clinical judgement is assessed as competent.

APPENDIX II

Standards

Recommendations of Practice

1. I.V. Nursing Teams

Professional, specially trained I.V. nursing teams decrease the risk of I.V. related complications and infections, insure patient protection, deliver quality I.V. care and are cost effective.

Recommendations of Practice

1. I.V. nursing teams should be placed under one of the following hospital departments: Pharmacy, Blood Bank, Pathology, Administration, and have a close relationship with Nursing Service and the Infection Control Department.
2. I.V. Departments should be an independent department.
3. I.V. Departments should be cost effective.
4. I.V. Departments shall have a medical advisor who is a physician.
5. All I.V. policies and procedures shall be approved by a member of the medical staff.
6. All I.V. policies and procedures shall be reviewed and updated annually.

2. I.V. Policies and Procedures

To insure safe and standardized I.V. therapy within the health care facility; to protect the patient by maximizing benefits and minimizing risks associated with this therapy and to protect the practice(s) of the registered professional I.V. nurse.

Recommendations of Practice

1. I.V. policies shall be written general statements that encompass a specific area of practice.
2. I.V. procedures shall be written and specifically detailed to a particular I.V. practice.
3. I.V. policies and procedures shall be submitted by an I.V. Supervisor, by the medical staff and appropriate hospital governing body that governs the specialty of I.V. therapy.
4. I.V. policies and procedures that are established within a given institution are solely intended for use within that particular institution.
5. I.V. policies and procedures shall be updated continuously and reviewed annually.
6. All registered professional I.V. nurses are accountable for thorough knowledge of the I.V. policies and procedures within their particular institution.
7. I.V. policies and procedures should be in keeping with these Standards.

3. Initiation of I.V. Therapy

The initiation of I.V. therapy shall be to provide intravascular access for definite therapeutic or diagnostic indications.

Recommendations of Practice

1. Ascertain the physician's order.

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written and signed. If a verbal order is taken from a physician or a registered professional LV. nurse, the verbal order shall be written and signed as soon as possible.

3. The nursing process shall be utilized in evaluating the medical order and the patient's needs.
4. Identify the patient.
5. Explain the procedure, specific therapy and consideration of therapy to the patient.
6. Collect and assemble appropriate equipment so the equipment will be aseptically handled in order of its use.

4. Choice of Cannula for Peripheral Infusions

Use the smallest gauge device that will achieve the prescribed treatment and a vein large enough to maintain sufficient blood flow around the LV.

1. Plastic catheters shall be used for routine peripheral LV. therapy in order to establish a secure access to the vascular system.
2. Stainless steel cannulas may be used for short-term or one-dose peripheral LV. therapy but tend to infiltrate and dislodge more frequently than LV. plastic catheters.
3. This Association advocates the use of radiopaque catheters for LV. use.
4. Stylets shall never be reinserted when LV. catheters are initiated.
5. Through-the-needle catheters are not recommended for routine peripheral LV. use.
6. Only one device shall be utilized for each attempt.
7. The nurse should not make more than two attempts to initiate LV. therapy.

5. Handwashing

Before inserting an LV. cannula, hospital personnel shall wash their hands.

Recommendations of Practice

1. Soap and water is adequate for most peripheral insertions.
2. An antiseptic solution should be used for handwashing prior to the insertion of peripheral central catheters.

6. Site Selection

In vein selection, the patient's condition, vein condition, age and the type and duration of therapy shall be assessed to insure ideal and safe LV. access.

Recommendations of Practice

1. Veins most appropriate for LV. therapy are metacarpal veins, cephalic veins, basilic veins and the median veins.
2. Start peripheral routine LV. therapy in distal areas of the upper extremities.
3. Palpation of the vein is important in assessing the condition of the vein and in differentiating it from an artery. Fingers should be used for palpation to access the vein. The thumb shall not be used since it is not as sensitive as the

fingers and the thumb pulse may be confused in detecting an artery.

4. To distend the vein, apply a tourniquet or pressure cuff 4-6 inches above the site selected.
5. Tourniquets should be applied with enough pressure to stop venous flow but not arterial flow.
6. Application of heat may be indicated for prevention of vein dilatation. Care should be taken to avoid burns when applying heat.
7. Subsequent venipunctures should be made in areas proximal to previous LV. sites.
8. Avoid the antecubital fossa since this is the preferred site of venipuncture for drawing blood tests and peripheral central line access.
9. Avoid lower extremities (legs) unless specifically ordered by the physician or necessitated by the patient's condition.
10. Cannulas inserted into lower extremities shall be changed as soon as a satisfactory site can be established.
11. Avoid previously used veins, injured veins and sensitive veins and areas of flexion unless you immobilize the joint with an armboard or similar device.
12. Avoid veins in the affected arm of an axillary dissection.

Consideration

Liquid crystal thermographic patterns may be considered in evaluating venous physiology for site selection.

7. Site Preparation

The LV. site shall be scrubbed with an antiseptic solution prior to venipuncture insertion.

Recommendations of Practice

1. If necessary, wash the skin with soap and water prior to application of antiseptic solution.
2. When excessive hair exists, clipping the hair is recommended rather than shaving.
3. Tincture of iodine (1-2%), iodophors or 70% isopropyl alcohol can be used as antiseptic solutions.
4. If the patient is sensitive to iodine, 70% isopropyl alcohol is recommended.
5. The antiseptic solution should be applied liberally and allowed to dry.
6. In an emergency, when there has been inadequate skin preparation, as soon as the patient has been stabilized, a second line should be established, the emergency line removed and the previous site observed for 48 hours.

8. Cannula Placement

Safe and effective LV. access is accomplished by strict aseptic cannula placement.

Recommendations of Practice

1. Prior to use, the nurse shall confirm the integrity of the product.
2. Product defects should be ascertained by inspection and if defective, the product should be discarded and returned to the manufacturer.

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sites for peripheral vascular access.

4. Strict aseptic technique shall be adhered to for cannula placement. In an emergency situation, when an I.V. cannula has been placed without adequate skin preparation, the I.V. cannula should be removed as soon as possible and the previous site observed for 48 hours.
5. Irrigation of I.V. cannulas should be avoided.
6. The type, gauge, length, insertion date and initials of person inserting the device shall be recorded in the medical record and written on a tape, close to the dressing, where it can be easily identified.
7. The cannula should be secured to stabilize it at the insertion site.
8. The nurse shall ascertain patency and placement of the cannula after placement. Evaluation of patency and placement should continue throughout therapy.

Consideration

Maximum mobility and easy viewing should be taken into consideration when taping and securing an I.V. cannula.

9. Cannula Site and I.V. Dressing Care

Cannula site and I.V. dressing care is to provide regular, standardized cannula site inspection, site care and to apply a sterile dressing. These measures should reduce or prevent the complications of cannula related sepsis.

Recommendations of Practice

1. If a topical ointment is used, it should be applied at the I.V. site at the time of insertion.
2. If a topical ointment is used, the use of antimicrobial (povidone-iodine) is the ointment of choice and widely accepted.
3. A sterile dressing shall be applied over all I.V. sites to cover the I.V. cannula entrance site.
4. A sterile transparent, semi-permeable membrane adhesive dressing may be applied over I.V. sites to cover the I.V. cannula entrance site.

Consideration

Some researchers have suggested that the use of polyantibiotic ointment may be efficacious at the skin-cannula junction site and that antiseptic ointments, e.g., povidone-iodine have marginal benefits.

10. I.V. Cannula Removal

Peripheral I.V. cannulas shall be routinely changed every 48-72 hours. Peripheral I.V. cannulas shall be inspected and evaluated through an intact dressing at least every 8 hours. These measures should reduce or prevent cannula related complications.

Recommendations of Practice

1. Routine peripheral I.V. cannulas shall be changed to a new site every 48-72 hours provided no I.V. related complications are encountered before this time.
2. Cannulas inserted in an emergency situation

new site at the earliest opportunity.

3. Peripheral cannulas that must remain in place for prolonged periods (over 72 hours) due to the patient's condition should be considered a higher risk of potential complication and require more frequent assessment and evaluation.
4. The cannula should be removed if there is pain or tenderness at the insertion site.
5. Intermittent devices (heparin locks) shall be treated as peripheral cannulas.
6. Central catheters that are inserted through a peripheral vein and peripheral arterial catheter should be treated as a peripheral catheter. The proper frequency for changing these catheters is not known.
7. The nurse, as dictated by hospital policy, will remove central venous catheters, using aseptic, no-touch technique.
8. To ascertain complete removal of the catheter, the nurse will assess the length of the terminated catheter and inspect visually the tip for smoothness.

Considerations

1. The nurse, as dictated by established hospital policy, will culture appropriately the catheter in a routine, standardized manner, using aseptic, no touch technique. This practice should be especially encouraged when the catheter is suspected of being contaminated or when the patient has an unexplained fever.
2. A semiquantitative method of catheter culture is recommended.

11. I.V. Administration Set Change

Changing the I.V. administration set is to prevent or minimize sepsis related to the I.V. delivery system.

Recommendations of Practice

1. I.V. administration tubing shall be changed every 24-48 hours.
2. Changing of I.V. administration sets should be carried out in a routine, standardized manner and at the time a new container of I.V. solution is initiated.
3. An appropriate method of indicating the date of change of administration shall be employed.
4. "Piggy-back" tubing shall be routinely changed every 24 hours.
5. "Piggy-back" administration sets accommodating blood, blood products or lipid emulsions should be changed immediately after their administration.
6. I.V. administration sets used for Total Parenteral Nutrition should be changed every 24 hours.
7. Tubing junctions should be secured by an appropriate method such as can be accomplished with a luer lock or junction clamping device.
8. All additives to the administration set such as stop-cocks and extension tubings should be changed at the same time the I.V. administration set is changed.

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9. I.V. systems should be maintained as closed systems whenever possible. All entries into the administration set such as the administration of medications should be made through injection ports that are disinfected before entry.

10. Blood specimens should not be withdrawn through I.V. tubing.

11. Flushing or irrigation of the I.V. system to improve flow should be avoided.

12. The entire I.V. system (cannula, administration set and fluid) shall be changed immediately if purulent thrombophlebitis, cellulitis or I.V. related bacteremia are noted or strongly suspected.

13. For phlebitis, without concomitant signs of infection, the cannula and administration set should be changed and the fluid evaluated as a possible source for phlebitis.

12. Dressing Changes

Changing I.V. dressings is to evaluate the insertion site, prevent complications and minimize sepsis.

Recommendations of Practice

1. The I.V. dressing should be changed every 24-48 hours and immediately if the dressing becomes soiled, wet or loose.

2. Aseptic technique shall be used to change I.V. dressings.

3. During dressing change, the insertion site should be inspected and evaluated for redness, swelling and other signs and symptoms of infection.

4. If the dressing is changed, the site should be cleaned with 70% isopropyl alcohol or povidone-iodine solution and allowed to dry, followed by reapplication of iodophor ointment and sterile dressing.

13. Culturing for Suspected I.V. Related Infections

Culturing is to ascertain the source and microorganisms of suspected contamination.

Recommendations of Practice

1. If the I.V. system is terminated because of suspected I.V. related infection, i.e., purulent thrombophlebitis and bacteremia, the skin at the cannula junction should be cleaned with alcohol and allowed to dry before the cannula is removed. The cannula should be cultured using a semiquantitative technique.

2. If the I.V. system is terminated because of suspected fluid contamination or related bacteremia, the fluid should be cultured and the implicated bottle saved and the lot number recorded.

3. If intrinsic contamination (contamination during manufacturing) is suspected, the health authorities should be notified immediately.

14. Quality Control of I.V. Solutions

To observe for possible intrinsic contamination and assure against possible extrinsic contamination.

complications.

Recommendations of Practice

1. Personnel shall wash their hands before opening and administering parenteral fluids.

2. All containers of parenteral fluid shall be inspected prior to use and checked for visible turbidity, discoloration, leaks, cracks, damaged caps, particulate matter and for the manufacturer's expiration date before use. If a problem is found, the fluid shall not be used.

3. Once started, all parenteral fluids shall be completely used or discarded within 24 hours.

4. Infusions of lipid emulsions should be completed within 12 hours of starting.

5. All parenteral solutions shall have affixed a label indicating time and date started.

15. Admixture of Parenteral Fluids

To insure control and minimize possible complications of parenteral compounding.

Recommendations of Practice

1. Parenteral and hyperalimentation fluids should be admixed in the pharmacy unless clinical urgency requires admixture in patient-care areas.

2. Personnel shall wash their hands before admixing.

3. Single dose vials should be used for admixture whenever possible.

4. All medications should be compounded using the manufacturer's recommendations.

5. A selective supplementary label shall be affixed to all admixed (compounded) parenteral solutions stating the additive, dosage, solution amount, date, time of compounding, expiration date and person who did the compounding.

6. A laminar flow hood should be used for admixing parenteral solutions.

7. Handling of admixtures should be in keeping with the Recommendations Guidelines and Standards of the American Society of Hospital Pharmacists.

8. Compatibility of solution ingredients shall be authorized by the pharmacy before admixing.

9. In the absence of a vacuum, an I.V. solution container shall be covered with a sterile air tight, water proof cover after admixture.

10. When admixing occurs outside the pharmacy, hospital policy shall be strictly observed and absolute aseptic technique practiced.

16. Intermittent I.V. Therapy

A mechanism for intermittent I.V. therapy shall be employed to provide intravascular access for the patient whose condition will possibly require or necessitate definite therapeutic or diagnostic I.V. therapy. Intermittent I.V. therapy shall be employed when continuous therapy is not required by the patient's condition.

Recommendations of Practice

1. Intermittent vascular access shall be treated as I.V. peripheral catheters.

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7. All I.V. cannulas locked with a rubber port male adapter may be used for intermittent I.V. therapy.
3. If heparin is used, a dose of heparin that does not alter the patient's clotting factors shall be used for maintaining patency of I.V. intermittent cannula devices. These devices should be flushed with heparinized saline solution routinely and whenever necessary to maintain patency.
4. The use of obturators is not recommended.
5. In flushing intermittent devices, consideration should be given to drug incompatibilities.
6. Use of small bore and short length needles is recommended for administering I.V. therapy through rubber ports of the intermittent device.
7. The optimal frequency for entering the rubber port is not known and leakage depends on the size of the needle inserted through the rubber port and the specific grade of rubber.
8. Utilization of intermittent devices may be established by hospital policy and may be useful in the maintenance of intermittent medications, blood and blood components, I.V. fluids, or as vascular access for the critically ill patient or unstabilized patient, for laboratory procedures and for home I.V. therapy.

17. Labeling of I.V. Administration Sets, Cannulas and I.V. Solutions

1. All I.V. solutions shall be labeled according to the Standards of Practice as stated in the section *Quality Control of I.V. Solutions* under the Recommendations of Practice.
2. All admixed parenteral fluids shall be labeled according to the Standards of Practice as stated in the section *Admixture of Parenteral Fluids* under the Recommendations of Practice.
3. All I.V. administration sets shall be labeled according to the Standards of Practice as stated in the section *I.V. Administration Set Change* under the Recommendations of Practice.
4. All I.V. cannulas shall be labeled according to the Standards of Practice as stated in the section *Cannula Placement* under the Recommendations of Practice.

18. Administration of I.V. Medications

Administration of I.V. medications shall be initiated by a prescription of a medical doctor and provide a therapeutic outcome.

Recommendations of Practice

1. The registered professional I.V. nurse may administer I.V. medications which have been established by hospital policy and in accordance with individual state regulations.
2. The health care facility shall provide a list of approved I.V. medications which includes generic and trade name, indications for usage, dosage with maximum limit, side effects, rate of administration, stability and storage requirements, appropriate diluents, incompatibilities,

toxicity, specific precautions and nursing interventions.

3. Prior to administering an I.V. medication, the registered professional I.V. nurse shall be cognizant of the implications of I.V. medication.
 4. If an I.V. medication has possible allergic implications, it is recommended that the physician administer the first dose.
 5. The approved drug list shall be updated and added to continually.
 6. The approved drug list shall be reviewed annually.
 7. The patient shall be evaluated for possible drug sensitivity and possible complications prior, during and after I.V. medication administration.
 8. Administration of I.V. medications shall be documented in the patient's permanent record.
 9. Aseptic technique shall be adhered to, in the administration of I.V. medications.
19. Administration of I.V. Investigational Drugs
The administration of I.V. investigational drugs shall be initiated by a prescription of a medical doctor with approval of the health care facility and provide a therapeutic outcome.

Recommendations of Practice

1. The administration of I.V. investigational drugs shall be in accordance with the Standards of Practice as stated in the section *Administration of I.V. Medications* under the Recommendations of Practice.
2. The health care facility shall establish specific guidelines, policies and procedures for the administration of I.V. investigational drugs and these guidelines, policies and procedures shall be stated in the I.V. Policy and Procedure Manual.
3. A separate approved list for the use of I.V. investigational drugs shall be employed.
4. All I.V. investigational drugs shall be approved by a hospital committee.
5. I.V. investigational drugs shall be initiated with the patient's consent.
6. I.V. investigational drugs shall be reviewed and monitored by the medical staff.

20. I.V. Push Medications

To provide instant absorption of I.V. medications in the blood, immediate therapeutic effect in an emergency situation and for a specific drug peculiarity.

Recommendations of Practice

1. An approved, separate list of I.V. push medications shall be provided by the health care facility and stated in the I.V. Policy and Procedure Manual.
2. The administration of I.V. push medications shall be initiated on the order of a medical doctor or on the judgement of a registered professional I.V. nurse in a life-threatening emergency situation according to the policy of the health care facility.

3. The administration of I.V. push medications should be in accordance with the Standards of Practice in the section *Administration of I.V. Medications* under the *Recommendations of Practice*.
4. Special emphasis shall be given to the rate of administration.
5. I.V. push medications shall be diluted sufficiently and according to the manufacturer's recommendations.

21. .22 Micron Air Eliminating Filters

To protect the patient from induced particulates, possible air emboli, pathogenic bacteria (microorganisms) and to minimize the risk of I.V. related complications and sepsis.

Recommendations of Practice

1. The routine use of .22 micron air eliminating filters is advocated in delivering routine I.V. therapy since these filters effectively remove particles and bacteria and prevent air from entering the I.V. system.
2. .22 micron air eliminating filters should be routinely changed every 24-48 hours.
3. Possible retention due to low dosage, solubility and absorption properties of I.V. drugs through a .22 micron air eliminating filter shall be considered and follow the manufacturers' recommendations.
4. Lipid emulsions and blood and blood products shall not be filtered through a .22 micron air eliminating filter.
5. The pressure tolerance of the filter housing and membrane shall be a major consideration prior to use.
6. The tolerated psi (pounds per square inch) of a filter shall not exceed the maximum pressure (psi) exerted by the I.V. pump.
7. .22 micron air eliminating filters should be placed at the terminal end of the I.V. administration set (as close to the I.V. cannula as possible).

Considerations

1. This Association believes that the use of .22 micron air eliminating filters is cost justified.
2. From an infection standpoint only, the Centers for Disease Control does not recommend the routine use of .22 micron air eliminating filters. Their recommendation is based on the lack of definitive studies to date, on the efficacy of .22 micron air eliminating filters studying filtration from an infection control standpoint. Such studies are difficult to accomplish. However, there have been many definitive studies attesting to the benefits of final filtration, e.g., minimizing phlebitis which is a precursor to infection and their air elimination properties protecting the patient from air emboli. Since .22 micron air eliminating filters screen out particles, remove microorganisms and prevent air from entering the I.V. system, the National Intravenous Therapy Association believes that many benefits of final filtration have been

very well documented in the literature and use of .22 micron air eliminating filters mixes potential risk to the patient, thus, use is recommended routinely for all I.V. therapy. Furthermore, their cost is justified, possibly cost effective by considering possible complications of therapy resulting in possible further medical treatment and longer patient stay days.

3. No I.V. filter is available that will prevent the passage of endotoxins or pyrogens.
4. Consideration should be given to the filter surface area to insure necessary flow rates.
5. Automatic air venting allows air bubbles to escape to the atmosphere.

22. Mechanical Controlling Devices

The use of mechanical controlling devices is to provide minimal deviation from the prescribed medical order in the delivery of solutions and/or medications, thus reducing the risk of possible I.V. complications.

Recommendations of Practice

1. Delivery of all aspects of I.V. therapy shall be controlled with minimal deviation from the prescribed rate ordered.
2. The use of gravity feed mechanical devices, e.g., I.V. controllers is advocated for the majority delivery of I.V. therapy.
3. The use of pressure feed mechanical devices, e.g., I.V. pumps is recommended for controlled I.V. delivery when a specified accuracy of delivery is mandatory due to patient risk.
4. I.V. pumps should maintain I.V. delivery within stringent deviation of the prescribed medical order and their accuracy or deviated limit (plus or minus) shall be stated by the manufacturer.
5. All I.V. electronic devices shall be routinely cleaned and checked for any possible malfunctions.
6. The use of electronic mechanical controlling infusion devices shall be prioritized and stated by hospital policy in the I.V. Policy and Procedure Manual.
7. The registered professional I.V. nurse shall be proficient and knowledgeable in the use of mechanical controlling devices within the health care facility.
8. Operating instructions for electronic mechanical I.V. controlling devices shall be affixed to the device.
9. Audible and visible alarms to detect air, deviated flow, occlusion, and any other deviations placing the patient at risk shall be integrated within the mechanical infusion device.
10. If the mechanical controlling device is battery operated, the life and potency of the battery(s) should be ascertained and changed accordingly.
11. Mechanical electronic controlling devices should be patient tamperproof.

Considerations

1. Consideration should be given to maximum

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occasional pressures should not be given and exceed.

- 2. Consideration should be given to accuracy over the range of back pressures.
- 3. The registered professional I.V. nurse should be cognizant of the Standards on Infusion Devices set forth by the Association for the Advancement of Medical Instrumentation.

23. Blood Component Therapy

The initiation of blood and blood component therapy shall be on the order of a medical doctor and shall provide a safe and therapeutic outcome as prescribed.

Recommendations of Practice

- 1. The administration of blood and blood components by a registered professional shall be in accordance with federal and state regulations and established hospital policy.
- 2. The administration of blood and blood components shall only be assumed by the registered professional nurse after successful testing of theory in immunohematology, blood grouping, blood and blood components and reactions, clinical competency of administration techniques and identification protocol of patient and products and nursing interventions for possible reactions shall be validated.
- 3. Policies and procedures for administration of blood and blood components shall be approved by the Medical Director of the Blood Bank and reviewed annually.
- 4. The patient may be required, according to established hospital policy, to sign a consent form prior to administering blood and blood component therapy.
- 5. The patient should be evaluated prior to, during and after blood and blood component administration.
- 6. All blood and blood products should be inspected prior to use to insure the integrity of the product and product expiration.
- 7. The physician's order for blood and blood components shall be written clearly and specifically.
- 8. The patient shall be observed for at least five minutes after the initiation of blood and blood components.
- 9. Adherence to aseptic technique in the administration of blood and blood components is mandatory.
- 10. The size of the cannula should be appropriate for accommodating blood or blood components.
- 11. The registered professional nurse shall be accountable for implementing appropriate intervention on all blood and blood component reactions.
- 12. Blood and blood products shall not be placed in a unit refrigerator where the temperature(s) are not specifically controlled and regulated for blood and blood products.
- 13. The use of 170 micron filters is recommended

components.

- 14. All initiation, termination and nursing intervention regarding blood and blood components shall be documented in the patient's record.
- 15. Interchange of blood and blood products shall be stated in established hospital policy.
- 16. The time for infusing blood or blood components shall be in keeping with the Bureau of Biologics, the American Association of Blood Bank Standards and any exception should be established in hospital policy with approval of the Medical Director of the Blood Bank.
- 17. The temperature variances for blood and blood products, prior to use, should be in keeping with the American Association of Blood Banks.
- 18. The use of blood warmers is advocated in certain medical conditions, e.g., Raynaud's Disease or a patient with cold agglutinins. These machines shall be checked routinely for temperature control and any malfunction.
- 19. Generally, no medication or solution should be added to blood or blood components unless approved by the Medical Director of the Blood Bank and established by hospital policy.
- 20. I.V. administration sets should be changed after the administration of blood and blood products.
- 21. When appropriate, I.V. lines should be flushed with saline solutions rather than dextrose solutions prior to and after administering whole blood or red cells since dextrose causes hemolysis of the red cell.
- 22. Blood and blood products should not be administered in conjunction with other I.V. solutions or interrupted for administration of another I.V. solution.

Considerations

- 1. The principle governing transfusion therapy is component therapy.
- 2. The use of fresh blood and blood components minimizes adverse reactions.
- 3. The use of microaggregata filters (20-40 microns) should be employed when clinically indicated and appropriate.
- 4. A unit of fresh blood, fresh frozen plasma or platelet concentration should be transfused for every 5-10 units of stored blood given within a 24-hour period.

24. I.V. Chemotherapy

I.V. Chemotherapy shall be initiated by a medical doctor's order for safe administration of I.V. antineoplastic agents in the treatment of cancer.

Recommendations of Practice

- 1. The administration of antineoplastic agents shall be conducted by the registered professional I.V. nurse who possesses knowledge and understanding of the basic principles of cancer therapy.
- 2. The administration of I.V. antineoplastic agents

- shall be in keeping with the recommendations stated in this document for general I.V. therapy.
3. An approved list of I.V. antineoplastic drugs including investigational agents and a recommendation for their preparation and administration shall be established in hospital policy.
 4. Determination of blood values shall be evaluated.
 5. A general history and assessment of clinical condition should be noted prior to treatment.
 6. Preservation of vascular access is mandatory for providing continued therapy.
 7. The choice of cannula shall be determined by the prescribed treatment, duration and condition of patient.
 8. Ascertaining placement of the I.V. device to avoid infiltration is mandatory.
 9. Drugs classified as vesicants shall be administered in conjunction with a continuous I.V. flow.
 10. Appropriate nursing intervention for extravasation of drugs, especially vesicants, shall be employed.
 11. Precautions in preparation and administration of antineoplastic agents shall be employed for protection of the patient and medical personnel.
 12. The rate of delivery of antineoplastic agents shall be precisely controlled and consideration should be given to the use of I.V. mechanical controlling devices.
 13. The use of .22 micron air eliminating filters should be employed unless contraindicated.
 14. Assessment for the use of Total Parenteral Nutrition should be employed.
 15. Assessment for the use of blood component therapy should be employed.
 16. Consent forms shall be mandatory for all I.V. investigational agents.
 17. The physical and psychological aspects of I.V. cancer therapy shall be clearly presented and discussed with the patient.
 18. Appropriate intervention for possible physical effects, including but not limited to alopecia, weight loss, nausea and vomiting should be employed.

Considerations

1. Consideration should be given to out patient therapy when appropriate.
2. Collaboration with other members of the health care team and local agencies shall be employed for meeting the psychosocial needs of the patient.

25. Documentation of I.V. Therapy

To protect the patient, nurse and health care facility and to retrieve statistical information by written documentation and verification of I.V. practices.

Recommendations of Practice

1. All I.V. procedures shall be documented, including but not limited to: initiation, daily monitoring, number of venipuncture attempts, new site changes, patient tolerance and termination of I.V. therapy.

2. Documentation of I.V. therapy shall be established by hospital policy and stated in the I.V. Policy and Procedure Manual.

26. Termination of I.V. Therapy

I.V. therapy is to be terminated on the order of a medical doctor or because of assessed patient complication.

Recommendations of Practice

1. The I.V. cannula shall be removed nearly flush with the skin, with adherence to aseptic technique and minimal trauma to the patient.
2. On removal, I.V. cannulas shall be visually inspected and assessed for length and tip smoothness to ascertain that the complete catheter has been removed.
3. Scissors should not be used around the I.V. cannula site in terminating I.V. therapy.
4. Apply firm pressure immediately after removal.
5. Termination of I.V. therapy should be documented on the patient's record.
6. A dry sterile dressing should be applied over the cannula site and removed in 24 hours.

27. Daily Monitoring of I.V. Therapy

To protect the patient by providing quality assurance with regular and standardized inspection of I.V. therapy. These measures shall reduce or prevent complications and related sepsis.

Recommendations of Practice

1. Peripheral I.V. cannulas should be changed every 48-72 hours.
2. I.V. administration sets should be changed every 24-48 hours and at the time a new container of I.V. solution is initiated.
3. The I.V. cannula site should be gently palpated and inspected for redness, swelling and any signs of sepsis.
4. The patient should be assessed for tolerance and any pain associated with this therapy.
5. The physician's order should be checked and the patient's record should be assessed to insure that the patient has received the prescribed therapy.
6. If the I.V. cannula requires change, a new I.V. access should be established before removal of the existing cannula.
7. If the dressing is changed at a 48-hour interval, the site should be cleaned with 70% isopropyl alcohol or iodophor solution and a topical ointment should be reapplied, if used. A sterile dressing should then be applied.
8. I.V. sites, through an intact dressing and flow rates should be checked at least every 8 hours.
9. Labeling of cannula, dressing, I.V. administration set and solutions should be in accordance with these Standards as stated under the designated Sections.
10. Daily monitoring and care shall be documented in accordance with practices as is stated these Standards.
11. Adherence to strict aseptic technique and

avoidance of touch contamination shall be mandatory in daily monitoring and care.

12. Emphasis shall be placed on minimal manipulations of the I.V. system.

Consideration

Because manipulation and touch contamination are common causes for potential I.V. complications, consideration should be given to not interrupting the I.V. system for 48 hours. Although it has not yet been documented in the literature, it is the belief of this Association that the entire system (cannula, filter, dressing and I.V. administration set), except for I.V. solutions, should remain intact and changed at a 48-hour interval, provided no I.V. related complications are encountered before this time.

28. Quality Assurance

The patient receiving I.V. therapy shall be guaranteed an optimal level of I.V. care. A quality assurance program will maximize quality I.V. care and minimize possible I.V. complications and sepsis and insure proper intervention in a timely manner.

Recommendations of Practice

1. Quality assurance is integrated into all aspects of I.V. therapy including, but not limited to: cannula placement and care, I.V. solution preparation, filter application, I.V. administration set change and dressing change.
2. Quality assurance of I.V. therapy should be in compliance with the Recommendations of Practice in each section of the Standards.
3. All products and packaging of products related to this specialty shall be inspected prior to use for integrity, sterility (if applicable), malfunctions, expirations and any product damaged or questioned shall be unacceptable for use.
4. The registered professional I.V. nurse shall be accountable for implementing appropriate intervention for possible local and/or systemic I.V. complication. Early recognition of signs and symptoms of I.V. complications shall be the basis for appropriate intervention.
5. I.V. care should be documented and a means of retrieving this documented data should be employed.
6. Data should be reviewed periodically with a predetermined criteria to evaluate efficiency, quality, complications and interventions of I.V. care.
7. Professional, specially trained I.V. nursing teams decrease the risk of I.V. related complications and infections and insure an optimal level of I.V. care by providing quality assurance and patient protection.
8. Quality assurance programs of I.V. therapy shall be stated in the I.V. Policy and Procedures Manual.
9. Collaboration with and education of other hospital departments and members of the health care team are necessary to assure im-

plementation of a quality assurance I.V. program.

29. Pediatrics

To insure safe administration and delivery of I.V. therapy to children, infants, neonates and premature infants.

Recommendations of Practice

1. The registered professional I.V. nurse shall have specialized knowledge of I.V. solution and medication dosages for children, infants, neonates and premature infants.
2. I.V. therapy for the pediatric patient shall follow the Recommendations of Practice set forth in these Standards.
3. A volume control mechanism shall be employed to insure accurate safe delivery of I.V. solutions.
4. The pediatric patient shall be evaluated and assessed more frequently than the adult patient.
5. I.V. policies and procedures shall be specific and categorized with special consideration for each of the following: children, infants, neonates and premature infants.
6. Generally, no more than 800 ml of any I.V. solution should be hung on a pediatric patient.
7. Adequate restraint but maximum mobility is essential in delivering I.V. therapy to the pediatric patient.
8. Psychological approaches should be relative to the pediatric patient in delivering I.V. therapy.

30. Infection Control

To minimize I.V. related sepsis, infection control is integrated into many aspects of I.V. therapy, including, but not limited to: I.V. cannula, I.V. dressings, I.V. solutions, I.V. administration set change and the .23 micron air eliminating I.V. filters. Early recognition of the signs and symptoms of sepsis, as well as awareness that the patient may be a compromised host, will maximize the prevention of sepsis and insure appropriate intervention in a timely manner.

Recommendations of Practice

1. Infection control I.V. practices are implied by the outcome criteria in each section throughout these Standards in the Recommendations of Practice.
2. Suspected related I.V. infections shall be documented and brought to the attention of the attending physician and hospital infection control department.
3. Generally, there should be no interruptions in I.V. lines by add-on devices.
4. I.V. administration set junctions should be secured with a lock or junction clamping device.
5. Strict aseptic technique shall be employed when "piggy-back" medications or bolus medication injections are delivered through rubber ports on the I.V. administration set. The injection port

- of I.V. administration sets shall be disinfected prior to entry.
6. Assessment of phlebitis should be evaluated as a sign and symptom that precedes a possible I.V. infection.
 7. 22 micron air eliminating filters effectively screen all bacteria, reducing the patient's risk of I.V. related sepsis.
 8. Frequent manipulation of the I.V. system should be avoided.

Considerations

1. Professional, specially trained I.V. nursing teams decrease I.V. related infections by providing control and technical expertise.
2. Collaboration with hospital infection control personnel is advocated.

31. Metabolic and General Assessment

To evaluate the patient's physical and mental status; assess the prescribed I.V. order; recognize and maximize the benefits of I.V. treatment; implement nursing intervention and minimize the risks and potential complications associated with this therapy.

Recommendations of Practice

1. The nursing process should be utilized in assessment.
2. Nursing history of the patient should include the collection of subjective and objective data.
3. The patient should be assessed for metabolic acidosis and any mental changes during therapy should be observed, noted and reported.
4. General physical assessment should include observation of the patient's condition and the condition of hair, skin, nails, weight and mouth.
5. Evaluation of laboratory values and fluid balance should be assessed on a daily basis.
6. Patient allergies shall be documented in the patient record and reported to the attending physician and other members of the health care team.
7. Daily intake and output shall be documented on patient's receiving I.V. therapy.
8. Prescribed infusion and medication should be maintained and delivered as prescribed.
9. Active physical exercise should be encouraged.
10. Passive physical exercise should be employed when necessitated by the patient's condition.
11. The patient's skin turgor should be observed.
12. Dependent/generalized edema should be recognized and reported.
13. The registered professional I.V. nurse should be cognizant of abnormal serum levels of glucose, electrolytes, vitamins and blood cell counts relative to I.V. management.
14. A microdrip I.V. administration set may be employed when delivering low volume infusions that are unassisted by mechanical gravity flow devices.
15. Electronic infusion controlling I.V. devices should be considered for maintaining constant rate of an I.V. infusion.

16. Vital signs should be monitored if warranted by the patient's treatment or condition.
17. A question by a registered professional I.V. nurse on a prescribed order should be clarified by the medical doctor prior to implementing and administering therapy to the patient. Prescribed orders that are questioned should not be carried out.
18. Continuous patient assessments should be made at regular intervals.

32. Home I.V. Therapy Programs

Home I.V. therapy programs are designed for patients who are ready to leave the hospital but require I.V. therapy. Teaching the patient and significant others and follow-up I.V. care by the registered professional I.V. nurse will insure safe I.V. therapy for the home patient.

Recommendations of Practice

1. Written medical orders shall be ascertained for placing a patient on home I.V. therapy.
2. The patient and significant others shall be evaluated for competency and comprehension of the particular I.V. therapeutic regime prior to becoming a candidate for a home I.V. therapy program.
3. All possible complications of the patient's particular treatment shall be discussed and explained with the patient and significant others.
4. A consent form stating understanding and acceptance of possible consequences of I.V. complications shall be signed by the patient.
5. Home I.V. procedures shall be explained and demonstrated to the patient and significant others.
6. Patient and significant others shall return demonstrations of I.V. procedures and aseptic techniques. The competency and proficiency of the patient and significant others shall be evaluated and documented.
7. Patient and significant others shall feel secure with the home I.V. program prior to the patient being discharged.
8. Patient should be discharged with adequate supplies, medications and solutions.
9. Site inspection of the home by the registered professional I.V. nurse may be necessary to ascertain an area in the home for clean storage of supplies and an appropriate area for using sterile supplies.
10. I.V. catheter and I.V. dressings shall be changed as stated in the specific sections of these Standards under Recommendations of Practice.
11. The changing time interval is not known for central I.V. catheters that are considered long term catheters.
12. Peripheral I.V. catheters (excluding those catheters whose tips lie in central vessels) for patients on home I.V. therapy shall be changed every 48-72 hours.
13. I.V. administration sets should be changed at

Revised November 1981

The National Intravenous Therapy Association's Intravenous Nursing Standards of Practice #10

Editor Note: The following are the "Home I.V. Therapy Nursing Standards of Practice" which have been revised, updated, and approved by the Standards Committee and the NITA Board of Directors. These Home I.V. Therapy Standards replace Section 32 in the existing "Standards of Practice" document. The following Home Standards are applicable to all aspects of I.V. therapy delivered outside the hospital. The entire NITA "Standards" document is in the process of a complete revision and will be expanded. Since the completed revision of the NITA "Standards" will be a lengthy process, and since home I.V. therapy is a growing area of practice, the Board of Directors felt it responsible to publish the "Home I.V. Therapy Nursing Standards of Practice" at this time.

Home I.V. Therapy

Home I.V. therapy standards are written for nurses delivering intravenous care outside of the hospital. The nurses practice shall comply with state laws and all standards set forth by this Association which are applicable to the delivery of home I.V. therapy. The primary goals of home I.V. therapy are to achieve the highest level of self care and quality of life for the patient by providing patient training and follow-up nursing care.

1. A physician's order shall be written regarding patient referral(s) for home I.V. therapy.
2. A medical order shall be written and signed by a physician to initiate and direct home I.V. therapy.
3. The written medical order(s) shall be reviewed and updated by the physician routinely.
4. Only physicians shall initiate a verbal medical order(s). Verbal medical order(s) shall be documented immediately by the registered nurse and brought to the physician's attention to be countersigned by the physician as soon as possible.
5. To insure that prescribed care is administered safely, the registered nurse shall have the knowledge and skills to interpret and implement the written medical order.
6. A consent form should be established and signed by the patient and/or legal guardian.
7. The patient shall be assessed for his/her ability to safely administer the prescribed home I.V. therapy.
8. If after the nursing assessment the patient is unable to achieve a determined level of self care, a significant other(s) shall be incorporated into the home I.V. therapy care plan and the physician shall be notified.
9. The significant other(s) shall be assessed for his/her ability to safely administer the prescribed home therapy treatment(s).
10. As the primary educator, the registered nurse shall address indication(s), benefits, methods and risks of therapy.
11. The teaching process for the patient and/or significant other(s) shall include written instructions, verbal explanations, demonstrations, evaluation and documentation of competency, proficiency in performing therapy-related procedures, self-monitoring, scope of physical activities, necessary intervention(s), safe discard of disposable equipment and specific actions to be taken in a possible emergency situation.
12. Therapy specific teaching instructions will be utilized during the educational process and shall be given to and remain with the patient and/or significant other(s).
13. All supplies and equipment necessary for therapy shall be available in the home before therapy is initiated.
14. Supply and equipment needs shall be continuously evaluated and met.
15. By the date of discharge, a registered nurse shall perform a home assessment and assist the patient and/or significant other(s) to determine an appropriate area for clean, safe storage of supplies/equipment, select a suitable area for procedures to be performed, and determine a safe discard of disposable equipment.
16. An ongoing assessment of patient and/or significant other(s) compliance in performing therapy related procedures shall be done at periodic intervals depending on patient condition and therapy.
17. All communication(s) with and/or site visit(s) to the patient shall be documented.
18. A summary of patient care shall be communicated to the physician at regular intervals.
19. Any pertinent observation that requires medical intervention shall be reported to the physician immediately.
20. The patient and/or significant other(s) shall be provided 24 hour access to appropriate health care professional(s).
21. It is recommended that the patient carry and/or wear appropriate identification indicative of therapy.
22. Psycho-social concerns of home I.V. therapy should be evaluated.



KENTUCKY BOARD OF NURSING

4010 DUPONT CR.-Suite 430
 Louisville, Kentucky 40207
 (502) 897-5143

OPINION

Roles of Nurses in Intravenous Therapy Practice

The primary mission of the Kentucky Board of Nursing, performed through the regulation of nurses and nursing education and practice, is to protect the public, and to assure that safe and effective nursing care is provided by nurses for the citizens of the Commonwealth. In order to protect and safeguard the health and safety of the citizens who receive intravenous therapy and to address the numerous inquiries relative to the scope of nursing practice in intravenous therapy/procedures, it is necessary to define the appropriate roles of nurses in intravenous therapy practice.

Numerous inquiries regarding intravenous therapy practice have been received by the Board. The minutes of the past Kentucky Board of Nursing meetings document that there has been ongoing study of the roles of nurses in intravenous therapy practice and that the Board has issued opinions relative to this matter since 1976. In June, 1982, the Board constituted a Practice Committee, composed of persons representing various areas of the Commonwealth and various kinds of nursing practice settings, to study and make recommendations regarding the appropriate roles of nurses in intravenous therapy practice. The Practice Committee's research of this issue included extensive review of standards of nursing practice, curricula of Board approved nursing education programs in the Commonwealth, and laws governing nursing practice. Relevant sections of the Kentucky Revised Statutes Chapter 314 (Kentucky Nursing Practice Act) include the following:

Section 314.011(5) "Registered nursing practice" shall mean the performance of acts requiring substantial specialized knowledge, judgment and nursing skill based upon the principles of psychological, biological, physical and social sciences in the application of the nursing process in:

- a) the care, counsel and health teaching of the ill, injured or infirm.
- b) the maintenance of health or prevention of illness of others.

- c) the administration of medication and treatment as prescribed by a physician or dentist licensed in this state and as further authorized or limited by the Board, and which are consistent either with the American Nurses' Association standards of practice or with standards of practice established by nationally accepted organizations of registered nurses.
- d) the supervision and teaching of other personnel in the performance of activities relating to nursing care.
- e) the performance of other nursing acts which are authorized or limited by the Board, and which are consistent either with the American Nurses' Association standards of practice or with standards of practice established by nationally accepted organizations of registered nurses.

Section 314.011(9) "Licensed practical nursing practice" shall mean the performance of acts requiring the knowledge and skills such as - are taught or acquired in approved schools for practical nursing in:

- a) the observing and caring for the ill, injured or infirm under the direction of a registered nurse, a licensed physician or dentist.
- b) the giving of counsel and applying procedures to safeguard life and health, as defined and authorized by the Board.
- c) the administration of medication or treatment as authorized by a physician or dentist licensed in this state and as further authorized or limited by the Board which are consistent with the National Federation of Licensed Practical Nurses or with standards of practice established by nationally accepted organizations of licensed practical nurses.
- d) teaching or supervising except as limited by the Board.
- e) the performance of other nursing acts which are authorized or limited by the Board and which are consistent with the National Federation of Licensed Practical Nurses' standards of practice established by nationally accepted organizations of licensed practical nurses.

Section 314.011(11) "Continuing education" shall mean participation in approved offerings beyond the basic nursing education program that present specific content planned and evaluated to meet competency based behavioral objectives which develop new skills and upgrade knowledge.

Section 314.021(2) All individuals licensed under provisions of this chapter shall be responsible and accountable for making decisions that are based upon the individuals' educational preparation and experience in nursing.

In accordance with these sections of KRS Chapter 314 and after study of the issue, the Practice Committee identified three categories of intravenous therapy practices. After review of the Practice Committee's study and recommendation, it was the opinion of the Board that the practice of the registered nurse and the licensed practical nurse be guided by the three categories as herein defined.

Category I: Because of the knowledge and skills acquired in approved programs for practical nursing, the licensed practical nurse may perform the following procedures upon successful completion of a Board approved practical nursing program and licensure and under the supervision* of a registered nurse, physician or dentist:

1. Perform simple calculation and adjust flow rate.
2. Observe and report subjective and objective signs of adverse reactions to IV administration.
3. Inspect insertion site, change dressing and remove intravenous needle or catheter from peripheral veins except as limited** by the Board.

Category II: Because the curricula taught in approved programs for practical nursing provide the basic background knowledge for the licensed practical nurse to develop new skills and upgrade knowledge through continuing education, the licensed practical nurse may perform the following procedures upon successful completion of a Board approved continuing education course for intravenous therapy/procedures and under the supervision* of a registered nurse, physician or dentist:

1. Perform venipuncture to withdraw blood from peripheral veins except as limited** by the Board.
2. Perform venipuncture to start intravenous fluids in peripheral veins except as limited** by the Board.
3. Perform venipuncture to start the following IV fluids - D₅W, D₅NS, D₅ $\frac{1}{2}$ NS, D₅ $\frac{1}{4}$ NS, NS, $\frac{1}{2}$ NS, $\frac{1}{4}$ NS in peripheral veins except as limited** by the Board.
4. Hang the following IV fluids - D₅W, D₅NS, D₅ $\frac{1}{2}$ NS, D₅ $\frac{1}{4}$ NS, NS, $\frac{1}{2}$ NS, $\frac{1}{4}$ NS to pre-existing venipunctures in peripheral veins except as limited** by the Board.
5. Change IV administration set except as limited** by the Board.

Category III: The registered nurse may perform all procedures in Categories I and II. Because the basic curricula taught in approved programs for registered nursing include the in-depth application of principles of psychological, biological, physical and social sciences for the performance of those acts requiring substantial specialized knowledge, judgment and nursing skills, only the registered nurse may perform, but is not limited to, the following intravenous procedures:

1. Hang blood or blood components.
2. Hang solution for intravenous parenteral nutrition, e.g. hyperalimentation or similar solution.
3. Administer medication via intravenous route:
 - a. Add medication to an intravenous solution.
 - b. Hang piggy back infusions.
 - c. Inject medication into an auxiliary fluid chamber, e.g. volutrol, buretrol.
 - d. Inject medication via direct intravenous route, e.g. bolus, push.
4. Flush or aspirate an IV line, arterial line, needle or catheter.
5. Change dressing, IV administration set or remove an intravenous cannula from the following: femoral, subclavian, or jugular vein, any venous or arterial site in which a central line is inserted or any arterial site or cut-down site.
6. Change dressing, IV administration set or remove an intravenous cannula when the peripheral cannula must remain in place for prolonged periods (>72 hours) or the patient has an unexplained fever and/or there is pain or tenderness at the site of insertion, or other signs of cannula related infection, phlebitis or other complications from IV administration.

*"Supervision" shall mean immediately available to assess and evaluate patient response(s) and to assess, direct and evaluate nurse performance.

**"Except as limited" shall mean the specified IV procedure shall not be performed when the following sites/procedures are used for IV administration: femoral, subclavian or jugular vein; any peripheral vein in which a central line is inserted, any arterial site/line, any central line insertion procedure or cut-down procedure.

Effective July 1, 1984.

DESCRIPTION OF KENTUCKY

ADVANCE DIRECTIVE LAW

In compliance with the mandate for Kentucky to develop a written description of its statutory and case law concerning advance directives, this office presents such a description below, which is based on statutory law, there being no case law which has specifically addressed the issue.

KENTUCKY LAW ON ADVANCE DIRECTIVES FOR MEDICAL DECISIONS

THE KENTUCKY LIVING WILL ACT

The 1990 session of the Kentucky General Assembly passed and the Governor signed into law House Bill No 113, known as the Kentucky Living Will Act, which is codified at KRS 311.622-644 and now sanctions the right of adult Kentuckians of sound mind to execute a written declaration which would allow life-prolonging treatments to be withheld or withdrawn in the event they become terminally ill and can no longer participate in making decisions about their medical care. The living will must be signed by the declarant in the presence of two subscribing witnesses who must not be blood relatives who would be beneficiaries of the declarant, beneficiaries of the declarant under the descent and distribution statutes of Kentucky, an employee of a health care facility in which the declarant is a patient, an attending physician of the declarant, or any person directly financially responsible for the declarant's health care. The living will must be notarized.

Two physicians, one of whom being the patient's attending physician, would have to certify that the declarant's condition was terminal before the living will could be implemented. The living will would not allow for the withholding or withdrawal of food or water, or medication or medical procedures deemed necessary to alleviate pain, and it would not apply to pregnant women.

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session of the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-986 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity of the person who executed the durable power of attorney.

PREPARED BY:

THE CABINET FOR HUMAN RESOURCES
OFFICE OF GENERAL COUNSEL
APRIL 22, 1991

DESIGNATION OF HEALTH CARE SURROGATE

I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S) TO MAKE ANY HEALTH CARE DECISIONS FOR ME WHEN I NO LONGER HAVE DECISIONAL CAPACITY.

IF _____ REFUSES OR IS NOT ABLE TO ACT FOR ME,

I DESIGNATE _____ AS MY HEALTH CARE SURROGATE(S).

ANY PRIOR DESIGNATION IS REVOKED.

SIGNED THIS _____ DAY OF _____, 19_____

SIGNATURE AND ADDRESS OF THE GRANTOR

IN OUR JOINT PRESENCE, THE GRANTOR, WHO IS OF SOUND MIND AND EIGHTEEN YEARS OF AGE, OR OLDER, VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE DATED AND SIGNED FOR THE GRANTOR.

SIGNATURE AND ADDRESS OF WITNESS

SIGNATURE AND ADDRESS OF WITNESS

COMMONWEALTH OF KENTUCKY

COUNTY

BEFORE ME, THE UNDERSIGNED AUTHORITY, CAME THE GRANTOR WHO IS OF SOUND MIND AND EIGHTEEN (18) YEARS OF AGE, OR OLDER, AND ACKNOWLEDGED THAT HE VOLUNTARILY DATED AND SIGNED THIS WRITING OR DIRECTED IT TO BE SIGNED AND DATED AS ABOVE.

DONE THIS _____ DAY OF _____, 19_____

SIGNATURE OF NOTARY PUBLIC

DATE COMMISSION EXPIRES: _____

ADVANCE DIRECTIVE ACKNOWLEDGMENT

NAME: _____ DATE OF BIRTH: _____

SOC. SEC. #: _____

PLEASE READ THE FOLLOWING FIVE STATEMENTS:

Place your initials after each statement.

1. I have been given written materials about my right to accept or refuse medical treatment. _____ (Initialed)
2. I have been informed of my right to formulate advance directives. _____ (Initialed)
3. I understand that I am not required to have an advance directive in order to receive medical treatment. _____ (Initialed)
4. I understand that the terms of any advance directive that I have executed will be followed by my caregivers to the extent permitted by law. _____ (Initialed)
5. I understand that I can change my mind at any time and that my decision will not result in the withholding of any benefits or medical services. _____ (Initialed)

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS:

- I HAVE EXECUTED AN ADVANCE DIRECTIVE.
- I HAVE NOT EXECUTED AN ADVANCE DIRECTIVE.

Patient/Guardian DATE: _____

Health Care Provider Representative DATE: _____

**PATIENT SELF-DETERMINATION PROTOCOL FOR CERTIFIED
HEALTH CARE PROVIDERS**

- 1. The Certified Health Care Provider shall inform all adult patients, in writing and orally, of information under Kentucky Law concerning their right to make decisions relative to their medical care.**
- 2. The Certified Health Care Provider shall present each adult patient with a written copy of the agency's policy concerning implementation of their rights.**
- 3. The Certified Health Care Provider shall not condition the provision of care or otherwise discriminate against any patient based on whether the patient has executed an advance directive.**
- 4. The Certified Health Care Provider shall document in the patient's medical record whether or not the patient has executed an advance directive.**
- 5. The Certified Health Care Provider shall ensure compliance with requirements of Kentucky Law concerning advance directives.**
- 6. The Certified Health Care Provider shall educate all agency staff and the general public concerning advance directives.**

PATIENT SELF-DETERMINATION

Policy:

Advise all adult patients (a person eighteen [18] years of age or older and who is of sound mind) of their rights concerning advance directives. (According to provider type, i.e., admission, start of care, etc.)

Purpose:

1. To assure individuals understand they have the right to:
 - a. Accept or refuse medical or surgical treatment; and
 - b. Formulate advance directives.

Procedure:

Each Certified Health Care Provider shall:

1. Designate a person or persons responsible for informing adult patients of their right to make decisions concerning their medical care.
2. Distribute to each adult patient the following information:
 - a. The Cabinet for Human Resources' description of Kentucky Laws on Advance Directives.
 - b. Agency policy regarding implementation of advance directives.

NOTE: Recommend distribution of additional information to assist patients and/or staff in understanding advance directives. The following materials are acceptable:

"Advance Directives Issues and Answers"
Hospice of the Bluegrass

"Advance Directives, Living Will, Health Care
Surrogate, Durable Power of Attorney" Video
Hospice of the Bluegrass

"About Advance Medical Directives"
Channing Bete Co., Inc.

"Living Will"
Division of Aging Services

PATIENT SELF-DETERMINATION (Continued)

"Planning For Difficult Times - Tomorrow's Choices"
"Planning For Difficult Times - A Matter of Choice"
American Association of Retired Persons

3. Maintain *Living Will* and *Designation of Health Care Surrogate* documents for distribution to adult patients upon request.
4. Documentation supporting compliance with the requirements regarding non-discriminatory care shall be incorporated into the Quality Assurance process.
5. Documentation supporting the patient's decision to formulate an advance directive shall be included in the medical record. (Recommend use of attached *Advance Directive Acknowledgment Form*.) A process shall be developed to assure appropriate staff are advised of the patient's directive.
6. Documentation supporting all aspects of the staff and general public education campaign shall be recorded by appropriate personnel.
7. Stipulate by policy, family members or guardians will be provided with information regarding advance directives when the patient is comatose or otherwise incapacitated and unable to receive the information. Once he or she is no longer incapacitated the information must be provided directly to the adult patient.

Printed with State Funds
An Equal Opportunity Employer M/F/H

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Medical Insurance Code indicates type of insurance coverage.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

NOTICE
OMB
Info.

Date card was issued

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	DATE OF BIRTH MO-YR	SEX
ELIGIBILITY PERIOD		*** THIS PERSON IS ALSO ELIGIBLE FOR OMB BENEFITS ***			
FROM:	08-01-90				
TO:	07-01-90				
CASE NUMBER					
ISSUE DATE: 06-27-90					
CASE NAME AND ADDRESS					
Jane Smith 400 Block Ave. Frankfort, KY 40601		Smith, Jane	1234567890	2 0353	M
		Smith, Kim	2345678912	2 1284	M
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS					
SEE OTHER SIDE FOR SIGNATURE					
MAP 520 REV 8/88					

Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member.

For
Kentucky Medicaid
Program Statistical
Purposes

Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for Kentucky Medicaid benefits.

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

WHITE CARD (ALSO)

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D./Q.M.B.) CARD

(BACK OF CARD)

Information to Providers.
Insurance identification
codes indicate type of
insurance coverage as
shown on the front of the
card in "Ins." block.

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES																		
<p>This card certifies that the person(s) listed hereon is/are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621-0001</p>	<ol style="list-style-type: none"> 1. This card may be used to obtain certain services from participating hospitals, drug stores, physicians, dentists, nursing homes, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening, and family planning services. 2. Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you. 3. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card. 4. If you have questions, contact your eligibility worker at the county office. 5. Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. <p style="text-align: right;">_____ Signature</p>																		
<p>Insurance Identification</p> <table border="0"> <tr> <td>A-Part A Medicare Only</td> <td>F-Private Medical Insurance</td> </tr> <tr> <td>R-Part A Medicare Premium Paid</td> <td>G-Champus</td> </tr> <tr> <td>B-Part B Medicare Only</td> <td>H-Health Maintenance Organization</td> </tr> <tr> <td>C-Both Parts A & B Medicare Premium Paid</td> <td>J-Unknown</td> </tr> <tr> <td>S-Both Parts A & B Medicare Premium Paid</td> <td>K-Other</td> </tr> <tr> <td>D-Blue Cross Blue Shield</td> <td>L-Absent Parent's Insurance</td> </tr> <tr> <td>E-Blue Cross Blue Shield Major Medical</td> <td>M-None</td> </tr> <tr> <td></td> <td>N-United Mine Workers</td> </tr> <tr> <td></td> <td>P-Black Lung</td> </tr> </table>	A-Part A Medicare Only	F-Private Medical Insurance	R-Part A Medicare Premium Paid	G-Champus	B-Part B Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare Premium Paid	J-Unknown	S-Both Parts A & B Medicare Premium Paid	K-Other	D-Blue Cross Blue Shield	L-Absent Parent's Insurance	E-Blue Cross Blue Shield Major Medical	M-None		N-United Mine Workers		P-Black Lung	<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance and to report changes relating to eligibility or permissive use of the card by an ineligible person.</p>
A-Part A Medicare Only	F-Private Medical Insurance																		
R-Part A Medicare Premium Paid	G-Champus																		
B-Part B Medicare Only	H-Health Maintenance Organization																		
C-Both Parts A & B Medicare Premium Paid	J-Unknown																		
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E-Blue Cross Blue Shield Major Medical	M-None																		
	N-United Mine Workers																		
	P-Black Lung																		

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B.) CARD

(FRONT OF CARD)

Eligibility period is the month, day and year of QMB eligibility represented by this card.
* From* date is first day of eligibility of this card. *To* date is the day eligibility of this card ends and is not included as an eligible day.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Medical Insurance Code indicates type of insurance coverage.

Red

Blue

LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ELIGIBLE RECIPIENT AND ADDRESS	ELIGIBILITY PERIOD	COVERAGE IS LIMITED TO:
 Jane Smith 400 Block Ave. Frankfort, KY 40601	FROM:	* MEDICARE PART A PREMIUMS * MEDICARE PART B PREMIUMS * MEDICARE CO-INSURANCE * MEDICARE DEDUCTIBLES SEE REVERSE SIDE FOR ADDITIONAL INFORMATION
	TO:	
	MEDICAID QMB ID. NO.	
	SEX CODE	
	INSURANCE ID.	
ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE	DATE OF BIRTH MONTH/YEAR	PLEASE SIGN IMMEDIATELY
MAP 520-C REV (8-88)		

Name of member eligible to be a Qualified Medicare Beneficiary. Only the person whose name is in this block is eligible for Q.M.B. benefits.

Date of Birth shows month and year of birth of eligible individual.

RED, WHITE, AND BLUE CARD

QUALIFIED MEDICARE BENEFICIARY IDENTIFICATION (Q.M.B) CARD

(BACK OF CARD)

Information to Providers, including insurance identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through CMB.

PROVIDER OF SERVICE	RECIPIENT OF SERVICES																		
<p>1. The individual named on this card is a qualified Medicare beneficiary and is eligible for Medicaid payment for Medicare part A and Part B Co-insurance and Deductibles only.</p> <p>2. Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to:</p> <p style="text-align: center;">Cabinet for Human Resources Department for Medicaid Services 275 East Main Street Frankfort, KY 40621-0001</p>	<p>1. Show this card whenever you receive Medical Care.</p> <p>2. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.</p> <p>3. Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</p> <p>4. If you have questions, contact your case worker at the Department for Social Insurance County office.</p>																		
<p style="text-align: center;">Insurance Identification</p> <table border="0"> <tr> <td>A-Part A, Medicare Only</td> <td>F-Private Medical Insurance</td> </tr> <tr> <td>R-Part A, Medicare Premium Paid</td> <td>G-Champus</td> </tr> <tr> <td>B-Part B Medicare Only</td> <td>H-Health Maintenance Organization</td> </tr> <tr> <td>C-Both Parts A & B Medicare</td> <td>J-Unknown</td> </tr> <tr> <td>S-Both Parts A & B Medicare Premium Paid</td> <td>K-Other</td> </tr> <tr> <td>D-Blue Cross Blue Shield</td> <td>L-Absent Parent's Insurance</td> </tr> <tr> <td>E-Blue Cross Blue Shield Major Medical</td> <td>M-None</td> </tr> <tr> <td></td> <td>N-United Mine Workers</td> </tr> <tr> <td></td> <td>P-Black Lung</td> </tr> </table>		A-Part A, Medicare Only	F-Private Medical Insurance	R-Part A, Medicare Premium Paid	G-Champus	B-Part B Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	J-Unknown	S-Both Parts A & B Medicare Premium Paid	K-Other	D-Blue Cross Blue Shield	L-Absent Parent's Insurance	E-Blue Cross Blue Shield Major Medical	M-None		N-United Mine Workers		P-Black Lung
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S-Both Parts A & B Medicare Premium Paid	K-Other																		
D-Blue Cross Blue Shield	L-Absent Parent's Insurance																		
E-Blue Cross Blue Shield Major Medical	M-None																		
	N-United Mine Workers																		
	P-Black Lung																		
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 206.824, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>																			

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(FRONT OF CARD)

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day. KenPAC services provided during this eligibility period must be authorized by the Primary Care provider listed on this card.

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number

Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age.

Names of members eligible for Kentucky Medicaid. Persons whose names are in this block have the Primary Care provider listed on this card.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	AGE
ELIGIBILITY PERIOD FROM: 06-01-90 TO: 07-01-90		CASE NUMBER 037 C 000123456				
CASE NAME AND ADDRESS ISSUE DATE: 05-27-90 Jane Smith 400 Block Ave. Frankfort, KY 40601		Smith, Jane Smith, Kim	1234567890 2345678912	2 2	0353 1284	M M
ATTENTION: SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		KENPAC PROVIDER AND ADDRESS Warren Peace, M.D. 1010 Tolstoy Lane Frankfort, KY 40601 502-346-9832 PHONE				
SEE OTHER SIDE FOR SIGNATURE		MAP 520K (11/91)				

Case name and address show to whom the card is mailed. This person may be that of a relative or other interested party and may not be an eligible member.

Name, address and phone number of the Primary Care provider.

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

GREEN CARD

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR KENPAC PROGRAM

(BACK OF CARD)

Information to Providers, including Insurance Identification codes which indicate type of insurance coverage as shown on the front of the card in "Ins." block.

Information to Recipients, including limitations, coverage and emergency care through the KenPAC system.

PROVIDERS OF SERVICE	RECIPIENT OF SERVICES																		
<p>This card certifies that the person listed hereon is eligible during the period indicated on the reverse side, for current benefits of the Kentucky Medicaid Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>NOTE: This person is a KenPAC recipient, and you should refer to sections (1) and (2) under "Recipient of Services."</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to: Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621</p>	<ol style="list-style-type: none"> The designated KenPAC primary provider must provide or authorize the following services: physician, hospital (inpatient and outpatient), home health agency, laboratory, ambulatory surgical center, primary care center, rural health center, nurse anesthetist, durable medical equipment, and advanced registered nurse practitioners. Authorization by the primary provider is not required for ophthalmologists, psychiatric, and obstetrical services; or for other covered services not listed above. In the event of an emergency, payment can be made to a participating medical provider rendering service to this person, if it is a covered service, without prior authorization of the primary provider shown on the reverse side. Covered services which may be obtained without preauthorization from the KenPAC primary provider include services from pharmacies, community mental health centers, nursing facilities, mental hospitals, nurse midwives, and participating providers of dental, hearing, vision, ambulance, non-emergency transportation, screening, family planning services, and birthing centers. Show this card to the person who provides these services to you whenever you receive medical care. You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the person listed on the front of this card. If you have questions, contact your eligibility worker at the county office. Recipient(s) temporarily out of the state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. 																		
<p>Insurance Identification</p> <table border="0"> <tr> <td>A-Part A, Medicare Only</td> <td>F-Private Medical Insurance</td> </tr> <tr> <td>R-Part A, Medicare Premium Paid</td> <td>G-Champus</td> </tr> <tr> <td>B-Part B Medicare Only</td> <td>H-Health Maintenance Organization</td> </tr> <tr> <td>C-Both Parts A & B Medicare</td> <td>J-Unknown</td> </tr> <tr> <td>S-Both Parts A & B Medicare</td> <td>K-Other</td> </tr> <tr> <td>Premium Paid</td> <td>L-Absent Parent's Insurance</td> </tr> <tr> <td>D-Blue Cross Blue Shield</td> <td>M-None</td> </tr> <tr> <td>E-Blue Cross Blue Shield</td> <td>N-United Mine Workers</td> </tr> <tr> <td>Major Medical</td> <td>P-Black Lung</td> </tr> </table>	A-Part A, Medicare Only	F-Private Medical Insurance	R-Part A, Medicare Premium Paid	G-Champus	B-Part B Medicare Only	H-Health Maintenance Organization	C-Both Parts A & B Medicare	J-Unknown	S-Both Parts A & B Medicare	K-Other	Premium Paid	L-Absent Parent's Insurance	D-Blue Cross Blue Shield	M-None	E-Blue Cross Blue Shield	N-United Mine Workers	Major Medical	P-Black Lung	<p>_____ Signature</p>
A-Part A, Medicare Only	F-Private Medical Insurance																		
R-Part A, Medicare Premium Paid	G-Champus																		
B-Part B Medicare Only	H-Health Maintenance Organization																		
C-Both Parts A & B Medicare	J-Unknown																		
S-Both Parts A & B Medicare	K-Other																		
Premium Paid	L-Absent Parent's Insurance																		
D-Blue Cross Blue Shield	M-None																		
E-Blue Cross Blue Shield	N-United Mine Workers																		
Major Medical	P-Black Lung																		
<p>RECIPIENT OF SERVICES: You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility, or permits use of the card by an ineligible person.</p>																			

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(FRONT OF CARD)

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services.

Eligibility period shows dates of eligibility represented by this card. "From" date is first day of eligibility of this card. "To" date is the day eligibility of this card ends and is not included as an eligible day.

Name and provider number of Lock-In physician. Kentucky Medicaid payments will be limited to this physician (with the exception of emergency services and physician referral unless otherwise authorized by the Kentucky Medicaid Program).

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS		
ELIGIBLE RECIPIENT & ADDRESS	FROM TO	ELIGIBILITY PERIOD PHYSICIAN NAME PHYSICIAN PROVIDER NO. PHARMACY NAME PHARMACY PROVIDER NO.
SEE OTHER SIDE FOR SIGNATURE	MEDICAL ASSISTANCE IDENTIFICATION NUMBER SEX CODE INSURANCE DATE OF BIRTH MONTH YEAR CASE NUMBER	MAP S20A REV 11/80

Name and address of member eligible for Medical Assistance benefits. All eligible individuals in the Lock-In Program will receive a separate card.

Currently
Left Blank

Insurance
Code

Department for Social Insurance case number. This is NOT the Medical Assistance Identification Number.

Name, address, and provider number of Lock-In pharmacy. Payment for pharmacy services is limited to this pharmacy, except in cases of emergency. In case of emergency, payment for covered services can be made to any participating pharmacy, provided notification and justification of the service is given to the lock-in program.

PINK CARD

KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (M.A.I.D.) CARD FOR LOCK-IN PROGRAM

(BACK OF CARD)

Information to Providers, including procedures for emergency treatment, and identification of insurance as shown on the front of the card in "Ins." block.

ATTENTION

This card certifies that the person listed on the front of this card is eligible during the period indicated for current benefits of the Kentucky Medical Assistance Program. Payment for physician and pharmacy services is limited to the physician and pharmacy appearing on the front of this card.

In the event of an emergency, payment can be made to any participating physician or participating pharmacy rendering service to this person if it is a covered service. The patient is not restricted with regard to other services, however, payment can only be made within the scope of Program benefits. Recipient temporarily out of state may receive emergency medical services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services. Questions regarding scope of services should be directed to the Lock-In Coordinator by calling 502-564-6560.

You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the Cabinet for the amount of medical assistance paid on your behalf.

Insurance Identification

- | | |
|--|-----------------------------------|
| A-Part A Medicare Only | F-Private Medical Insurance |
| R-Part A, Medicare Premium Paid | G-Champus |
| B-Part B Medicare Only | H-Health Maintenance Organization |
| C-Both Parts A & B Medicare | J-Unknown |
| S-Both Parts A & B Medicare Premium Paid | K-Other |
| D-Blue Cross Blue Shield | L-Absent Parent's Insurance |
| E-Blue Cross Blue Shield Major Medical | M-None |
| | N-United Mine Workers |
| | P-Black Lung |

I have read the above information and agree with the procedures as outlined and explained to me

Signature of Recipient or Representative

Date

RECIPIENT OF SERVICES

Federal law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required.

COMMONWEALTH OF KENTUCKY
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
PROVIDER AGREEMENT

THIS PROVIDER AGREEMENT, made and entered into as of the ____ day of _____, 19__, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____
(Name of Provider)

(Address of Provider)

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above named Provider desires to participate in the Kentucky Medical Assistance Program as a

(Type of Provider and/or level of care)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

(1) Agrees to comply with and abide by all applicable federal and state laws and regulations, and with the Kentucky Medical Assistance Program policies and procedures governing Title XIX Providers and recipients.

(2) Certifies that he (it) is licensed as a _____, if applicable, under the laws of Kentucky for the level or type of care to which this agreement applies.

(3) Agrees to comply with the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90. (The Cabinet for Human Resources shall make no payment to Providers of service who discriminate on the basis of race, color, national origin, sex, handicap, religion, or age in the provision of services.)

(4) Agrees to maintain such records as are necessary to disclose the extent of services furnished to Title XIX recipients for a minimum of 5 years and for such additional time as may be necessary in the event of an audit exception or other dispute and to furnish the Cabinet with any information requested regarding payments claimed for furnishing services.

(5) Agrees to permit representatives of the state and/or federal government to have the right to examine, inspect, copy and/or audit all records pertaining to the provision of services furnished to Title XIX recipients. (Such examinations, inspections, copying and/or audits may be made without prior notice to the Provider.)

(6) Assures that he (it) is aware of Section 1909 of the Social Security Act; Public Law 92-603 (As Amended), reproduced on the reverse side of this Agreement and of KRS 194.500 to 194.990 and KRS 205.845 to 205.855 and 205.990 relating to medical assistance fraud.

(7) Agrees to inform the Cabinet for Human Resources, Department for Medicaid Services, within 30 days of any change in the following:

- (a) name;
- (b) ownership;
- (c) licensure/certification/regulation status; or
- (d) address.

(8) Agrees not to discriminate in services rendered to eligible Title XIX recipients on the basis of marital status.

(9) (a) In the event that the Provider is a specialty hospital providing services to persons aged 65 and over, home health agency, or a skilled nursing facility, the Provider shall be certified for participation under Title XVIII of the Social Security Act.

(b) In the event that the Provider is a specialty hospital providing psychiatric services to persons age 21 and under, the Provider shall be approved by the Joint Commission on Accreditation of Hospitals. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Hospitals.

(10) In the event that the provider desires to participate in the physician or dental clinic/corporation reimbursement system, Kentucky Medical Assistance Program payment for physicians' or dentists' services provided to recipients of the Kentucky Medical Assistance Program will be made directly to the clinic/corporation upon proper issuance by the employed physician or dentist of a Statement of Authorization (MAP-347).

This clinic/corporation does meet the definition established for participation and does hereby agree to abide by all rules, regulations, policies and procedures pertaining to the clinic/corporation reimbursement system.

2. In consideration of approved services rendered to Title XIX recipients certified by the Kentucky Medical Assistance Program, the Cabinet for Human Resources, Department for Medicaid Services agrees, subject to the availability of federal and state funds, to reimburse the Provider in accordance with current applicable federal and state laws, rules and regulations and policies of the Cabinet for Human Resources. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Human Resources, Department for Medicaid Services.

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3. Either party shall have the right to terminate this agreement at any time upon 30 days' written notice served upon the other party by certified or registered mail; provided, however, that the Cabinet for Human Resources, Department for Medicaid Services, may terminate this agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the Provider by registered or certified mail with return receipt requested.

4. In the event of a change of ownership of an SNF, ICF, or ICF/MR/DD facility, the Cabinet for Human Resources agrees to automatically assign this agreement to the new owner in accordance with 42 CFR 442.14.

5. In the event the named Provider in this agreement is an SNF, ICF, or ICF/MR/DD this agreement shall begin on _____, 19__, with conditional termination on _____, 19__, and shall automatically terminate on _____, 19__, unless the facility is recertified in accordance with applicable regulations and policies.

PROVIDER

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

BY: _____
Signature of Authorized Official

BY: _____
Signature of Authorized Official

NAME: _____

NAME: _____

TITLE: _____

TITLE: _____

DATE: _____

DATE: _____

PENALTIES

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan,

shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both.

CERTIFICATION ON LOBBYING
CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES

The undersigned Second Party certifies, to the best of his or her knowledge and belief, that for the preceding contract period, if any, and for this current contract period:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for such failure.

SIGNATURE: _____

NAME: _____

TITLE: _____

DATE: _____

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16. If group practice, number of providers in group (specify provider type):

17. If corporation, name, address, and telephone number of corporate office:

Telephone No: _____

Name and address of officers:

18. If partnership, name and address of partners:

19. National Pharmacy No. (If applicable): _____
(Seven-digit number assigned by the National Council for Prescription Drug Programs.)

20. Physician/Professional Specialty Certification Board (submit copy of Board Certificate):

1st _____ Date _____

2nd _____ Date _____

21. Name of Clinic(s) in which Provider is a member:

1st _____

2nd _____

3rd _____

4th _____

22. Control of Medical Facility:
___ Federal ___ State ___ County ___ City
___ Charitable or religious
___ Proprietary (Privately-owned) ___ Other

23. Fiscal Year End: _____

24. Administrator : _____ Telephone No. _____

25. Assistant Admin: _____ Telephone No. _____

26. Controller: _____ Telephone No. _____

27. Independent Accountant or CPA: _____
Telephone No. _____

28. If sole proprietorship, name, address, and telephone number of owner:

29. If facility is government owned, list names and addresses of board members:

President or Chairman of Board: _____

Member: _____

Member: _____

30. Management Firm (If applicable):

31. Lessor (If applicable):

32. Distribution of beds in facility:

	Total Licensed Beds	Total Kentucky Medicaid Certified Beds
Acute Care Hospital	_____	_____
Psychiatric Hospital	_____	_____
Nursing Facility	_____	_____
MR/DD	_____	_____

33. NF or MR/DD owners with 5% or more ownership:

Name	Address	% of Ownership
_____	_____	_____
_____	_____	_____
_____	_____	_____

34. Institutional Review Committee Members (If applicable):

35. Providers of Transportation Services:

Number of Ambulances in Operation: _____
Number of Wheelchair Vans in Operation: _____
Basic Rate \$ _____ (Includes up to _____ miles)
Per Mile \$ _____ Oxygen \$ _____
Extra Patient \$ _____ Other \$ _____

36. Has this application been completed as the result of a change of ownership of a previously enrolled Medicaid provider? ___ yes ___ no

37. Provider Authorized Signature: I certify, under penalty of law, that the information given in this Information Sheet is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or prosecution for Medicaid Fraud. I hereby authorize the Cabinet for Human Resources to make all necessary verifications concerning me and my medical practice, and further authorize and request each educational institute, medical/license board or organization to provide all information that may be sought in connection with my application for participation in the Kentucky Medicaid Program.

Signature: _____

Name: _____

Title: _____

Return all enrollment forms, changes and inquiries to:

Medicaid-Provider Enrollment
Third Floor East
275 East Main Street
Frankfort, KY 40621

INTER-OFFICE USE ONLY
License Number Verified through _____ (Enter Code)
Comments: _____
Date: _____ Staff: _____

Agreement Between the
Kentucky Medicaid Program
and
Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The _____ has
(Name of Billing Agency)

entered into a contract with _____,
(Name of Provider)

_____ to submit claims via electronic media for services provided to
(Provider Number)

KMP recipients. The billing agency agrees:

1. To safeguard information about Program recipients as required by state and federal laws and regulations;
2. To maintain or have access to a record of all claims submitted for payment for a period of at least five (5) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.

This agreement may be terminated upon written notice by either party without cause.

Signature, Authorized Agent of Billing Agency

Date: _____

Contact Name: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

Signature, Representative of the
Department for Medicaid Services

Date: _____

CABINET FOR HUMAN RESOURCES
DEPARTMENT FOR MEDICAID SERVICES
KENTUCKY MEDICAL ASSISTANCE PROGRAM

Provider Agreement Electronic Media Addendum

This addendum to the Provider Agreement is made and entered into as of the ____ day of _____, 19____, by and between the Commonwealth of Kentucky, Cabinet for Human Resources, Department for Medicaid Services, hereinafter referred to as the Cabinet, and _____,

Name and Address of Provider

hereinafter referred to as the Provider.

WITNESSETH, THAT:

Whereas, the Cabinet for Human Resources, Department for Medicaid Services, in the exercise of its lawful duties in relation to the administration of the Kentucky Medical Assistance Program (Title XIX) is required by applicable federal and state regulations and policies to enter into Provider Agreements; and

Whereas, the above-named Provider participates in the Kentucky Medical Assistance Program (KMAP) as a

(Type of Provider and/or Level of Care)

(Provider Number)

Now, therefore, it is hereby and herewith mutually agreed by and between the parties hereto as follows:

1. The Provider:

- A. Desires to submit claims for services provided to recipients of the Kentucky Medical Assistance Program (Title XIX) via electronic media rather than via paper forms prescribed by the KMAP.
- B. Agrees to assume responsibility for all electronic media claims, whether submitted directly or by an agent.
- C. Acknowledges that the Provider's signature on this Agreement Addendum constitutes compliance with the following certification required of each individual claim transmittal by electronic media:

"This is to certify that the transmitted information is true, accurate, and complete and that any subsequent transactions which alter the information contained therein will be reported to the KMAP. I understand that payment and satisfaction of these claims will be from Federal and State funds and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal and State Law."

- D. Agrees to use EMC submittal procedures and record layouts as defined by the Cabinet.
- E. Agrees to refund any payments which result from claims being paid inappropriately or inaccurately.
- F. Acknowledges that upon acceptance of this Agreement Addendum by the Cabinet, said Addendum becomes part of the previously executed Provider Agreement. All provisions of the Provider Agreement remain in force.
- G. Agrees to refund to the State the processing fee incurred for processing any electronic media billing submitted with an error rate of 25% or greater.

2. The Cabinet:

- A. Agrees to accept electronic media claims for services performed by this provider and to reimburse the provider in accordance with established policies.
- B. Agrees to assign to the provider or its agent a code to enable the media to be processed.
- C. Reserves the right of billing the provider the processing fee incurred by the Cabinet for all claims submitted by any electronic media billing that are found to have a 25% or greater error rate.

Either party shall have the right to terminate this Addendum upon written notice without cause.

PROVIDER

CABINET FOR HUMAN RESOURCES
Department for Medicaid Services

BY: _____
Signature of Provider

BY: _____
Signature of Authorized Official
or Designee

Contact Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Telephone No.: _____

Software Vendor
and/or Billing Agency: _____

Media: _____

(REV. 7/91)

THIRD PARTY LIABILITY
LEAD FORM

Recipient Name : _____ MAID # _____

Date of Birth : _____ Address: _____

Date of Service : _____ To: _____

Date of Admission: _____ Date of Discharge: _____

Name of Insurance Company: _____

Address: _____

Policy #: _____ Start Date: _____ End Date: _____

Date Filed with Carrier: _____

Provider Name: _____ Provider #: _____

Comments: _____

Signature: _____ Date: _____

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER PROVIDER NAME
 RA SEQ NUMBER 2 PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* PAID CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	CHARGES NOT COVERED	AMT. FROM OTHER SOURCES	CLAIM PMT AMOUNT	EOB
023104	DONALDSON R	3000000000	9883324-552-580	030192-033192	265.00	10.00	0.00	255.00	365
01 PS 4	PROC/REV 550	QTY 4		030192-033192	240.00	8.00		232.00	365
02 PS 4	PROC/REV 270	QTY 5		030192-033192	25.00	2.00		23.00	365

CLAIMS PAID IN THIS CATEGORY: 1 TOTAL BILLED: 265.00 TOTAL PAID: 255.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* DENIED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
023104	JONES R	4000000000	9838348-552-010	030192-033192	60.00	262
01 PS 4	PROC/REV 550	QTY 1		030192-033192	60.00	

CLAIMS DENIED IN THIS CATEGORY: 1

TOTAL BILLED: 60.00

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* CLAIMS IN PROCESS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	TOTAL CHARGES	EOB
571384	JOHNSON P	200000000	9883342-564-210	030192-033192	120.00	260
574632	MITCHELL J	400000000	9883347-575-240	030192-033192	240.00	260

CLAIMS PENDING IN THIS CATEGORY: 2 TOTAL BILLED: 360.00

APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
RA SEQ NUMBER 2

PROVIDER NAME
PROVIDER NUMBER

CLAIM TYPE: HOME HEALTH SERVICES

* RETURNED CLAIMS *

INVOICE NUMBER	-RECIPIENT NAME	IDENTIFICATION- NUMBER	INTERNAL CONTROL NO.	CLAIM SVC DATE	EOB
324789	SMITH	5000000000	9883324-552-060	030192-033192	999

TOTAL CLAIMS RETURNED IN THIS CATEGORY: 1

20
APPENDIX IX

KENTUCKY MEDICAL ASSISTANCE TITLE XIX REMITTANCE STATEMENT

AS OF 04/06/92

RA NUMBER
 RA SEQ NUMBER 2

PROVIDER NAME
 PROVIDER NUMBER

SUMMARY OF BENEFITS PAID

CLAIMS PAYMENT SUMMARY	CHECK NUMBER	3286364				
	CLAIMS PAID/DENIED	CLAIMS PD AMT.	WITHHELD AMOUNT	NET PAY AMOUNT	CREDIT AMOUNT	NET 1099 AMOUNT
CURRENT PROCESSED	2	255.00	0.00	255.00	0.00	48.00
YEAR-TO-DATE TOTAL	36	1340.00	50.00	1290.00	0.00	1290.00

DESCRIPTION OF EXPLANATION CODES LISTED ABOVE

- 061 PAID IN FULL BY MEDICAID
- 262 THE RECIPIENT IS NOT ELIGIBLE ON DATES OF SERVICE
- 260 ELIGIBILITY DETERMINATION IS BEING MADE
- 999 REQUIRED INFORMATION NOT PRESENT

ND

PROVIDER INQUIRY FORM

EDS
P.O. Box 2009
Frankfort, KY 40602

Please remit **both**
copies of the Inquiry
Form to EDS.

1. Provider Number		3 Recipient Name (first, last)	
2. Provider Name and Address		4. Medical Assistance Number	
		5. Billed Amount	6. Claim Service Date
		7. RA Date	8. Internal Control Number
9. Provider's Message			

10. _____
Signature Date

or Provider:

- _____ This claim has been resubmitted for possible payment.
- _____ EDS can find no record of receipt of this claim as indicated above. Please resubmit.
- _____ This claim paid on _____ in the amount of _____.
- _____ This claim was denied on _____ with EOB code _____.

- _____ This claim denied on _____ with EOB 294 "Kenpac Recipient. Referring provider number is missing or is not the Kenpac primary physician/clinic number for the date(s) of service."
- _____ This claim denied on _____ with EOB 295 "Kenpac Recipient. Billing and/or referring provider number is not the Kenpac primary physician/clinic for date(s) of service."
- _____ This claim denied on _____ with EOB 281 "Recipient has other medical coverage. Bill other insurance first or attach documentation of denial from the insurance carrier."
- _____ Aged claim. Please see attached documentation concerning services submitted past the 12 month filing limit.

Other: _____

MAIL TO: EDS FEDERAL CORPORATION
P. O. BOX 2009
FRANKFORT, KY 40602

APPENDIX XI

ND

ADJUSTMENT REQUEST FORM

1. Original Internal Control Number (I.C.N.) 	EDS FEDERAL USE ONLY		
2. Recipient Name	3. Recipient Medicaid Number		
4. Provider Name/Number/Address	5. From Date Service	6. To Date Service	
	7. Billed Amt.	8. Paid Amt.	9. R.A. Date

10. Please specify WHAT is to be adjusted on the claim.

11. Please specify REASON for the adjustment request or incorrect original claim payment.

IMPORTANT: THIS FORM WILL BE RETURNED TO YOU IF THE REQUIRED INFORMATION AND DOCUMENTATION FOR PROCESSING ARE NOT PRESENT. PLEASE ATTACH A COPY OF THE CLAIM AND REMITTANCE ADVICE TO BE ADJUSTED.

12. Signature _____ 13. Date _____

EDSF USE ONLY--DO NOT WRITE BELOW THIS LINE

Field/Line:
New Data:
Previous Data:

Field/Line:
New Data:
Previous Data:

Other Actions/Remarks:

(Revised 1/92)

DEPARTMENT FOR MEDICAID SERVICES
DRUG PRE-AUTHORIZATION POLICIES AND PROCEDURES

INTRODUCTION

The purpose of the Drug Pre-Authorization Procedure shall be to provide Department for Medicaid Services (DMS) recipients with access to certain legend drugs not normally covered on the DMS Outpatient Drug List, under the condition that provision of the drug(s) in question is expected to make an otherwise inevitable hospitalization or higher level of care unnecessary. The requests shall be referred to the Program by physicians, pharmacists, and social workers. Determinations shall be made based on the merits of the individual request and information received.

To assist with determining the kinds of requests which shall be considered for pre-authorization, the following outline of criteria and procedures has been developed for your convenience.

I. DRUG PRE-AUTHORIZATION CRITERIA

A. Request Criteria

1. The requested drugs shall be used in lieu of hospitalization to maintain the patient on an outpatient basis or prevent a higher level of care.
2. The requested drug shall be a legend drug. The only exception shall be non-legend nutritional supplements when: 1) general pre-authorization criteria are met; 2) the patient's nutrition shall be maintained through the use of the nutritional product; and 3) the patient would require institutional care without the nutritional supplement.
3. The requested drug shall be used in accordance with standards and indications, and related conditions, approved by the Food and Drug Administration (FDA).
4. The requested drug shall not be considered for pre-authorization if it is currently classified by FDA as "less than effective" or "possibly effective" or if the labeler has not signed a rebate agreement with the Health Care Financing Administration (HCFA).
5. Drugs on the formulary shall be tried, when appropriate, with documentation of ineffectiveness prior to pre-authorization.

APPENDIX XII

6. The Program shall not preauthorize the trial usage of a maintenance drug except when the drug has been tried for at least two (2) weeks with successful results prior to the request. In these cases, when all criteria shall be met, retroactive pre-authorization for two (2) weeks shall be considered in addition to the usual pre-authorization period.

B. Pre-Authorization of Therapeutic Categories

Any therapeutic category may be considered for pre-authorization in accordance with the diagnosis. However, all Program criteria and guidelines shall be met.

C. Guidelines For Specific Drug Categories

1. Analgesics

Requests for analgesics shall be approved for cancer, AIDS, spinal cord injury, and rehabilitation patients up to a period of six (6) months. A seven (7) day approval may be made following out-patient surgery.

2. Antibiotics

Requests for antibiotics shall be considered ONLY if culture and sensitivity tests have identified specific sensitivity or ONLY if drugs included on the Drug List have been tried unsuccessfully. However, if a course of treatment had been started while hospitalized, consideration shall be given to the request.

3. Anti-Inflammatory Drugs (NSAID's)

Request for anti-inflammatory drugs shall not be pre-authorized unless drugs on the Drug List or NSAID certification list have been tried unsuccessfully.

4. Antitussives, "Cough Mixtures," Expectorants, Antihistamines

Request for "cough mixture" preparations such as expectorants and antitussives shall not be pre-authorized. Only specified antihistamines may be preauthorized if all other criteria have been met.

5. Chemotherapeutic Agents

Request for anti-neoplastic agents shall be considered for approved FDA indications.

APPENDIX XII

6. Hypnotics and Sedatives

Requests for sedatives and hypnotics shall be considered only after covered antidepressant or antipsychotic drugs have been tried unsuccessfully and if hospitalization would be prevented. Also these requests shall be accompanied by an appropriate psychiatric diagnosis. Hypnotics and sedatives shall not be approved for more than two (2) weeks, unless there is a diagnosis of terminal cancer.

7. Maintenance-Type Drugs

Requests for maintenance-type drugs shall be considered only if the drugs have been tried for at least two (2) weeks with successful results prior to the request and related drugs on the formulary have been unsuccessful.

8. Non-Legend Drugs

Non-legend (over-the-counter) drugs shall be excluded from coverage under drug pre-authorization.

The only exceptions shall be non-legend nutritional supplements as noted in I. A. 2. above and nicotinic acid.

9. Ophthalmics and Topical Preparations

Requests for ophthalmics or topical preparations shall not be preauthorized unless related preparations included on the Drug List have been tried unsuccessfully, and a higher level of care would ensue without further medication.

10. Tranquilizers, Minor

Requests for minor tranquilizers shall be considered only for acute anxiety, alcohol or drug withdrawal (with a one (1) month limitation), cancer, seizure disorders, and quadriplegia/paraplegia.

11. Ulcer Treatment Drugs, Legend

On the basis of ulcer symptoms, legend ulcer treatment drugs may be preauthorized if other applicable pre-authorization criteria are met.

12. Total Parenteral Nutrition

May be preauthorized if the need exists.

13. Transdermal Antihypertensive Medication

Transdermal antihypertensive medication may be pre-authorized without first prescribing oral forms when the prescriber certifies that the medication is certified for an elderly patient who is unable to follow directions in using oral forms of the medication.

D. Pharmacy Lock-In

The pharmacy originally selected by the recipient shall remain the provider during the period of the pre-authorization unless a valid reason for change exists.

E. PreAuthorization Period

The maximum period for which any drug shall be preauthorized shall be six (6) months. A request for renewal shall be considered if the need for the drug continues to exist. Extensions may be backdated if the dates do not interfere with already existing segments on the drug file.

F. Minimum Cost Requirement

Only those requests for oral, non-liquid drugs which cost \$5.00 or more to the pharmacy for a month's supply or a course of treatment shall be considered for pre-authorization.

G. Routine Immunizations

Immunizations requested for routine health care shall not be approved. An underlying medical condition which would make the patient more susceptible to the disease must be present.

H. Exceptions to Existing Policy

The Commissioner for the Department for Medicaid Services, or his designate, may grant an exception to existing policy when sufficient documentation exists to override this policy. The request should be written, or followed up in writing, if necessary.