HIGHMARK HEALTH OPTIONS

Private Duty Nursing Quick Guide

The information provided in this document is intended to facilitate collaboration with agencies providing private duty nursing services. This information is subject to change.

Need help? Contact Highmark Health Options Utilization Management Department at 1-844-325-6251.

Acronyms	
AI	Additional Information
CC	Care Coordinator
DFS	Division of Family Services
DMMA	Department of Medicaid and Medical Assistance
LCD	Last Covered Date
LOMN	Letter of Medical Necessity
POC	Plan of Care / 485

Contact Information

Utilization Management Department
Phone: 1-844-325-6251
Private Duty Nursing Fax: 1-855-445-4239

- For LOMNs, POCs, notes, etc.
- Information requested by CC.
- Member's name must be written on the document (not the cover page).
- Information about multiple members (even siblings) must be sent in separate faxes (as required per HIPAA).
- All information intended for an appeal or a retroactive start date should be faxed directly to the Appeals Department, 1-844-325-3435.

Coordination of Care

The Highmark Health Options CC must be immediately notified when:

- An event necessitates an incident report, family complaint regarding practice, or agency concern.
- A member is switching health plans.
- The member's medical needs change.
- There is a change or question regarding the caregiver's work (if services authorized to cover work obligation).
- A member is discharged from the hospital. (Fax copy of the discharge summary to Private-Duty Nursing Utilization Management, 1-855-445-4239).
- DFS is involved, including caseworker's name and phone number.
- There is a change in the family's psychosocial needs.
- There is a change in the member's needs while at school or on the school bus. (Fax most recent school schedule, academic calendar, and bus schedule to Private-Duty Nursing Utilization Management, 1-855-445-4239.)
- Staffing issues are present.
- Other situations apply based on agency judgment.

Time Frames

Requests

- Decision made within 7 calendar days, unless extended.

Attempts to Request AI

- Highmark Health Options will attempt up to 3 times to gather AI if needed for the request.

- A 14-day extension period may be initiated by Highmark Health Options if AI is still needed after 7 days.

Written Extension for AI

- Allows 14 additional days for AI to be gathered and submitted to Highmark Health Options.
- AI gathered for a review (not an appeal/grievance) should be faxed to the Private-Duty Nursing Department.

Peer Review

- Offered to the requesting physician when a request is reduced or denied.
- Families and agencies are notified of the decision once it has been rendered.

Authorization Time Frames and LCD

- LCD is specified in Highmark Health Options' written communication with agencies regarding approvals and reductions.
- If services are required past the LCD, information must be submitted to Highmark Health Options for review prior to the LCD to avoid interruption in services.

LOMN Format

- Uses the requesting provider's letterhead or the provider's employer letterhead.
- Includes the signature of the requesting provider.
- Includes the provider's name and date printed below the signature.
- Describes level of care requested (e.g., Private-Duty Skilled Nursing or Home Health Aide Services).
- Describes summary of medical history and needs required for level of care requested.
- Outlines when and how all requested hours would be scheduled for all days for which services are requested.
- Provides start and end dates if request is for an episode of care (e.g., vacation, post-op services).
- Provides current caregiver information.

Common Errors	
• No level of care stated	• No indication of how or when hours will be used
• Insufficient clinical history	• Unsigned, illegible, or not on correct letterhead

Understanding Appeals

Refer to Highmark Health Options' determination letter for additional information.

Appeals and Grievances

- First Level: Filed with Highmark Health Options for internal review.
- Continuity is extended only when requested by the member/family, when appeal is filed within 10 days of denial letter and services were previously approved. This must be requested from the Appeals Department.
- Can be filed by member/family or provider (with member's written consent) up to 60 days from denial letter.

State Fair Hearings

- Second Level: Filed externally from Highmark Health Options.
- Highmark Health Options can neither ensure nor authorize continuity until notification from DMMA has been received confirming that filing occurred within 10 days of decision.

- Families can file after the internal appeal process has been completed.