8.540.6 PROVIDER 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. Home Health Agencies must comply with the Medicaid rules, 10 CCR 2505-10. The Home Health Agency shall make access to these rules available to all staff and all members on service.

4. A Home Health Agency cannot discontinue or refuse services to a member unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal. The Home Health Agency must provide notice of at least thirty days to the member, or the member's legal guardian.

5. In the event a Home Health Agency is ceasing operations, provider agencies must notify the Department within 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:

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1. Employs nursing staff currently licensed in Colorado that possess the education and experience in providing care to Technology Dependent high acuity, medically complex persons in the home 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 care requirements.

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. Requires the primary nurse and other personnel to receive training in the hospital prior to the initial hospital discharge or after Re-Hospitalization, to refine skills and learn individualized care requirements, as needed.

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. Assists with the hospital discharge planning process by providing input and information to, and by obtaining information from, the hospital discharge planner and attending physician/authorized provider regarding the home care plan.

b. Assesses the home prior to the initial hospital discharge and on an ongoing basis for safety compliance.

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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/authorized provider 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, 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 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.

11. 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:

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1. Is able to assume some portion of the client's member's care.

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 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 special needs person in the household.

12. 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 telephone is available 24 hours a day.

8.540.6.F. Physician/Authorized Provider Role

The Home Health Agency shall coordinate with the client's member's attending physician/authorized provider 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/authorized providers who are treating the client member.

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5. Communicate with the Home Health Agency about changes in the client member's medical condition and care, 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.

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