Title of Rule: Revision to the Medical Assistance Act Rule concerning Private Duty Nursing, Section 8.540.
Rule Number: MSB 25-01-30-A
Division / Contact / Phone: Benefits and Services Management / Christine Merriman / 5439

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this rule revision is to update two specific sections of the rules regarding the Private Duty Nursing (PDN) Benefit, to include language about the requirement of the Skilled Care Acuity Assessment and the role of the Nurse Assessor for state plan members who utilize benefits under PDN.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain: N/A

3. Federal authority for the Rule, if any:

   42 CFR § 440.80

4. State Authority for the Rule:

   Section § 25.5-5-303, C.R.S.
   Sections 25.5-1-301 through 25.5-1-303, C.R.S.

Initial Review **05/09/25** Final Adoption **06/13/25**
Proposed Effective Date **08/14/25** Emergency Adoption

DOCUMENT #05

Title of Rule: Revision to the Medical Assistance Act Rule concerning Private Duty Nursing, Section 8.540.
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REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Individuals affected by this proposed rule revision are State Plan members, both adult and pediatric, who require more individual and continuous care than is provided through the Long-Term Home Health benefits. Private duty nursing (PDN) care is RN- or LPN-level care provided in the home or community at the level of care routinely provided in hospitals or nursing facilities. Providers affected by this rule revision are Class A licensed, skilled home health agencies certified to provide services for Health First members.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons.

   Members and providers will benefit from clear language regarding the use of the Skilled Care Acuity Assessment and the role of the Nurse Assessor in relation to the Private Duty Nursing benefit. These rules clarify the utilization of the assessment and the Nurse Assessor. This clarity will improve the quality of services provided and the efficiency of service delivery.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no financial impacts associated with this revision.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   This proposed revision of the Private Duty Nursing Rule will include the definitions and role of the Skilled Care Acuity Assessment and the Nurse Assessor Program under this benefit. Inaction would cause confusion from stakeholders regarding new program requirements.

5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

Title of Rule: Revision to the Medical Assistance Act Rule concerning Private Duty Nursing, Section 8.540.
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This revision is the most cost-effective and least intrusive method for achieving simplification of the Private Duty Nursing regulations.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   This proposed rule revision is the most effective way of achieving the goal of having the rule language match the implementation of the Nurse Assessor Program using the Skilled Care Acuity Assessment on July 1, 2025.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

A. 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.

B. Family/In-Home Caregiver means an individual who assumes a portion of the member's care in the home in the absence of agency staff. A Family/In-Home Caregiver may either live in the member's home or travel to the member's home to provide care.

C. 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.

D. Home Health Agency (HHA) means an agency or organization that is certified for participation as a Medicare Home Health provider pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider as required by § 25-27.5-103(1), C.R.S.

E. Medical Necessity is as defined in Program Integrity rules at Section 8.076.1.8. For children and youth under the age of 21 ~~20 and younger~~, this is further defined to include the requirements set forth in the Early and Periodic Screening, Diagnosis, and Treatment rules at Section 8.280.1.

F. [Nurse Assessor Vendor means a third-party vendor contracted by the Department to complete the Skilled Care Acuity Assessment for specific skilled care services.]

~~G~~F. [PDN Nursing Assessment means an individualized comprehensive assessment of a member that is completed by the HHA RN case coordinator. This assessment documents a member's health status by gathering subjective and objective data to understand a member's needs and develop a plan of care/CMS Form 485. Additionally, for members receiving ongoing care, the responses to treatment and skilled interventions are included in the assessment documentation. PDN nursing assessments are done at admission and, at 60-day intervals while under HHA care or at the change in member's condition. ~~.~~]{~~PDN Nursing Assessment means an individualized comprehensive assessment completed by the HHA 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~~.}

~~G~~H. Physician or Allowed Practitioners means an enrolled 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 as set forth at Colorado Revised Statutes, Title 25, Articles 240 or 255, as applicable.

~~H~~I. Plan of Care (POC) means a completed Centers for Medicare and Medicaid Services (CMS) Form 485, also referred to as a care plan, developed by the HHA in consultation with the member, that has been ordered by the physician or allowed practitioner for the provision of services to a member at his/her residence or community setting, and is periodically reviewed and signed by the physician or allowed practitioner in accordance with Medicare requirements at 42 CFR § 484.60.~~Private Duty Nursing (PDN) means medically necessary nursing services that are more individual and continuous care than is available under the Home Health benefit, or routinely provided by the nursing staff of a hospital or skilled nursing facility, that allow a member to remain~~

~~in their home or community-based setting.~~ The Department incorporates by reference 42 C.F.R. 438.60. [No amendments or later additions of this regulation are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 303 E. 17th Ave, Suite 1100, Denver, CO 80203.]

~~I~~J. Private Duty Nursing (PDN) means medically necessary nursing services that are more individual and continuous care than is available under the Home Health benefit~~,~~ or routinely provided by the nursing staff of a hospital or skilled nursing facility, that allow a member to remain in their home or community-based setting.

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

L. [Skilled Care Acuity Assessment means the ~~proprietary~~ assessment that will be used to assess members for their skilled care needs. The Skilled Care Acuity Assessment will only be accepted as valid documentation when completed by the authorized Nurse Assessor Vendor. The Assessment was finalized on September 25, 2024 and is available at https://hcpf.colorado.gov/nurse-assessor.]

M.~~K~~. Skilled Nursing/Skilled Nursing Service means services provided under the licensure, scope, and standards of the Colorado Nurse and Nurse Aide Practice Act, § 12-255-101, C.R.S., 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 a RN and the direction of a physician or allowed practitioner, for care that cannot be delegated by the judgment of the RN or LPN.

~~L~~N.. Technology Dependent means the daily use of medical devices or procedures to maintain a bodily function without which adverse health consequences creating further disability, hospitalization or death could likely follow.

~~M~~O.. Utilization Review Contractor (URC) means a third-party vendor contracted by the Department to perform utilization management functions for specific services.

8.540.2 CRITERIA FOR SERVICES

8.540.2.A To receive PDN services, a member must receive an approved PAR as set forth in Section 8.540.6 and satisfy the following criteria:

1. The member is able to be safely served in their home or community setting by a HHA under the agency requirements and limitations of the PDN benefit and with the staff services available.

2. The member is not residing in a nursing facility or hospital at the time PDN services are delivered.

3. The member has previously been determined to be eligible for the medical assistance program pursuant to Section 8.100.

4. The member meets one of the following criteria:

   a. Members aged 21 years or older who demonstrate medical necessity for Skilled Nursing Services in accordance with Section 8.076.1.8, are technology dependent, and for whom a delay in 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.

b. Members under the age of 21~~aged 20 years or younger~~ who demonstrate medical necessity in accordance with Early and Periodic Screening, Diagnostic, and Treatment benefits requirements at Section 8.280.4.E.

i. Members under the age of 21~~0 years or younger~~ shall require skilled nursing assessment, intervention, and evaluation of both equipment (if applicable) and member.

ii. The services provided shall be medical in nature, safe, effective, generally recognized as an accepted method of treatment, not experimental/investigational, cost-effective, necessary for care of a member's condition, and within accepted standards of nursing practice.

8.540.3 BENEFITS

8.540.3.A All PDN services require prior authorization as set forth in Section 8.540.6-7.

1. The ongoing need for PDN care shall be re-evaluated annually, at a minimum, or when necessary due to a change in the member's condition. The Department, in coordination with the URC, determines the number of PDN hours based on documented medical necessity. PDN hours may be increased or reduced when necessitated by a change in the member's condition as documented in the member's medical record.

2. Authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Reimbursement for PDN claims requires that the member have active coverage on the date of service. Submitted claims shall comply with current billing policies effective on the date of service as set forth in the Home Health Billing Information Manual.

3. A member's need for skilled nursing care is determined 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.

4. Authorized PDN hours shall be used only to meet the medically necessary needs as described in the POC and approved prior authorization request (PAR).

8.540.3.B PA ~~p~~ediatric member~~s~~ under the age~~d~~ of 21~~0 or younger~~ may be approved for up to 24 hours per day of PDN services if the member meets the URC medical necessity criteria defined at Section 8.540.1.E.

8.540.3.C Adult members aged 21 or older may be approved up to 23 hours per day of PDN services if the member meets medical necessity criteria defined at Section 8.540.1.E.

8.540.3.D A member may be eligible for a short-term increase in PDN services for a change of condition. The HHA shall apply for additional hours through a revision to the original PAR.

8.540.3.E A member who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the member's activities of daily living

take him or her away from the home. The total hours authorized shall not exceed those that would have been authorized if the member received all care in the home.

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 as either a PDN or Home Health benefit. 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 Total hours of PDN services shall not exceed what has been determined medically necessary by the URC and ordered by the physician or allowed practitioner.

8.540.4.C PDN services shall not be authorized under the following circumstances:

1. The services consist 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. The services consist of 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. The PDN services are used solely for the convenience of the member or other caregiver.
5. The services are custodial or stand-by care to ensure compliance with treatment.
6. The services are intended for other members of the household who are not receiving approved, group PDN services.
7. The services are duplicative of care covered by another benefit or funding source.

8.540.4.D HOSPITAL DISCHARGE PROCEDURES

1. The hospital discharge planner shall plan for the member's hospital discharge by coordinating with the HHA to:
   a. Arrange services with the HHA, medical equipment suppliers, counselors and other healthcare service providers as needed.
   b. Coordinate a safe home care plan in conjunction with the physician or allowed practitioner and the HHA that meets program requirements.
   c. Advise the HHA of any changes in medical condition and care needs.
   d. Ensure that the member, family and caregivers are educated about the member's medical condition and trained to perform the home care in the absence of HHA staff.

8.540.5 PROVIDER AND FAMILY REQUIREMENTS

8.540.5.A. Provider Eligibility

1. HHA services shall be provided by an HHA certified for participation pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider pursuant to § 25-27.5-103(1), C.R.S.

2. All Home Health Agency providers shall comply with applicable regulations promulgated by the Board of Health, Medical Services Board, Medical Board, Nursing Board, Department of Labor and Employment, and the Centers for Medicare and Medicaid Services.

8.540.5.B Provider Agency Requirements

1. An HHA shall:

   a. Be certified for participation as a Medicare Home Health provider pursuant to 42 U.S.C. § 1395bbb and licensed as a Class A provider as required by § 25-27.5-103(1), C.R.S.;

   b. Be a Colorado Medicaid enrolled provider;

   c. Maintain liability insurance for the minimum amount set annually as set forth at 6 CCR 1011-1, Chapter 26, Section 4.2. ~~;~~[The Department incorporates by reference 6 CCR 1011-1, Chapter 26, Section 4.2. No amendments or later additions of this regulation are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 303 E. 17th Ave, Suite 1100, Denver, CO 80203;] and

   d. Hold a State of Colorado Class A Home Care Agency license in good standing.

2. Home Health Agencies that perform tests in the member's home that are identified as eligible for a Clinical Laboratory Improvement Amendments (CLIA) waiver pursuant to 42 C.F.R. § 493.15 shall possess a certificate of waiver from CMS or its Designee. [The Department incorporates by reference 42 C.F.R. 493.15. No amendments or later additions of this regulation are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 303 E. 17th Ave, Suite 1100, Denver, CO 80203.]

3. A HHA shall not discontinue or refuse services to a member unless documented efforts have been made per agency policies to resolve the situation that triggers the discontinuation or refusal. The HHA shall provide at least 30 calendar days advance notice to the member or the member's designated representative.

4. In the event an HHA ceases operations, it shall notify the Department within 30 calendar days. The notification shall be submitted through the Provider Portal as a maintenance application for the disenrollment request. The provider shall also email the notice to the Department at the designated Home Health email inbox.

8.540.5.C. Provider Responsibilities

1. A certified HHA that provides PDN services shall meet all of the following:

   a. Employ nursing staff nursing staff licensed to practice in Colorado pursuant to the Nurse and Nurse Aide Practice Act, § 12-255-101, C.R.S. that possess education and experience in providing care to individuals who require skilled nursing care in

a home or community-based setting in accordance with HHA policy, state practice acts, and professional standards of practice

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

c. Provide appropriate nursing skills orientation and ongoing in-service education to nursing staff to meet the member's specific nursing care needs.

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

e. Provide adequate supervision and training for all nursing staff as required by the agencies listed in Section 8.540.5.A.2. To be reimbursed for time billed, nursing staff shall be engaged in an activity that directly benefits the member receiving services. Staff shall be physically able and mentally alert to carry out the duties of the job.

f. Coordinate services with a supplemental certified HHA, if necessary, to meet the staffing needs of the member.

g. Designate a case coordinator who is responsible for the management of private duty nursing services,

h.[Ensure that members have a current Skilled Care Acuity Assessment or, if there is not a current assessment, make timely referral to the Nurse Assessor for an assessment.]

~~h~~i. Develop the individualized care plan by completing the PDN [N]{~~n~~}ursing [A]{~~a~~}ssessment ~~[~~]and obtaining information from the attending physician or allowed practitioner and the primary caregiver.

~~i.~~j. For members discharging from a hospital, include information from the discharge planner in the care planning process.

~~j~~k. Assess the home prior to the initial start of services or hospital discharge and on an ongoing basis for safety compliance.

~~k~~l. Involve the member and Family/In-Home Caregiver in the plan for home care and the provision of home care.

~~l.~~m. Assist the member to reach maximum independence.

~~m~~n. Communicate changes in the member's status with the 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, and revise the PAR if a change in services is required to meet the member's changed needs.

~~n~~o. Assist with communication and coordination between the service providers supplementing the primary HHA, the primary care physician or allowed practitioner, specialist(s) and the primary HHA as needed.

~~o~~p. Make regular on-site visits according to HHA policies and procedures and professional standards of practice to monitor the safety and quality of home care and make appropriate referrals to other agencies for care as necessary.

~~p~~q. Ensure that a complete and current care plan prepared within the prior 60 days and nursing chart are in the member's home at all times. The nursing chart 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 care plan.

~~q~~r. Communicate with the Case Management Agency and/or Regional Accountability Entity as needed regarding service planning and coordination.

~~r~~s. Make and document the efforts made to resolve any situation that triggers a discontinuation of or refusal to provide services prior to discontinuation or refusal to provide services.

8.540.5.D. Family/In-Home Caregiver Responsibilities

1. The HHA shall inform the member and their Family/In-Home Caregiver of the following responsibilities for PDN services and ensure that the caregiver:

a. Is able to assume some portion of the member's care when agency staff is not available.

b. Has the specific skills necessary to care for the member.

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

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

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

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

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

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

8.540.5.E. Environmental Requirements

1. Prior to providing PDN services, the HHA shall perform an in-home assessment and document that the home meets the following safety requirements:

a. Adequate electrical power, including a backup power system.

b. Adequate space and ventilation for equipment and supplies.

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

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

e. A working phone available 24 hours a day.

8.540.5.F. Physician or Allowed Practitioner Role

1. The HHA shall coordinate with the member's attending physician or allowed practitioner to:

a. Determine that the member is medically stable, except for acute episodes that may be managed by PDN services, and that the member may be safely served within the requirements and limitations of the PDN benefit.

b. Cooperate with the URC in establishing medical eligibility.

c. Prescribe a ~~plan of care~~POC at least every 60 days.

d. Coordinate with any other physician(s) or allowed practitioner(s) treating the member.

e. Communicate changes in the member's medical condition and care, including discharge from the hospital.

f. Empower the member and the Family/In-Home Caregiver by working with them to maximize the member's independence.

8.540.6 PRIOR AUTHORIZATION PROCEDURES

8.540.6.A A PAR is required for all PDN services. Prior authorization is a request for medically necessary services, based on the needs of the member. The presence of additional members in the home shall not impact the individual member's medical necessity determination.

~~]~~8.540.6.B The PAR may be approved for up to six months for a new member and up to one year for ongoing care.

8.540.6.C The PAR shall include the following:

1. [A current Skilled Care Acuity Assessment completed by the Nurse Assessor. The assessment results are one component to be used to determine medical necessity but do not independently determine whether the requested services are medically necessary.]

2~~1~~. A current POC on CMS Form 485, or form of similar format, that summarizes health conditions, specific care needs, and current treatments, signed by the physician or allowed practitioner or a documented verbal order. The POC shall include~~:~~:

a. A signed PDN Nursing Assessment, a current clinical summary or 60-day summary of care, orders for all disciplines and treatments signed by the physician or allowed practitioner, and goals of care/rehabilitation potential, if applicable.

b. A current diagnosis list and medication list including PRN medications.

c. A documented process by which the member receiving services and support may continue to receive necessary care, which may include backup care, if the member's Family or In-Home Caregiver is unavailable due to an emergency situation or unforeseen circumstances. The Family or In-Home Caregiver shall be informed of the alternative care provisions at the time the individual plan is initiated.

d. A hospital discharge summary if there has been a hospitalization since last PAR.

32. Identification of professional disciplines supporting the medical needs of the member in the home and responsible for the delivery of care. If care overlaps, documentation shall identify overlapping care and the rationale for the overlap.

43. For new members approved for PDN directly upon discharge from the hospital, a copy of the transcribed verbal physician or allowed practitioner orders may be substituted for the POC.

54. Documentation submitted shall 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. The HHA shall not misrepresent or omit facts in a treatment plan.

65. If a member's condition necessitates a change in PDN hours, the HHA shall submit a PAR revision request within 10 business days of a change. The revision may be an increase or a decrease in hours. Discharge notification is also required within 10 business days via a PAR revision request.

76. In the event a member changes provider agencies, the receiving HHA shall submit a Change of Provider Form and POC to the URC within 10 business days of starting PDN services.

87. 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 the HHAs comply with the following:

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

b. The two HHAs shall coordinate the member's POC and maintain the POC and documentation on all services rendered by each PDN Provider in the member's records.

c. Each HHA shall obtain prior authorization, identify to the URC the coordinated POC and revise the PAR as needed to ensure coverage.

8.540.7 UTILIZATION REVIEW

8.540.7.A Providers shall submit requests for prior authorization of PDN services directly to the URC within 10 business days of starting PDN services. Incomplete requests shall be held in pending status for up to 10 business days for the provider to submit additional, required information.

8.540.7.B The criteria for approval of PDN services are based upon the submission of records that demonstrate the skilled nature of the nursing care needed, including physician and/or allowed

practitioner records, specialty notes, and nursing notes. The URC shall review requests for prior authorization according to the information submitted and the application of the medical criteria as described herein.:

1. The URC shall consider combinations of technologies and co-morbidities when making medical determinations that would qualify the member for care pursuant to EPSDT exceptions to benefit limits and coverage standards. The medical judgment of the attending physician or allowed practitioner and the URC shall be used for an individual determination whenever the medical criteria are not defined by specific measurements.

2. Within 10 business days of receipt of the complete PAR, the URC shall approve or deny the PAR~~,~~ or refer the PAR to the URC physician reviewer.

3. The URC shall process the physician review referrals and approve, partially approve, or deny the PAR within 10 business days of referral to the physician reviewer.

8.540.7.C The URC shall issue written notification of all PAR denials, including a member's appeal rights, to the member or member's designated representative and the submitting provider within one business day of the determination.

1. The HHA may request reconsideration by the URC if the PAR is only partially approved or is denied. The HHA also may request a Peer-to-Peer review if the ordering physician or allowed practitioner agrees.

2. Services provided during the period between the provider's submission of the PAR to the URC through 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 for up to 30 calendar days prior to PAR approval, whichever is shorter.

3. When a PAR determination results in the reduction or termination of services, services shall be approved for 30 additional calendar days after the date on the member's notice of denial letter. If the termination or reduction of PDN services is appealed by the member in accordance with Section 8.057.5, services shall be maintained at the previously approved level for the duration of the appeal until the final agency action is rendered.

4. For appeals of an initial PAR denial, continuation of benefits is not applicable.

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

8.540.8 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 under the age~~d~~ of 21~~0 or younger~~ and no more than 23 hours per day for members aged 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 HHA to submit claims to the Medicaid fiscal agent for authorized PDN services provided during the authorized period.

Payment of claims is conditioned upon the member's benefit eligibility on the date 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, except as provided in Section 8.540.7.C.2.

8.540.8.E Skilled Nursing services provided as a PDN benefit shall be reimbursed in units of one hour at the lesser of the provider's usual and customary charge or the maximum Medicaid allowable rates established by HCPF.

1. Units of one hour may be billed for RN or LPN.

2. The RN group rate shall be utilized when a registered nurse is providing PDN services to more than one member at the same time in the same setting.

3. The LPN group rate shall be utilized when a licensed practical nurse is providing PDN services to more than one member at the same time in the same setting.

4. The blended RN/LPN rate shall be requested by the HHA when utilizing an RN or LPN as the assigned staff for more than one member at the same time in the same setting.

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 shall not exceed what is required for one licensed nurse to safely care for each member simultaneously, based on member acuity and the availability of additional support in the home.

8.540.8.F Reimbursement shall not be allowed at any time when nursing staff is sleeping during the provision of PDN services.

8.540.8.G No individual nurse shall be reimbursed for over 16 hours of care per day, except in a documented emergency situation.