COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

TITLE:	**HOME HEALTH AND PRIVATE DUTY NURSING PROVIDER RESPONSIBILITIES**
SUPERSEDES NUMBER:	**N/A**
EFFECTIVE DATE:	**OCTOBER 26, 2022**
DIVISION AND OFFICE:	**BENEFITS AND SERVICES MANAGEMENT DIVISION, OFFICE OF COMMUNITY LIVING**
PROGRAM AREA:	**HOME HEALTH SERVICES**
KEY WORDS:	**LTHH, PDN, PAR, KEPRO, PRIVATE DUTY NURSING**
OPERATIONAL MEMO NUMBER: HCPF OM 22-049 **ISSUE DATE: OCTOBER 27, 2022** **APPROVED BY: CANDACE BAILEY**	

HCPF Memo Series can be accessed online: https://www.colorado.gov/hcpf/memo-series

Purpose and Audience:

The purpose of this Operational Memo is to provide information about Private Duty Nursing (PDN) and the role of the Home Care agency and their responsibilities in the Prior Authorization Request (PAR) submission and service authorization process.

Information:

Home Care agencies play an important role in assisting members to access critical skilled nursing services. These agencies have certain responsibilities throughout the process. It is important for the agency to work with the member to assess medical needs and determine how the needs can be met through continuous skilled nursing services, intermittent skilled nursing services, a combination of the two, or other Long-Term Home Health services such as Certified Nursing Assistant (CNA). The plan of care (POC) is developed with the member and the member's medical providers to identify the most appropriate care interventions. Documentation, submitted with the POC, should reflect the assessment. The documentation provided to the Department of Health Care Policy & Financing (Department) must align with professional licensing requirements for the level of care requested.

Effective immediately, the Department is initiating a temporary Administrative Approval process on PDN PARs. Please note this is an Administrative Approval process, not a pause. Providers will still need to submit all necessary documentation.

All members who received a denial letter will be notified directly by the Department's vendor of this administrative approval.

Providers must submit a PAR for services through Atrezzo before services commence, or before the expiration of an existing PAR. All PDN providers must obtain prior authorization before starting services. Documentation must demonstrate medical necessity and appropriate clinical information to justify the care to be provided.

This temporary Administrative Approval process means:

- All PDN PARs that have been denied will receive continuation of benefits through Dec. 31, 2022, and incoming requests will be administratively approved through Dec. 31, 2022. This applies to both technical denials and denials for medical necessity. During this time:
    - Providers who serve members who have PARs that were denied with an end date before Dec. 31, 2022, will need to submit a PAR Reconsideration to https://portal.kepro.com/ with documentation to support the request by Nov. 30, 2022.

Providers who serve members who have PARs that were denied with an end date after Dec. 31, 2022, will have until Jan. 15, 2023, to submit a PAR Reconsideration with documentation to support the request.

The following is a list of required information that must be uploaded at the time of submission:

- Member demographics including name, Medicaid ID, and DOB
- CPT, Revenue, or HCPCS codes to be requested
- Dates of service (DOS) and number of units requested
- ICD-10 code for the diagnosis
- Servicing provider (billing provider) NPI if different than the requesting provided
- A completed Plan of Care/485 with a physician's signature or documented verbal order to include:
    - a signed nursing assessment
    - a current clinical summary or update of the member's condition
    - a physician's plan of treatment

  - a hospital discharge summary shall be included if there was a hospitalization since the last PAR.

Further medical documentation may include:

- 60-day assessment that systematically reviews each body system and reflects progress and problems encountered in the period and outlines plans for recertification period
- A completed PDN acuity tool
- The duties, treatments, and tasks to be performed by the nurse
  - PRN (as needed) interventions should be accompanied with notes or logs from the 60-day assessment (e.g., oxygen, medications, seizure tracking, and interventions)
- Nursing notes reflecting the nature of care provided during the 60-day assessment
- Physician orders that specify how often treatment or visits will be and the length of each visit
- Physician specialty notes reflecting current treatment recommendations identified in the POC (if relevant) (e.g., Gastroenterology, Neurology, Pulmonology)
- Medication Administration Records (MAR)

PAR Process

Once the PAR has been submitted, one of the following outcomes listed below will be provided. Please note that in the case of a potential appeal, continuation of benefits as well as payment will continue through the appeal process. If services are denied, the Department will offer benefits counseling to discuss the member's needs and talk to families about the different benefits available to them.

- Approval
  - All criteria were met, and the service(s) requested was approved either at the first level review or at physician level.
- Request for additional information
  - Information for determination is not included and vendor requests this to be submitted to complete the review within 10 business days.
- Technical Denial
  - Health First Colorado coverage policy is not met for reasons including, but not limited to, the following:

        - Untimely Request
        - Requested information not received/Lack of Information (LOI)
        - Duplicate to another request approved for the same provider
        - Service is previously approved with another provider
    - If a Technical Denial is determined, the provider can request a Reconsideration.
- Reconsideration Request – reconsiderations and peer-to-peer (P2P) reviews can occur concurrently.
    - The servicing provider may request a reconsideration to Kepro within 10 days of the initial denial. If the reconsideration does not overturn the denial, the next option is a P2P Request.
    - An ordering provider may request a P2P review within 10 business days from the date of a medical necessity adverse determination.
- Medical Necessity Denial
    - Physician-level reviewer determines that medical necessity has not been met and has been reviewed under appropriate guidelines. The Physician may fully or partially deny a request.
    - If a Medical Necessity Denial was determined, it was determined by the Utilization Management Medical Director. Therefore, the next step would be requesting a Peer-to-Peer.

PAR Revisions

If the number of approved units needs to be amended, the provider must submit a request for a PAR Revision in Atrezzo prior to the PAR end date. The physician order, POC, the PDN tool, and any additional documentation must appropriately reflect the adjustment of hours requested. Please note, a new PAR is not required, as this would overlap with the existing PAR and therefore increase the likelihood the claim will be denied for duplication of services.

When a member receiving services changes providers during an active PAR certification, the receiving provider will need to complete a Change of Provider (COP) Form and upload into Atrezzo to transfer the member's care from the previous provider to the receiving agency.

Appeal Process

During a PDN appeal process, a continuation of benefits is automatic. Providers can continue to bill for services during this time and should ensure all services continue to be provided.

Attachment(s):

None

Contact:

HomeHealth@state.co.us