OPTIONS SERIES: New private duty nursing definitions

TOPIC
The purpose of the Options Series is to inform readers about changes intended to increase access to community services. This bulletin describes new definitions and rates for private duty nursing (PDN) services designed to provide consistency across programs and to eliminate barriers to service for consumers.

PURPOSE
Provide definitions, rates, and information about “regular” and “complex” PDN services

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For TTY, contact Minnesota Relay Service at 1 (800) 627-3529

Minnesota Department of Human Services
Community Supports for Minnesotans with Disabilities (CSMD)
444 Lafayette Road North
St. Paul, Minnesota 55155-3857

SIGNED

MARIA R. GÓMEZ
Assistant Commissioner
Continuing Care
OPTIONS INITIATIVE

Minnesota has a strong commitment to providing home and community-based support options for people with disabilities and special health care needs. Our state’s experience over the past two decades demonstrates that most individuals currently institutionalized can be appropriately served in home and community-based settings. Additionally, the 1999 United States Supreme Court “Olmstead” decision, affirmed that states have an obligation to insure that people with disabilities are not forced to move to or remain in segregated or institutional settings.

This bulletin is one of the “OPTIONS” series designed to introduce program and administrative changes that will result in increased access to community services and supports for Minnesotans with disabilities and special health care needs as well as strengthen the capacity of Minnesota’s communities to respond to their needs. Some of these changes are the result of significant action of the 2001 Minnesota Legislature. Others are administrative in nature and complement changes in statute. The changes encompass the Minnesota Home Care and Waiver programs, as well as other program areas, and are collectively designed to begin to address identified barriers to the provision of successful and stable community-based supports.

BACKGROUND

Private duty nursing (PDN) services are available for persons with disabilities and special health care needs through Medical Assistance (MA) and for some recipients of MinnesotaCare. In the past, there have been different definitions and reimbursement levels for PDN services between MA home care and home and community-based services (HCBS) waivers. This has created barriers and reduced the availability of staff for consumers who require nursing services to successfully live in the community. Legislation passed in 2001 created new definitions and funding for PDN intended to improve access to these services.

This bulletin provides new information on PDN including:

- Definitions for PDN services
- A streamlined assessment form to replace the current Medical Assistance Private Duty Nursing Assessment/Care Plan form
- A revised home care fax form
- Reimbursement rates.

This bulletin also includes private duty nursing information that is unchanged but has not been recently published in a bulletin:

- General information about PDN services and the PDN assessment
NEW PDN DEFINITIONS

The 2001 legislation defines PDN as either “regular” or “complex.” With this new definition, any PDN references to vent dependent and intensive care unit (ICU) home health nursing have been changed or eliminated. In addition, reimbursement rates were increased to provide consistency across the programs and to eliminate barriers to service for consumers.

All PDN services for MA home care, Community Alternative Care (CAC), Community Alternatives for Disabled Individuals (CADI), Traumatic Brain Injury Waiver (TBIW), Elderly Waiver (EW) and Alternative Care (AC) will now be designated as either regular or complex. The following are definitions for complex and regular private duty nursing services.

Please note: The consumer does not need to be homebound to be eligible for regular or complex PDN services.

Complex Private Duty Nursing

Complex PDN is nursing provided to consumers who are “ventilator dependent” OR who require an “intensive level of care” as noted in the physician’s orders.

Ventilator Dependent

A consumer is considered ventilator dependent when mechanical ventilation for life support is needed for at least six hours per day and the person is expected to be or has been dependent for at least 30 consecutive days.

Intensive Level of Care

A consumer has medical needs that meet intensive level of care when the doctor’s orders require complex nursing assessments and interventions that are in response to life-threatening episodes of instability. The interventions would be needed immediately based on either anticipated or unanticipated changes in the consumer’s health status.

Regular Private Duty Nursing

Regular PDN is nursing provided to a consumer who is not ventilator dependent and does not require an intensive level of care.
Regular PDN assessments and interventions are needed for a consumer who is considered stable but has episodes of instability that are not immediately life threatening. Nursing observation, monitoring and assessment is needed to determine appropriate interventions that maintain or improve the consumer’s health status.

GENERAL INFORMATION - PRIVATE DUTY NURSING

Who Can Provide PDN Services

The following is a list of agencies and individuals that may provide PDN services:

1. MA enrolled home health agencies
2. MA enrolled PDN provider agencies
3. MA enrolled independent registered nurses (RN)
4. MA enrolled independent licensed practical nurses (LPN) who have a Class A home care license from the Minnesota Department of Health
5. Parent of minor child, spouse, or non-corporate legal guardian who is a nurse, is employed by an agency and who meet criteria to receive a hardship waiver. For more information, see Bulletin #01-56-24, OPTIONS SERIES: Hardship waivers for PCA and PDN Services.

Please Note: PDN services may not be reimbursed if the nurse is the foster care provider of a recipient who is under age 18.

Where Services Can Be Provided

The following is a list of places where both complex and regular PDN services may be provided:

1. Consumer’s home
2. Outside of the consumer’s home during hours when normal life activities take the person outside of their home
3. School
   A. Individual Education Plan (IEP) Services
PDN services are available through a child’s IEP. PDN services reimbursed through the IEP does not reduce the total number of PDN hours that can be authorized through MA home care or HCBS waivers.

B. MA home care PDN services

The parent or guardian may choose to use part of the PDN units authorized through MA home care at school. The parent/guardian must provide written authorization in the care plan identifying the chosen provider and the daily amount of PDN services to be used at school. This plan will change the total number of hours available for non-school hours and may result in a parental fee.

For more information, see Bulletin #01-56-01, Coordinating home care with health-related special education services for children.

Using the Shared Care Option for Regular or Complex PDN

Consumers receiving regular or complex PDN services may use the shared care option. The complex rate though, is only available when the consumer is receiving 1:1 complex PDN services. This means that a consumer can share complex PDN services, but the agency will only receive the complex rate during the hours the recipient is receiving the 1:1 services. Refer to the billing section of this bulletin for current rate information.

For more information on the shared care option, see Bulletin #00-56-18, Legislation authorized MA coverage for shared private duty nursing services. In reading the bulletin, any references to ventilator or ICU rates for PDN should be disregarded.

**ASSESSMENT FOR PRIVATE DUTY NURSING**

Please Note: The assessment process for PDN is unchanged with the exception of a new assessment tool and instructions (Attachment A).

An assessment is required to determine the need for PDN services. The assessment for private duty nursing services must be completed by a registered nurse (RN) from one of the following:

- Home health agency
- PDN agency
- Independent enrolled RN
Determination of Regular or Complex PDN

In completing the PDN assessment tool, the RN must document the nursing cares required to meet the medical and nursing needs of the recipient. The nurse will also record the determination of regular or complex PDN on the CMS (HCFA) 485 or similar form that is reviewed and signed by the physician.

Nursing assessment determinations of regular and complex PDN are based on:

! Assessment and interventions required to keep the recipient safe and healthy
! Episodes of instability
! Complexity of the nursing assessment and interventions including frequency and intensity
! Whether the consumer is ventilator dependent and/or requires an intensive level of care.

Documentation Requirements

The provider is responsible to maintain the following documentation in the recipient’s file:

! MA Home Care - PDN Assessment Form (Attachment A)
! CMS (HCFA) 485 or similar form indicating regular or complex PDN determination including:
  ! Physician’s orders
  ! Physician’s signature
! Payer Determination Form (DHS 3273)
! Date and nature of services provided
! Review and approval for continuation of the service at least every 60 days by the ordering physician
! Service agreement(s) authorizing PDN services for the recipient
! Other medical information such as diagnostic or testing information, social or medical histories, psychological evaluations, and hospital or facility admission and discharge summaries.
! Completed OASIS or similar data collection tool.
! Approval or denial from DHS of hardship waiver requests, if any were submitted
Name(s) of each licensed RN and/or LPN providing service

PRIOR AUTHORIZATION FOR PRIVATE DUTY NURSING

Please note: The prior authorization process for MA home care has not changed. The MA Home Care - PDN Assessment form (Attachment A) and the Home Care Fax Form (Attachment B) have been revised. (The Home Care Fax Form, sent out with Bulletin #01-56-21, has been revised to include shared PDN units.)

The following describes the documentation to be submitted for initial and continuing authorization requests. Authorizations may be given for up to one year. If the recipient continues to require home care services beyond the duration of the prior authorization, the home care provider must request a new prior authorization. Requests for authorization must be submitted to:

Minnesota Medical Assistance
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3870

Fax: (651) 282-6044

Please Note: For prior authorizations for shared care PDN, please refer to DHS Bulletin #00-56-18 for the current requirements.

45-Day Temporary Service Authorization

An authorization for an initial start of services can be issued temporarily for up to 45 days by submitting the Home Care Fax Form (Attachment B). The 45-day authorization allows providers to receive a response from DHS and start service delivery immediately. If the fax form is used for a temporary authorization, the above documentation must be submitted prior to the end of the 45 days in order to continue the authorization. Back-to-back temporary requests cannot be approved.

Service Authorization (Initial and Continuing)

All PDN services require prior authorization before services are provided or services are continued beyond an authorized period with those exceptions listed below. An authorization can be issued for up to a year via a complete service agreement request.
Within 30 to 45 days (but no more than 60 days) prior to the end of the existing authorization period the agency/independent RN must submit the required information to request continued authorization for services.

For a complete service agreement request, the agency/independent nurse must submit the following initial or updated documents:

- MA Home Care - PDN Assessment form completed by the RN
- Current clinical update
  CMS (HCFA) 485 or similar form including the physician’s signature on this form indicating that regular or complex PDN is required
- Page 4 of Payer Determination Form
- Service Agreement

**Service Increase**

When an increase in PDN services is needed, the agency/independent RN may submit the Home Care Fax Form indicating the reason for the increased need, number of units, and duration requested. The time period approved will not exceed the existing service authorization period. A revised CMS (HCFA) 485 and/or revised doctor’s orders may be requested as supporting documentation for the service increase.

**Exceptions to Prior Authorization**

A required authorization can be requested after a home care service is provided to a recipient under the following conditions:

**Emergency service provision**

The home care services were required to treat an emergency medical condition that if not immediately treated, could cause a recipient serious physical or mental disability, continuation of severe pain, or death. The provider must request retroactive authorization no later than five working days after giving the initial service by faxing the appropriate form to DHS at (651) 282-6044. If the provider does not have a fax machine and is leaving an initial authorization request, the provider may call (651) 296-7722 or 1-800-657-3606, ext 6-7722. The provider must be able to substantiate the emergency by documentation such as reports, notes, and admission or discharge histories.
Pending MA eligibility

The home care services were provided on or after the date on which the consumer’s eligibility began, but before the date on which the consumer was notified that the case was opened. Authorization will be considered if the request is submitted by the provider within 20 working days of the date the recipient was notified that the case was opened. Please submit required documents according to the service authorization section above. A copy of the notice of eligibility must be included with the authorization request.

Third party payer

A third party payer for home care services has denied or adjusted a payment. Authorization requests must be submitted by the provider within 20 working days of the notice of denial or adjustment. Please submit required documents according to the service authorization section above. A copy of the third party payer’s notice must be included with the request.

Administrative error

An error was made by the county or DHS. Please submit required documents according to the service authorization section above. The provider must include a statement that specifies which agency made the error, what the error was, and when it occurred. If a county human services agency made the error, supporting documentation from the county agency must be included with the request.

After-the-fact authorization requests will be evaluated according to the same criteria applied to prior authorization requests.

BILLING FOR PRIVATE DUTY NURSING

The following tables replace any previous PDN billing codes and rates, including those for extended PDN services under the HCBS waivers. This information was also provided in DHS Bulletin #01-56-19, 2001 Legislation Increases Rate Limits for Waivered Services, MA and MinnesotaCare Home Care Services. PDN services must be billed on a CMS (HCFA) 1500 claim form.
### MA/MinnesotaCare Home Care Services

<table>
<thead>
<tr>
<th>Service Effective July 1, 2001</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Shared Indicator</th>
<th>Service Unit</th>
<th>Rate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN - Regular Private Duty Nursing</td>
<td>X5648</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$5.78</td>
</tr>
<tr>
<td>LPN - Shared Private Duty Nursing 1:2</td>
<td>X5648 52 Y</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$4.34</td>
</tr>
<tr>
<td>LPN - Complex Private Duty Nursing</td>
<td>X5649</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$6.77</td>
</tr>
<tr>
<td>RN - Regular Private Duty Nursing</td>
<td>X5646</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$7.52</td>
</tr>
<tr>
<td>RN - Shared Private Duty Nursing 1:2</td>
<td>X5646 52 Y</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$5.64</td>
</tr>
<tr>
<td>RN - Complex Private Duty Nursing</td>
<td>X5647</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$9.03</td>
</tr>
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</table>

### Community Alternative Care (CAC) Community Alternatives for Disabled Individuals (CADI) Traumatic Brain Injury Waiver (TBIW) Elderly Waiver (EW)

<table>
<thead>
<tr>
<th>Active Codes Effective July 1, 2001</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Shared Indicator</th>
<th>Service Unit</th>
<th>Rate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN - Regular Home Health, Extended</td>
<td>X5267</td>
<td></td>
<td></td>
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<td>$5.78</td>
</tr>
<tr>
<td>LPN - Shared Home Health, Extended 1:2</td>
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<td></td>
<td></td>
<td>15 minutes</td>
<td>$4.34</td>
</tr>
<tr>
<td>LPN - Complex Home Health, Extended</td>
<td>X5437</td>
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<tr>
<td>RN - Regular Extended</td>
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<td></td>
<td></td>
<td>15 minutes</td>
<td>$7.52</td>
</tr>
<tr>
<td>RN - Shared Home Health, Extended 1:2</td>
<td>X5266 52 Y</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$5.64</td>
</tr>
<tr>
<td>RN - Complex Home Health, Extended</td>
<td>X5434</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$9.03</td>
</tr>
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</table>

### Alternative Care (AC)

<table>
<thead>
<tr>
<th>Service Effective July 1, 2001</th>
<th>Procedure Code</th>
<th>Modifier</th>
<th>Shared Indicator</th>
<th>Service Unit</th>
<th>Rate Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN - Regular Home Health</td>
<td>X5662</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$5.78</td>
</tr>
<tr>
<td>LPN - Shared Home Health 1:2</td>
<td>X5662 52 Y</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$4.34</td>
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</tr>
<tr>
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<td></td>
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<td>15 minutes</td>
<td>$5.64</td>
</tr>
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<td>RN - Complex Home Health</td>
<td>X5647</td>
<td></td>
<td></td>
<td>15 minutes</td>
<td>$9.03</td>
</tr>
</tbody>
</table>

1. Complex codes for EW and AC are effective as of November 1, 2001.
Consumers Eligible for Both MA and Medicare / Insurance

PDN services provided by a home care provider are subject to the Medicare Home Health Prospective Payment System (HHPPS). Under HHPPS, a 60-day episode is the basic unit of payment. During the 60-day episode, the home care provider is responsible for billing all the home care services including PDN, to Medicare. Refer to Provider Update #66 for more information.

After the consumer has exhausted Medicare and/or insurance benefits for PDN, the services may be reimbursed by MA as outlined above.

COMBINATION OF HOME CARE SERVICES

A recipient may use a combination of home care services, such as personal care assistant (PCA) and PDN, to meet episodic or long term changes to care needs and staffing issues. The following provides guidelines for providers and county public health nurses (PHNs):

1. Assessments
   ! Assessments for PCA services are completed by the county PHN
   ! Assessments for skilled nurse visit (SNV) and/or home health aide (HHA) services are completed by the provider agency RN
   ! Assessments for PDN are completed by the provider agency RN or the independent RN

2. Home Care Rating
   ! The PDN Decision Tree (Attachment C) has been changed from a limit set with “hours” per day to a “dollar cap” per day
   ! If recipient requires PDN services plus PCA, SNV and/or HHA visits, use the appropriate limit as specified on PDN Decision Tree.
   ! PCA and PDN home care rating dollar caps/limits are now calculated and applied to the time period of the entire service agreement. This will allow flexibility for providing needed services to the consumer.

3. Coordination of Authorized Services
   A combination of home care services will be approved by DHS / CDMI using the appropriate home care rating. (CDMI, Care Delivery Management Inc., is a contracted agency providing prior authorization for home care services.) CDMI may contact the agency or county PHN if more information is needed to approve services. Examples of information that may be needed include the decision to use a combination of services or the service request will exceed the home care rating.
LEGAL AUTHORITY

Laws of Minnesota 2001, First Special Session, chapter 9, article 3, sections 16, 17 and 40
Minnesota Statutes, section 256B.0627

RESOURCES ON THE INTERNET

Minnesota statutes and rules:  http://www.leg.state.mn.us

DHS bulletins and manuals:  http://www.dhs.state.mn.us Click on “Publications and Manuals”

DHS provider updates:  Click on “Providers and Vendors”

ALTERNATIVE FORMATS

This information is available in other forms to persons with disabilities by calling (651) 297-4112, or contact us through the Minnesota Relay Service at 1 (800) 627-3529 (TTY) or 1 (877) 627-3848 (speech-to-speech relay service).
Prior to completing this assessment form, the nurse will complete a data collection tool such as the OASIS or similar assessment tool. Complete this form using the data collected by the nurse, to identify and document consumer/caregiver needs, concerns, and recommendation for services. Directions can be found following this form and in Bulletin #00-56-26.

<table>
<thead>
<tr>
<th>MEDICAL/NURSING INTERVENTIONS</th>
<th># Units/day</th>
</tr>
</thead>
<tbody>
<tr>
<td>G Skin Care including wound or decubiti care, special treatments</td>
<td></td>
</tr>
<tr>
<td>G Seizures – Observation, assessment, intervention</td>
<td></td>
</tr>
<tr>
<td>G Respiratory Therapy including use of oxygen, BDs, vents, suctioning, etc</td>
<td></td>
</tr>
<tr>
<td>Kind of vent ___________________________ # hr/day on the vent ____________</td>
<td></td>
</tr>
<tr>
<td>G Tracheostomy Care including cleaning, suctioning, changing, etc.</td>
<td></td>
</tr>
<tr>
<td>G Tube Feeding including bolus or continuous</td>
<td></td>
</tr>
<tr>
<td>G Parenteral Therapy including intravenous fluids/meds, flushes, site/port care, etc.</td>
<td></td>
</tr>
<tr>
<td>G Urinary System cares including catheters, irrigation, etc.</td>
<td></td>
</tr>
<tr>
<td>G Gastrointestinal System cares including ostomies, bowel program, etc.</td>
<td></td>
</tr>
<tr>
<td>G Prosthetics/Orthotics including application, maintenance and monitoring</td>
<td></td>
</tr>
<tr>
<td>G Laboratory testing including blood glucose monitoring, blood draws, urine testing</td>
<td></td>
</tr>
<tr>
<td>G Vital Signs including observation, assessment, intervention</td>
<td></td>
</tr>
<tr>
<td>G Other</td>
<td></td>
</tr>
</tbody>
</table>

Based on assessment data recipient requires:

- G Nurse available to provide immediate interventions for episodes of instability that are life threatening OR
- G Nurse available to provide interventions for episodes of instability that are not life threatening.

| BEHAVIOR/MENTAL HEALTH ISSUES | |
|-------------------------------| |
| Identify issues, needed observations, and interventions affecting the nursing care needed. | |
# MA HOME CARE – PDN ASSESSMENT

## DAILY LIVING NEEDS/CARES

Check areas where consumer needs assistance

| G Dressing | G Mobility |
| G Grooming | G Positioning |
| G Bathing  | G Toileting |
| G Eating   | G Meal Prep |
| G Transfers | G Other |

## NURSING INTERVENTION(S)

– include complexity & frequency

Give overall narrative of nursing care required describing complexity, frequency, interventions, etc. Give a picture of the daily needs and interventions.
MA HOME CARE – PDN ASSESSMENT

Information about the supports available and caregiver needs/concerns are important to the health and safety of the consumer in the community. Describe the following: the family and/or community supports in place for the consumer; availability of supports, if trained in cares, and other comments as appropriate.

<table>
<thead>
<tr>
<th>CONSUMER SUPPORTS - Comments</th>
<th>Available</th>
<th>Trained in Cares</th>
<th>None Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Caregiver if applicable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>CAREGIVER CONCERNS - Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IDENTIFIED NEEDS To Promote Success In The Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check the assessed needs for both recipient and caregiver as appropriate and add comments about referral, etc.</td>
</tr>
<tr>
<td>G Case Management/Service Coordination</td>
</tr>
<tr>
<td>G Children’s MH Behavior Aid</td>
</tr>
<tr>
<td>G Chore service</td>
</tr>
<tr>
<td>G Community Integration</td>
</tr>
<tr>
<td>G County agency referral</td>
</tr>
<tr>
<td>G Educational services</td>
</tr>
<tr>
<td>G Equipment/supplies</td>
</tr>
<tr>
<td>G Financial assistance</td>
</tr>
<tr>
<td>G Homemaker service</td>
</tr>
<tr>
<td>G Home modification</td>
</tr>
<tr>
<td>G Hospice</td>
</tr>
<tr>
<td>G Mental Health Rehab Option or Community Support Plan</td>
</tr>
<tr>
<td>G Physician referral</td>
</tr>
<tr>
<td>G Respite</td>
</tr>
<tr>
<td>G Therapies</td>
</tr>
<tr>
<td>G Transportation</td>
</tr>
<tr>
<td>G Vehicle modification</td>
</tr>
<tr>
<td>G Vocational evaluation</td>
</tr>
<tr>
<td>G Waiver referral</td>
</tr>
<tr>
<td>G Other</td>
</tr>
</tbody>
</table>
## MA HOME CARE – PDN ASSESSMENT

### ASSESSMENT RESULTS and RECOMMENDATIONS

<table>
<thead>
<tr>
<th>Assessment Area</th>
<th>Requested Time/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integral nursing tasks not assessed in other areas</td>
<td>8 units/day</td>
</tr>
<tr>
<td>Medical/Nursing Interventions (page 1)</td>
<td></td>
</tr>
<tr>
<td>Daily Living Needs/Cares (page 2)</td>
<td></td>
</tr>
<tr>
<td>Medication Regimen (List/route of meds on 485 or similar form)</td>
<td></td>
</tr>
</tbody>
</table>

### CATEGORY AND TOTAL PDN UNITS/DAY

<table>
<thead>
<tr>
<th>Category</th>
<th>Nurse Type</th>
<th>Code</th>
<th>Units/Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>LPN Regular</td>
<td>X5648</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>LPN Regular</td>
<td>X5648</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>LPN Regular</td>
<td>X5648</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>RN Regular</td>
<td>X5646</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>RN Regular</td>
<td>X5646</td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>RN Regular</td>
<td>X5646</td>
<td></td>
</tr>
</tbody>
</table>

Added Comments About Request

### SIGNATURE OF CONSUMER OR RESPONSIBLE PARTY

I have participated in this assessment and identification of my needs. This is a true and accurate description of my/the consumer’s condition and care needs. I have been provided a copy of this assessment form.

Signature: ___________________________ Date: ____________

Signature of nurse completing assessment

Provider Agency: ___________________________ Phone #: ____________ Provider #: ____________
MA HOME CARE – PDN ASSESSMENT
DIRECTIONS

DHS MA Home Care policy staff understand the many responsibilities assumed in the home care business and have attempted to provide a simplified, revised PDN Assessment Form. Every effort has been made to reduce duplication and to provide a comprehensive assessment to allow efficient data gathering, planning, and prior authorization.

The intent is to provide this tool as a draft for six months. At the end of that time, we will be evaluating the revised form. Your input will be valuable. Please keep track of those areas that are difficult, missing information, have duplication, etc.

Thank you for helping us in this process.

OVERVIEW
This form is to be used in conjunction with the CMS OASIS or similar data collection tool used by a home care agency. Independent PDNs can download the OASIS B-1 data collection tool from www.hcfa.gov/medicaid/oasis/oasisdat.htm. A copy of the data collection tool needs to remain in the recipient’s file in the home care agency. There is NOT a requirement to submit the data collection tool to DHS during the prior authorization process unless there is a specific request from one of the prior authorization nurses. A copy of the MA Home Care PDN Assessment (4 pages) is required when requesting prior authorization.

CONSUMER’S NAME/PMI #
Provide the consumer’s name and 8-digit PMI number. All other demographic information should be available on the CMS (HCFA) 485 or similar agency tool.

MEDICAL/NURSING INTERVENTIONS REQUIRED BY THE CONSUMER
• Using the boxes, check those areas where the consumer requires nursing care.
• A specific narrative is not required for each area
• Add the # units/day needed in each area checked -- (Reminder: Unit = 15 minutes)
• Based on your assessment and professional judgement, indicate 1 of the 2 choices for PDN
• Add the total # of units/day needed to completed the interventions identified

BEHAVIOR/MENTAL HEALTH ISSUES
• Identify issues, needed observations, and interventions that could or will affect the nursing care needed.
• Example: A person who has both physical and mental disabilities may have delusions of “voices” telling him to not take his medication. For the nurse, it means that it will take more time when giving medications.

DAILY LIVING NEEDS/CARES
• Check the areas where the consumer needs assistance.
• No narrative is required; space is available for nurse’s notes if needed
• Add cumulative time for these areas in the box labeled Total #units/day

NURSING INTERVENTION(S)
• Write narrative of required nursing care describing complexity, frequency, and inventions
• Give a picture of the daily needs – a typical day for the consumer
• Describe the episodes of instability; what does the nurse need to do as intervention
• If more space is needed, please use additional paper

CONSUMER SUPPORTS
• This information is important to the health and safety of the consumer in the community.
• It may also be used by other service providers such as a waiver case manager
• Indicate who provides support to the consumer--could be family, friends, organizations, etc.
• List the primary caregiver on 1st line if applicable
• Indicate availability, if trained in cares, and if no supports available, mark None Available
MA HOME CARE – PDN ASSESSMENT
DIRECTIONS

CAREGIVER CONCERNS
• Indicate caregiver concerns and needs in this section
• This information may lead to other community referrals for additional resources.

IDENTIFIED NEEDS
• This is a list of potential referral resources.
• Indicate any and all identified needs of the consumer and caregiver.
• Add any comments about these needs and any action taken such as referral(s) made

LIST DEFINED:
• Case Management/Service Coordination – Refer for county case management or Home Care Service Coordination (scheduled to be available in 2002)
• Children’s Mental Health Behavior Aide – In process – for children meeting eligibility criteria
• Chore Service – Heavy housecleaning and home maintenance program
• Community Integration – Being connected in community; socialization, outings outside of home
• County agency referral – Other resources available in your county
• Educational services – School services for consumers under age 21
• Equipment/supplies – Referral for identified needs for equipment and supplies
• Financial assistance – Referral for community based agencies providing support for basic needs including food shelves, energy assistance, etc.
• Homemaker Service – Housekeeping tasks
• Home Modification – Payment for adaptive changes to place of residence
• Hospice – End of life care and issues
• Mental Health Rehab Option – Scheduled to be available 2002.
• Community Support Plan – Developed by the county mental health department
• Physician referral – Either to recipient’s physician or specialist
• Therapies – Physical, Occupational, Speech, Respiratory
• Transportation – Provide resources and information for recipient
• Vehicle modification – Payment for adaptive changes to vehicle
• Vocational evaluation – Referral to appropriate agencies in your county
• Waiver referral – For identified needs not met by other sources
• Other – Anything else that may be identified during the assessment such as housing, advocacy groups, support groups, etc.

ASSESSMENT RESULTS AND RECOMMENDATIONS
1. Assessment Area and Requested Time/Day
   • Indicate the requested time in units for each section identified.
   • Time for integral nursing tasks including coordination, communication, evaluation, and follow-up for consumer needs not addressed in other areas may be assessed at 8 units/day.
2. Category and Total PDN Units/Day
   • Indicate the category of PDN
   • Indicate the TOTAL number of units per day of the type of PDN selected
3. Added Comment About Request
   • This area is provided if the nurse assessor has information that would be helpful in completing the prior authorization.

SIGNATURES
1. Signature of Consumer or Responsible Party
   • After completing the assessment, have the consumer or responsible party sign and date the form
   • The agency or individual completing this form is to give a copy to the consumer.
2. Signature of nurse, date, provider, phone number, and provider number
FAX FORM

Home Care 45-Day Prior Authorization or Service Agreement Change Request for Recipients of Medical Assistance

Please print legibly. All information is required. When completed, fax this form to health care operations at (651) 282-6044. Warning: because this form contains confidential information, you may not fax this form without a cover sheet or with a cover sheet that has confidential information documented on it.

Select One:
- ☐ Start of service request (up to 45 days)
- ☐ Change of service request (up to 45 days)
- ☐ Change to an existing Service Agreement due to a change in recipient medical status (within SA date span)
- ☐ Technical change or correction to an existing Service Agreement (within SA date span)
  (Includes Provider Changes)
- ☐ Change of Personal Care Provider Agency (only)

Side One

1. Recipient Information

<table>
<thead>
<tr>
<th>LAST NAME</th>
<th>FIRST NAME</th>
<th>MI</th>
<th>PM# (ALL 8 DIGITS REQUIRED)</th>
<th>DATE OF BIRTH (M/D/Y)</th>
</tr>
</thead>
</table>

2. Home Health (HH)

ENTER TOTAL FOR DATES REQUESTED

<table>
<thead>
<tr>
<th>VISITS (LIMITED TO 2 PER DAY)</th>
<th>START/CHANGE DATE</th>
<th>END DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

FREQUENCY OF HH:
- ✔ 1 = DAILY
- ☑ 2 = WEEKLY
- ☑ 3 = MONTHLY
- ☑ 5 = YEARLY

3. PROVIDER #:

PROVIDER NAME

4. Private Duty Nursing (PDN)

<table>
<thead>
<tr>
<th>VISITS (LIMITED TO 1 PER DAY)</th>
<th>START/CHANGE DATE</th>
<th>END DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

FREQUENCY OF PDN:
- ✔ 1 = DAILY
- ☑ 2 = WEEKLY
- ☑ 3 = MONTHLY
- ☑ 5 = YEARLY

3. PROVIDER #:

PROVIDER NAME

Change of Personal Care Provider Agency (only)

ENTER INFORMATION FOR NEW PROVIDER AGENCY.

TOTAL UNITS TO BE TRANSFERRED (REQUIRING FLEXIBLE USE):

3. PROVIDER #:

PROVIDER NAME

4. Assessing Nurse

<table>
<thead>
<tr>
<th>NAME/TITLE</th>
<th>1. DIAGNOSIS:</th>
<th>ICD-9 CODE</th>
</tr>
</thead>
</table>

PHONE #

| RN | PHN |
| 2 | |

AGENCY

| 3 | DIAGNOSIS: | ICD-9 CODE |
| 2 | |

5. Diagnosis and ICD-9 Codes [Enter most specific and current code]

6. Treatment Plan/Change Request

☐ EXIT FROM COUNTY WAIVER PROGRAM

END DATE (M/D/Y) __ / __ / __

☐ REFERRAL TO COUNTY FOR SERVICES THROUGH (CIRCLE ONE):

PCA TBI CAC CADI MR/RC EW AC

INSURANCE:

MEDICARE

HOME CARE RATING:

START DATE (M/D/Y) __ / __ / __

CHANGE OF SERVICE REQUESTS TO EXISTING SERVICE AGREEMENTS (GREATER THAN 45 DAYS):

CHECK AND ATTACH ALL THAT APPLY:

☐ CURRENT HCFA-485 PLAN OF TREATMENT

☐ UPDATED PDN ASSESSMENT/CARE PLAN

☐ CURRENT PP. 4 OF PDF

Minnesota Department of Human Services

MS-1866 (10/01)
Home Care 45-Day Prior Authorization or Service Agreement
Change Request for Recipients of Medical Assistance

General Information. For purposes of this form, home care service means Skilled Nurse (SN), Home Health Aide (HHA), and Private Duty Nursing (PDN). Do not use this form to request prior authorization of Personal Care Assistant (PCA) services (other than a change of agency). This FAX FORM is used for: 1) initial service requests up to 45 days, 2) temporary and permanent service changes to existing Service Agreements (SA) due to a change in recipient status, and 3) all technical corrections to existing Service Agreements (SA). This prior authorization request may be returned or denied for missing, incorrect or inaccurate information. Proper completion of this form will expedite Department response. All information is required.

Limitations. The department will not issue two consecutive 45 day temporary authorizations (i.e., same service requests for the same provider without SA and required documentation.) The written plan of care required for each MA service requirement must be received by mail only if service provision extends beyond 45 days. Likewise, service requests beyond 45 days must be accompanied by the required written documentation. The department is not able to authorize more than two skilled nurse (SN) visits, nor more than one home health aide (HHA) visit, on the same day of service. Recipient needs that require more than one home health aide (HHA) visit may require personal care assistant (PCA) service. Only public health nurses (PHNs) employed by or contracted through the county public health agency may assess need for, submit requests for or request changes to PCA services, other than provider agency changes.

Eligibility. Recipients of home care services must be eligible for Medical Assistance (MA). All providers submitting service authorization requests are responsible for viewing the recipient Medical Assistance Identification Card and verifying current recipient program eligibility through the Eligibility Verification System (EVS) on the date of service. This system will verify the: 1) availability of other payers (Private insurance or Medicare), 2) major public (state) program eligibility, and 3) eligibility for date of service requested. Recipients whose major service program is General Assistance Medical Care (GAMC) or MinnesotaCare without MA benefits are not eligible for home care benefits through Medical Assistance. Contact EVS at (651) 282-5354, or 1(800) 657-3613. Appropriate Payer. MA is the last payer if other payers are available and appropriate. The provider must seek service delivery and payment from other available and appropriate resources prior to submitting a prior authorization request for payment through MA. Complete and file the Payer Determination Form (PDF) (DHS-3273) before submitting any temporary service requests. Submit page 4 of the form only if service extends beyond 45 days.

Instructions. At the top of the form make one selection indicating the primary reason for the request. 1. Recipient Information: Enter the recipient’s complete legal name and 8 digit PMI# (Medical Assistance Number) as it appears on the recipient’s MA card. Enter the recipient’s date of birth. 2. Service Information: Check the box for each Health Care Procedure Code (HCPC) that applies to the services or changes requested. Enter the corresponding total number of visits or units requested for the entire date span requested. Enter the date service will begin or change and the date service will end for each service requested. If more than one set of dates applies, use the additional space provided below. Select the frequency code based on how units or visits will be delivered (scheduled.) Prior Authorization for shared PDN services. Document the number of 1:1 PDN units in the 1:1 PDN service area. Document the number of shared PDN units in the shared PDN service area. Remember complex PDN nursing service cannot be shared. NOTE: If you do not request a line item for 1:1 PDN services, you cannot request to “move units” from shared care to 1:1. You will have to request to have a new line item added to the service authorization and then request to “move” units from the shared care line item. 3. Provider Information: Enter the provider name as it appears on the MHCP provider enrollment listing. Enter the CORRECT 9-digit provider number that corresponds to the appropriate category of service for each service requested. 4. Nurse and Agency Information: Enter your first name, last name, middle initial, and title as they appear on your professional license. 5. Diagnoses: Enter the primary, secondary and tertiary diagnoses that demonstrate the medical necessity to initiate or change services. Enter the same diagnostic codes that appear on the recipient medical record at the ordering physician’s office. Do not submit surgical codes. The diagnoses must correspond with the written terminology and most specific code listed in the ICD-9 reference book. 6. Medical Necessity/Notes: In the space provided, enter the interventions for which services are ordered, including relevant changes in the recipient’s status. Enter the home care rating applicable to the services requested. Determination of the home care rating includes consideration of all other home care services provided to the recipient. KEY: HH=Home Health services only, Private Duty Nursing=Refer to PDN Decision Tree. Documentation. 1. To request prior authorization beyond the initial 45 day authorization, submit the following documentation: SN and HHA; submit SA, CMS (HCFA)-485, and page 4 of PDF. PDN; submit SA, PDN Care Plan, CMS (HCFA)-485, page 4 of PDF, and any other supporting documentation. 2. To request a change to the existing SN, HHA or PDN Service Agreement beyond the temporary 45 day request due to a change in medical status, submit this FAX FORM including the documentation noted above for each service category, excluding the SA form.

Technical Changes to existing Service Agreements. To request a technical change to an existing Service Agreement, send this FAX FORM with the complete information and any additional documentation. Change of PCA provider: Enter the appropriate service code, total units to be transferred, the new provider name and number, and the date service will begin. The request must be accompanied by a release of service signed by the previous provider or the recipient. Change of Recipient Name and/or MA#: Must be submitted together on two separate fax forms; one to discontinue service, and one to begin service with the new name and/or MA#. Misc.: Note the reason for technical change in the space provided for hand written comments, e.g., provider change, change of living arrangement, name change, correct units, eligibility renewal, etc.

More Information. Refer to the Minnesota Health Care Programs (MHCP) Provider manual, Chapter 24: Home Care Services, or the Provider Quick Reference Tool. Frequently used telephone numbers are: Resource Center: (651) 282-2086, or 1(800) 383-7888. Home Care Intake Line: (651) 296-7722 or toll free at 1(800) 657-3606.
Private Duty Nursing Service
Decision Tree
Effective 7-1-01

Recipient requires private duty nursing service

Is the recipient ventilator dependent? (on vent at least 6 hr/day for at least 30 days)

- NO
  - Is the recipient applying for CAC or appealing insurance coverage?
    - NO
      - Does the recipient meet hospital admission criteria?
        - NO
          - Up to $10,712/month; $352.17/day
        - YES
          - Up to $26,368/month; 866.88/day during CAC application or insurance appeal process
          - $17,578/month; $577.92/day
    - YES
      - $27,592/month; $907.13/day

NOTE: If recipient requires private duty nursing services plus personal care, skilled nurse visits, and/or home health aide visits, use appropriate limit as specified on Private Duty Nursing Service Decision Tree. The cap amount is calculated over and applied to the time period of the entire service agreement. The cap must cover any combination services, even if the added service is only temporary. The cap is exceeded ONLY when total services authorized on the service agreement are greater than the cap calculated over the time period of the entire service agreement.