31

31 Private Duty Nursing

The purpose of the Private Duty Nursing Program is to provide payment for quality, safe, cost-efficient skilled nursing care to Medicaid recipients who require a minimum of four consecutive hours of continuous skilled nursing care per day. Skilled nursing care is defined as prescribed care that can only be provided by a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) which is medically necessary to treat or ameliorate medical conditions identified as a result of an EPSDT screening. The medical criteria herein must be present when the specified condition listed below is found. For conditions not found in the Alabama Medicaid Administrative Code, medical necessity review will be conducted by the Medicaid Medical Director. Medicaid recipients who do not meet the medical necessity requirements for the Private Duty Nursing Program have access to a variety of nursing and related community services. The Agency will make referrals to the appropriate programs based on the level of care needed.

A private duty-nursing agency is a public agency, voluntary non-profit organization, or proprietary agency that provides a minimum of four hours per day of continuous skilled nursing care in the recipient's home. Recipients eligible for in-home private duty-nursing services may be considered for services when normal life activities take the recipient outside the home.

The recipient must be under 21 years of age and referred as the result of an EPSDT screening.

NOTE:

Providers of private duty nursing services under the Technology Assisted (TA) Waiver for Adults should refer to the Alabama Medicaid Provider Manual, Chapter 107 for policy provisions.

The policy provisions for private duty-nursing providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 11.

31.1 Enrollment

HPE enrolls private duty-nursing providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

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National Provider Identifier, Type, and Specialty

A private duty nursing provider who contracts with Medicaid is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nursing-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Private duty nursing providers are assigned a provider type of *52* (Private duty nursing). The valid specialty is Private duty nursing (580).

Enrollment Policy for Nursing Providers

Private duty-nursing providers enroll as EPSDT only. Only in-state private duty-nursing providers and out-of-state providers within 30 miles of the state line qualify for participation in the Medicaid program. Private duty-nursing providers must have a RN on staff.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

31.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Nursing services must be prescribed as medically necessary by a licensed physician as a result of an EPSDT screening referral, based on the expectation that the recipient's medical needs are adequately and safely met in the home.

The EPSDT screening is valid for up to one year. If the need for services continues beyond the valid date, a new EPSDT screening is required.

All private duty-nursing services require prior authorization. Additionally, the recipient must be under 21 years of age to qualify and must be Medicaid eligible. The recipient must require skilled nursing care which exceeds the caregiver's ability to care for the recipient without the assistance of at least four consecutive hours of skilled nursing care.

Qualified Caregiver

Major commitment on the part of the recipient's family is mandatory to meet the recipient's needs. The primary caregiver must sign the *Private Duty Nursing Agreement for Care* form agreeing to participate in and complete training. Additional caregivers identified for training must be indicated on

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the *Private Duty Nursing Agreement for Care* form (Form 388). In the event that multiple caregivers exist, an adjustment in the hours approved for PDN will occur.

- The family must have at least one member capable of and willing to be trained to assist in the provision of care for the recipient in the home.
- The family must provide evidence of parental or family involvement, and an appropriate home situation (for example, a physical environment and geographic location for the recipient's medical safety).
- Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

Hours Allowed For Continuation of Private Duty Nursing Services Under the Following Circumstances:

- Temporary Illness: Private duty nursing hours may be provided for a period up to 90 days if the primary caregiver is incapacitated due to personal illness or illness of another family member who is dependent upon the caregiver and there is no other trained caregiver available in the home. Temporary illness includes a required surgical procedure due to illness/disease, an illness which would be a danger to the child because of contagion, or an illness which is debilitating for a limited period. Medical documentation from the caregiver's attending physician is required. The number of hours approved is dependent upon the specific circumstances.
- Patient at Risk: Private duty nursing hours may be approved if the patient appears to be at risk of abuse, neglect, or exploitation in the domestic setting and a referral for investigation has been made to the appropriate state agency. The number of hours approved is dependent upon the specific circumstances.
- Sleep: Private duty nursing hours may be provided up to eight hours depending on the situation of the primary care giver. For example, a single parent with no other family support may be granted a full eight hours while two parents serving as primary caregivers may require fewer hours or only hours on an occasional basis.
- Work: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is at work plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. *A Private Duty Nursing Verification of Employment/School Attendance* form (Form 387) providing documentation of work hours must be completed.
- School: Private duty nursing hours provided will be up to the number of hours that the primary caregiver is attending class plus one hour travel time. If additional travel time is needed beyond one hour, documentation must be provided to justify the increase. A current course selection guide published by the school, validated class schedule from school, curriculum guide and transcripts of previous courses taken must be provided along with a completed *Private Duty Nursing Verification of Employment/School Attendance form (Form 387)*. The coursework must be consistent with the requirement for obtaining a GED, college degree, or some other type of certification for employment. Courses selected must follow a logical approach with

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class hours being taken one after the other unless the course has been indicated by school officials as “closed”.

NOTE:

The private duty-nursing program does not cover recipients receiving skilled nursing care through the home health program. Nursing care covered by Medicaid in both programs would result in duplicate reimbursements.

NOTE:

Any private duty nursing hours approved will be reduced by the number of hours of care which are provided or are available from other resources. Hours provided by sources other than Medicaid must be reported on the Private Duty Nursing Agreement for Care form (Form 388). In the event a child eligible for Medicaid is already attending or plans to attend public school, the case manager should contact the Special Education Coordinator within the appropriate school district to request that the child’s Individual Education Program (IEP) committee meet to determine the student’s need for related services. The names and contact information for the coordinators are on the education website at www.alsde.edu**.** The Individuals with Disabilities Education Act (IDEA) guarantees every child the right to a free, appropriate public education and related services in the least restrictive environment. The case manager may be asked to be part of the client’s IEP team to facilitate the coordination of necessary related services. Related services needed in the school that are the same as services provided in the home should be closely coordinated. For example, a child needing nursing services should be evaluated and recommended for the appropriate level of care to ensure no break in services if services previously provided by Medicaid are subsequently provided by the school district. For children attending public school, the number of approved hours may be modified during the summer months and school breaks.

NOTE:

When a Private Duty Nursing (PDN) applicant is added to the PDN Program, they may be granted more PDN hours beyond what is normally approved. The purpose of the additional hours initially is to give the PDN provider time to train the qualified caregiver(s). However during the recertification period, the PDN hours may be decreased to the hours determined by the PDN criteria.

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31.2.1 Criteria for Non-Ventilator-Dependent Recipients

High technology non-ventilator-dependent recipients may qualify for private duty-nursing services if they meet either of the following criteria and at least one qualified caregiver has been identified:

- Any one of the primary requisites is present.
- Two or more secondary requisites are present.

Primary Requisites

Primary requisites include, but may not be limited to, the following as qualifying criteria for nursing recipients:

- Tracheotomy –Coverage for a functioning tracheotomy requiring oxygen supplementation; and nebulizer treatments or cough assist/inexsufflator devices. Continuation of nursing services may be approved after initial certification for those periods of time when the qualified primary caregiver is away from the home for work or school or otherwise unable to provide the necessary care.
- Total Parenteral Nutrition (TPN) - Coverage up to two months for acute phase with additional certification based upon the need for continuing therapy
- Intravenous Therapy - Coverage up to two months for a single episode. The number of hours required for a single infusion must be at least four continuous hours and require monitoring and treatment by a skilled nurse. An additional period of certification may be approved based on medical necessity for continuing therapy. Additional hours may also be approved for secondary criteria requisites listed below in conjunction with the primary criteria requisites.

Secondary Requisites

Secondary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Decubitus ulcers - coverage for stage three or four ulcers
- Colostomy or ileostomy care - coverage for new or problematic cases
- Suprapubic catheter care - coverage for new or problematic cases
- Internal nasogastric or gastrostomy feedings - coverage for new or problematic cases
- Tracheotomy
- A documented illness or disability, which requires ongoing skilled observation, monitoring and judgment to maintain or improve health status of a medically fragile or complex condition to include at least one (1) of the following:
    a. An unstable seizure disorder
    b. Unstable respiratory function
    c. Unstable vital signs
    d. A cardiac pacemaker
    e. Unstable shunted hydrocephalus or otherwise unstable neurological status and delayed skilled intervention is expected to result in:

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  - Deterioration of a chronic condition
  - Loss of function
  - Imminent risk to health status due to medical fragility
- Extensive or complete assistance with activities of daily living in a child of an age normally expected to perform ADLs such as eating, bathing, dressing, and mobility, bowel and bladder control.

31.2.2 Criteria for Ventilator-Dependent Recipients

Ventilator dependent recipients may qualify for private duty-nursing services if any one of the primary requisites is present and at least one qualified caregiver has been identified.

Primary Requisites

Primary requisites include, but may not be limited to the following as qualifying criteria for nursing recipients:

- Mechanical ventilator support is necessary for at least six hours per day and appropriate weaning steps are in progress on a continuing basis.
- Frequent ventilator checks are necessary. Frequent ventilator checks are defined as daytime versus nighttime setting changes, weaning in progress, or parameter checks a minimum of every eight hours with subsequent ventilator setting changes.
- Oxygen supplementation for ventilator dependent recipients is at or below an inspired fraction of 40 percent (Fi02 of 0.40).

31.2.3 Scope of Services

This section lists the scope of services provided by professional nurses and licensed practical nurses.

Registered Nurse Services (RN)

A registered nurse employed by a Medicaid-enrolled private duty-nursing agency may provide continuous skilled nursing services to the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization.

The RN completes an in-home assessment to determine if services may be safely and effectively administered in the home. The registered nurse establishes a nursing care plan complying with the plan of treatment.

The RN must make monthly supervisory visits to evaluate the appropriateness of services rendered by a licensed practical nurse (LPN). An RN must be on call 24 hours a day, seven days a week.

Licensed Practical Nurse Services (LPN)

The LPN may provide continuous skilled nursing services for the recipient if a licensed physician prescribes the services and Medicaid grants prior authorization. The LPN works under the supervision of the RN.

The RN evaluates the recipient and establishes the plan of care prior to assigning recipient services to the LPN.

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The Medicaid program requires that the RN on a monthly basis provides direct or indirect supervisory visits of the LPN in the home of each recipient the LPN serves. Direct supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is present. Indirect supervisory visits are made by the RN to observe the appropriateness of LPN services when the LPN is not present.

Missed Visits

(1) A missed visit occurs when the client is at home waiting for scheduled services, but the services are not delivered.

(2) The DSP shall have a written policy assuring that when a Private Duty Nurse is unavailable, the Supervisor assesses the need for services and makes arrangements for a substitute to provide services as necessary.

(a) If the Supervisor sends a substitute, the substitute will complete and sign the service log after finishing duties.

(b) If the Supervisor does not send a substitute, the Supervisor will contact the client and inform them of the unavailability of the Private Duty Nurse.

(3) The DSP will document missed visits in the client's files.

31.2.4 Documentation of Services

The private duty-nursing agency is responsible for establishing and maintaining a permanent medical record for each recipient including the following:

- Home Health Certification and Plan of Care form (HCFA-485) for certification and re-certification signed by the physician
- Medical Update and Patient Information form (HCFA-486)
- Private Duty Nursing Agreement for Care form (Form 388)
- Alabama Medicaid Agency Referral form (Form 362)
- Any additional physician orders
- Signature log with dates, duration of visits, types of service, and signature of the RN/LPN and the caregiver (a copy must be provided to the recipient or recipient's representative).
- Continuous progress reports
- Documentation of in-home RN visits to supervise the LPN

Medical records shall be retained for at least three years plus the current year.

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Plan of Care

A plan of care must be developed and submitted with each request for service documenting the extent of nursing needs. Each professional participating in the recipient's care must carefully review the recipient's status and needs. Each discipline must formulate goals and objectives for the recipient and develop daily program components to meet these goals in the home. This plan must also include the following:

- Designation of a home care service coordinator
- Involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate
- Family access to a telephone
- A plan for monitoring and adjusting the home care plan
- A defined backup system for medical emergencies
- A plan to meet the educational needs of the recipient
- A clearly shown planned reduction of private duty hours
- Criteria and procedures for transition from private duty-nursing care, when appropriate

At each certification, the care plan will be denied, approved, or returned to request additional information. The recipient should transition to the most appropriate care when the recipient no longer meets the private duty-nursing criteria. The most appropriate care may be home care services, nursing facility placement, or the Home and Community Based Waiver Program.

31.2.5 Non-Covered Private Duty Nursing Services

When the recipient does not meet the medical need and diagnosis criteria or does not require at least four consecutive hours of continuous skilled nursing care per day, Medicaid will not cover private duty-nursing services.

Medicaid does not provide private duty-nursing services under the following circumstances:

- Observational care for behavioral, eating disorders, or for medical conditions that do not require medically necessary intervention by skilled nursing personnel
- Services not prescribed to treat or improve a condition identified as a result of an EPSDT screening
- Custodial, sitter, and respite services
- Services after the recipient is admitted to a hospital or a nursing facility
- Services after the recipient is no longer eligible for Medicaid

If the provider fails to comply with agency rules and program policies, Medicaid may recoup payments and terminate the provider contract.

Please refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 11, for detailed policy information.

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31.3 Prior Authorization and Referral Requirements

All private duty-nursing services require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

Private duty-nursing providers are required to submit to HPE the following forms for consideration of authorization for services:

- Alabama Prior Review and Authorization Request form (Form 342)
- EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362)
- Home Health Certification and Plan of Care form (HCFA-485) for certification and recertification signed by the physician.
- Medical update and Patient Information form (HCFA-486)
- Private Duty Nursing Agreement for Care form (Form 388)
- Any additional physician orders

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

The EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362) is valid for one year from date of screening. If the recipient continues to be approved for services beyond the one year screening date, a new EPSDT Referral for Services form (Form 167), Patient 1st EPSDT Referral for Services form (Form 345), or Alabama Medicaid Agency Referral form (Form 362) indicating the current screening date and appropriate information must be submitted.

Re-certification

Every three months, documentation consisting of the Home Health Certification and Plan of Care (Form CMS 485), the Medical Update and Patient Information (Form CMS 486), and two weeks of nursing record documentation must be submitted to HPE to support the need for continuation of private duty-nursing services. Providers must submit re-certification requests to HPE **at least** 14 days prior to the re-certification due date. Re-certifications not received timely will be approved when criteria are met based on date of receipt. The request for re-certification will be approved or denied based on Medicaid criteria. HPE denies claims for services rendered after the cancellation date.

In an emergency situation where the delay of adjustment of prior authorization hours would endanger the health of the recipient, the case manager, private duty-nursing agency, or parent should initiate a change request within 24 hours of the onset of the emergency by contacting Qualis Health at (888) 213-7576. If the emergency situation occurs after hours, on weekends, or on a holiday, a voice message left at the same number or a fax sent to (888) 213-8548 will be accepted for consideration. The message must include the following information:

- Recipient's name
- Recipient's Medicaid number (13 digits)

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- NPI of Private Duty Nursing Agency
- Phone number of Private Duty Nursing Agency
- Phone number and name of case manager, if applicable
- Nature of emergency and number of hours involved
- Contact person and contact telephone number for follow-up

The Addendum to the Care Plan (HCFA-487) and a Medical Update and Patient Information Form (HCFA-486) must be received by Qualis within ten calendar days of the voice message/fax request. Form HCFA-486 should indicate the reason for the emergency request (example; “child is ill and did not report to school”) giving the date and the number of hours involved. If the documentation is not received within ten calendar days, the authorized START DATE will be the Julian (receipt) date of approval. To be approved, the request must meet established guidelines and criteria as set forth in Chapter 31 of the Provider Manual. Initiation of the Emergency Procedures does not guarantee approval, but establishes the earliest start date.

31.4 Cost Sharing (Copayment)

Copayment does not apply to services provided by private duty-nursing providers.

31.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Private duty-nursing providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. When completing the UB-04, enter type of bill 331. Medicare-related claims must be filed using the Institutional Medicaid/Medicare Related Claim Form (Form 341).

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

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31.5.1 Time Limit For Filing Claims

Medicaid requires all claims for private duty-nursing providers to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

31.5.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

31.5.3 Procedure Codes

Private duty-nursing providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most Medicaid required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986.

The following revenue codes and procedure codes apply when filing claims for private duty-nursing services:

Revenue Code	*Procedure Code*	*Description*
551	S9123/Modifier EP	Private Duty Nurse/RN
551	S9124/Modifier EP	Private Duty Nurse/LPN

31.5.4 Place of Service Codes

Place of services codes do not apply when filing the UB-04 claim form.

31.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following:

- Claims With Third Party Denials

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NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more details about these attachments.

31.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
UB-04 Claim Filing Instructions	Chapter 5
Institutional Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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