8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

Designated Representative means a person appointed by the member to act on their behalf for healthcare and treatment decisions as documented in the member's advanced healthcare directive or other comparable documentation.

Family/In-Home Caregiver means an ~~unpaid~~ individual who assumes a portion of the ~~client's~~ member's Private Duty Nursing care in the home, when Home Health Agency staff is ~~not present~~ absent. A Family/In-Home Caregiver may either live in the ~~client's~~ member's home or go to the ~~client's~~ member's home to provide care.

Group Nursing means the provision of Private Duty Nursing services by a Registered Nurse or Licensed Practical Nurse to more than one member, at the same time, in the same home or community-based setting.

Home Health Agency means an ~~public~~ agency or ~~private~~ organization ~~or part of such an agency or organization which~~ that is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act and licensed as a Class A provider through the Colorado Department of Public Health and Environment.

Medical Necessity means a Medical Assistance program good or service as defined in Program Integrity rules (10 CCR 2505-10, 8.076.1.8). For children 20 and younger, this is further defined to include the requirements outlined in the Early and Periodic Screening, Diagnosis, and Treatment rules (10 C.C.R. 2505-10,8.280.1.)

Nursing Assessment means an individualized comprehensive assessment completed by the Home Health Agency case coordinator that accurately reflects the member's current health status and includes information that may be used to demonstrate the member's progress toward achievement of the desired outcomes. The comprehensive assessment shall identify the member's need for home care and meet the member's medical, nursing, rehabilitative, social, and discharge planning needs.

Physician or Allowed Practitioners means a physician, physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) who oversees the delivery of skilled care to a member within their scope of practice, in accordance with State law who is actively enrolled with Health First Colorado.

Plan of Care means a care plan, also referred to as the Form CMS-485, developed by the Home Health Agency in consultation with the ~~client~~ member, that has been ordered by the ~~attending~~ physician or allowed practitioner for the provision of services to a ~~client~~ member at his/her residence or community setting, and periodically reviewed and signed by the physician or allowed practitioner in accordance with Medicare requirements at 42 C.F.R. 484.18.

Private Duty Nursing (PDN) means ~~face-to-face Skilled Nursing that is more individualized skilled nursing care that requires the application of skilled nursing care, including judgment, assessment, planning, intervening, and evaluation, provided in the that is available under the home or community-based setting by a registered nurse or a licensed practical nurse under the supervision of a registered nurse who is employed by or contracted with a licensed Home Health Agency. health benefit or routinely provided in a hospital or nursing facility.~~ medically necessary nursing services for members who require more individual and continuous care than is available under the Home Health benefit or routinely provided by the nursing staff of the hospital or skilled nursing facility.

Re-Hospitalization means any hospital admission that occurs after the initial hospitalization for the same condition.

Skilled Nursing/skilled nursing service means services provided under the licensure, scope, and standards of the Colorado Nurse and Nurse Aide Practice Act, Title 12 Article 255 of the Colorado Revised Statutes,

performed by a registered nurse (RN) under the direction of a physician or allowed practitioner, or a licensed practical nurse (LPN) under the supervision of an RN and the direction of a physician or allowed practitioner, for care that cannot be delegated by the judgment of the nurse.

Technology Dependent means the use of medical devices without which adverse health consequences or hospitalization would likely follow. ~~a client who:~~

~~a. Is dependent at least part of each day on a mechanical ventilator; or~~

~~b. Requires prolonged intravenous administration of nutritional substances or drugs; or~~

~~c. Is dependent daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support or tube feedings when they are not intermittent.~~

Utilization Review Contractor means a third-party vendor contracted by the Department to perform utilization management functions for specific services.

8.540.2 ELIGIBILITY

8.540.2.A. A ~~client~~ member shall be eligible for PDN services when the ~~client~~ member ~~is~~:

~~1. Technology Dependent~~
~~2. Medically stable, except for acute episodes that can be safely managed under PDN, as determined by the attending physician.~~

1. Requires skilled nursing interventions to maintain or improve health status.

2. Delayed skilled nurse-level interventions would result in deterioration of a chronic condition, loss of function, imminent risk to health status due to medical fragility, or risk of death.

3. Requires skilled nursing services that exceed what can be managed with home health services.

4. Care are ordered per the physician's or allowed practitioner's treatment plan and involves the application of the nursing process. Clinical documentation supports the skilled nature of the care.

5. Requires skilled nursing services that can be safely managed under PDN and are ordered as medically necessary by a licensed physician or allowed practitioner as part of a written treatment plan developed in coordination with the Home Health Agency.

6. ~~3.~~ Can be safely served in their home by a home health agency under the agency requirements and limitations of the PDN benefit and with the staff services available.

7. ~~4.~~ Is not residing in a nursing facility or hospital at the time PDN services are delivered.

8. ~~5.~~ Is an eligible member of Health First Colorado~~ for Medicaid in a non-institutional setting~~.

9. ~~6.~~ ~~Able to~~ Meets one of the following ~~medical~~ criteria:

a. Members aged 21 years or older that demonstrate medical necessity that require skilled nursing services and are dependent on technology daily and will be reviewed in accordance with 10 CCR 2505-10 § 8.076.1.8.

i. Skilled nursing, include, but are not limited to:

a.) Systems assessments, including multistep approaches of systems (e.g., respiratory assessment, airway assessment, vital signs, nutritional

and hydration assessment, complex gastrointestinal assessment and management, seizure management requiring intervention, or level of consciousness).

b.) Administration of treatment for complex respiratory issues related to technological dependence requiring multistep approaches on a day-to-day basis (e.g., ventilator tracheostomy).

c.) Assessment of complex respiratory issues and interventions with use of oximetry, titration of oxygen, ventilator settings, humidification systems, fluid balance, or any other cardiopulmonary critical indicators based on medical necessity.

d.) Skilled nursing interventions of intravenous/parenteral administration of multiple medications and nutritional substances on a continuing or intermittent basis with frequent interventions.

e.) Skilled nursing interventions of enteral nutrition and medications requiring multi-step approaches daily.

b. Members aged 20 years or younger that demonstrate medical necessity in accordance with Early and Periodic Screening, Diagnostic, and Treatment requirements at 10 CCR 2505-10 § 8.280.4.E.

i. Member's age 20 years or younger must require skilled nursing assessment, intervention, and evaluation of both equipment (if applicable) and member.

ii. The services provided are reasonable and necessary for care of a member's condition and are within accepted standards of nursing practice.

iii. PDN service is considered supplemental to the care provided by a member's family or designated caregivers and allows the member to remain in their residence rather than an institution.

iv. The severity of the member's clinical condition makes the services medically necessary to ensure member safety.

~~a. The member needs PDN services while on a mechanical ventilator.~~

~~***b.*** The member needs PDN services for ventilator weaning during the hours necessary to stabilize the member's condition. A stable condition shall be evidenced by the ability to clear secretions from tracheostomy, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.~~

~~c. The pediatric member needs PDN services after tracheostomy decannulation during the hours necessary to stabilize the member's condition. A stable condition shall be evidenced by the ability to clear secretions, not using auxiliary muscles for breathing, vital signs that are stable, blood gases that are stable with oxygen greater than 92% and a pulse oximetry greater than 92%.~~

~~d. The pediatric member needs PDN services during the hours spent on continuous positive airway pressure (C-PAP), until the member is medically stable.~~

~~e. The pediatric member needs PDN services for oxygen administration only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximeter readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases and/or skin color changes. If oxygen is the only technology present, the URC shall review for an individual determination of medical necessity for PDN.~~

~~f. The pediatric member needs PDN services during the hours required for prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids.~~

~~g.~~ c. The Utilization Review Contractor (URC) shall consider combinations of technologies and co-morbidities when making medical determinations. ~~for the following medical conditions:~~

~~i) A pediatric member with tube feedings, including nasogastric tube, gastric tube, gastric button and jejunostomy tube, whether intermittent or not, who is not on mechanical ventilation.~~

~~ii) An adult member with a tracheostomy, who is not on mechanical ventilation or being weaned from mechanical ventilation.~~

~~iii) An adult member with a tracheostomy decannulation, who is not on mechanical ventilation or being weaned from mechanical ventilation.~~

~~iv) An adult member who has Continuous Positive Airway Pressure (C-PAP), but is not on mechanical ventilation or being weaned from mechanical ventilation.~~

~~v) An adult member with oxygen supplementation, who is not on mechanical ventilation or being weaned from mechanical ventilation.~~

~~vi) An adult member receiving prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids who is not on mechanical ventilation or being weaned from mechanical ventilation.~~

~~vii) An adult member with tube feedings that are continuous, including nasogastric tube, gastric tube, gastric button and jejunostomy tube who is not on mechanical ventilation nor being weaned from mechanical ventilation.~~

~~7. The medical judgment of the attending physician and the URC shall be used to determine if the criteria are met wherever the medical criteria are not defined by specific measurements.~~

8.540.2.B. The criteria for approval of PDN services is based upon the submission of records that demonstrate the skilled nature of the nursing care provided, including physician and/or allowed practitioner records, specialty notes, and nursing notes.

8.540.2.C. A member's need for skilled nursing care is based solely on their unique condition and individual needs at the time the services were ordered and what was, at that time, expected to be appropriate treatment throughout the certification period, whether the illness or injury is acute, chronic, terminal, stable, or expected to extend over a long period.

8.540.3 BENEFITS

~~8.540.1.B. Beginning November 1, 2021, providers must submit a prior authorization request for all~~

~~new PDN services. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request in accordance with the schedule provided in Section 8.540.7.G.~~

8.540.3.A All private duty nursing (PDN) services require prior authorization as outlined in section 8.540.7.

1. The ongoing need for PDN care is periodically re-evaluated with a minimum of an annual review. HCPF, in coordination with the URC, determines the number of PDN hours, based on documented medical necessity. PDN hours may be increased or reduced based on medical necessity accompanied by a change in condition as documented in the medical records.

   ~~The URC and/or HCPF will determine the number of hours medically necessary with each prior authorization submission. The review will be based upon the medical plan of care outlined by the physician or allowed practitioner providing care for the member..~~

   ~~The need for, and the length of, service is determined by the condition of the member and the level of care required.~~

2. Authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the member having active coverage and claims meet current billing policies effective at the time of services as outlined in the Home Health Billing Manual.

8.540.3.B. A pediatric ~~client~~ member aged 20 or younger may be approved for up to 24 hours per day of PDN services if the member meets the medical necessity criteria identified by HCPF and used by the URC. ~~PDN for pediatric members is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.~~

~~2. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy.~~

~~3. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.~~

~~4. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.~~

~~8.540.2.C Twenty-four hour care may be approved for pediatric members during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.~~

8.540.3.~~D~~.C. Adult members aged 21 or older may be approved up to 23 hours per ~~day when determined medically necessary~~ of PDN services if the member meets medical necessity criteria identified by HCPF and used by the URC. ~~PDN for adult members is limited to the hours determined medically necessary by the URC pursuant to section 8.540.4.A, as applicable.~~

8.540.3.D. A member may be eligible for a short-term increase in PDN services for a change of condition. The Home Health Agency must apply for additional hours through a revision to the original prior authorization request.

8.540.4 BENEFIT LIMITATIONS

8.540.4.A A member who meets both the eligibility requirements for PDN and home health shall be allowed to choose whether to receive care under PDN or under home health. The member may

choose a combination of the two benefits if the care is not duplicative and the resulting combined care does not exceed the medical needs of the member.

8.540.4.B Hours of PDN shall never exceed what has been determined medically necessary.

8.540.4.C. When a service can be safely and effectively performed (or self-administered) without the direct intervention or delegation of a registered nurse or licensed practical nurse, the service is not considered a nursing service.

8.540.4.D. The following limitations apply to the PDN benefit and will not be approved:

1. Services consisting only of assistance with activities of daily living or other non-skilled services.

2. The physician's or allowed practitioner's treatment plan does not identify the need for skilled nursing.

3. Observation or monitoring for medical conditions not requiring skilled nursing assessment and intervention as documented in the physician's or allowed practitioner's treatment plan and/or nursing notes.

4. PDN services when used solely for the convenience of the member or other caregiver.

5. Custodial or sitter care to ensure compliance with treatment.

6. The care is intended for other members of the household that are not receiving approved PDN services under a group rate.

7. The care is a duplication of care covered under another service or funding source.

8.540.5 ~~APPLICATION~~ HOSPITAL DISCHARGE PROCEDURES

8.540.5.A. The hospital discharge planner shall plan for the member's hospital discharge by coordinating with the Home Health Agency to:

~~1. Refer the client member or the client's member's authorized representative to appropriate agencies for Medicaid eligibility determination in the non-institutional setting, as needed.~~

~~2. Plan for the client's member's hospital discharge by:~~

1. Arrange services with the Home Health Agency, medical equipment suppliers, counselors and other healthcare service providers as needed.

2. Coordinate a safe home care plan that meets program requirements in conjunction with the physician or allowed practitioner and the Home Health Agency.

3. Advise the Home Health Agency of any changes in medical condition and care needs.

4. Ensure that the ~~client~~ member, family and caregivers are educated about the ~~client's~~ member's medical condition and trained to perform the home care.

~~3. Submit an application to determine PDN eligibility to the URC if the member is hospitalized when services are first requested or ordered.~~

~~8.540.5.B. The Home Health Agency case coordinator shall submit the application for PDN services to the URC if the member is not in the hospital.~~

~~8.540.5.C. An application may be submitted up to six months prior to the anticipated need for PDN services. Updated medical information shall be sent to the URC as soon as the service start date is known.~~

8.540.5.D. ~~The application shall be submitted on a Department PDN application form. Any medical information necessary to determine the member's medical need shall be included with the application form~~.

~~8.540.5.E. If the member has other insurance that has denied PDN coverage, a copy of the denial letter, explanation of benefits or the insurance policy shall be included with the application.~~

~~8.540.5.F. If services are being requested beyond the 16 hour per day benefit as a result of an EPSDT medical screening, written documentation of those screening results shall be included with the application. The EPSDT claim form shall not meet this requirement.~~

~~8.540.5.G. The URC nurse reviewer shall review applications for PDN according to the following procedures:~~

~~1. Review the information provided and apply the medical criteria.~~

~~2. Return the application to the submitting party for more information within seven working days of receipt of an incomplete application if the application is not complete.~~

~~3. Approve the application, or refer the application to the URC physician reviewer within 10 working days of receipt of the complete application. The physician reviewer shall have 10 working days to determine approval or denial of the application for PDN.~~

~~4. Notify the member or the member's designated representative and the submitting party of application approval.~~

~~5. Notify the member, the member's designated representative and the submitting party of the member's appeal rights by placing written notification in the mail within one working day of a denial decision.~~

~~8.540.5.H. members who are approved and who subsequently discontinue PDN for any reason do not need an application to request resumption of PDN services within six months of discontinuing PDN services. Services may be resumed upon approval of a Prior Authorization Request (PAR).~~

8.540.6 PROVIDER AND FAMILY REQUIREMENTS

8.540.6.A. Provider Eligibility

1. Services must be provided by a Medicare and Medicaid-certified Home Health Agency.

2. All Home Health Agency providers shall comply with the rules and regulations set forth by the Colorado Department of Public Health and Environment, the Colorado Department of Health Care Policy and Financing, the Colorado Department of Regulatory Agencies, the Centers for Medicare and Medicaid Services, and the Colorado Department of Labor and Employment.

8.540.6.B Provider Agency Requirements

1. A Home Health Agency must:

a. Be certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act;

b. Be a Colorado Medicaid enrolled provider;

c. Maintain liability insurance for the minimum amount set annually as outlined in 6 CCR 1011-1 Chapter 26; and

d. Be licensed by the State of Colorado as a Class A Home Care Agency in good standing.

2. Home Health Agencies which perform procedures in the member's home that are considered waivered clinical laboratory procedures under the Clinical Laboratory Improvement Act of 1988 shall possess a certificate of waiver from the Centers for Medicare and Medicaid Services (CMS) or its Designee.

3. A Home Health Agency cannot discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers the discontinuation or refusal. The Home Health Agency must provide notice of at least thirty (30) calendar days to the member, or the member's designated representative.

4. In the event a Home Health Agency is ceasing operations, provider agencies must notify the Department within thirty (30) calendar days. The notification must be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider must also email the Department the notice at the designated Home Health email inbox.

8.540.6.C. Provider Responsibilities

A certified Home Health Agency ~~may be authorized to~~ that provides PDN services ~~if the agency~~ shall meet all of the following:

1. Employs nursing staff currently licensed in Colorado that possess the education and experience in providing care to ~~Technology Dependent~~ individuals who require skilled nursing care in a home and community based setting in accordance with Home Health Agency policy, state practice acts, and professional standards of practice.

a. Employs nursing personnel with documented skills, training and/or experience appropriate for the ~~client's~~ member's individualized needs and care requirements, including cultural and disability competency.

b. Provides appropriate nursing skills orientation and ongoing in-service education to nursing staff to meet the ~~client's~~ member's specific nursing care needs.

~~Employs staff with experience or training, in providing services to the client's particular demographic or cultural group~~.

c. Requires nursing staff to complete cardiopulmonary resuscitation (CPR) instruction and certification at least every two years.

d. Provides adequate supervision and training for all nursing staff as required by the agencies listed in 8.540.6.A.2.

e. Staff must be engaged in an activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will HCPF compensate an agency for PDN nursing staff time when sleeping.

f. The maximum number of hours provided by an individual nurse will be restricted to a level that can safely and reasonably be provided. No individual nurse will be authorized to work more than a sixteen (16) hour shift per day except in an emergency situation.

2. Coordinates services with a supplemental certified Home Health Agency, if necessary, to meet the staffing needs of the ~~client~~ member.

~~5. Requires the primary nurse and other personnel to spend time in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements.~~

~~6. Provides appropriate nursing skills orientation and on going in-service education to nursing staff to meet the client specific nursing care needs.~~

~~7. Requires nursing staff to complete cardio pulmonary resuscitation (CPR) instruction and certification at least every two years.~~

~~8. Provides adequate supervision and training for all nursing staff.~~

3. Designates a case coordinator who is responsible for the management of private duty nursing services for the ~~client~~ member, which includes the following:

a. Develops the individualized care plan by completing the PDN assessment and obtaining information from the attending physician or allowed practitioner and the primary caregiver.

i. If discharging from the hospital, information from the discharge planner must be included in the care planning process.

b. Assesses the home setting prior to the start of care and on an ongoing basis for safety compliance.

~~c. Submits an application for PDN to the URC if the client is not in the hospital at the time services are requested.~~

~~d. Refers the client's designated representative to the appropriate agency for Medicaid eligibility determination, if needed.~~

~~e. Ensures that a completed PAR is submitted to the URC prior to the start of care and before the previous PAR expires.~~

~~f. Provides overall coordination of home services and service providers.~~

c. Involves the ~~client~~ member and Family/In Home Caregiver in the plan for home care and the provision of home care.

d. Assists the ~~client~~ member to reach maximum independence.

e. Communicates changes in the case status with the attending physician or allowed practitioner and the URC on a timely basis, including changes in medical conditions and/or psychological/social situations that may affect safety and home care needs. A revision to the prior authorization request may be warranted.

f. Assists with communication and coordination between the service providers supplementing the primary Home Health Agency, the primary care physician or allowed practitioner, specialists and the primary Home Health Agency as needed.

g. Makes regular on-site visits ~~to monitor the safety and quality of home care~~ according to Home Health Agency policies and procedures and professional standards of practice to monitor the safety and quality of home care, and makes appropriate referrals to other agencies for care as necessary.

h. Ensures that complete and current care plans, no older than 60 days, and nursing charts are in the ~~client's~~ member's home at all times. Charts shall include interim physician or allowed practitioner orders, current medication orders and nursing notes. Records of treatments and interventions shall clearly show compliance with the times indicated on the care plans.

i. Communicates with ~~Single Entry Point or other case managers~~ Case Management Agency and/or Regional Accountability Entity as needed regarding service planning and coordination.

4. Makes and documents the efforts made to resolve any situation that triggers a discontinuation or refusal to provide services prior to discontinuation or refusal to provide services.

8.540.6.D. ~~Documents that the~~ Family/In-Home Caregiver Responsibilities:

The Home Health Agency must inform the member and their family/in-home caregiver of the following responsibilities for PDN services and ensure the caregiver:

1. Is able to assume some portion of the ~~client's~~ member's care when an agency nurse is not available.

2. Has the specific skills necessary to care for the ~~client~~ member.

3. Has completed CPR instruction or certification and/or training specific to the ~~client's~~ member's emergency needs prior to providing PDN services.

4. Is able to maintain a home environment that allows for safe home care, including a plan for emergency situations.

5. Participates in the planning, implementation and evaluation of PDN services.

6. Communicates changes in care needs and any problems to health care providers and physicians or allowed practitioners as needed.

7. Works toward the ~~client's~~ member's maximum independence, including finding and using alternative resources as appropriate.

8. Has notified power companies, fire departments and other pertinent agencies, of the presence of a person relying on skilled nursing in the household.

8.540.6.E Environmental Requirements

The Home Health Agency performs an in-home assessment and documents that the home meets the following safety requirements:

1. Adequate electrical power including a backup power system.

2. Adequate space and ventilation for equipment and supplies.

3. Adequate fire safety and adequate exits for medical and other emergencies.

4. A clean environment to the extent that the ~~client's~~ member's life or health is not at risk.

5. A working ~~tele~~phone is available 24 hours a day.

8.540.6.F. Physician or Allowed Practitioner Role

The Home Health Agency shall coordinate with the ~~client's~~ member's attending physician or allowed practitioner to:

1. Determine that the ~~client~~ member is medically stable, except for acute episodes that can be managed under PDN, and that the ~~client~~ member can be safely served under the requirements and limitations of the PDN benefit.

2. Cooperate with the URC in establishing medical eligibility.

3. Prescribe a plan of care at least every 60 calendar days.

4. Coordinate with any other physicians or allowed practitioner treating the ~~client~~ member.

5. Communicate changes in the ~~client~~ member's medical condition and care including ~~especially upon~~ discharge from the hospital.

6. Empower the ~~client~~ member and the Family/In-Home Caregiver by working with them and the Home Health Agency to maximize the ~~client's~~ member's independence.

8.540.7 PRIOR AUTHORIZATION PROCEDURES

8.540.7.A. A prior authorization request (PAR) is required for all PDN services to review the utilization of services and assess the medical necessity of skilled nursing services. Prior authorization is performed for a single member and based on the needs of the member. Additional members in the home do not impact the individual member's needs. ~~The Home Health Agency shall submit the initial PAR to the URC prior to the start of PDN.~~

8.540.7.B. The PAR shall be approved for up to six months for a new member ~~client~~ and up to one year for ongoing care, based on medical necessity. ~~depending upon the prognosis for improvement or recovery, according to the medical criteria.~~

8.540.7.C. Prior authorization requests must include the following: ~~The PAR information shall:~~

~~. Be submitted on a Department PAR form. A copy of the current plan of care shall be included. For new clients admitted to PDN directly from the hospital, a copy of the transcribed verbal physician orders may be substituted for the plan of care if the client has been approved for admission to PDN.~~

1. Current plan of care (POC) on CMS 485 form, or form of similar format, that summarizes health conditions, specific care needs and current treatments signed by the physician or allowed practitioner or has a documented verbal order. The POC should include: ~~Be submitted with the plan of care that:~~
   a. A signed nursing assessment, a current clinical summary or 60-day summary of care, the physician or allowed practitioner's signed plan of care including orders for all disciplines and treatments, and goals of care/rehabilitation potential, if applicable. ~~Is on the CMS 485 form, or a form that is identical in format to the CMS 485. All sections of the form relating to nursing needs shall be completed.~~
   b. Current diagnosis list and medication list including PRN medications. ~~Includes a signed nursing assessment, a current clinical summary or update of the client's condition and a physician's plan of treatment. A hospital discharge summary shall be included if there was a hospitalization since the last PAR.~~
   c. ~~Indicates the frequency and the number of times per day that all technology- related care is to be administered. Ranges and a typical number of hours needed per day are required. The top of the range is the number of hours ordered by the physician as medically necessary. The lower number is the amount of care that may occur due to family availability or choice, holidays or vacations or absence from the home.~~
   d. ~~Includes a~~ A documented process by which the ~~client~~ member receiving services and support may continue to receive necessary care, which may include ~~respite~~ backup care, if the ~~client's~~ member's family or caregiver is unavailable due to an emergency situation or unforeseen circumstances. The family or the caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.
2. A hospital discharge summary, if there has been a hospitalization since last PAR.
3. Completion of PDN Tool to reflect an assessment of the member within the certification period encompassing the PAR start date. Documentation submitted should support the score on the Tool. ~~Include an explanation for the decision to use an LPN. This decision shall be at the discretion of the attending physician, the Home Health Agency and the RN responsible for supervising the LPN.~~
4. Identification of professional disciplines supporting the medical needs of the member in the home and responsible for the delivery of care. Documentation should identify overlapping care and rationale for the overlap. ~~Cover a period of up to one year depending upon medical necessity determination.~~
5. For new members admitted to PDN directly from the hospital, a copy of the transcribed verbal physician or allowed practitioner orders may be substituted for the plan of care if the member has been approved for admission to PDN services. ~~Include only the services of PDN-RN and/or PDN-LPN. If any other services are included on the PAR, the URC shall return the PAR without processing it.~~
6. ~~Be submitted within five working days of the change as a revision when a change in the plan of care results in an increase in hours. A revised plan of care or a copy of the~~

~~physician's verbal orders for the increased hours including the effective date shall be included with the PAR form.~~

6. Documentation submitted should include sufficient information to demonstrate the medical necessity of skilled nursing services. The number of hours authorized may differ from the number of hours requested based on the clinical review of the request and supporting documentation. A HHA must not misrepresent or omit facts in a treatment plan. ~~Be submitted within five working days of the discharge or death, as a revised PAR when a client is discharged or dies prior to the end date of the PAR. The revision is to the end date and the number of service units.~~

7. If a member's condition necessitates a change in PDN hours, the HHA must submit a revision request within ten (10) working days of a change. The revision can be an increase or a decrease in hours. Discharge notification is also required within ten (10) working days via PAR revision.

8. In the event a member changes provider agencies, there shall be a 60-day transitional period to enable time for provider transitions or starts of care to occur. The HHA must submit a Change of Provider Form to the the URC and indicate the date for which the start of care will begin. The temporary authorization will be for no more than sixty days to ensure continuity of care for the member and allow HHA time to assess the member and obtain all necessary documentation.

9. In the event of limited nursing resources for a HHA, two HHAs may coordinate care and provide services to the same member as long as there is no duplication of services on the same date(s) of service and requires the following:

a. The HHAs must document the need and reason for two HHAs to render services to a member; and

b. The two HHAs must coordinate the member's Plan of Care, (POC) maintain the POC, and documentation on all services rendered by each PDN Provider in the member's records.

c. Each HHA obtains prior authorization and identifies to the URC the coordinated POC and revises the PAR as needed to ensure coverage.

8.540.8. **UTILIZATION REVIEW** ~~The URC shall review PARs according to the following procedures:~~

8.540.8.A. Providers must submit requests for prior authorization of private duty nursing (PDN) services directly to the Utilization Review Contractor (URC) within ten (10) business days of starting PDN services. ~~Review information provided and apply the medical criteria as described herein.~~

1. Incomplete requests will be pended back to the HHA for ten (10) days to acquire additional information.

2. HHAs should only request services for care outlined in the POC and under the PDN benefit.

8.540.8.B. The URC will review requests for prior authorization according to the information provided and the application of the medical criteria as described herein. ~~Return an incomplete PAR to the Home Health Agency for correction within ten working days of receipt.~~

1. The URC will approve the PAR, or refer the PAR to the URC physician reviewer, within ten (10) working days of receipt of the complete PAR.

2. The URC will process the physician review referrals and approve, partially approve, or deny the PAR within 10 working days of receipt from the nurse reviewer. ~~The URC physician reviewer shall attempt to contact the attending physician or the primary care physician for more information prior to a denial or reduction in services.~~

8.540.8.C. Written notification of all PAR denials, including a member's appeal rights, will be issued within one business day of the determination to the member or member's designated representative and the submitting provider.

1. The Home Health Agency may request a reconsideration from the URC if the PAR is denied. The HHA also may request a Peer to Peer review if the ordering physician or allowed practitioner is in agreement.

2. Services provided during the period between the provider's submission of the PAR to the URC to the final approval or denial by HCPF may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 calendar days, whichever is shorter. ~~Provide written notification to the client or client's designated representative and submitting party of all PAR denials and the client's appeal rights, within one working day of the decision.~~

3. When denied or reduced, services shall be approved for thirty (30) additional calendar days after the date on the member's notice of denial letter. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained at the currently approved level for the duration of the appeal until the final agency action is rendered. ~~Approve subsequent continued stay PARs that have been to physician review without referral, if the client's condition and the requested hours have not changed.~~

~~7. Notify the Department of all extraordinary PDN services approved as a result of an EPSDT screen.~~

~~8. Notify the submitting party of all PAR approvals.~~

8.540.8.D. Expedited PAR reviews may be requested in situations where adhering to the time frames above would seriously jeopardize the client's life or health.

~~8.540.7.E. No services shall be approved for dates of service prior to the date the URC receives a complete PAR. PAR revisions for medically necessary increased services may be approved back to the day prior to receipt by the URC if the revised PAR was received within five working days of the increase in services. Facsimiles may be accepted.~~

~~8.540.7.F. The URC nurse reviewer may attend hospital discharge planning conferences, and may conduct on site visits to each client at admission and every six months thereafter.~~

~~8.540.7.G. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request (PAR) in accordance with the schedule in Sections 8.540.7.G.1-10. When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client.~~

~~1. Ten percent (10%) of PARs must be submitted by November 30, 2021;~~

~~2. An additional 10% of PARs must be submitted by December 31, 2021;~~

~~3. An additional 10% of PARs must be submitted by January 31, 2022;~~

~~4. An additional 10% of PARs must be submitted by February 28, 2022;~~

~~5. An additional 10% of PARs must be submitted by March 31, 2022;~~

~~6. An additional 10% of PARs must be submitted by April 30, 2022;~~

~~7. An additional 10% of PARs must be submitted by May 31, 2022;~~

~~8. An additional 10% of PARs must be submitted by June 30, 2022;~~

~~9. An additional 10% of PARs must be submitted by July 31, 2022;~~

~~10. The final 10% of PARs, with a total of 100% of PARs initiated prior to November 1, 2021, must be submitted by August 31, 2022.~~

8.540.9 **REIMBURSEMENT**

8.540.8.A. No skilled services shall be authorized or reimbursed if the skilled hours of service, regardless of funding source, total more than 24 hours per day for members age 20 or younger and no more than 23 hours per day for members age 21 or older.

8.540.8.B. No services shall be reimbursed if the care is duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health or other insurance.

8.540.8.C. Approval of the PAR by the URC shall authorize the Home Health Agency to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period. Payment of claims is conditional upon the ~~client's~~ member's ~~financial~~ benefit eligibility on the dates of service and the provider's use of correct billing procedures.

8.540.8.D. No services shall be reimbursed for dates of service prior to the PAR start date as authorized by the URC.

8.540.8.E. Skilled Nursing services under PDN shall be reimbursed in units of one hour, at the provider's usual and customary charge or the maximum Medicaid allowable rates established by HCPF ~~the Department~~, whichever is less.

1. Units of one hour may be billed for RN or LPN based on the personnel rendering the care.

2. RN group rate should be utilized when a registered nurse is providing PDN services to more than one member at the same time in the same setting. ~~(registered nurse providing PDN to more than one client at the same time in the same setting),~~

3. LPN group rate should be utilized when a licensed practical nurse is providing PDN services to more than one member at the same time in the same setting. ~~(licensed practical nurse providing PDN to more than one client at the same time in the same setting) or~~

4. Blended RN/LPN rate is used as a group rate by request of the Home Health Agency only~~)~~.

5. PDN services may be provided by a single nurse to an individual or to multiple individuals in a non-institutional group setting as described above. The nurse-member ratio will not exceed what can be safely cared for simultaneously by one licensed nurse depending on member acuity and additional support in the home.