



Benefits Collaborative FAQs: Private Duty Nursing (PDN)

This FAQ document summarizes:

- Frequently asked questions regarding Department efforts to codify the Private Duty Nursing Benefit through the Benefits Collaborative; and
- Suggestions made during the Benefits Collaborative process.

Below each item, the Department has provided a response.

Important Note: This FAQ document indicates the Department's position as of 1/19/2016. The Department's Private Duty Nursing Rule remains the current policy.

Item 1

The Department convened a listening session in February 2015 to solicit feedback on a proposal to limit PDN services to clients who are ventilator dependent, as is the case in many other Medicaid states. What did the Department do with this feedback?

- Stakeholders provided several examples of non-ventilator dependent clients who currently receive PDN services whose needs are best met by the current PDN benefit.
- The Department will continue to provide the scope of services detailed in the current PDN rule in [section 8.540](#) and will not limit the benefit to only those clients who are ventilator dependent.

Item 2

On September 21, 2015, the Department reconvened stakeholders to discuss a draft PDN Benefit Coverage Standard, originally authored in 2013 with input from PDN providers. Where is the draft located?

- To the best recollection of stakeholders who participated in the 2013 workgroup, there were a few workgroup suggestions that were not incorporated in the [draft](#) proposed on September 21, 2015.



Item 3

What are the next steps?

- The Department will continue to provide the scope of services detailed in the current PDN rule, and will not publish a PDN Benefit Coverage Standard at this time.

Item 4

On September 21, 2015, stakeholders proposed several changes to policy that would constitute an expansion of services. Examples are included below:

Several stakeholders requested that the Department raise the (16) hour per day limit on PDN services for clients 21 and older because, for example, those who require more than 16 hours of care may not otherwise be able to receive that care in their community and some caregivers require additional support.

Several stakeholders also requested that, should the 16 hour limit remain standard policy, an exception process be created for adults with exceptional needs, and/or that a step-down process be created to ease the transition in care for children 20 and younger who received more than 16 hours of PDN prior to their 21st birthday.

Does the Department plan to make these changes?

- Per EPSDT federal regulations, children aged 20 and younger are evaluated on a case-by-case basis to determine the medically necessary amount of PDN care needed per day above the 16 hour limit.
- The Department does not presently have state and federal authority to expand services beyond their present limits, except when EPSDT requirements are applicable.
- In addition, on November 2, 2015, Governor Hickenlooper released his proposed budget for FY 2016-17. The [Governor's budget letter](#) provides a high level overview of the budget and priorities and can be found on the Colorado Office of State Planning and Budgeting [website](#). The proposed budget reflects a constrained budget environment and only includes technical adjustments and reductions. More information on how the budget proposal impacts Medicaid can be found in the FY 2016-17 Budget Overview Fact Sheet posted to the Department's [website](#).
- The Colorado Medicaid PDN benefit is equivalent to, or is more expansive than, many other states' Medicaid PDN benefits. For example, PDN services are limited to 112 hours per week in Massachusetts, 8 hours per day in New Hampshire, and 28 hours per week in Delaware. Twenty-eight states do not cover adult PDN services.



- The Department offers a wide range of benefits to meet clients' needs across the continuum of care. Clients who have case managers can work directly with their case manager to identify services and benefits that may best meet their needs. Additional benefit information can be found [here](#).
- Several stakeholders in the September 21st meeting expressed that the 16 hour limit is reasonable as written.
- Individuals who were approved for more than 16 hours of PDN services per EPSDT requirements should consider a transition plan for a reduction in hours prior to their 21st birthday.

Item 5

The Department was asked how the policy works in a host home situation. Stakeholders conveyed that skilled care cannot be provided by host home staff.

- PDN services can be provided by licensed RNs and LPNs in host homes.

Item 6

Several stakeholders stated that the requirements of the draft proposed on September 21st, which require a client be technology-dependent to receive PDN services, are too limited. Examples are included below:

A patient with a history of tonic-clonic seizure, a ventriculoperitoneal shunt and a gastrostomy tube, who can decompensate quickly (airway patency declines, oxygen level changes), may need a nurse to provide oxygen, and engage in other activities, to stabilize the patient.

- The co-morbidity section of the current PDN rule, at 8.540.A.6.g states:
 - *The URC shall consider combinations of technologies and co-morbidities when making medical determinations for the following medical conditions:*
 - i) A pediatric client with tube feedings, including nasogastric tube, gastric tube, gastric button and jejunostomy tube whether intermittent or not, who is not on mechanical ventilation*

Gastrostomy tubes and associated technologies should be added to the list of specified medical criteria on page 5, rather than be part of an exception process.

- These items appear in current rule, at 8.540.A.6.g.



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The specified medical criteria on page 5 that states "Needs PDN services after tracheostomy decannulation to stabilize the client's condition" should be modified to include tracheostomy management. Perhaps by saying "Needs PDN services if tracheostomy is present with suctioning needs or after tracheostomy decannulation to stabilize the client's condition."

- PDN services are available to clients with a tracheostomy per section 8.540.4.A.6 of the PDN rule. There is no need to add language regarding "if tracheostomy is present with suctioning needs" as this language limits the current benefit.

Item 7

Is there, or will there be, an acuity tool that accompanies this benefit, to assist in the determination of how many hours of care clients should receive? Can the Department post the existing acuity tool to the web for the reference of interested stakeholders?

- Yes, the existing tool can be found [here](#).

Can the Department post the draft (newer) acuity tool to the web for the reference of interested stakeholders?

- The PDN acuity tool is not currently under revision by the Department, nor is another acuity tool under development at this time.
- Another acuity tool was presented to the Department for review in the past, however the tool did not align with Department policies.
- Stakeholder feedback will be solicited if changes are made to the current PDN acuity tool in the future.

When the Department worked with stakeholders to create similar acuity tools for pediatric home health and personal care, there were certain types of providers who were excluded from providing certain types of services. In creating the PDN benefit and acuity tool, please ensure that we do not limit the benefit to an extent that there are benefit gaps and clients are unable to access medically necessary care.

- Access to quality care is a Department priority. Stakeholder feedback will be solicited if changes are made to the current PDN policy and/or acuity tool in the future.



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Item 8

Language in the second solid bullet on page 9 of the draft proposed on September 21st describes the practice of needing to close out a prior authorization when the client is changing providers. The new utilization management vendor, eQHealth, has asked providers, during this vendor transition period, not to close out a PAR but, instead, to have the family fill out a change-in-vendor authorization form. Moving forward, can the Department make this a permanent practice?

- The language on page 9 of the draft Benefit Coverage Standard is not official Department policy, as it was never finalized and published. Current Department policy requires that a Change of Provider Form be submitted for approved PARs. The [Change of Provider Form](#) should be submitted when the Medicaid client has an approved PAR with another provider:
 - For the same service/supply
 - During the same/overlapping timeframe
- If a PAR was entered incorrectly and the ordering physician is listed as the rendering/billing provider, a helpline ticket should be submitted to eQHealth requesting that the rendering/billing provider information is changed. Please visit <http://www.coloradopar.com> to submit a helpline ticket.