Private Duty Nursing

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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

This policy provides information regarding the coverage of, as determined by applicable federal and/or state legislation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

PURPOSE

This policy outlines Highmark Health Options reimbursement for private duty nursing.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

Home Health Services – Home health care includes skilled nursing care, as well as other skilled care services, like physical and occupational therapy, speech-language therapy, and medical social services. These services are given by a variety of skilled health care professionals at home.

Home Health Agency – An agency or organization which is primarily engaged in providing skilled nursing care services and other therapeutic services.

Private Duty Nursing (PDN) – The services provided by a private-duty nurse or other private-duty home health aide. Private-duty nurses or private-duty home health aides are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or home health aide. Such persons are engaged or paid by an agency or financial management service provider or by someone acting on their behalf, including a hospital that initially incurs the costs and looks to the patient for reimbursement for such noncovered services.

PROCEDURES

PRIVATE DUTY NURSING

Prior authorization is required.

Requirements for Coverage

Private Duty Nursing (PDN) services are covered and considered Medically Necessary for members requiring individual and continuous Skilled Care when ordered by the member's primary care and/or treating physician as part of a Treatment Plan and the member meets all the following criteria:

- Needs Skilled Care that exceeds the scope of Intermittent Care; and
- Needs services that require the professional proficiency and skills of a licensed nurse (RN or LPN); and
- Is unable to have their care tasks provided through Intermittent Care; and
- Has a complex medical need and/or unstable medical condition that requires four (4) or more continuous hours of Skilled Care which can be safely provided outside an institution; and
- Requires Skilled Care that is Medically Necessary for the member's disease, illness, or injury, as defined by the member's physician; and
- Has family or other appropriate support that has the ability and availability to be trained to care for the member and assume a portion of the care (Note: The intent of PDN services is to support, not replace, the caregiver); and
- Periodically reviewed Treatment Plan (no more frequently than every 60 days) updated by the treating physician; and
- The services are more cost-effective in the Home than in an alternative setting such as a hospital or a facility that provides Skilled Care (Note: Refer to federal, state, or contractual requirements for benefit coverage, as applicable)

Documentation Requirements

Initial Request for Authorization

Initial service requests of PDN services (i.e., the first-time member is requesting services with Highmark Health Options for PDN services) must be submitted with all the following clinical documentation:

- Letter of Medical Necessity (LOMN) signed by a physician and/or advanced practice registered nurse (M.D. or D.O.); and
- A comprehensive assessment of the member's health status including but not limited to documentation of the Skilled Care need and medication administration record; and
- Discharge summary or recent progress note if member is being discharged from an inpatient setting (Note: If member is requesting PDN services for discharge from inpatient setting, subspecialist visit notes are not required); and
- Consultation notes if the member is receiving services from subspecialist; and
- An assessment of the scope and duration of PDN services being requested; and

- An assessment of the available support system must include but not limited to the following:
  - Availability of the member's primary caregiver; and
  - Ability of the member's primary caregiver to provide care; and
  - School attendance and availability of coverage for services by school district, including the member's individualized education plan (IEP), if applicable; and
  - Primary caregiver's work schedules, as applicable Additional documentation clarifying clinical status (such as well child check and/or specialist visit notes) may be requested if clinical documentation provided does not clearly support the hours being requested.

Renewal of Services/Changes to Existing Approval of Services

Requests for renewal of PDN services (i.e., any request for PDN services after the initial request for PDN services made to Highmark Health Options) will require submission of all the following specific clinical documentation to support Medical Necessity, every six months:

- Nurses' notes, logs, and daily care flow sheets; and
- Physician's signed plan of care (485) or for HHA services
- Updated Plan of Care
- Signed current Supervisory Note for services rendered
- Verification of primary caregiver's employment schedule annually, as applicable

Annual Requests for Renewal will require the following documentation for review:

- Letter of Medical Necessity (LOMN) signed by a physician and/or advanced practice registered nurse (M.D. or D.O.); and
- Nurses' notes, logs, and daily care flow sheets; and
- Verification of primary caregiver's employment schedule annually, as applicable
- Updated school information to include the IEP, school calendar and bus schedule.

Changes to Existing Approval of Services will require the following documentation for review:

- Letter of Medical Necessity (LOMN) signed by a physician and/or advanced practice registered nurse (M.D. or D.O.); and
- Nurses' notes, logs, and daily care flow sheets; and
- Verification of primary caregiver's employment schedule, as applicable
- Any documentation to deemed necessary to support the request for a change in services.

Transition of Services

If a member is transitioning from another health plan and is already receiving PDN services, then a copy of the current approval documentation, outlining the discipline and hours approved must be submitted from the provider currently providing the approved coverage. Services will be auto approved for a period of 90 days, following transfer to HHO, for continuity of care.

Prior to the 90-day continuity of care expiration, all the following documentation must be submitted for review for medical necessity, under HHO criteria:

- Letter of Medical Necessity (LOMN) signed by a physician and/or Advanced Practice Registered Nurse (M.D. or D.O.); and
- Nurses' notes, logs, and daily care flow sheets; and
- Verification of primary caregiver's employment schedule, as applicable
- If applicable, school documentation to include IEP, school calendar and bus schedule.

PRIVATE DUTY HOME HEALTH AIDE

Prior authorization is required.

Members under four (4) years of age are excluded from this benefit.

Who qualifies for HHA services:

- Member must be under the care of a physician and the home health care services must be furnished under a plan of care that is established, periodically reviewed, and ordered by a physician or allowed practitioner. **NOTE:** A patient is expected to be under the care of the physician or allowed practitioner who signs the plan of care. It is expected that in most instances, the physician or allowed practitioner who certifies the patient's eligibility for home health services will be the same physician or allowed practitioner who establishes and signs the plan of care.

Home Health aide services may include:

- Personal care
- Simple dressing changes that do not require the skills of a licensed nurse
- Assistance with medications which are self-administered and do not require the skills of a licensed nurse to be provided safely and effectively
- Assistance with activities which are directly supportive of skilled therapy services but do not require the skills of a therapist to be safely and effectively performed such as routine maintenance exercises and repetitive practice of functional communication skills to support speech-language pathology services
- Provision of services incidental to personal care services, not care of prosthetic and orthotic devices

PRIVATE DUTY NURSING-SKILLED CARE

Prior authorization is required.

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury and must be intermittent. Coverage of skilled nursing care does not turn on the presence or absence of a patient's potential for improvement from the nursing care, but rather on the patient's need for skilled care.

Requirements for Coverage

The services being requested must meet the following:

- Member must be diagnosed with a medical condition that requires skilled nursing
- PDN services must be ordered and directed by the treating practitioner or specialist (Medical Doctor, Doctor of Osteopathic Medicine, Advanced Practice Registered Nurse) after a face-to-face evaluation by the physician, or advanced practice nurse practitioner.
- A Letter of Medical Necessity (LOMN) is required from the members physician and Advanced Practice Registered Nurse, it must include the following:
  - Members name, date of birth, date of request, level of care, frequency of care and medical reasons for requesting this care
  - Be signed, dated, and submitted on office letterhead
- PDN services are subject to frequent reassessments and changes in treatment:
  - Continuation of services require documentation to support the need of ongoing treatment

- Provided in the home or an approved community setting
- Is not custodial care
- Member must meet one or more of the following specific criteria:
  - Requires feeding tube and/or medication enterally (i.e.., jejunostomy tube, nasogastric, gastrostomy tube)
  - Requires parenteral feeding such as total parenteral nutrition (TPN) including care of intravenous (IV) catheter (i.e., peripherally inserted central catheter, central venous line, Broviac line)
  - Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding
  - Member is technology dependent
  - Requires care and management for ventilator dependence, nasopharyngeal and/or tracheostomy aspiration, insertion and sterile irrigation and replacement of catheters
  - Requires care and management for use of continuous positive airway pressure (CPAP) or Bilevel Positive Airway Pressure (BiPAP)
  - Member needs application of dressings involving prescription medication and aseptic techniques
  - Requires treatment of extensive decubitus ulcers or other widespread skin disorder
  - Requires skilled observation and monitoring of the patient's conditions (does not include the observation and monitoring of patient's behavioral health condition)
  - Member needs evaluation and initiation of appropriate preventive and rehabilitative nursing procedures, including the related teaching and adaptive aspects of nursing, i.e., implementation and supervision of bowel and bladder training programs
  - Requires oxygen administration, pulse-ox monitoring, seizure monitoring and interventions (medications, oxygen)
- PDN services must be clinically appropriate and not more costly than alternative health services such as those provided in an institutional setting.

Coverage Limitations and Exclusions

The following are considered limited or excluded from the benefit:

- Services beyond the plan benefits
- Requested services excluded from the state contract
- Requested services defined as non-skilled or custodial care
- Respite care is a separate benefit and is not covered under PDN services
- Services when a member does not meet criteria for skilled services
- Member is no longer eligible for benefits under the state Contract: Twenty-four (24) hours per day of care-in this case that 24 hours per day is being requested, an institutional setting should be discussed with the member and family as an alternative
- PDN services are not covered if the member is in an acute inpatient hospital, inpatient rehabilitation, skilled nursing facility, intermediate care facility or a resident of a licensed residential care facility
- PDN services are not considered medical necessary solely because there is no caregiver to assume this role. Caregiver obligations outside of the home are not a guarantee of authorization of PDN hours
- PDN services will only be authorized where there is at least one (1) caregiver willing and able to accept responsibility for the individuals care when the nurse is not available. Therefore, HHO expects that caregivers are willing and capable to accept responsibility for the member's care. If the caregiver cannot or will not accept responsibility for the member's care when PDN services are not authorized or available, the member is deemed not to be in a safe environment and PDN services will not be authorized
- HHO cannot guarantee PDN services will be available from a specific provider

Determination of Hours

- More than eight (8) hours per day shift and/or eight (8) hours per night shift of skilled nursing care is not considered medically necessary.
- Additional PDN hours above what is typically approved may be considered medically necessary in any of the following circumstances:
  - Assist caregivers adjust and ensure all equipment is functioning following a transition or discharge from a hospital or other facility to community
  - Once a transition occurs, PDN services are gradually reduced based upon individually assess medical necessity
  - Member becomes acutely ill and additional skilled nursing care will prevent a hospital readmission or institutional placement
  - Member meets medical necessity criteria for admission in a skilled nursing facility (SNF), but a SNF bed is not available; additional skilled nursing may be provided until a SNF bed is available
- PDN services may be adjusted based on the availability of the parent/caregiver as determined by HHO. “Availability” is individually determined based on total circumstances. HHO requires documentation of parent/caregiver unavailability be provided annuals or when/if changes occur
- PDN services may be reduced by the introduction of a Home Health Aide (HHA) in lieu of PDN services when appropriate and cost-effective

Considerations and Guidelines for Authorizations

- The number of skilled needs that the member requires
- Caregiver’s abilities and availability
- Stability of member’s condition
- The nature of member’s illness/condition
- The goal is to make the family as independent as possible and to wean nursing care as the member’s medical condition improves
- A nurse may accompany the member when the member’s normal life activities (such as a child attending school) take the member outside of the home. The medical needs of the child must meet the criteria requiring PDN. The term “normal life activities” does not include coverage of hospital, physician’s office, or other medical care settings
- PDN services may be authorized during the school day with parental consent and when HHO determines that it is medically necessary for school-age children. This may include accompanying the children during the transport to and from school and providing medically necessary care during school hours
- PDN services may be approved when a child is home sick or there are unplanned school closures or inclement weather days. However, additional hours must be pre-authorized. Home Health Agencies may not be able to provide “on demand” or “same-day” service. Parents/caregivers should contact HHO as soon as they know about an unplanned school closure
- PDN services may be approved to cover summer vacations as well as scheduled school year holiday vacations for school-age children if it is determined that the services are medically necessary

UNSTAFFED PDN HOURS

A member, member’s parent/guardian/caregiver may reach out to the assigned Care Management staff or the agency providing services, for approval to use hours lost due to the agency not having staffing (i.e.,

a downshift), if sufficient time is available for missed hours to be used within the same month that the downshift occurred:

- The HHO Utilization Management Reviewer (UMR) places no restrictions on the member/member's parent/guardian/caregiver's staffing plan, if the agency can accommodate the staffing plan requested by the member, member's parent/guardian/caregiver within the established guidelines and timeframes.
- The PDN Care Management staff engages member, members' parent/guardian/caregiver and refers the member to a secondary agency when staffing issues are frequent and long standing.
- If there is a complaint about missed shifts from the member, member's parent/guardian/caregiver, it may be referred to HHO Appeals and Grievances Department to allow a grievance to be filed.

If a member, member's parent/guardian/caregiver requests approval to use hours lost due to the agency not having staffing (i.e., downshift), but there is insufficient time available for missed hours to be used within the same month that the downshift has occurred:

- For hours missed due to a downshift occurring within seven (7) days prior to the end of the month, the member, member's parent/guardian/caregiver may use those hours during the subsequent month.
- The HHO UMR:
  - Amends the authorization for the hours that were missed in the previous month (in which the downshift occurred), deducting the hours missed
  - Amends the authorization for the subsequent month, adding the hours deducted from the previous month (the month the downshift occurred)
  - Places no restrictions on the member, member's parent/guardian/caregiver's staffing plan, if the agency can accommodate the staffing plan requested by the member, member's parent/guardian/caregiver within the established guidelines and timeframes.

Post-payment Audit Statement

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

Place of Service: Outpatient

CODING REQUIREMENTS

OUTPATIENT SERVICES

CPT codes	Description
S9123	Nursing care, in the home; by registered nurse, per hour (use for general nursing care only, not to be used when CPT codes 99500-99602 can be used).
S9124	Nursing Care, in the home; by licensed practical nurse, per hour.
G0156	Services of home health/hospice aide in home health or hospice settings, each 15 minutes.

REIMBURSEMENT

Participating facilities will be reimbursed per their Highmark Health Options contract.

The number of weekly hours of PDN services authorized for each individual is based on the individual's needs and documented in the provider Plan of Care.

Prior approval of services does not guarantee that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and must determine if beneficiaries have other health insurance.

The Home Health agency may not bill HHO for travel time. The time billed for the nurse is only for the actual time spent with the member.

Documentation should contain the total time spent with the patient, including the beginning and end of the visit, to substantiate the number of units billed.

References

Center for Medicare and Medicaid Services. (2021) Medicare Benefit Policy Manual. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf

Center for Medicare and Medicaid Services. (2022). Home Health Providers. Retrieved from https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs