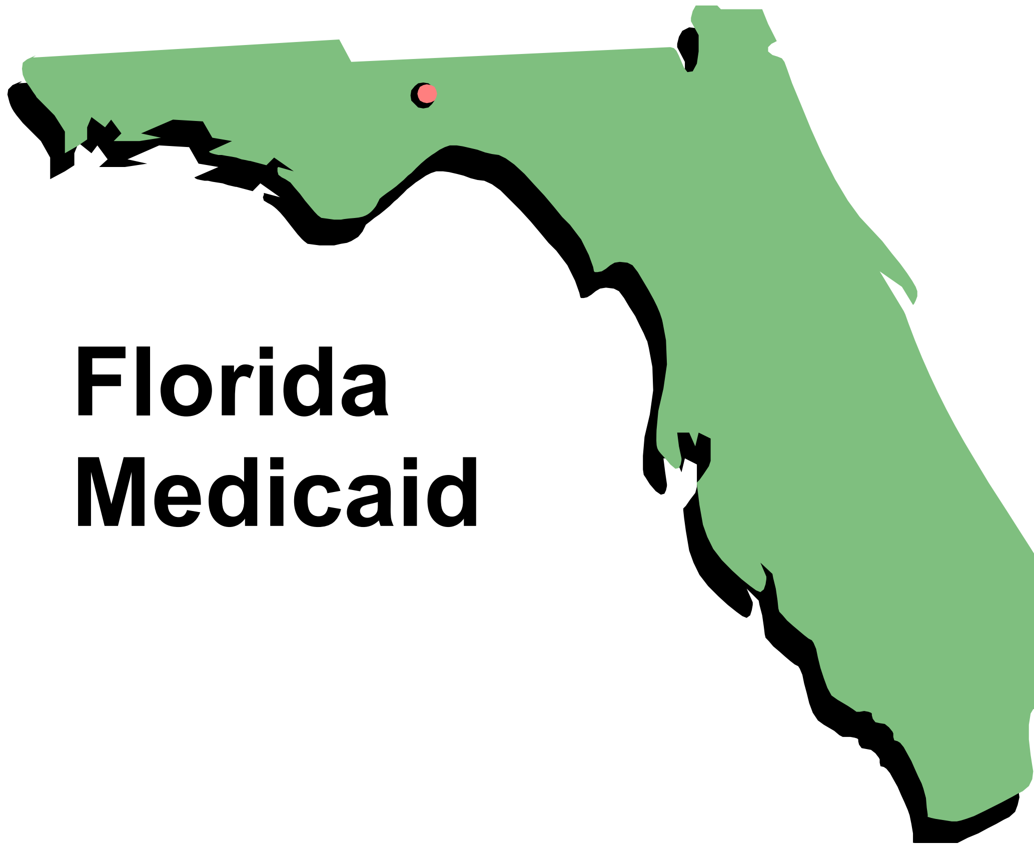

Private Duty Nursing Services Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

1.1 Description

Florida Medicaid private duty nursing (PDN) services provide medically necessary skilled nursing to recipients whose medical condition, illness, or injury requires the care to be delivered in their home or in the community.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render private duty nursing services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Private duty nursing services are authorized by the following:

- Section 1861 (m) of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), section 440.80
- Section 409.905, Florida Statutes (F.S.)
- Rule 59G-4.261, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Babysitting

Custodial care, daycare, afterschool care, supervision, or similar childcare unrelated to the services that are documented to be medically necessary for the recipient.

1.3.2 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Home Health Services

Medically necessary services that can be safely provided to the recipient in their home or in the community that include home health visits (skilled nursing and home health aide services), PDN, and personal care services.

1.3.6 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

Note: Subparagraph (a)(5) of the medical necessity definition shall not be applied when determining the medical necessity of private duty nursing services. All other medical necessity criteria apply and must be met in order to receive reimbursement from Florida Medicaid.

1.3.7 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.3.8 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary PDN services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's General Policies on copayment and coinsurance.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid private duty nursing services.

3.2 Who Can Provide

Services must be rendered by providers meeting one of the following:

- Home health agencies licensed in accordance with section 408.810, F.S., and Rule Chapter 59A-8, F.A.C.
- Licensed practical nurses (LPN) licensed in accordance with Chapter 464, F.S.
- Registered nurses (RN) licensed in accordance with Chapter 464, F.S.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for up to 24 hours of PDN services per day, per recipient, when the recipient meets all of the following criteria:

- Is under the care of a physician and has a physician's order for PDN services
- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community

For recipients requiring less than two hours of PDN services per day, please refer to the Florida Medicaid home health visits services coverage policy.

4.2.1 Private Duty Nursing Provided by Parent or Legal Guardian

Florida Medicaid may reimburse an enrolled home health agency provider for up to 40 hours per week, per recipient, for PDN services rendered by a parent or legal guardian who has a valid RN or LPN license in the state of Florida, and who is employed by the home health agency.

The initial assessment and all subsequent plan of care (POC) recertification assessments, must be completed by an RN who is employed by the home health agency provider and who is not a relative or member of the recipient's household. Any other authorized service hours must be provided by a non-relative RN or LPN.

4.2.2 Services Provided by Independent RNs and LPNs

Florida Medicaid reimburses for PDN services rendered by an independent RN or LPN in accordance with 42 CFR 440.70 (b)(1), when there is no home health agency provider available in the area to furnish the care. A physician must direct and monitor the services provided by an independent RN or LPN, and must be available to consult on the recipient's medical condition.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's General Policies on authorization requirements.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- A skill level other than what is prescribed in the physician order and approved POC
- Babysitting
- Certification of the POC by a physician
- Nursing assessments related to the POC
- Professional development training or supervision of home health staff or other home health personnel

- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services furnished by relatives as defined in section 429.02(18), F.S., household members, or any person with custodial or legal responsibility for the recipient (except as described in section 4.2.1)
- Services provided in any of the following locations:
  - Hospitals
  - Intermediate care facilities for individuals with intellectual disabilities
  - Nursing facilities
  - Prescribed pediatric extended care centers
  - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence

Florida Medicaid may reimburse for some services listed in this section through a different service benefit.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's General Policies on recordkeeping and documentation.

6.2 Specific Criteria

Providers must maintain the following in the recipient's file:

- Assessments completed in accordance with 42 CFR 484.55 and 42 CFR 440.70(f)(3)-(4)
- Written physician's orders completed in accordance with section 409.905, F.S.
- A POC developed in accordance with 42 CFR 409.43 and section 409.905, F.S.

Providers must include any home health services being furnished by another provider in the POC.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's General Policies on authorization requirements.

7.2 Specific Criteria

Providers must obtain authorization from the Medicaid contracted Quality Improvement Organization (QIO) at least every 180 days, or more frequently if there is a change in the recipient's condition requiring an increase or decrease in authorized services.

7.2.1 Review Criteria

The QIO uses the review criteria specified in section 9.0 for the first level review.

7.2.2 Review Process

The QIO assigns a care coordinator who:

- Conducts an initial home visit to assess the recipient's need for PDN services
- Convenes a multidisciplinary team to consider the authorization request for PDN services

The multidisciplinary team will develop a service plan recommending the number of PDN service hours.

7.2.3 Intensified Review

The QIO's physician peer reviewer will review the authorization request if the multidisciplinary team cannot reach consensus on the amount of PDN service hours to include in the service plan.

The QIO's physician peer reviewer will review all of the available information collected as a part of the multidisciplinary team process, and attempt to contact the recipient's physician to discuss the case.

7.2.4 Monthly Contact

The QIO care coordinator will maintain monthly contact with the recipient and the recipient's parent or legal guardian to stay abreast of the recipient's condition.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Modifiers

Providers must include the following on the claim form as appropriate:

- TT Services rendered to multiple recipients in the same setting
- UF Services provided by more than one provider in the same setting

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, incorporated by reference in Rule 59G-4.002, F.A.C., visit the AHCA Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 Rate Adjustment for Multiple Recipients

Florida Medicaid reimburses providers for services that can be rendered during the same time period by one nurse to two or more recipients who share a dwelling space as follows:

- One hundred percent of the Florida Medicaid rate for the first recipient
- Fifty percent of the Florida Medicaid rate for the second recipient
- Twenty-five percent of the Florida Medicaid rate for the third and subsequent recipients

9.0 Appendix

9.1 Review Criteria for Private Duty Nursing Services

REVIEW CRITERIA FOR PRIVATE DUTY NURSING SERVICES

First level reviewers evaluate all of the following information to ensure requested services are appropriate. Reviewers will approve the frequency and duration of services that are medically necessary.

If the first level reviewer cannot determine medical necessity, or additional hours are requested, the case will be referred to a physician reviewer for final determination.

1. Service Criteria for First Level Reviewers:

All documentation submitted must substantiate the recipient's specific diagnoses, system and organ function, home environment, and necessary skilled nursing requested. Providers must include assessments from both the private duty nursing services provider and the treating physician.

First level reviewers will consider information that includes, at a minimum, the following:

a. Provider assessment of:

- Home environment
- Care required in the home or community

b. Provider documentation of organ system dysfunction, including:

- Genitourinary system
  - Initiate or continue teaching of self-catheterization and voiding schedule
  - Catheter change, irrigation, or reinsertion
  - Postvoid residual
  - Suprapubic tube
- Cardiovascular system
  - Significant arrhythmias
  - Blood pressure monitoring
  - Signs of congestive heart failure

c. Endocrine system

- Fluid monitoring for diabetes insipidus
- Care for diabetes mellitus including
  - Insulin injections and pump
  - Blood sugar testing and monitoring
  - Diet and meal planning
  - Eye, foot, and skin care

d. Gastrointestinal system and nutrition

- Initiate and continue teaching of prescribed bowel regimen
- Manual disimpaction
- Aspiration precautions
- Feeding tube care (includes pump management)
- Total parenteral nutrition
- Formula medication administration
- Site care and dressing

e. Hematologic system

- Administration of injectable anticoagulants

f. Neurologic system

- Seizure precautions and interventions
- Vagal nerve stimulator

g. Musculoskeletal system

- Cast care
- Wound care
- Decubiti and pressure ulcers

h. Respiratory system

- Tracheostomy care
- Technology dependent child

2. Clinical Indicators for Private Duty Nursing

All documentation must substantiate the need for skilled nursing based on the following clinical indicators:

a. Clinical Presentation - One or more of the following must be satisfied:

- Illness, injury, exacerbation, or surgery
- Discharge from inpatient facility
- Newborn or infant and poor weight gain

b. Skilled intervention required - One or more of the following must be satisfied:

- Modification of initial or ongoing treatment or medication regimen
- Lack of adherence
- Management of plan of care
- Exacerbation of known illness

c. Care required in the home or community - One or more of the following indicators must be satisfied:

- Activity restrictions requiring at least minimum assistance in transfer, bed mobility, or locomotion to leave home or residence
- Isolation or immunocompromised host or communicable disease