Title of Rule: Revision to the Medical Assistance Act Rule concerning Private Duty Nursing and Long-Term Home Health Prior Authorization Requirements, Sections 8.520 and 8.540.
Rule Number: MSB 21-04-07-A
Division / Contact / Phone: Health Programs Office / Rachel Entrican/303-866-3026 / Matt Colussi/303-866-5118 / Whitney McOwen/303-866-4441

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).

   This rule revision will remove the prior authorization requirement for Private Duty Nursing and Long-Term Home Health Services currently codified at 10 CCR 2505-10 Sections 8.520.8.C.1. and 8.540.2.A. This will bring the rule in line with current Department practice.

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:

   These revisions are required to bring Department regulations in line with current practice. The Department otherwise risks deferral or disallowance from CMS for being out of compliance. A deferral or disallowance would impact the Department's ability to provide adequate services to members.

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

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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.

   Members in need of, and providers providing, PDN and LTHH services will benefit from the proposed rule as it will make Department regulations consistent with current practice and alleviate any confusion caused by the inconsistency.

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

   As the temporary policy change being codified with this rule is already in practice, the impact of the rulemaking is minimal, but will add clarity for members and providers.

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 anticipated costs to the Department and to any other agency due to the implementation and enforcement of the proposed rule as it is codifying existing practice.

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

   The probable cost of inaction is risk of deferral and disallowance of PDN and LTHH claims due to the inconsistency between Department regulations and current practice regarding PAR requirements. The probable cost of implementing the rule is maintaining current utilization trends for these programs, which may be higher than historical trends when PARs were required. The probable benefit of the proposed rule is aligning Department regulations with current practice; there is no probable benefit of inaction.

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

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There are no less costly or intrusive methods to achieve the purpose of the proposed rule as the current rule explicitly notes that prior authorization is required for these services.

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.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.520 HOME HEALTH SERVICES

8.520.8 Prior Authorization

8.520.8.A. General Requirements

1. Approval of the PAR does not guarantee payment by Medicaid.

2. The client and the HHA shall meet all applicable eligibility requirements at the time services are rendered and services shall be delivered in accordance with all applicable service limitations.

3. Medicaid is always the payer of last resort and the presence of an approved or partially approved PAR does not release the agency from the requirement to only bill for Medicaid approved services to Medicare or other third party insurance prior to billing Medicaid.

    a. Exceptions to this include Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP) and the following services that are not a skilled Medicare benefit (CNA services only, OT services only, Med-box pre-pouring and routine lab draws).

8.520.8.B. Acute Home Health

1. Acute Home Health Services do not require prior authorization. This includes episodes of acute home health for long-term home health clients.

2. If a client receiving long-term Home Health Services experiences an acute care event that necessitates moving the client to an acute home health episode, the agency shall notify the Department or its Designee that the client is moving from long-term home health to acute Home Health Services.

3. If the client's acute home health needs resolve prior to 60 calendar days, the Home Health Agency shall discharge the client, or submit a PAR for long-term Home Health Services if the client is eligible.

    a. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 9 calendar days or less, the Home Health Agency shall resume the client's care under the current acute home health Plan of Care.

    b. If an acute home health client experiences a change in status (e.g. an inpatient admission), that totals 10 calendar days or more, the Home Health Agency may start a new Acute Home Health episode when the client returns to the Home Health Agency.

    c. The Home Health Agency shall inform the SEP case manager or the Medicaid fiscal agent within 10 working days of the beginning and within 10 working days of the end of the acute care episode.

8.520.8.C. Long-Term Home Health

1. Long-term Home Health Services do not require prior authorization under Section 8.017.E.

2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

3. The complete formal written PAR shall include:

   a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

   b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;

   c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance;

   d. Any other medical information which will document the medical necessity for the Home Health Services;

   e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

   f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

   g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

   h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

   a. PARs shall be submitted for, and may be approved for up to a one year period.

b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

ii) When denied, services shall be approved for 15 additional days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider’s submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.1 DEFINITIONS

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

Home Health Agency means a public agency or private organization or part of such an agency or organization which is certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act.

Plan of Care means a care plan developed by the Home Health Agency in consultation with the client, that has been ordered by the attending physician for provision of services to a client at his/her residence, and periodically reviewed and signed by the physician 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 and continuous than the nursing care that is available under the home health benefit or routinely provided in a hospital or nursing facility.

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

Skilled Nursing means services provided under the licensure, scope and standards of the Colorado Nurse Practice Act, Title 12 Article 38 of the Colorado Revised Statutes, performed by a registered nurse (RN) under the direction of a physician, or a licensed practical nurse (LPN) under the supervision of a RN and the direction of a physician.

Technology Dependent means 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.

8.540.2 BENEFITS

8.540.2.A. ~~All~~ PDN services do not require prior authorization.~~shall be prior authorized by the Department's Utilization Review Contractor (URC).~~

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.

1. 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.

2. 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.

3. 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 clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.

8.540.2.D. Adult clients may be approved for up to 16 hours of PDN per day.

8.540.2.E. A client who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home.