



PRIVATE DUTY NURSING BENEFIT COVERAGE STANDARD

Note: Capitalized terms within this Benefit Coverage Standard, which do not refer to the title of a benefit, program, or organization, have the meaning specified within the Definitions section, found on page 10.

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BRIEF COVERAGE STATEMENT

Private duty nursing (PDN) services are a benefit of the Colorado Medicaid program. PDN is continuous, face-to-face, Skilled Nursing Care in a client's place of Residence and in the community, when the client's Activities of Daily Living occur outside of their Residence. PDN services are covered when a client requires more individualized and continuous care than is available under the Colorado Medicaid Home Health benefit and the client's care needs can be safely met in the community. PDN services are provided by licensed and certified Home Health Agencies (HHAs) that meet additional requirements as specified in this Benefit Coverage Standard. Clients must meet eligibility criteria for services as defined in this Benefit Coverage Standard.

RELATED BENEFITS ADDRESSED IN OTHER BENEFIT COVERAGE STANDARDS AND DEPARTMENT GUIDING DOCUMENTS

- Home Health Care
- Hospice Services
- HCBS Homemaker Services
- HCBS Personal Care Services
- HCBS Respite Services

ELIGIBLE PROVIDERS

All rendering providers must be enrolled with Colorado Medicaid.

PRESCRIBING PROVIDER

- Physician
- Doctor of Osteopathy

RENDERING PROVIDER

Qualified staff who are not excluded from participation in federally funded health care programs by the US Department of Health and Human Services (HHS)/Office of Inspector General (OIG) and may be employed by, or under contract to, the Home Health Agency (HHA), for which the HHA may bill for his/her services:

- Registered Nurses (RN) and Licensed Practical Nurses (LPN), licensed in accordance with the Colorado Nurse Practice Act (CRS 12-38-1010):
 - Whose initial and on-going competency in skills required for the client's care is documented.



- The HHA must ensure the nurse is qualified to perform specific nursing interventions related to the client's needs;
- Who possess current cardio pulmonary resuscitation (CPR) certification from a nationally recognized entity.

ADDITIONAL PROVIDER REQUIREMENTS WHEN CARING FOR VENTILATOR-DEPENDANT CLIENTS

All nurses who care for clients who are ventilator-dependent (whether the nurse cares for ventilator clients on a full-time or occasional basis), must be competent in the following interventions:

- Tracheostomy Care;
- Oxygen Therapy including, when applicable, humidification;
- Suctioning of a client via tracheostomy;
- Weaning strategies when applicable;
- Operation and interpretation of monitoring devices including cardio-respiratory monitoring, pulse oximetry;
- Operation of ventilators and associated equipment;
- Other respiratory therapies including positive airway pressure, chest physiotherapy, respiratory assessment, and operation of aerosol and humidity devices; and
- Pulmonary Rehabilitation

AGENCY REQUIREMENTS

Home Health Agencies must:

- Be licensed by the State of Colorado as a Class A Home Health Agency in good standing;
- Be Medicare and Medicaid certified; and
- Be determined to comply with the Medicare Conditions of Participation for HHAs, as specified by Title 42 CFR, Part 440.70 by meeting one of the following two criteria:
 - Meet the Home Health Medicare Conditions of Participation as determined through a survey conducted by the Colorado Department of Public Health and Environment; or
 - Be accredited or have deemed status by the Joint Commission (JC), Community Health Accreditation Program (CHAP) or the Accreditation Commission for Health Care, Inc. (ACHC).



ELIGIBLE PLACE OF SERVICE

PDN services are provided in a client's place of Residence or outside a client's place of Residence, when Activities of Daily Living take the client outside of their Residence. A client's Residence may also include:

- Temporary accommodations, such as a relative's home, foster home, Assisted Living Residence Facility - including an Alternative Care Facility (ACF), or hotel;
- Locations outside of Colorado, but within the United States, when visited for short periods of time. If a client is receiving PDN services outside of Colorado, the HHA must continue to follow all applicable Colorado state rules and regulations.
- Group or host home settings where multiple PDN clients reside;
- School grounds, when the school is unable to meet the medical and technological care needs of the client.

Note: Medicaid does not reimburse PDN services provided in nursing facilities, Intermediate Care Facility for People with Intellectual Disabilities (ICF/ID) or hospitals.

ELIGIBLE CLIENTS

All Colorado Medicaid eligible clients, who meet the criteria listed within this section and the *Covered Services* section of this Benefit Coverage Standard, may receive PDN services, when Medically Necessary.

PDN services covered by Colorado Medicaid are limited to Skilled Nursing Services provided on an hourly basis for clients who:

- Due to their medical condition, would require inpatient hospital services in the absence of home based care; and
- Have a short or long-term reliance on machines or medical technology, to avoid death or serious injury.

A Medicaid client is eligible for PDN services when the client meets all of the following requirements:

- Requires on-going and continuous nursing care to remain in the community;
- Requires more nursing care than can be provided through an Intermittent Home Health visit;
- Medically stable, except for acute episodes that can be safely managed under PDN, as determined by the attending physician;
- Able to be safely served in their home by a Home Health Agency under the agency requirements and limitations of the PDN benefit and with the staff services available



- The client has Family/Caregivers who are able to provide care when a client's needs exceed the Colorado Medicaid benefit limit, Medical Necessity determination and/or the HHA staffing ability;
- Technology Dependent;
- Eligible for Medicaid in a non-institutional setting;
- The client meets one of the following specified medical criteria:
 - Needs PDN services while on a mechanical ventilator;
 - Needs PDN services for ventilator weaning to assess and stabilize the client's response;
 - Needs PDN services after tracheostomy decannulation to stabilize the client's condition;
 - Needs PDN services during the hours spent on continuous positive airway pressure (C-PAP) and (BI-PAP);
 - Needs PDN services for oxygen administration
 - only if there is documentation of rapid desaturation without the oxygen as evidenced by a drop in pulse oximetry readings below 85% within 15-20 minutes, and/or respiratory rate increases, and/or heart rate increases and/or skin color changes.
 - If oxygen is the only technology present, the Department's Designated Review Entity, must review the PAR for an individual determination of Medical Necessity for PDN services; or
 - The-client needs PDN services during the hours required for prolonged intravenous infusions, including Total Parenteral Nutrition (TPN), medications and fluids.

A condition is considered stable when evidence exists that the client is able to clear secretions, when vital signs are identified as stable by the Attending Physician, and when client's pulse oximetry greater than 92%.

Clients who do not meet one of the above specified medical criteria may be determined eligible for PDN services by the Department's Designated Review Entity, when a combination of illness, diagnosis, disability, prognosis, and technology needs are found to demonstrate Medical Necessity and appropriateness for the PDN level of care.

SPECIAL PROVISION: EXCEPTION TO POLICY LIMITATIONS FOR CLIENTS AGED 20 AND YOUNGER

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid program that requires the state Medicaid agency to cover services, products, or procedures for Medicaid clients ages 20 and younger 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 clinician). EPSDT covers most of the medical or remedial care a child needs to improve or



maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

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

- Unsafe, ineffective, or experimental/investigational.
- Not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

GENERAL REQUIREMENTS

PDN services are covered when the services are:

- Deemed Medically Necessary as defined in section 8.076.1.8 of Colorado Medical Assistance Program rule;
- Ordered and provided under a current written Plan of Care with the Attending Physician's oversight;
- Provided on a continuous, or shift, basis;
- Prior authorized by the Department's Designated Review Entity prior to initiating PDN care;
- Not covered by Medicare or other third party insurance.

PLAN OF CARE REQUIREMENTS

- PDN services must be ordered in writing by the client's Attending Physician as part of a written Plan of Care.
- A registered nurse must complete the initial admission assessment - or continuation of care assessment - every 60 calendar days, in compliance with Medicare regulations.
- Unless it is requested by the Department or its Designated Review Entity, it is not necessary to submit the updated Plan of Care to Colorado Medicaid unless the client's status has changed significantly and/or a new Prior Authorization Request (PAR) is submitted.
- The written Plan of Care must be on a CMS-485, or a form identical in content, and associated documentation must include:
 - Identification of the Attending Physician;
 - Physician orders, including frequency and duration of nursing hours as well the planned interventions for each PDN visit;



- The number of hours daily that the HHA, client, Family/Caregiver and client's Attending Physician agree to request based on availability of PDN services, the client's needs and the amount of care that will be provided by the Family/in-home Caregiver.
- An explanation of the Medical Necessity for the requested Medicaid PDN services, including:
 - Identification of the specific diagnoses, including the primary diagnosis, for which PDN services are requested. Diagnoses must be noted on the Plan of Care using the current federal coding guidelines; the primary diagnosis for which PDN care is needed must be listed first;
 - A complete list of all medications including, but not limited to, prescription medications, herbal supplements and over-the-counter remedies along with the dose, the frequency and the route the medication is taken;
 - The specific medical supplies, appliances or durable medical equipment to be provided or used by the client;
 - Current clinical summary or updates of the client's health status;
 - The goals and planned outcomes of treatment;
 - Other diagnoses and other relevant information related to the health care needs of the client including, but not limited to, mental status, prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications and treatments; and
 - The Attending Physician's approval must be evidenced by signing and dating the Plan of Care within 20 business days of creation. If an electronic signature is used, the agency must keep a copy of the physician's physical signature on file.

COVERED SERVICES AND LIMITATIONS

Note: Skilled Nursing Services provided by an LPN must be provided under the direct supervision of an RN.

PDN services include, but are not limited to:

- Assessment of respiratory capacity, patency of an airway, vital signs, hydration, level of consciousness and comfort;
- Monitoring and maintaining durable medical equipment and medical technology and parameters for IVs, ventilators, feeding pumps, central lines, pulse oximeters, and Continuous Positive Airway Pressure (C-PAP) and Bilevel Positive Airway Pressure (BiPAP) equipment;
- Administration of intravenous medication and other fluids;
- Administration of intramuscular injections, hypodermoclysis, subcutaneous injections, oral and respiratory medications - only when not able to be self-administered appropriately by the client or their Family/Caregiver;



- Insertion, replacement and sterile irrigation of catheters;
- Colostomy and ileostomy care, excluding care performed by clients or the Family/Caregiver;
- Nasopharyngeal, tracheotomy, and ventilator care;
- Levin tube and gastrostomy feedings, excluding feedings performed by the client, Family/Caregiver; and
- Meeting the client's total care needs during the time services are delivered.

LIMITATIONS

- Adults are limited to 16 hours of PDN services a day.
 - Additional PDN services in excess of this benefit limit may be requested by the agency and approved by Colorado Medicaid or its Designated Review Entity on a case-by-case basis, if adhering to benefit maximum daily hours would seriously jeopardize the client's life or health.
 - Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury, or absence periodically for up to 21 days in a calendar year.

PRIOR AUTHORIZATION REQUIREMENTS

- All PDN services must be prior authorized before a HHA initiates PDN services for the client.
 - An agency may request that Colorado Medicaid's Designated Review Entity expedite the client's application and PAR reviews in situations where adhering to required timeframes would seriously jeopardize the client's life or health.
 - A PAR for a new PDN client cannot exceed six months. However, requests for continuation of services may be made for up to one calendar year as determined by the client's needs and their status by Colorado Medicaid's Designated Review Entity.
- In order to request a prior authorization for PDN services, the agency must provide, at a minimum, the following documentation to Colorado Medicaid's Designated Review Entity, prior to starting care:
 - The Colorado Medicaid defined Assessment Tool;
 - The Colorado Medicaid designated prior authorization request form;
 - A completed CMS-485, or other form that is identical, which includes the anticipated start of care date (a physician's signature may be absent if the form is less than 20 days after the start date of the current form);
 - A complete nursing assessment that is no more than 60 calendar days prior to the PAR request date;



- If the client was hospitalized or received care in a nursing facility within the past 60 days, include the hospital or nursing facility discharge summary;
 - Any additional medical documentation to support the Medical Necessity of the requested PDN services; and
 - Documentation specifying a process for continuation of necessary home care if the client's Family or in-home Caregiver is unavailable due to an emergency situation or unforeseen circumstances.
- Requests for continuation or revisions of PDN services must be received by the Department's Designated Review Entity within 10 business days of the end of the client's current PAR period.
 - If a client begins receiving PDN services from a different HHA during a current PAR period, the new HHA must submit a new PAR, with all associated documentation, prior to seeing the client for the first time.
 - If a client is discharged from PDN services due to improved health status, death, transfer or other reason, the HHA must submit a revised PAR to the Department's Designated Review Entity within 10 business days of the discharge date. The PAR's requested units must be the number of actual visits completed as of midnight on the date of discharge, and the end date must be the last day that services were provided.
 - A PAR will not be processed until all of the required documentation is received. The start of care date may be amended by Colorado Medicaid's Designated Review Entity to reflect the date that PDN services were approved.
 - Approval of the PAR does not guarantee payment by Medicaid.
 - The client and the HHA must meet all applicable eligibility requirements at the time services are rendered and services must be delivered in accordance with all applicable service limitations.
 - Colorado Medicaid is always the payer of last resort, excluding Early Intervention Services documented on a child's Individualized Family Service Plan (IFSP). The presence of an approved, or Partially Approved, Medicaid PAR does not release the agency from the requirement to bill PDN services to the client's primary insurance, if applicable.



NON-COVERED SERVICES AND GENERAL LIMITATIONS

Colorado Medicaid does not reimburse for the following services under the PDN benefit:

- PDN is continuous nursing care and must not utilize intermittent Home Health benefits to supplement hours that are not covered by the PDN benefit.
- Private Duty Nurses are responsible for the total care of the client, which include assistance with activities of daily living. A Home Health CNA must only be utilized to assist in providing ADL services when a private duty nurse is not available or when the nurse requires assistance to safely complete the ADLs for the client.
- Services provided solely for the convenience of the HHA, client, or Family/Caregiver.
- Services provided that are not deemed by Colorado Medicaid or its Designated Review Entity as Medically Necessary.
- Services that are duplicative of care reimbursed under another benefit, such as, but not limited to, Home Health Services or services provided by the school district.
 - When Hospice care is not duplicative, it may occur at the same time PDN services are received.
- PDN services that exceed the hours per day approved in the PAR.
- Skilled Nursing Care to assist other members of the client's household, even if the client would be responsible for tasks that they are not able to perform due to their medical needs.
- Services that are covered by Medicare, or other third party insurance.
- Services provided prior to receiving PAR approval from the Department's Designated Review Entity.
- Care of client's siblings, other Family members or any other individual, regardless of their Medicaid eligibility (excluding group PDN clients with an approved PAR).
- Services that are duplicative of care that is being reimbursed under another benefit or funding source, including, but not limited to, Medicaid Home Health Services or other insurance.
- Care that does not require a skilled nurse to perform the task(s).
- Services described in a Plan of Care completed by a person other than the Family/Caregiver.
- Family/Caregivers who hold a current and active nursing license may be reimbursed as the nurse providing care, but may not act as the case manager on their child's care plan and are subject to all rules and requirements set forth by the Colorado Department of Labor and Employment.
- Services rendered without a specific physician's signed order.

Note: Two staff (any combination of RN, LPN, CNA) from the same or different agency, completing the same task, for one client during one visit, is not reimbursable. The only exception to this is when two staff are required for transfers or to complete the task safely and there are no other persons available to assist, and when there is a justifiable reason why adaptive equipment cannot be used instead.



DEFINITIONS

All the terms within this Benefit Coverage Standard are not necessarily part of the PDN benefit but are mentioned within the body of this document and are defined below. These definitions are only applicable within the scope of this Benefit Coverage Standard.

Term	Definitions
Activities of Daily Living (ADL)	Everyday routines that generally involve functional mobility and personal care, such as bathing, dressing, toileting, and meal preparation.
Alternative Care Facility (ACF)	Assisted Living Residence licensed by the Colorado Department of Public Health and Environment, and certified by the Department to provide Assisted Living Residence Care Services and Protective Oversight to Medicaid clients.
Assisted Living Residence	An Assisted Living Residence as defined in 6 CCR 1011-1 Chapter VII.
Attending Physician	<p>A client's primary care physician, personal physician or medical home provider. For clients admitted into PDN care from an inpatient hospital or nursing facility, the Attending Physician may be the physician who was responsible for writing discharge orders until such time as the client is able to start/continue care with an outpatient physician.</p> <p>The billing provider for PDN services is a Home Health Agency that submits bills for treatment rendered by their staff and contractors. The HHA must be an active Medicaid provider in good standing with both the Department and the Colorado Department of Public Health and Environment.</p>
Biologicals	Product made from cells or living organisms that are used for the prevention or treatment of disease.



Term	Definitions
Care Coordination	The deliberate organization of client care activities between two or more participants (including the client) involved in a client’s care to facilitate the appropriate delivery of health care and other health care support services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required client care activities, and is often managed by the exchange of information among participants responsible for different aspects of care with the understanding that this information is or will be incorporated into the current or future medical care of the client.
Case Management Agencies	<p>Colorado Medicaid contracted case management agencies are Single Entry Point (SEP) agencies, Community Centered Boards (CCBs) and other case management agencies as designated by the Department (which may also include the State contracted fiscal agent, the State contracted utilization management entity, State contracted Behavioral Health Organizations or State contracted Regional Care Collaborative Organizations.)</p> <p>These case management entities are responsible for all contracted case management tasks as assigned by the Department including utilization review.</p>
Colorado Medicaid	Colorado Medicaid is a free or low cost public health insurance program that provides health care coverage to low-income individuals, families, children, pregnant women, seniors, and people with disabilities. Colorado Medicaid is funded jointly by the federal and state government, and is administered by the Colorado Department of Health Care Policy and Financing.



Term	Definitions
Designated Review Entity	<p>Designated review entity means an agency that has been contracted by the Department to review the Medical Necessity and appropriateness of the requested PDN prior authorization requests.</p> <p>A designated review entity may be a SEP, CCB, Medicaid’s Fiscal Agent or other entity as determined by the Department.</p>
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	<p>Program authorized under Title XIX of the Social Security Act which was designed to provide early and periodic screening and diagnosis of Medicaid clients ages 20 and younger to ascertain physical and mental conditions, and provide treatment to correct or ameliorate conditions found. Colorado Medicaid rules and regulations specific to EPSDT can be found in the Code of Colorado Regulations 10 C.C.R. 2505-10 §8.280.</p>
Family/Caregiver	<p>The client’s parent, guardian, foster parent, family member (whether relation is by legal, kinship or biological means), spouse or significant other that is legally responsible for or accountable for the care needs of a client.</p> <p>Family/caregiver is an individual who assumes a portion of the client's care in the home when PDN staff is not present.</p> <p>A family/caregiver may either live in the client's home or go to the client's home to provide care.</p>
Home Health Agency (HHA)	<p>Home Health Agency means an agency or organization that is licensed as a Class A Home Care Agency by the State of Colorado, and certified for participation as a Medicare Home Health provider under Title XVIII of the Social Security Act (“Medicare certified”). A HHA may provide Intermittent Home Health and/or PDN services.</p>



Term	Definitions
Home Health Services	As a Medicaid covered benefit, Home Health services means-Intermittent, medically necessary services provided by skilled nursing, home health aide, physical therapy (PT), occupational therapy (OT) and speech/language pathology (SLP).
Intermittent	A visit that has a distinct start time and stop time (not to exceed 4.5 hours in length) and is task oriented with the goal of meeting a client's specific needs during the visit.
Medical Necessity	Medical necessity for State Plan PDN services is defined in 10 CCR 2505-10, Sec. 8.076.1.8. See also 10 C.C.R. 2505-10, § 8.280 for children age 20 and younger.
Medically Fragile	<p>Medically Fragile individuals are those who have medically intensive needs. His/her chronic health-related dependence continually or with unpredictable periodicity, necessitates a 24-hour a day skilled health care provider or specially trained Family Member/Caregiver, as well as the ready availability of skilled health care supervision. If the technology, support and services being received by the individual are interrupted or denied, he or she may without immediate health care intervention, experience irreversible damage or death.</p> <p>Medically Fragile also includes individuals who are at risk for medical vulnerability. The individual's chronic health-related dependence does not require 24-hour supervision by a skilled health care provider, but he/she does experience unpredictable life threatening occurrences. Without appropriate monitoring and the availability of licensed, certified or registered providers his/her condition could deteriorate and the intensity of his/her medical needs increase.</p>



Term	Definitions
Partially Approved	<p>A portion of the requested PDN Services are found to be (1) medically unnecessary; (2) not appropriate to meet the client’s needs; and/or (3) are found to not be in compliance with applicable Medicaid rules and policies.</p> <p>If the Designated Review Entity partially approves a PAR, the provider may submit a PAR revision request with any additional information that further supports the requested services.</p>
Plan of Care (POC)	<p>A coordinated plan developed by the HHA as ordered by the Attending /Ordering Physician for the provision of PDN services. The plan outlines the care that will be delivered to the client by the HHA and is developed in coordination with the client, when applicable, the client’s Family/Caregiver and the client’s ordering physician.</p> <p>The plan of care is signed by the Attending Physician and are the orders for the provision of PDN services. The POC is reviewed and signed by the physician in accordance with Medicare requirements.</p>
Private Duty Nursing (PDN)	<p>Hourly line of sight skilled nursing that is more individualized and continuous than the nursing care that is available under the Home Healthbenefit.</p>
Residence	<p>Wherever the client makes their home. This may be a house, an apartment, a relative's home or other place rented or purchased for the purpose of housing a client for a specified time. A residence does not include nursing facilities or other institutions as defined by CMS and the State of Colorado.</p>



Term	Definitions
Respite	Additional care or services provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. An individual client shall be authorized for no more than thirty (30) days of respite care in each calendar year.
Skilled Nursing Services	Services provided by a registered nurse under applicable state and federal laws, within the professional standards and applicable practice act. Nursing services also include those provided by a licensed practical nurse under the direction of a registered nurse, to the extent allowed under applicable state and federal laws.
Technology Dependent	<p>An individual who has a medical condition which would require inpatient hospital services in the absence of home based care, and who has a short or long-term reliance on machines or medical technology in order to avoid death or serious injury.</p> <p>Technology Dependent means a client who is (1) dependent at least part of each day on a mechanical ventilator; (2) requires prolonged intravenous administration of nutritional substances or drugs; or (3) is dependent on daily, continuous (not Intermittent) care for other respiratory or nutritional support, including tracheostomy tube care, suctioning, enteral or <i>parenteral nutrition</i>.</p>
Total Patient Care	The nurse is responsible for planning and carrying out all of the care that the client (or group of clients) requires during the PDN shift, including all medical care, technology monitoring, comfort care, all assistance with ADLs and any other client associated needs.



LEGAL REFERENCES

REGULATION	REFERENCE
10 C.C.R. 2505-10, § 8.076.1.8.	Medical Necessity Definition
10 C.C.R. 2505-10, § 8.280	Early Periodic Screening, Diagnostic and Treatment Provisions

Medicaid Director Signature

Date