DRAFT

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

Table of Contents

1.0 Description of the Procedure, Product, or Service 1
1.1 Definitions 1
1.1.1 Skilled Nursing 1
1.1.2 Nursing Care Activities 1
1.1.3 Substantial 2
1.1.4 Complex 2
1.1.5 Continuous 2
1.1.6 Significant Change in Condition 2
1.1.7 Primary Caregivers 2
2.0 Eligibility Requirements 2
2.1 Provisions 2
2.1.1 General 2
2.1.2 Specific 3
2.2 Special Provisions 3
2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid 3
Beneficiary under 21 Years of Age 3
2.2.2 EPSDT does not apply to NCHC beneficiaries 4
2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age 4
3.0 When the Procedure, Product, or Service Is Covered 4
3.1 General Criteria Covered 4
3.2 Specific Criteria Covered 5
3.2.1 Specific criteria covered by both Medicaid and NCHC 5
3.2.2 Medicaid Additional Criteria Covered 5
3.2.3 NCHC Additional Criteria Covered 5
3.3 Health Criteria 5
3.3.2.1 Medical Fragility Criteria: 6
3.4 Amount, Duration, Scope, and Sufficiency of PDN Services 6
3.4.1 PDN and Schools 6
3.4.2 Congregate Care 7
3.4.3 Short Term Increase in PDN Services for a Significant Change in Condition 7
4.0 When the Procedure, Product, or Service Is Not Covered 8
4.1 General Criteria Not Covered 8
4.2 Specific Criteria Not Covered 8
4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC 8
4.2.2 Medicaid Additional Criteria Not Covered 8
4.2.3 NCHC Additional Criteria Not Covered 9
5.0 Requirements for and Limitations on Coverage 9
5.1 Prior Approval 9

DRAFT

5.2 Prior Approval Requirements....9
5.2.1 General....9
5.2.2 Specific Criteria....9
5.2.2.1 Initial Referral Process....9
5.2.2.2 Initial PDN Service Review Documentation Requirements....9
5.2.2.3 Initial Referral Provisional Approval....10
5.2.2.4 Initial Referral Continuation Approval....11
5.2.2.5 Plan of Care....11
5.2.2.6 Reauthorization Process....12
5.2.2.7 Documentation Required for PDN Service Reauthorization....12
5.2.2.8 Re-Evaluation during the Approved Period....13
5.2.3 Requests to Change the Amount, Duration, Scope, and Sufficiency of Services 13
5.2.3.1 Plan of Care Changes....13
5.2.3.2 Temporary Changes....13
5.2.3.3 Emergency Changes....14
5.2.4 Termination or Reduction....14
5.2.4.1 Notification of Termination....14
5.2.4.2 Notification of Reduction....14
5.2.5 Changing Service Providers....15
5.2.5.1 Transfer of Care Between Two Branch Offices of the Same Agency....15
5.2.5.2 Transfer of Care Between Two Different Agencies....15
5.2.5.3 Discharge Summary....15
5.2.5.4 Approval Process....15
5.2.6 Coordination of Care....16
5.2.6.1 Transfers Between Health Care Settings....16
5.2.6.2 Drug Infusion Therapy....16
5.2.6.3 Enteral or Parenteral Nutrition....16
5.2.6.4 Home Health Nursing....16
5.2.6.5 Medical Supplies....16
5.3 Limitations on the Amount, Frequency, and Duration....16
5.3.1 Unauthorized Hours....16
5.3.2 Transportation....16
5.3.3 Weaning of a Medical Device....17
6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service....17
6.1 Provider Qualifications and Occupational Licensing Entity Regulations....17
6.2 PDN Service Provider Responsibilities....17
6.3 Provider Relationship to Beneficiary....18
6.4 Nurse Supervision Requirements....18
6.5 Provider Certifications....18
7.0 Additional Requirements....18
7.1 Compliance....18
7.2 Documentation Requirements....19
7.2.1 Contents of Records....19

7.2.2 Termination of Operations 19
7.3 Verification of Eligibility 19
7.4 Qualified Family and Other Designated Caregivers 19
7.4.1 Primary Caregiver 19
7.4.2 Training 20
7.4.3 Documenting Competency 20
7.4.4 Emergency Plan of Action 20
7.4.5 Evaluation of Health and Safety 20
7.5 Patient Self Determination Act 20
7.6 Marketing Prohibition 20
8.0 Policy Implementation and History 20
Attachment A: Claims-Related Information 22
A. Claim Type 22
B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) 22
C. Code(s) 22
D. Modifiers 23
E. Billing Units 23
F. Place of Service 23
G. Co-payments 23
H. Reimbursement 23
I. Unit Limitations 23
Attachment B: Home Health Certification and Plan of Care Form (CMS-485) 24
Attachment C: Physician's Request Form for Private Duty Nursing 25
Attachment D: PDN Prior Approval Referral Form (DMA-3061) 27
Attachment E: PDN Medical Update/Beneficiary Information Form 28
Attachment F: Verification of Employment Form 29
Attachment G: Hourly Nursing Review Criteria 30
Attachment H Employment Attestation Form 34
Attachment I: Verification of School Nursing form 35

DRAFT

Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:

3A*, Home Health Service*
3G-1, P*rivate Duty Nursing for Beneficiaries Age 21 and Older*
3D, *Hospice*
3H-1 *Home Infusion Therapy*
3K-1 *Community Alternatives Program for Children (CAP/C)*
5A, *Durable Medical Equipment*
8P, *NC Innovations*
10D *Independent Practitioners Respiratory Therapy Services*

1.0 Description of the Procedure, Product, or Service

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing care that is considered supplemental to the care provided to a beneficiary by the beneficiary's family, foster parents, and delegated caregivers, as applicable. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility; or that requires more continuous care than is available through home health services. PDN care must be medically appropriate and medically necessary for the beneficiary to be covered by the NC Medicaid.

PDN services are provided:

a. Only in the beneficiary's private primary residence;
b. Under the direction of a written individualized plan of care; and
c. Authorized by the beneficiary's primary physician.
d. PDN services must be rendered by a registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing (NCBON) and employed by a state licensed and accredited home care agency.

1.1 Definitions

1.1.1 Skilled Nursing

For this policy, nursing services as defined by 10A NCAC 13J.1102 is referred to as "skilled nursing."

Skilled nursing does not include those tasks that can be delegated to unlicensed personnel pursuant to 21 NCAC 36.

1.1.2 Nursing Care Activities

Activities as defined by 21 NCAC 36 .0401. For this policy, Nursing Care Activities are referred to as "tasks."

CPT codes, descriptors, and other data only are copyright 2020 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

CPT codes, descriptors, and other data only are copyright 2018 American Medical Association. All rights reserved. Applicable FARS/DFARS apply.

1.1.3 Substantial

Substantial means there is a need for interrelated nursing assessments and interventions. Interventions not requiring an assessment or judgment by a licensed nurse are not considered substantial.

1.1.4 Complex

Complex means scheduled, hands-on nursing interventions. Observation in case an intervention is required is not considered complex skilled nursing and is not covered by Medicaid as medically necessary PDN services.

1.1.5 Continuous

Continuous means nursing assessments requiring interventions are performed at least every two (2) or three (3) hours during the period Medicaid-covered PDN services are provided.

1.1.6 Significant Change in Condition

Significant change means a change in the beneficiary's status that is not self-limiting, impacts more than one (1) area of functional health status, and requires multidisciplinary review or a revision of the plan of care according to program requirements specified in **Sections 3.0** and **4.0** of this policy.

1.1.7 Primary Caregivers

a. A **fully available** primary caregiver is one who lives with the beneficiary, is not employed and who is physically and cognitively able to provide care.
b. A **partially available** primary caregiver is one who lives with the beneficiary and has verified employment or who has been determined by the Social Security Administration to be unable to work due to a disability and the nature of the disability is one that limits the ability of that person to provide care to the PDN beneficiary.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***) **a. Medicaid**

An eligible Medicaid beneficiary shall be under 21 years of age.

Eligibility categories are:

1. Fee-for-Service: Beneficiaries covered by Medicaid are eligible to apply for PDN services.
2. Medicaid for Pregnant Women (MPW): Pregnant women may be eligible to apply for PDN services if the services are medically necessary for a pregnancy-related condition.
3. Medicare Qualified Beneficiaries (MQB): Medicaid beneficiaries who are Medicarequalified beneficiaries (MQB) are not eligible for PDN.
4. Managed Care: Medicaid beneficiaries participating in a managed care program, such as Medicaid health maintenance organizations and Community Care of North Carolina programs(CCNC), (Carolina ACCESS and ACCESS II/III), must access home services, including PDN, through their primary care physician.

b. NCHC

NCHC beneficiaries are not eligible for Private Duty Nursing (PDN).

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is

found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover PDN when:

a. Eligibility criteria in **Section 2.0** are met;
b. Health criteria in **Section 3.3** are met;
c. Provided only in the primary private residence of the beneficiary. The basis for PDN approval is the need for skilled nursing care in the primary private residence to prevent institutionalization. A beneficiary who is authorized to receive PDN services in the primary private residence may make use of the approved hours outside of that setting when normal life activities temporarily take him or her outside that setting. Normal life activities are supported or sheltered work settings, licensed childcare, school and school related activities, and religious services and activities. Normal life activities are not inpatient facilities, outpatient facilities, hospitals, or residential-type medical settings;
d. PDN services have been requested by (Refer to **Attachment C**) and ordered by the beneficiary's primary physician (MD) or Doctor of Osteopathic Medicine (DO) licensed by the North Carolina Board of Medicine and enrolled with Medicaid) on the CMS-485 (Home Health Certification and Plan of Care Form);
e. Prior approval has been granted by NC Medicaid according to **Section 5.0 of this policy** (Refer to **Attachment A**); and
f. The beneficiary has at least one (1) trained primary informal caregiver to provide direct care to the beneficiary during the planned and unplanned absences of PDN staff. It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.

3.2.3 NCHC Additional Criteria Covered

None Apply

3.3 Health Criteria

To qualify for PDN services a beneficiary shall be determined to be medically fragile (refer to **Subsection 3.3.2**) and the care needs to meet medical necessity as detailed in **Subsection 3.3.1**.

3.3.1 Medical Necessity

Medical necessity, for this policy, refers to skilled nursing care, which may be justified as reasonable, necessary and appropriate. This care must be based on evidence-based clinical standards of care. Skilled services are those considered effective for the beneficiary's illness, injury or disease and not primarily for the convenience of the beneficiary or caregiver.

3.3.2 Medical Fragility

Medical fragility refers to a chronic physical condition, which results in prolonged dependency on medical care for which skilled nursing interventions are medically necessary. Primary medical diagnosis(es) to include conditions such as chronic cardiovascular disease, chronic pulmonary disease, congenital anomalies, chronic disease of the alimentary system, chronic endocrine and metabolic disorders, chronic infectious disease, chronic musculoskeletal conditions, chronic

neurological disorders, chronic integumentary disease, chronic renal disease, genetic disorders, oncologic and hematologic disorders.

3.3.2.1 Medical Fragility Criteria:

Medical fragility criteria are:

a. A life threatening medical condition characterized by reasonably frequent periods of acute exacerbation which requires frequent physician supervision or consultation and which in the absence of such supervision or consultation would result in hospitalization;
b. Beneficiary need for frequent, ongoing and specialized treatments and nursing interventions which are medically necessary, and
c. Beneficiary dependency on life-sustaining medical technology such that without the technology a reasonable level of health could not be maintained. PDN service assisted technology are dependence on ventilator, endotracheal tube, gastrostomy tube (G-tube), oxygen therapy, cough assist device, chest physical therapy (PT) vest and suction machine, or care to compensate for the loss of bodily function.

3.4 Amount, Duration, Scope, and Sufficiency of PDN Services

NC Medicaid shall determine the amount, duration, scope, and sufficiency of PDN services - not exceed 112 hours per week or 16 hours per day - required by the beneficiary based on a comprehensive review of all the documents listed in **Subsection 5.2.2.7**, along with the following characteristics of the beneficiary: a. Primary and secondary diagnosis;

b. Overall health status;
c. Level of technology dependency;
d. Amount and frequency of specialized skilled interventions required;
e. Amount of caregiver assistance available. Verification of employment hours are conducted annually. Allowances are not for second jobs, overtime, or combination of work and school, when the additional hours cause the policy limit to be exceeded;

Hours are approved on a per-week basis beginning 12:01 a.m. Sunday and ending at 12:00 a.m. Saturday. A beneficiary may use the hours as he or she chooses. A beneficiary approved for 70 hours per week may use 10 hours per day seven (7) days per week, or may use 14 hours per day five (5) days per week. It is the responsibility of the beneficiary, caregiver and provider to schedule time to ensure the health and safety of the beneficiary. Additional hours are not approved because the family planned poorly and 'ran out' before the end of the week.

Note: Unused hours of services must not be "banked" for future use or "rolled over" to another week.

3.4.1 PDN and Schools

Individuals and caregivers are responsible for determining if the beneficiary is receiving the appropriate nursing benefit in the school system, and formulating the child's Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), 504 Plan or Individual Health Plan (IHP), to report nursing coverage in the school system.

If any nursing hours are approved for school coverage, these hours are reported to NC Medicaid (refer to **Attachment I**), but are kept separate from the allotted PDN home hours.

The nurse shall document the hours and specific place of service when care is rendered in a school, along with how transported to school (bus, parent vehicle, etc.). All other PDN requirements must be met. In addition to the IEP, IFSP, 504 Plan or IHP, there must be a CMS485 (Home Health Certification and Plan of Care Form), signed only by a Medical Doctor (MD) or Doctor of Osteopathic (DO); a Verification of School Nursing form (refer to **Attachment I**); and a current school calendar. The CMS-485 l documents allotted PDN home hours as well as school hours. The name of the school system responsible for nursing coverage of school hours must be documented. The CMS-485 may include up to 60 hours every calendar-year for sick days, adverse weather days, and/or scheduled school closings. Any hours above this limit must be submitted on a change request form as short term intensive services, and be approved by a NC Medicaid Nurse Consultant (refer to **Subsection 3.4.3**).

A parent or caregiver signed notification explaining any unscheduled school absences is required for PDN agency reimbursement of hours worked in the home (refer to **Attachment I**). Once required documentation has been received by NC Medicaid, the Prior Authorization (PA) for the affected time frame is adjusted to document the hours provided at the primary private residence.

3.4.2 Congregate Care

PDN allows congregate nursing services, where two (2) or more Medicaid beneficiaries requiring private duty nursing services reside within the same home. These hourly nursing services are limited to a **maximum ratio** of one (1) private duty nurse to two (2) individuals receiving nursing services. If there are more than two (2) individuals residing within the same home that require PDN services, the provider shall contact a NC Medicaid PDN consultant to determine the individual needs for each beneficiary.

The provider shall report the most specific billing code that accurately and completely describes the procedure or service provided. The provider shall indicate which level of nurse provides care with modifier codes specific to either a Registered Nurse (RN) or Licensed Practical Nurse (LPN). The level of nurse providing PDN services must also be documented on the CMS-485 Plan of Care.

3.4.3 Short Term Increase in PDN Services for a Significant Change in Condition

A short term increase in PDN services is limited to a maximum of four (4) calendar weeks. The amount and duration of the short-term increase is based on medical necessity, and approved by NC Medicaid's PDN Nurse Consultant.

Medicaid shall cover a short-term increase in PDN service when the beneficiary meets ONE of the following significant changes in condition:

a. A beneficiary with new tracheostomy, ventilator, or other technology need, immediately post discharge, to accommodate the transition and the need for training of informal caregivers. Short term increases are weaned down to within normal policy limits over the course of four (4) consecutive weeks;
b. An acute, temporary change in condition causing increased amount and frequency of nursing interventions; or
c. A family emergency, when the back-up caregiver is in place but requires additional support because of less availability or need for reinforcement of training.
d. A beneficiary is out of school, and has used their allotted 60 hours per calendar year for sick days, adverse weather days, or school closings. If additional PDN hours are deemed

medically necessary by the physician, a physician-signed request for these hours shall be submitted to NC Medicaid's PDN Nurse Consultants.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover PDN if any of the following are true:

a. the beneficiary is receiving medical care in a hospital, nursing facility, outpatient facility, or residential-type medical setting where licensed personnel are employed;
b. the beneficiary is a resident of an adult care home, group home, family care home, or nursing facility;
c. the service is for custodial, companion, respite services (short-term relief for the caregiver) or medical or community transportation services;
d. the nursing care activities rendered can be delegated to unlicensed personnel (Nurse Aide I or Nurse Aide II), according to 21 NCAC 36.0401 and 21 NCAC 36.0221(b); e. the purpose of having a licensed nurse with the beneficiary is for observation or monitoring in case an intervention is required;
f. the service is for the beneficiary or caregiver to go on vacation or overnight trips away from the beneficiary's private primary residence. **Note:** Short-term absences from the primary private residence that allow the beneficiary to receive care in an alternate setting for a short time, may be allowed as approved by the PDN Nurse Consultant and when not provided for respite, when not provided in an institutional setting, and when provided according to nurse and home care licensure regulations;
g. services are provided exclusively in the school or home school;
h. the beneficiary does not have informal caregiver support available as per **Subsection 3.2.2.f**;
i. the beneficiary is receiving home health nursing services or respiratory therapy treatment (except as allowed under clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services*) during the same hours of the day as PDN;
j. the beneficiary is receiving infusion therapy services as found under the clinical coverage policy 3H-, *Home Infusion Therapy (HIT)* program; or

k. the beneficiary is receiving hospice services as found under clinical coverage policy 3D, *Hospice Services*, except as those services may apply to children under the Patient Protection and Affordable Care Act. H.R.3590.
l. the beneficiary is receiving services from other formal support programs (such as NC Innovations) during the same hours of the day as PDN.

4.2.3 NCHC Additional Criteria Not Covered

NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

1. No services for long-term care.
2. No non-emergency medical transportation.
3. No EPSDT.
4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Medicaid shall require prior approval (PA) before rendering Private Duty Nursing (PDN) Services.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Personnel the following: a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.3** of this policy.

5.2.2 Specific Criteria

5.2.2.1 Initial Referral Process

A hospital discharge planner or referring medical provider shall refer a potential beneficiary to a PDN service agency to initiate the service review process.

The PDN service agency shall submit documents (as listed in **Subsection 5.2.2.2**) with an initial request for PDN services.

5.2.2.2 Initial PDN Service Review Documentation Requirements

Specifically, the following documents are required for an eligibility assessment review:

a. PDN Prior Approval Referral Form DMA-3061(refer to **Attachment D**);

b. NC Medicaid Physician's Request Form DMA-3075 (refer to **Attachment C**) *or* a physician signed letter of medical necessity.

Either type of physician's request must contain all the following:

1. The current diagnosis(es);
2. History and date of onset of the illness, injury, or medical condition for which PDN services are requested;
3. Date(s) of any related surgeries;
4. The projected date of hospital discharge, if applicable;
5. A prognosis and the estimated length of time PDN services is required; and
6. The specific licensed nursing interventions needed and the frequency of those interventions.

c. Hospital discharge summary (if from hospital discharge) or clinical notes from the last two (2) office visits;

d. Most recent history and physical;

e. Signed physician's order from the referring physician or discharging physician which must contain the specific skilled nursing interventions and the frequency of those interventions; and

Note: If observation and assessment are the only skilled nursing interventions required, then the beneficiary's skilled needs are not sufficient for PDN services.

f. Employment Attestation Form for caregiver(s) (refer to **Attachment H**)

Note: PDN service providers shall indicate in their submitted documents the family members and other caregivers who are available to furnish care and that they have been or shall be provided training on the necessary care.

Once all required documents are received, NC Medicaid shall complete a clinical review for PDN services. Incomplete documentation is handled as unable to process or as an incomplete request.

5.2.2.3 Initial Referral Provisional Approval

When all required documents are received by NC Medicaid (refer to **Subsection 5.2.2.2**), NC Medicaid shall conduct a comprehensive clinical review for PDN services. With NC Medicaid approval, the initial provisional request for PDN services is granted for 30 calendar days only. This is a provisional approval pending receipt of final documentation. The physician signed Home Health Certification and Plan of Care Form (CMS-485), Verification of Employment form (refer to **Attachment F**), the provider's consent to treat form, and the Verification of School Nursing form, if applicable (refer to **Attachment I**) are due by day 30. When NC Medicaid receives these documents, approval is granted for the remainder of the six (6) -month certification period.

Note: Beyond the provisional time frame, PA is only granted from the date of documents submission.

5.2.2.4 Initial Referral Continuation Approval

To receive PA for service provision for the remainder of the six (6) - month certification period, the PDN agency shall:

a. Complete a comprehensive in home assessment with 24 hours of the start of care (SOC).
b. PDN service providers shall upload, into NC Tracks, the physician signed CMS-485 along with the Employment Verification form, provider's consent to treat, and the Verification of School Nursing form, if applicable, as supporting documentation for PA requests by day 30 of the Provisional PA period.
c. NC Medicaid shall process the continuation approval for PDN services within 15 business days of the receipt of all required information from the PDN service provider.
d. A letter is sent to the beneficiary or the beneficiary's representative. The approval letter contains:
    1. the beneficiary's name and MID number;
    2. the name and provider number of the authorized PDN service provider;
    3. the number of hours per week approved for PDN services, beginning with Sunday at 12:01 am; and ending at 12:00 a.m. Saturday.
    4. the starting and ending dates of the approved certification period, Certification periods are six (6) months.

5.2.2.5 Plan of Care

The signed Home Health Certification and Plan of Care Form (CMS-485) must document:

a. All pertinent diagnoses along with the beneficiary's mental status;
b. The type of services, medical supplies, and equipment ordered;
c. The number of hours of PDN per day and number of days per week, according to 42CFR 409.43 Pan of Care Requirements.
d. Specific assessments and interventions to be administered by the licensed nurse;
e. Individualized nursing goals with measurable outcomes;
f. Verbal order and date, signed by RN if CMS-485 (Line 23) is not signed by the physician in advance of the recertification period;
g. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications-indicating new or changed in last 30 calendar days, and treatments;
h. Teaching and training of caregivers;
i. Safety measures to protect against injury;
j. Disaster plan in case of emergency or natural occurrence; and
k. Discharge plans individualized to the beneficiary.

Note: The PA period is a maximum of six (6)-months, but the physician signed CMS-485 shall be uploaded every 60 days. Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

5.2.2.6 Reauthorization Process

To recertify for PDN services, the PDN service provider shall submit the reauthorization documents to NC Medicaid at least 30 calendar days prior to the end of the current approved certification period. Submitted documents required are: Hourly Nursing Review Criteria form (refer to **Attachment G**), PDN Medical Update/ Beneficiary Information Form DMA-3062 (refer to **Attachment E**), physician signed Home Health Certification and Plan of Care Form CMS-485 (refer to **Attachment B**), and Verification of School Nursing form (refer to **Attachment I**), if applicable.

The CMS-485 must document:

a. All pertinent diagnoses along with the beneficiary's mental status;
b. The type of services, medical supplies, and equipment ordered;
c. The specific number of hours of PDN per day (a range of hours is not acceptable) and number of days per week;
d. Specific assessments and interventions to be administered by the licensed nurse;
e. Individualized nursing goals with measurable outcomes;
f. Verbal order and date, signed by RN if CMS-485 (Locator 23) is not signed by the physician in advance of the recertification period;
g. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications-indicating new or changed in last 30 calendar days, and treatments;
h. Teaching and training of caregivers;
i. Safety measures to protect against injury;
j. Disaster plan in case of emergency or natural occurrence; and
k. Discharge plans individualized to the beneficiary.

Note: The PA period is a maximum of six (6)-months, but the physician signed CMS-485 shall be uploaded every 60 days. Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

If any of the documents are omitted or incomplete, the request for PA is treated as an incomplete request and NC Medicaid is unable to process.

Note: If the recertification request is received after the beginning of the new certification period. NC Medicaid shall only approve PA from the date of submission of the request.

5.2.2.7 Documentation Required for PDN Service Reauthorization

All the following documents are required for reauthorizations:

a. A copy of the completed PDN Medical Update-Beneficiary Information Form, which also indicates the date of the last physician visit (refer to **Attachment E**);
b. A copy of the Home Health Certification and Plan of Care Form (CMS-485) signed and dated by the attending physician (refer to **Attachment B**). The

CMS-485 needs to specify at a minimum - skilled nursing care to be provided, recertification dates, frequency and duration of PDN services being requested;

c. The completed Hourly Nursing Review Criteria (refer to **Attachment G**);
d. At NC Medicaid's discretion, an in-home assessment may be performed by NC Medicaid;
e. NC Medicaid reserves the right to verify caregiver's employment schedule annually and as deemed appropriate by NC Medicaid. Verification consists of a statement on employer letterhead signed by a supervisor or representative from the employer's Human Resources Department, detailing the employee's current status of employment (such as active or on family medical leave) and typical work schedule. If a caregiver is self-employed or unable to obtain a letter, the Verification of Employment form, **Attachment F**, may be used;
f. Nurses' notes from the latest certification period as requested by NC Medicaid; and
g. The Verification of School Nursing form (refer to **Attachment I**), if applicable.

Note: The PA period is a maximum of six (6)-months, but the physician signed CMS-485 shall be uploaded every 60 days. Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

Note: If any of the above documents are omitted or incomplete, the request for PA is treated as incomplete and NC Medicaid is unable to process.

5.2.2.8 Re-Evaluation during the Approved Period

If the beneficiary experiences a significant change of condition, the PDN service provider shall notify NC Medicaid. NC Medicaid shall re-evaluate services at that time.

5.2.3 Requests to Change the Amount, Duration, Scope, and Sufficiency of Services

Any requests to change the amount, scope, frequency, or duration of services must be ordered by the attending physician and approved by NC Medicaid.

5.2.3.1 Plan of Care Changes

Any request to increase or decrease the amount, scope, frequency or duration of services must be approved by NC Medicaid prior to implementation.

5.2.3.2 Temporary Changes

Requests to decrease the amount, scope, frequency, or duration of services for seven days or less, such as over a holiday when additional family members are available to provide care and services, do not require NC Medicaid approval. Previously approved service levels can resume after the family situation returns to the normal routine. The

agency shall document the reason for the decrease in services and supportive information, notifying the physician as appropriate.

5.2.3.3 Emergency Changes

Sudden changes in the amount, scope, frequency or duration of services are based on true emergent medical necessity of the beneficiary or their primary caregiver. Emergency changes initiated outside of regular business hours must be reported to NC Medicaid the next business day. The written request must provide specific information regarding changes in the beneficiary's or their primary caregiver's medical condition and a documented verbal order. A physician signed order must be provided to NC Medicaid within 15 business days of initiating emergency care nursing services.

5.2.4 Termination or Reduction

PDN services may be reduced or terminated by the beneficiary's attending physician, the beneficiary or their legal representative, or NC Medicaid. Upon termination or reduction, NC Medicaid enters information into the fiscal agent's claims system to deny payment for all services provided after the termination date. Important information about the Medicaid Beneficiary Due Process (Appeal Rights) is found on the NC Medicaid website: https://medicaid.ncdhhs.gov/.

5.2.4.1 Notification of Termination

The termination process is determined by the following:

a. If the PDN service provider discharges the beneficiary, the service provider shall send a copy of the physician's order to terminate services to NC Medicaid within five (5) business days.

b. If the PDN service provider discharges the beneficiary from Medicaid coverage because there is another source of nursing care coverage, the service provider shall notify NC Medicaid in writing. The notification must report the last date that PDN services were provided and can be billed to Medicaid and the name of the other source of coverage as applicable.

c. If the attending physician discharges the beneficiary, the PDN service provider shall provide to NC Medicaid, within five (5) business days, the physician's order to terminate beneficiary services.

d. If services are terminated as a result of the beneficiary's loss of Medicaid, or if no PDN services are provided during the 30 consecutive days for any reason such as a hospitalization, then the prior approval process must be initiated once again as outlined in **Subsections 5.1 and 5.2. PDN service providers shall notify NC Medicaid when a beneficiary is hospitalized.**

Note: The decision of the beneficiary's attending physician and/or the PDN service provider to discharge the beneficiary cannot be appealed to NC Medicaid.

5.2.4.2 Notification of Reduction

The reduction process is determined by the following:

a. PDN service provider reduces the PDN services: the service provider shall send NC Medicaid, within five (5) business days, a copy of the physician's order to reduce services.

b. The attending physician reduces the PDN services: the PDN service provider shall provide to NC Medicaid, within five (5) business days, the physician's order to reduce beneficiary services.

d. Based on a review of the beneficiary's health record, if a reduction in PDN services is being considered by NC Medicaid, NC Medicaid may request additional information from the PDN service provider or physician. In the event the additional information is not provided within 10 business days of the notice of the reduction (or other time frame agreed upon by the provider and NC Medicaid nurse consultant), NC Medicaid shall proceed with the reduction of services.

5.2.5 Changing Service Providers

Requests to change PDN service providers can occur as a result of a beneficiary's exercising freedom of choice.

5.2.5.1 Transfer of Care Between Two Branch Offices of the Same Agency

The new PDN service provider shall facilitate the change by coordinating the transfer of care with the beneficiary's attending physician, the current PDN service provider, and others who are involved in the beneficiary's care. The new PDN service provider is responsible for the following:

a. Submitting the transfer request to NC Medicaid within five (5) business days of the request;
b. Obtaining written permission from the beneficiary or legal guardian regarding the request to transfer;
c. Coordinating the date the new provider assumes beneficiary care, and ensuring that duplication of service is avoided;
d. Providing, in the written notification, the new provider's name and full mailing address, the new provider's PDN service provider number, the date the new provider plans to initiate services, the name of the person at the previous agency with whom the transfer was coordinated, the name and telephone number of the new provider's contact person, and the responsible party's contact information;
e. Ensuring that written and verbal orders are verified and documented according to 10A NCAC 13J, The Licensing of Home Care Agencies; and
f. Forwarding to NC Medicaid, prior to transfer, written notification of the transfer along with a copy of the attending physician's orders.

5.2.5.2 Transfer of Care Between Two Different Agencies

Follow the same procedure as listed above in **Subsection 5.2.5.1**, but also submit: a. the PDN Prior Approval Request Form DMA-3061 (refer to **Attachment D**)

b. the physician signed Home Health Certification and Plan of Care Form CMS-485 (physician's orders) (refer to **Attachment B**)
c. Physician's Request Form for Private Duty Nursing DMA 3075 (refer to **Attachment C**) *or* a letter of medical necessity signed by the physician.

5.2.5.3 Discharge Summary

The former PDN service provider shall forward to NC Medicaid a discharge summary that specifies the last day PDN services were provided to the beneficiary.

5.2.5.4 Approval Process

After all requirements are met, NC Medicaid approves the new PDN service provider and forwards an approval letter, with copies to the beneficiary's attending physician and the beneficiary (and representative if applicable) in accordance with the beneficiary notices procedure.

5.2.6 Coordination of Care

The beneficiary's attending physician and the PDN service provider are responsible for monitoring the beneficiary's care and initiating any appropriate changes in PDN services.

5.2.6.1 Transfers Between Health Care Settings

If a beneficiary is placed in a different health care setting due to a change in his or her medical condition, the PDN service provider shall contact NC Medicaid prior to the beneficiary's discharge to discuss any required changes in PDN services. A history and physical and a discharge summary must be submitted to NC Medicaid.

5.2.6.2 Drug Infusion Therapy

If a beneficiary requires drug infusion therapy, the Durable Medical Equipment (DME) supplier provides the drug infusion equipment, and drugs are provided through Medicaid's or Medicare's Part D pharmacy coverage. The PDN provider is responsible for the administration and caregiver teaching of the infusions.

5.2.6.3 Enteral or Parenteral Nutrition

If a beneficiary requires enteral or parenteral nutrition, the durable medical equipment and supplies (DME) supplier provides the equipment, supplies, and nutrients. Home health and Home Infusion would be duplication.

Refer to **Section 4.0** for information on services that are not covered when the beneficiary is receiving PDN services.

5.2.6.4 Home Health Nursing

Home Health Nursing services must not be provided concurrently with PDN Services. When a beneficiary requires Home Health medical supplies, the PDN provider shall provide and bill for those supplies. The PDN provider is also expected to handle blood draws, wound care, and other home health nursing tasks for a PDN beneficiary.

5.2.6.5 Medical Supplies

Medical supplies are covered as per the criteria for coverage of medical supplies and use of the miscellaneous procedure code for medical supplies defined in clinical coverage policies 3A, *Home Health Services* and 5A, *Durable Medical Equipment* (available here: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/clinical-coverage-policy-index).

An enrolled PDN provider may bill for Medicaid-covered medical supplies as above if provided to a NC Medicaid-approved PDN beneficiary during the provision of PDN services.

Refer to **Subsection 7.2** for documentation requirements.

5.3 Limitations on the Amount, Frequency, and Duration

5.3.1 Unauthorized Hours

PDN services provided in excess of the approved amount (the excess has not been authorized by NC Medicaid) are the financial responsibility of the provider agency.

5.3.2 Transportation

The PDN nurse shall not transport the beneficiary. The licensed nurse may accompany the beneficiary if medically necessary as defined in **Subsection 3.2** when his or her normal life

activities require that the beneficiary access the community within the NC Medicaid approved time scheduled for PDN services.

5.3.3 Weaning of a Medical Device

NC Medicaid may authorize PDN services for a brief period when the beneficiary no longer requires the medical device to compensate for loss of a vital body function. This period must not exceed two (2) weeks past the weaning of the medical device. The provider agency shall contact the physician to obtain an order to decrease PDN services once a significant change in condition and need for skilled nursing care has occurred.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall: a. meet Medicaid or NCHC qualifications for participation;

b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

PDN services must be provided by home care agencies accredited with Joint Commission, Community Health Accreditation Partner (CHAP), or Accreditation Commission for Health Care (ACHC); and holding a current license from the N.C. Division of Health Service Regulation (DSHR) or as applicable, Eastern Band of Cherokee providers must be a Medicare Certified Home Health Agency. The home care agency shall be an enrolled N.C. Medicaid provider approved by NC Medicaid to provide PDN services. Each office of the home care agency providing services shall have an individual N.C. Medicaid PDN National Provider Identifier (NPI) number.

6.2 PDN Service Provider Responsibilities

The PDN service provider is responsible for:

a. ensuring that qualified and competent licensed nurses are assigned to provide skilled nursing care as required by the plan of care and the services are provided within the nurses' scope of practice as defined by 21 NCAC 36;

b. ensuring appropriate nurse to patient staffing ratios are applied to congregate care cases;

c. ensuring accreditation with Joint Commission, Community Health Accreditation Partner (CHAP), Accreditation Commission for Health Care (ACHC) or federal law, including the IHCIA, 25 U.S.C.§ 1601, et seq. and/or 42 C.F.R. Part 136 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) of 2009. as appropriate.

d. ensuring orientation and competency assessment of skills are sufficient to meet the plan of care requirements before assigning the nurse to the beneficiary's care;

e. developing and providing orientation to licensed nurses for policies and procedures consisting of the following:

1. organizational chart and line of supervision;
2. on-call policies;
3. record keeping and reporting;
4. confidentiality and privacy of Protected Health Information (PHI);

5. patient's rights;
6. advance directives;
7. written clinical policies and procedures;
8. training for special populations such as pediatrics, ventilator care, tracheostomy care, wound, infusion care;
9. professional boundaries;
10. supervisory visit requirements to include new and experienced personnel; 11. criminal background checks;
12. Occupational Safety and Health Administration (OSHA) requirements, safety, infection control;
13. orientation to equipment;
14. cardiopulmonary resuscitation training and documentation;
15. incident reporting;
16. cultural diversity and ethnic issues; and
17. translation policy.

Note: Documentation of all training and competency must be retained in the personnel file of each licensed nurse and available to NC Medicaid upon request.

6.3 Provider Relationship to Beneficiary

To provide PDN services reimbursed by Medicaid, the provider agency shall not employ:

a. a member of the beneficiary's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step- and in-law relationships); or
b. a legally responsible person who maintains his or her primary private residence with the beneficiary; or
c. the nurse shall not live with the beneficiary in any capacity.

6.4 Nurse Supervision Requirements

The PDN nurse supervisor shall have at least two (2) years of Intensive Care Unit, Coronary Care Unit, Neonatal Intensive Care Unit, Pediatric Intensive Care Unit or other experience in other critical care settings or two (2) years' home care experience with medically fragile beneficiaries or a combination of the previous. NC Medicaid prefers additional direct clinical supervisory experience.

6.5 Provider Certifications

None Apply

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documentation Requirements

7.2.1 Contents of Records

The PDN service provider is responsible for maintaining complete and accurate records of all care, treatment, and interventions that fully document the beneficiary's condition, nursing interventions, and treatment provided containing ALL the following:

a. The date and time the skilled care was provided;
b. All nursing interventions, along with time, activity, and beneficiary's response;
c. Verification that all care was provided according to the attending physician's orders, the beneficiary's current individualized plan of care, and NC Medicaid approval;
d. Signature of beneficiary or caregiver acknowledging time spent and services rendered. This signature must be obtained daily;
e. Hourly Nursing Review (Refer to **Attachment G**).
f. Indicate place of service, if other than primary private residence (such as school, outings, travel to medical appointments);
g. Use of medical supplies to support quantities delivered and used;
h. Document to whom report was given and received from;
i. Indicate present and available caregivers;
j. Document caregiver education, competency and learning needs and progress toward teaching goals;
k. Document safety issues and appropriate interventions;
l. Coordination with other homecare services to ensure no duplication of services;
m. Document other in home services such as Respiratory Therapy, Therapy Services, Habilitation Aides, etc.;
n. Document a medical update (such as a face-to-face encounter with physician or Non-Physician Provider)- and submit to NC Medicaid with each reauthorization; and
o. Document supervisory visits according to agency policy and licensure rules.

The provider(s) shall submit to NC Medicaid any requested documents that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

7.2.2 Termination of Operations

If an agency ceases operation, NC Medicaid shall be notified in writing where the records are stored.

7.3 Verification of Eligibility

The PDN service provider shall verify the beneficiary's eligibility, Medicaid coverage category, other insurance coverage, and living arrangement before initiating services and during delivery of PDN services.

7.4 Qualified Family and Other Designated Caregivers

7.4.1 Primary Caregiver

The beneficiary shall have at least one (1) trained informal primary caregiver. It is recommended that there also be a second informal caregiver for instances of primary informal caregiver unavailability because of: illness or emergency and for occasional respite for the primary

caregiver. Both informal caregivers shall be trained and available to provide care in the home during the absence of the PDN nurse and as required by the beneficiary's medical status.

7.4.2 Training

As part of the PDN service, the PDN service provider shall provide and document training and educational needs of the beneficiary (when applicable), family members, and designated caregivers in accordance with the beneficiary's plan of care. Training provided by the PDN provider and by the hospital prior to a beneficiary's beginning PDN services, must be documented.

7.4.3 Documenting Competency

Family members and other designated caregivers shall demonstrate competency in providing the care that the beneficiary requires when the PDN nurse is not present. The PDN service provider is responsible for documenting family members and other designated caregivers who have demonstrated competency in providing the care required by the beneficiary. Documentation of discharge teaching provided by a hospital may be part of documenting competency.

7.4.4 Emergency Plan of Action

An emergency plan of action must be developed, and all family members or caregivers shall know the procedures to take if the beneficiary requires emergency medical care.

7.4.5 Evaluation of Health and Safety

Prior to initiating services and with continuation of PDN services, the PDN service provider is responsible for evaluating the family and home environment in terms of the health, safety, and welfare of the beneficiary and PDN nursing staff, consistent with the agency's policies and licensure requirements.

7.5 Patient Self Determination Act

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. Providers shall comply with these guidelines. *NCTracks Provider Claims and Billing Assistance Guide*: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

7.6 Marketing Prohibition

Agencies providing PDN under this Medicaid Program are prohibited from offering gifts or services of any kind to entice beneficiaries or their caregivers to choose said agency as their PDN Provider or to entice beneficiaries to change from their current provider.

8.0 Policy Implementation and History

Original Effective Date:

History:

Date	Section or Subsection Amended	Change

03/01/2017	All Sections and Attachment(s)	New Policy documenting expansion of PDN services for Medicaid beneficiaries under 21 years of age.
05/12/2017	All Sections and Attachment(s)	Policy posted 05/12/2017 with an Effective Date of 03/01/2017
11/01/2017	All Sections and Attachment (s)	Grammar, formatting, and hyperlink updates and corrections
11/01/2017	Sections 3.4.1, 3.4.3, 5.2.2, and Attachment I	Clarified PDN and Schools implementation process and added a new form, Verification of School Nursing (Attachment I)
11/01/2017	Sections 3.4.2, 6.2, and Attachment A	Clarified Congregate Care implementation process and HCPCS Codes
11/01/2017	All sections	Identified increased prior authorization (PA) certification period from 60 calendar days to six (6) months
11/01/2017	Sections 5.2.3.3, 5.2.4.1, 5.2.4.2	Removed text in 5.2.3.3 Emergency Changes, 5.2.4.1 Notification of Termination, and 5.2.4.2 Notification of Reduction, as it was duplicative of already posted Due Process Policies and Procedures.
11/01/2017	All Sections and Attachment (s)	Added 'physician' to clarify need for physician signed CMS_485 for PA approval.
11/01/2017	Section 3.4 and 4.2.2	Removed information about CAP/C beneficiaries – transition is complete. Moved information about hours for other formal support programs to Section 4.2.2
11/01/2017	Section 5.2.2.5	Removed 'specific' and 'range of hours not acceptable'. Per 42CFR 409.43 Plan of Care Requirements, the frequency of visits may be stated as a specific range to ensure the most appropriate level of care is provided.
	Section 5.2.6.5	Added the following language: Medical supplies are covered as per the criteria for coverage of medical supplies and use of the miscellaneous procedure code for medical supplies defined in clinical coverage policies 3A, *Home Health Services* and 5A, *Durable Medical Equipment* (available here: https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/clinical-coverage-policy-index).

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	Program Description
T1000	PDN Nursing Services

The following HCPCS Codes will be utilized depending on the skill level of nursing care provided for congregate care PDN hours.

HCPCS Code(s)	Program Description
S9123	Congregate Nursing Services, RN
S9124	Congregate Nursing Services, LPN

Note: Medical supplies are billed using HCPCS supply codes as indicated on the Home Health Fee Schedule. The Home Health Fee Schedule lists the covered supplies. Refer to NC Medicaid's Web site at http://dma.ncdhhs.gov/.

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Modifiers are required for billing PDN nursing services as follows: TD for RN care and TE for LPN care.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

1. PDN Services
   PDN services are billed in 15-minute units and must not exceed the NC Medicaid authorized number of PDN units per day. The qualifications of the nurse must be specified.
2. Medical Supplies
   Medical supplies are paid by item and quantity supplied and according to the Medicaid Home Health Fee Schedule. Refer to **Subsection 5.2.6.5** for coverage criteria.

F. Place of Service

PDN services are provided in the beneficiary's private primary residence. Refer to **Subsection 4.2**

G. Co-payments

For Medicaid refer to Medicaid State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

For NCHC refer to NCHC State Plan:
https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/

PDN providers shall bill their usual and customary charges.
Reimbursement is based on the NC Medicaid Home Health and Private Duty Maximum Rate Schedule,available at:
http://dma.ncdhhs.gov/

Program Integrity

The Program Integrity Section of NC Medicaid investigates PDN services provided without authorization.

I. Unit Limitations

The following limits apply:
1. Billed time cannot exceed the number of units per week authorized by NC Medicaid.

DRAFT

Attachment B: Home Health Certification and Plan of Care Form (CMS-485)

This form is available at: http://dma.ncdhhs.gov/

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address

7. Provider's Name, Address and Telephone Number

8. Date of Birth

9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis	Date
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies

15. Safety Measures

16. Nutritional Req.

17. Allergies

18.A. Functional Limitations

1 ☐ Amputation
2 ☐ Bowel/Bladder (Incontinance)
3 ☐ Contracture
4 ☐ Hearing
5 ☐ Paralysis
6 ☐ Endurance
7 ☐ Ambulation
8 ☐ Speech
9 ☐ Legally Blind
A ☐ Dyspnea With Minimal Exertion
B ☐ Other (Specify)

18.B. Activities Permitted

1 ☐ Complete Bedrest
2 ☐ Bedrest BRP
3 ☐ Up As Tolerated
4 ☐ Transfer Bed/Chair
5 ☐ Exercises Prescribed
6 ☐ Partial Weight Bearing
7 ☐ Independent At Home
8 ☐ Crutches
9 ☐ Cane
A ☐ Wheelchair
B ☐ Walker
C ☐ No Restrictions
D ☐ Other (Specify)

19. Mental Status
1 ☐ Oriented
2 ☐ Comatose
3 ☐ Forgetful
4 ☐ Depressed
5 ☐ Disoriented
6 ☐ Lethargic
7 ☐ Agitated
8 ☐ Other

20. Prognosis
1 ☐ Poor
2 ☐ Guarded
3 ☐ Fair
4 ☐ Good
5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

25. Date of HHA Received Signed POT

24. Physician's Name and Address

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (12-14) (Formerly HCFA-485) (Print Aligned)

DRAFT

Attachment C: Physician's Request Form for Private Duty Nursing

This form is available at: http://dma.ncdhhs.gov/.

NC DMA PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

DMA3075

A. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Requested SOC date:_____* Complete form within 15 business days of the start of care date and submit to NC DMA.

1. Patient Name:_____ 2. Address: _____
3. Phone Number:_____ 4. Recipient ID #: _____
5. Date of Birth:_____ 6. Diagnosis: _____
7. Prognosis and expectations of specific disease process: _____
8. Date of last physician assessment: _____
9. Services requested and why: _____
10. Specify how many hours/days/weeks requested: _____
11. Informal caregivers' availability and training received: _____

Technology Requirements and Nursing Care Needs

12. Ventilator dependent? ☐ No ☐ Yes Type: _____
13. Hours per day on ventilator: _____
14. Oxygen? ☐ No ☐ Yes Actual liters per minute and hours per day required: _____
15. Continuous prescribed rate?_____ or adjusted daily or more often? (specify): _____
16. Maintain sats >_____% Frequent need for adjustments and interventions? _____
17. Non-ventilator dependent tracheostomy? Circle one. ☐ No ☐ Yes
18. Name of Provider Agency: _____
19. Requesting Provider #:_____ NPI: ☐ Atypical: ☐ 20. Taxonomy: _____
21. Address: _____ 22. Nine Digit Zip Code: _____
23. Does that patient have insurance in addition to Medicaid? ☐ Yes ☐ No
24. Is PDN covered by private insurance? ☐ Yes ☐ No If Yes, explain coverage: _____
25. Date of last approval period: _____
26. Current attending physician: _____
27. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____
28. Date of last weight (adults), height and weight for pediatric recipients: _____
29. Date of last examination by MD (name of MD): _____
30. Changes in recipient's condition: _____

Page 1 of 2

NC DMA PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

DMA3075

Page 2

31. Home visit observations. Safety of environment, and caregiver information: _____

_____

_____

32. Critical incidents with the recipient (hospitalizations, falls, infections, etc): _____

_____

_____

33. Therapies recipient is receiving (PT, OT, ST, RT, etc): _____

_____

34. Emergency plan of care if nurse is not available; _____

_____

35. Training needs: _____

36. Education provided, return demonstrations and identification of ongoingneeds: _____

_____

_____

_____

Print Physicians Name: _____

Print Physicians Address & phone number_____

Physicians Signature:_____ Date:_____

DRAFT

Attachment D: PDN Prior Approval Referral Form (DMA-3061)

This form is available at: http://dma.ncdhhs.gov/.

NC DMA PRIVATE DUTY NURSING (PDN)

PRIOR APPROVAL REFERRAL FORM

DMA-3061

For initial PDN requests, submit either a) this form along with a DMA 3075 or b) a physician's letter of medical necessity.

PATIENT INFORMATION

Name:_____

Address:_____Phone Number: _____

MID #:_____Medicare #:_____Birthdate:_____Sex: _____

RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name:_____

Address:_____

Phone Number:_____Relationship: _____

CAREGIVER INFORMATION

Name:_____

Address: _____

Phone Numbers: work_____home_____

Relationship to Recipient: _____

Hours/Day Available to Care for Recipient: _____

PHYSICIAN INFORMATION

Community Attending's Name: _____

Address:_____Phone Number: _____

Names and Phone Numbers of Other Physicians Ordering Care: _____

_____

NURSING AGENCY INFORMATION

PDN Agency: _____

Address: _____

Nursing Contact Person:_____Contact's Phone Number: _____

Provider NPI Number: _____

INSURANCE INFORMATION

Insurer's Name: _____

Address:_____

Contact Person & Phone Number: _____

Policy or ID Number:_____Amount of PDN Covered by Insurance: _____

MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN: _____

_____

_____

Primary nursing interventions and the frequency with which these are performed at home: _____

_____

_____

_____

_____

Physician Orders for Daily Hours and Weeks' Duration: _____

_____

Decreasing Hours: _____

Referral Agency Name: _____

Phone Number: _____

DMA Fax Number: 919-715-2859

DRAFT

Attachment E: PDN Medical Update/Beneficiary Information Form

NC DMA Private Duty Nursing
Medical Update/Patient Information Form DMA-3062

1. Patient Name:_____ 2. Medicaid ID: _____
3. Name of Provider Agency:_____ 4. Provider NPI Number: _____
5. Does that patient have insurance in addition to Medicaid? ☐ Yes ☐ No
6. Is PDN covered by private insurance? ☐ Yes ☐ No If Yes, explain coverage: _____
_____
7. Date of last approval period: _____
8. Current attending physician: _____
9. Updated information. Please include (do NOT copy 485): Summary of Nursing Documentation for the last certification period: _____
_____
_____
_____
_____
_____
_____
10. Date of last weight (adults), height and weight for pediatric recipients: _____
11. Date of last examination by MD (name of MD): _____
12. Changes in recipient's condition: _____
_____
_____
13. Home visit observations. Safety of environment, and caregiver information: _____
_____
_____
14. Critical incidents with the recipient (hospitalizations, falls, infections, etc.): _____
_____
_____
15. Therapies recipient is receiving (PT, OT, ST, RT, etc.): _____
_____
16. Emergency plan of care if nurse is not available; _____
_____
17. Training needs: _____
18. Education provided, return demonstrations and identification of ongoingneeds: _____
_____
_____
_____

Nurses Signature and Title:_____ Date:_____
DMA Fax Number: 919-715-2859

Attachment F: Verification of Employment Form

This form is available: at: http://dma.ncdhhs.gov/

VERIFICATION OF EMPLOYMENT

Beneficiary's Name: _____
Beneficiary's Medicaid ID Number_____

Caregiver Name_____

This form is to be used only by individuals that are self-employed or are independent contractors

☐ A. I am self-employed.
☐ I am an independent contractor.

B. I work as a _____.

C. ☐ I do most of my work outside the home.
☐ I do most of my work at my home.

D. ☐ If I do most of my work at my home,
☐ I have a separate, dedicated work space in my home.
I do not have a separate, dedicated work space in my home.

E. ☐ If I do most of my work at my home,
☐ I can arrange my hours, interrupt my work, or be otherwise available for care if needed.
I can not be available for care; I would need to hire a caregiver to supplement the hours that PDN could not provide

F. My typical work hours are (do not include on-call hours):
Monday_____ Thursday_____ Saturday_____
Tuesday _____ Friday_____ Sunday _____
Wednesday_____

☐ G. My typical work schedule: never or rarely varies. varies sometimes.
☐ varies a lot.

H. My typical work hours are: very flexible.
☐ somewhat flexible.
☐ not flexible.
☐

I. Please elaborate on any of the above or include any additional relevant information on the back of this form.

An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate professional licensing agency for investigation.

Signature_____ Date_____

Attachment G: Hourly Nursing Review Criteria

This form is available at: http://dma.ncdhhs.gov/

DRAFT

Nursing Review Criteria Form

NC Division of Medical Assistance

Refer to instructions before completion

RECIPIENT NAME	RECIPIENT MID	PROGRAM □ PDN □ CAP/C
PRIMARY DIAGNOSIS	ADMIT DATE OR CAP EFFECTIVE DATE	DOB

TECHNOLOGY NEEDS			
ventilator dependent	□ dependent □ needs assistance □ independent □ intervention, continuous □ intervention, intermittent □monitoring	total 60	intermittent 50
tracheostomy not ventilator dependent	□ dependent □ needs assistance □ independent □ intervention, continuous □ intervention, intermittent □monitoring	continuous 50	passey-muir/cap 40
CPAP/BIPAP not tracheostomy	□ dependent □ needs assistance □ independent □ intervention, continuous □ intervention, intermittent □monitoring	continuous 40	intermittent 35
oxygen	□ dependent □ needs assistance □ independent □ intervention, continuous □ intervention, intermittent □monitoring	unstable 35	stable 15
hospitalizations	□ greater than three hospitalizations within the last year □ at least one extended (> two months) hospitalization within the last year	related to primary diagnosis	unrelated to primary diagnosis
SUBTOTAL TECHNOLOGY NEEDS			

SKILLED CARE NEEDS					
endotracheal suctioning	□ dependent □ needs assist □ independent	> QH 10	Q 2-4 hrs 8	Q 5-8 H 6	< Q8H 4
sterile dressing	□ dependent □ needs assist □ independent	QID 8	TID 6	BID 4	daily or less 2
nasogastric,gastrostomy, or jejunostomy tube feeds	□ dependent □ needs assist □ independent	bolus with reflux 8	bolus without reflux 6	daily or continuous with reflux 4	daily or continuous without reflux 2
intake and output specialized intervention	□ dependent □ needs assist □ independent	QID intervention 8	TID intervention 6	BID intervention 4	daily intervention 2
intermittent catheterization	□ dependent □ needs assist □ independent	QID 8	TID 6	BID 4	daily or as needed 2
intravenous: fluids or medications or nutrition	□ dependent □ needs assist □ independent	QID 8	TID 6	BID 4	daily or continuous 2
pulse oximetry, CO_2 levels, nebulizers, chest PT,	□ dependent □ needs assist □ independent	QID 8	TID 6	BID 4	daily or continuous 2
medication	□ dependent □ needs assist □ independent	complex 8	moderate 4		simple 2
SUBTOTAL SKILLED CARE NEEDS					

ACTIVITIES OF DAILY LIVING NEEDS			
naso-oropharyngeal suctioning frequency	dependent 2	needs assist 1	independent 0
nonsterile dressing/site care	dependent 2	needs assist 1	independent 0
oral feeding assistance (N/A for children < 3 yrs of age)	dependent 2	needs assist 1	independent 0
recording of intake and output	dependent 2	needs assist 1	independent 0
incontinence care (N/A for children < 3 yrs of age)	dependent 2	needs assist 1	independent 0
personal care (age inappropriate) (N/A for children < 3 yrs of age)	dependent 2	needs assist 1	independent 0
range of motion	dependent 2	needs assist 1	independent 0
ambulation assist, transfers, bed mobility	dependent 2	needs assist 1	independent 0
SUBTOTAL ACTIVITIES OF DAILY LIVING NEEDS			

TOTAL POINTS
CURRENT NURSE HOURS
CURRENT AIDE HOURS
LEVEL OF CARE/ HOURS AUTHORIZED
SIGNATURE AND TITLE OF PERSON COMPLETING FORM*
DATE

COMMENTS/HOME ENVIRONMENT/CAREGIVER INFORMATION

*This certifies the signee, and no one else, has completed the above in-home assessment of the client's condition. Falsification: an individual who certifies a material and false statement will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate licensing agency for investigation.

Rev12/16

DRAFT

Nursing Review Criteria Form Instructions
NC Division of Medical Assistance

This is ONE of several submitted documents that is reviewed and utilized for prior approval decisions and/or authorization. All recipients will be scored with the initial assessment and every two months thereafter by the Case Manager or Nurse Supervisor. Forms for PDN recipients should be submitted to DMA with the initial approval and with each 60 day reauthorization. Forms for CAP/C recipients should be submitted to DMA with the initial assessment, with each annual Continued Needs Review, and any time there is a change in the recipient's condition. It is expected that if total points start to decline, indicating that the recipient is improving, that total nursing hours will also decline.

RECIPIENT NAME as it is written on the Medicaid card	RECIPIENT MID	PROGRAM □ PDN □ CAP/C
PRIMARY DIAGNOSIS should match the primary diagnosis listed on the FL-2 and/or the CMS-485, as applicable	ADMIT DATE OR CAP EFFECTIVE DATE	DOB

TECHNOLOGY NEEDS Scores in the technology section reflect the risk of death or disability if the technology is lost, as well as the degree of licensed skilled nursing assessment/judgment necessary to operate the technology.	
ventilator dependent	Recipients using ventilators will not receive additional points for tracheostomy. The need for this technology is included in the points for the ventilator. Total is used for a recipient who is on the ventilator 24 hours per day. Intermittent is used for a recipient who is able to come off of the ventilator for a period of time; e.g., someone who uses the ventilator only during sleep.
tracheostomy not ventilator dependent	Recipients with a tracheostomy will not receive additional points for tracheostomy dressing changes. The need for this procedure is included in the points for the tracheostomy. Continuous is scored for a recipient who always breathes through an open tracheostomy. Passey-Muir/cap is scored for a recipient who is able to tolerate the use of a speaking valve or having the tracheostomy capped for a period of time.
CPAP/BIPAP not tracheostomy	Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure Continuous is scored for a recipient who is on the CPAP or BiPAP 24 hours per day. Intermittent is scored for a recipient who is able to come off of the CPAP or BiPAP for a period of time; e.g., someone who uses it only during sleep.
oxygen	Recipients are eligible to receive the points for unstable oxygen if the recipient has daily desaturations below doctor-ordered parameters AND if those desaturations require a response based on skilled nursing assessment and intervention. Recipients are NOT eligible for the unstable points if the oxygen use is routine and predictable; i.e., a recipient with Chronic Obstructive Pulmonary Disease who requires oxygen when walking would not receive the points for unstable.
hospitalizations	Use a rolling twelve month calendar. Emergency room visits without admission do not count. Recipients who have been hospitalized since birth and are just now going home for the first time are eligible to have this item checked.
SUBTOTAL TECHNOLOGY NEEDS Recipients must receive ?? or more points in the technology section to qualify for PDN or CAP/C Hospital Level of Care. A score of ?? or greater does not guarantee approval; rather, it is necessary to even be considered for approval for either PDN or CAP/C Hospital Level of Care.	

SKILLED CARE NEEDS Scores in the skilled care needs section reflect the time needed to perform the assessment and intervention. The recipient's nursing documentation, including the nurses' notes, nursing supervisor's reports, and/or case manager's assessment and notes, must support the frequency chosen. The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient with a tracheostomy has an acute respiratory infection, and the need for endotracheal suctioning increases for the duration of the illness, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill.	
endotracheal suctioning	If the recipient is able to self-suction at least some of the time, choose the frequency at which the caregiver has to perform the suctioning.
sterile dressing	Recipients with a tracheostomy will not receive an additional score for tracheostomy dressing changes. The need for this procedure is included in the score for the tracheostomy.
nasogastric,gastrostomy, or jejunostomy tube feeds	A continuous tube feeding is one that is administered over at least eight consecutive hours. If the tube feeding occurs more frequently, it is considered bolus. If the recipient uses a combination of a continuous and bolus feedings, score the feeding as bolus. To receive the points for reflux, the recipient must meet at least ONE of the following criteria: 1) a positive swallowing study performed within the last six months, 2) documented current and ongoing treatment for reflux, i.e., medications such as metoclopramide (Reglan), ranitidine (Zantac), or lansoprazole (Prevacid), 3) documented treatment for aspiration pneumonia within the last twelve months, or 4) a need for suctioning due to reflux at least daily (NOT including suctioning of oral secretions).
intake and output specialized intervention	This is intake and output which requires intervention; i.e., the nurse has to make adjustments to feedings or IV fluids based on the intake and output data. If there are no interventions other than recording the data and/or calling the physician, the recipient is ineligible for these points; see intake and output non-specialized monitoring below.
intermittent catheterization	If the recipient is able to self-catheterize at least some of the time, choose the frequency at which the caregiver has to perform the catheterization.
intravenous: fluids or medications or nutrition	The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient becomes acutely ill and requires a ten-day course of intravenous antibiotics, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill.
pulse oximetry, CO_2 monitoring, nebulizers, chest PT, _____	Include treatments that are done on a routine basis, whether standing or PRN. If the treatments are done together; i.e., nebulizer treatments (QID) followed by chest physiotherapy (BID), choose the frequency of the one done most often (choose QID). If the treatments are not done together; i.e., chest physiotherapy (BID) and specialized ostomy care (TID), award points based on the total frequency (five times per day). A recipient cannot be awarded more than eight points in this category no matter how many treatments he or she receives or how frequently he or she receives them.

Nursing Review Criteria Form Instructions, continued
NC Division of Medical Assistance

medication	Simple medications include scheduled, routine medications that do not require dosage adjustments, regardless of the number of those medications. Moderate and Complex medication includes medications which are PRN and/or require dosage adjustments by a licensed nurse. Recipients who have one to three such medications ACTUALLY GIVEN by the caregiver within an eight hour period qualify for moderate points. Recipients who have more than three such medications ACTUALLY GIVEN by the caregiver in an eight hour period qualify for complex points. PRN seizure medication; i.e., Diastat, should always be awarded moderate points. Oxygen, nebulizer treatments, and intravenous medications are not scored in this category, as they are scored elsewhere on the form. Please note that there are only three scores to choose from for medications.
SUBTOTAL SKILLED CARE NEEDS The total score for the nursing needs section will be used to determine the need for continuous, complex, and substantial skilled nursing care. Not all of the items in this section can be considered substantial, as they fall within the scope of practice for a Nurse Aide according to the regulations of the North Carolina Board of Nursing regarding delegation of tasks to Nurse Aides.	

ACTIVITIES OF DAILY LIVING NEEDS The activities of daily living section has minimal impact on approval, except for those recipients applying for CAP/C Nurse Aide services. These recipients must receive a score on at least two items in this section AND have a primary diagnosis that is medical in order to be considered for the CAP/C program. Meeting these criteria does not guarantee CAP/C approval. Normal age-appropriate care and parental responsibility should be considered; i.e., all 4 year olds need assistance with getting bathed and dressed, therefore 'needs assist' in this category is not scorable as it is an age-appropriate need, not a medical need.	
naso-oropharyngeal suctioning	Suctioning of the nose, mouth, or upper throat with a bulb syringe, yankaeur, or suction catheter. Does not include deep, or endotracheal, suctioning.
nonsterile dressing/site care	Recipients with a tracheostomy or gastrostomy will not receive an additional score for tracheostomy or gastrostomy dressing changes. The need for this procedure is included in the score for the tracheostomy or gastrostomy.
oral feeding assistance (N/A for children < 3 yrs of age)	Does not include meal/formula preparation. Does include hands-on assist with feeding and supervision during feeding.
recording of intake and output	Normal daily measurement of intake and output without the need to assess for fluid replacement or restriction. If such assessment is required, see intake and output specialized monitoring, above.
incontinence care (N/A for children < 3 yrs of age)	Cleaning after an incontinence episode, changing incontinence devices such as diapers and chux, emptying a foley catheter or colostomy.
personal care (age inappropriate) (N/A for children < 3 yrs of age)	Includes bathing, dressing, and grooming, and application of orthotics and prosthetics.
range of motion	
ambulation assist, transfers, bed mobility	Moving around within the recipient's residence with or without the use of an assistive device such as a walker, wheelchair, Hoyer lift, or trapeze.
SUBTOTAL ACTIVITIES OF DAILY LIVING NEEDS	

TOTAL POINTS
Total of technology, skilled care needs, and activities of daily living needs.

CURRENT NURSE HOURS
Record as number of hours per day and number of days per week; i.e., for a recipient who gets 18 hours 5 days per week and 10 hours 2 days per week, write as 18X5 & 10X2.

CURRENT AIDE HOURS
Record as number of hours per day and number of days per week; i.e., for a recipient who gets 18 hours 5 days per week and 10 hours 2 days per week, write as 18X5 & 10X2.

LEVEL OF CARE/ HOURS AUTHORIZED
Level of Care for CAP/C recipients,
Hours Authorized for PDN recipients.

SIGNATURE AND TITLE OF PERSON COMPLETING FORM
Case Manager or Nurse Supervisor

DATE
The date the form was COMPLETED, not the date it was submitted.

COMMENTS/HOME ENVIRONMENT/CAREGIVER INFORMATION
Include any special home environment needs or special caregiver needs in this section; i.e., a primary caregiver with health issues, multiple home-care recipients in the home, other stressors, other programs, other needs not identified above.

*This certifies the signee, and no one else, has completed the above in-home assessment of the client's condition. Falsification: an individual who certifies a material and false statement will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate licensing agency for investigation.

Submit the form to :
North Carolina Department of Health and Human Services
Division of Medical Assistance
Facility and Community Care
Home Care Initiatives Unit
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: 919 715 9025
Phone: 919 855 4380

DRAFT

Attachment H Employment Attestation Form

This form is available at: http://dma.ncdhhs.gov/

Private Duty Nursing Employment Attestation Form

This Attestation of Employment Form services to provide information about employment status for the purpose of determining Medicaid Private Duty Nursing benefits.

Beneficiary:_____ MID#_____
DOB:_____

Primary Caregiver Attestation
On this date, I _____(Print Name), certify that I am:
□ Employed
□ Not currently employed
□ attend an institution of higher education part time
□ attend an institution of higher education full time
If employed or attending institution of higher education provide daily schedule:

Secondary Caregiver Attestation
On this date, I _____(Print Name), certify that I am:
□ Employed
□ Not currently employed
□ attend an institution of higher education part time
□ attend an institution of higher education full time
If employed or attending institution of higher education provide daily schedule:

I attest that, to the best of my knowledge, the above information can be supported by documentation.

Primary Caregiver (print)_____ Date:_____
Signature (required)_____

Secondary Caregiver (print)_____ Date:_____
Signature (required)_____

DRAFT

Attachment I: Verification of School Nursing form

Verification of School Nursing

Beneficiary Name: _____ MID#: _____

Agency Name: _____ NPI#: _____

School System: _____

The child named above is a beneficiary of Private Duty Nursing (PDN) services.

Section A: Providing agency to complete this section
Please circle the appropriate option below.

Yes No The beneficiary has an Individualized Education Plan (IEP), Individualized Family Service Plan (IFSP), 504 Plan, or Individual Health Plan (IHP).
Yes No Nursing services provided at school are billed to Medicaid by the LEA as outlined in the DMA LEA Policy 10C.
Yes No The beneficiary is attending a private school, per parent preference, and the beneficiary needs medically necessary service during school hours.

Nursing hours provided at school: _____

Mode of transportation to/from school: _____

***Note:** The CMS-485 may include up to 60 hours every calendar year for sick days, adverse weather days, and/or scheduled school closings. Any hours above this limit must be submitted on a change request form as short term intensive services, and be approved by a DMA Nurse Consultant. A parent/caregiver signed notification explaining any unscheduled school absences is required for PDN agency reimbursement of hours worked in the home.

Signature of agency representative: _____ Date: _____

Section B: Parent/Caregiver to complete this section

Missed school hours:

Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____
Date: _____ Reason for absence: _____

Signature of parent/caregiver: _____ Date: _____

***Note:** A current school calendar shall accompany this document upon submission to DMA for review.