

**DEPARTMENT OF HEALTH AND SOCIAL SERVICES**  
**DIVISION OF MEDICAID AND MEDICAL ASSISTANCE**  
Statutory Authority: 31 Delaware Code, Section 512 (31 **Del.C.** §512)

**FINAL**

**ORDER**

**Private Duty Nursing Services**

Delaware Health and Social Services ("Department") / Division of Medicaid and Medical Assistance initiated proceedings to amend the Title XIX Medicaid State Plan and the Delaware Medical Assistance Program Provider Specific Policy Manual to revise and clarify Private Duty Nursing (PDN) services, specifically, *service requirements, coverage criteria, provider qualifications, service limitations and reimbursement methodology*. The Department's proceedings to amend its regulations were initiated pursuant to 29 **Del.C.** §10114 and its authority as prescribed by 31 **Del.C.** §512.

The Department published its notice of proposed regulation changes pursuant to 29 **Del.C.** §10115 in the October 2015 Delaware *Register of Regulations*, requiring written materials and suggestions from the public concerning the proposed regulations to be produced by October 30, 2015 at which time the Department would receive information, factual evidence and public comment to the said proposed changes to the regulations.

**SUMMARY OF PROPOSAL**

The purpose of this notice is to advise the public that Delaware Health and Social Services/Division of Medicaid and Medical Assistance is proposing to amend the Title XIX Medicaid State Plan and the Delaware Medical Assistance Program (DMAP) Provider Specific Policy Manual to revise and clarify Private Duty Nursing (PDN) services, specifically, *service requirements, coverage criteria, provider qualifications, service limitations and reimbursement methodology*.

**Statutory Authority**

- Section 1905(a)(8) of the Social Security Act, *includes private duty nursing services in the definition of medical assistance*
- 42 CFR §440.80, *defines Private Duty Nursing Services*
- 42 CFR §447.205, *Public notice of changes in statewide methods and standards for setting payment rates*

**Background**

Private Duty Nursing (PDN) is an optional Title XIX Medicaid service authorized by Section 1905(a)(8) of the Social Security Act and 42 CFR §440.80. PDN services means nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided—

- a) By a registered nurse or a licensed practical nurse;
- b) Under the direction of the beneficiary's physician; and
- c) To a beneficiary in one or more of the following locations at the option of the State—
  1. His or her own home;
  2. A hospital; or
  3. A skilled nursing facility.

**Summary of Proposal**

*Purpose*

To clarify the requirements and reimbursement provisions that governs Private Duty Nursing (PDN) services.

*Proposal*

The Delaware Medical Assistance Program (DMAP) Provider Manual is written specifically to address the contractual and regulatory requirements of delivering health care services to Delaware Medicaid beneficiaries. From time to time the Division of Medicaid and Medical Assistance (DMMA) update and revise these manuals as our policies or regulatory requirements change. Private Duty Nursing (PDN) Services are those medically necessary services related to the coverage described in the Private Duty Nursing Policy Provider Specific Manual. The proposed rule revises language in the designated provider manual to clarify Medicaid policy on service coverage for Private Duty Nursing services. Amendments to this rule include:

- Language throughout the rule has been restructured, replaced, relettered or in the case of redundancies, eliminated for clarity purposes.

- Revise language to clarify who is eligible to receive private duty nursing services.
- Revisions were made for clarification and consistency purposes that the number of hours of service to be authorized is determined by “Medical Necessity”.
- A definition of “technology dependent” was added.
- Language was added to clarify eligible private duty nursing providers and to reflect current practices.
- Deleted coverage and reimbursement language and the Healthcare Common Procedure Coding System (HCPCS) procedure code in Appendix B of Section 7, regarding self-employed nurses as PDN services cannot be provided by self-employed nurses.
- As PDN services can only be covered by DMAP if prior authorized, inserted language detailing how authorization for PDN services is obtained.
- Revised language to clarify how medically necessary hours are determined.

For conditions of coverage and payment, the Division of Medicaid and Medical Assistance (DMMA) proposes to amend Attachment 4.19-B of the Medicaid State Plan to reflect the above-referenced changes. Upon CMS approval, the proposed state plan amendment (SPA) is effective for dates of service on or after October 2, 2015.

**Public Notice**

In accordance with the *federal* public notice requirements established at Section 1902(a)(13)(A) of the Social Security Act and 42 CFR 447.205 and the *state* public notice requirements of Title 29, Chapter 101 of the Delaware Code, Delaware Health and Social Services (DHSS)/Division of Medicaid and Medical Assistance (DMMA) gives public notice and provides an open comment period for thirty (30) days to allow all stakeholders an opportunity to provide input to the requirements and reimbursement provisions governing private duty nursing services. Comments must be received by 4:30 p.m. on October 30, 2015.

**Centers for Medicare and Medicaid Services Review and Approval**

The provisions of this state plan amendment (SPA) relating to coverage and payment methodology for Private Duty Nursing (PDN) services are subject to approval by the Centers for Medicare and Medicaid Services (CMS). The draft SPA page(s) may undergo further revisions before and after submittal to CMS based upon public comment and/or CMS feedback. The final version may be subject to significant change.

**Provider Manuals Update**

Also, upon CMS approval, the applicable Delaware Medical Assistance Program (DMAP) Provider Policy Specific Manuals will be updated. Manual updates, revised pages or additions to the provider manual are issued, as required, for new policy, policy clarification, and/or revisions to the DMAP program. Provider billing guidelines or instructions to incorporate any new requirement may also be issued. A newsletter system is utilized to distribute new or revised manual material and to provide any other pertinent information regarding manual updates. DMAP provider manuals and official notices are available on the DMAP website: <http://www.dmap.state.de.us/home/index.html>

**Fiscal Impact Statement**

The following fiscal impact is projected:

	Federal Fiscal Year 2016	Federal Fiscal Year 2017
General (State) funds	\$77,930.05	\$80,267.95
Federal funds	\$64,200.26	\$66,126.27

**SUMMARY OF COMMENTS RECEIVED WITH AGENCY RESPONSE AND EXPLANATION OF CHANGES**

Highmark Health Options, the Governor's Advisory Council for Exceptional Citizens (GACEC) and the State Council for Persons with Disabilities (SCPD) offered the following summarized observations. The Division of Medicaid and Medical Assistance (DMMA) has considered each comment and responds as follows.

**Highmark Health Options**

Health Options agrees and supports the proposed language changes regarding medical necessity for private duty nursing services that are included throughout the above referenced policy manual. However, Health Options believes the proposed changes may have significant fiscal impact on its operations. It is difficult to provide specific comments regarding the fiscal impact due to Health Options' being in operation for less than one year and lacking historical data. However, it is our hope that DMMA will consider any fiscal impact the proposed changes will have on Health Options when determining appropriate reimbursement rates.

1. The following proposed policy language for section 5.2.3 will be integral in maintaining member safety and ensuring care is provided in the most appropriate setting with consideration of efficient use of resources:

*PDN services will only be authorized when there is at least one caregiver willing and able to accept responsibility for the individual's care when the nurse is not available. DMAP expects that caregivers be willing and capable to accept responsibility for their individual's care. If the caregiver cannot or will not accept responsibility for the individual's care when PDN services are not authorized or available, the individual is deemed not to be in a safe environment and PDN services will not be authorized.*

It will be particularly important to remain committed and focused on the language in 5.2.3 as authorizations are determined to address the revised language for policy manual sections 5.2.2, 5.2.5, 5.2.6, and 5.2.8. The revisions in these sections do propose expanded coverage criteria for school based services and transportation and eliminate considerations of parental/caregiver availability and ability from the decision making process. Health Options fully agrees that all decisions on a recipient's need for private duty nursing services should be based on medical necessity and will continue to make decisions based upon that standard. However, Health Options also believes that a determination of whether a parent/caregiver is available and able to provide care is an essential piece of the medical necessity determination and of utmost importance when determining how best to allocate limited state resources.

**Agency Response:** DMMA respectfully disagrees with the suggestion that our proposed revisions to the PDN manual in sections 5.2.2, 5.2.5, 5.2.6, and 5.2.8 result in expanded coverage criteria. Please see our section by section response to this comment below.

2. Health Options suggests that DMMA's proposed changes to the PDN manual results in expanded coverage criteria in §5.2.2.

**Agency Response:**

The original language in §5.2.2 is as follows:

*The on-going need for PDN care is routinely/periodically re-evaluated. DMMA may determine that because of parent/caregiver work schedule, stability of the patient, and other factors, that PDN hours may be reduced or increased.*

The suggested revision to §5.2.2 is as follows:

*The on-going need for PDN care is routinely/periodically re-evaluated. DMMA may determine that PDN hours may be increased based on medical necessity or reduced based on medical necessity accompanied by a change in circumstances or other good cause.*

DMMA feels that the revision to this section of the manual does not expand coverage criteria for PDN. The proposed revision continues to rely upon the determination of medical necessity in authorizing PDN.

3. Health Options suggests that DMMA's proposed changes to the PDN manual results in expanded coverage criteria in §5.2.5.

**Agency Response:**

The original language in §5.2.5 is as follows:

*DMMA reimburses for medically necessary transportation through a Medicaid transportation broker. DMMA expects the parent/caregiver to accompany the client in transport. If, because of employment or school, the parent/caregiver cannot accompany the client, the prior authorized PDN may accompany the client. If the client is transported to a medical appointment or the hospital with the PDN, as soon as the parent/caregiver arrives, the PDN service is no longer required. PDN will not be authorized for a nurse to accompany a client to a medical appointment or hospital stay when the parent/caregiver is available.*

The suggested revision to §5.2.5 is as follows:

*DMAP reimburses for medically necessary transportation through a Medicaid transportation broker. PDN services will be authorized for transportation when medically necessary, as determined on an individualized basis.*

DMMA feels that the revision to this section of the manual does not expand coverage criteria for PDN. The proposed revision continues to rely upon the determination of medical necessity in authorizing PDN.

4. Health Options suggests that DMMA's proposed changes to the PDN manual results in expanded coverage criteria in §5.2.6.

**Agency Response:**

The original language in §5.2.6 is as follows:

*PDN may be approved to accompany school-age children with a compromised airway or other DMAP approved high-risk condition in transport to school and to provide medically necessary care during school hours.*

The suggested revision to §5.2.6 is as follows:

*PDN services may be authorized during the school day with parental consent and when DMAP determines that it is medically necessary for school-age children. This may include accompanying the children during the transport to and from school and providing medically necessary care during school hours.*

DMMA feels that the revision to this section of the manual does not expand coverage criteria for PDN. The proposed revision continues to rely upon the determination of medical necessity in authorizing PDN.

5. Health Options suggests that DMMA's proposed changes to the PDN manual results in expanded coverage criteria in §5.2.8.

**Agency Response:**

The original language in §5.2.8 is as follows:

*DMMA may approve PDN to cover summer vacation as well as scheduled school year holiday vacations for school age children if the parent/caregiver requests coverage timely. Absence of parents/guardian from the home for employment or work-related education reasons must be documented.*

The suggested revision to §5.2.8 is as follows:

*PDN services may be approved to cover summer vacation as well as scheduled school year holiday vacations for school age children if it is determined that services are medically necessary.*

DMMA feels that the revision to this section of the manual does not expand coverage criteria for PDN. The proposed revision continues to rely upon the determination of medical necessity in authorizing PDN.

6. Section 5.3.4 of the proposed policy manual amendments does state that private duty nursing services may be adjusted based on the availability of the parent/caregiver. Health Options believes this language continues to permit considerations of parental/caregiver availability as one part of the overall medical necessity determination.

**Agency Response:** DMMA thanks you for your comment.

## **GACEC and SCPD**

As background, SCPD and Disabilities Law Program (DLP) representatives met with DHSS Administration in August, 2009 to review concerns with PDN standards. An agreement was reached to revise the standards. In 2010, DMMA shared draft revisions which resulted in submission of September 16, 2011 DLP-authored comments from the SCPD. In 2015, this initiative was revived. DMMA prepared a new set of proposed revisions resulting in DLP commentary and an agreement to incorporate additional changes. See attached August 26, 2015 DMMA letter. DMMA is now formally publishing revised PDN standards for comment. The proposed standards represent a major improvement in several contexts and generally merit endorsement subject to a few considerations. The proposed regulations represent a major improvement in several contexts and we appreciate consideration of past comments. We still have the following observations and concerns.

First, §1.1.4 contains the following recital: "Generally, the total cost of PDN services shall not exceed the cost of care provided in an institutional setting." Council is aware of concern by the Disabilities Law Program with this recital and concern with the DMMA response to concerns noted in Section 2 of the attached August 26, 2015 letter. Literally, it suggests that individual costs may "trump" other considerations, including the Americans with Disabilities Act (ADA) mandate to prioritize non-institutional services. The Centers for Medicare and Medicaid Services (CMS) have historically instructed that ADA principles should be reflected and embedded in state Medicaid program standards. See attached NASDDDS, "The ADA, Olmstead, and Medicaid: Implications for People with Intellectual and Developmental Disabilities (2013). The "not exceed the cost" recital provides a regulatory basis for Managed Care Organizations (MCOs) to justify institutional placement for individuals with higher Private Duty Nursing (PDN) needs. Moreover, the notion of "cost effectiveness" is contained in the attached regulatory definition of "medical necessity" so its deletion in the PDN standards does not result in ignoring cost considerations. The recital should be deleted.

**Agency Response:** DMMA respectfully disagrees with the suggestion to delete language in §1.1.4 regarding the consideration of the total cost of PDN services. DMMA considers a variety of factors, including cost, in the determination of appropriateness of services for our members with an emphasis on the importance of preventing or delaying institutionalization.

Second, §2.1.1 refers to a "certified registered nurse practitioner (CRNP) who has a professional license from the State to provide nursing services." The Delaware nurse licensing law refers to "advanced practice nurses" and "advanced practice registered nurses" [24 Del.C §1902(a)(b)]. There is no definition of a "certified registered nurse practitioner. DMMA

may wish to review this reference.

**Agency Response:** DMMA received clarification on this issue from the Board of Nursing. They have indicated that the correct title for us to use would be an Advance Practice Registered Nurse (APRN) rather than a Certified Registered Nurse Practitioner (CRNP). Therefore, we have revised §2.1.1 to the following:

Private duty nursing may be provided by any registered nurse (RN), licensed practical nurse (LPN) or advance practice registered nurse (APRN) who has a professional license from the State to provide nursing services.

Third, §3.1.1.2 refers to "attending practitioner". We recommend substituting either "prescribing practitioner" or, for consistency with §6.3.2, "primary care physician". See analysis in attached August 26, 2015 letter, Section 10. The term "attending physician" is based on institutional care environments while PDN is limited to non-institutional settings. See §1.1.4.

**Agency Response:** DMMA agrees with Councils' suggestion to change "attending practitioner" to "prescribing practitioner". Section 3.1.1.2 will be revised as follows:

A written plan of care that is established, signed and dated by the prescribing practitioner which includes orders for medications, treatments, nutritional requirements, activities permitted, special equipment and other ordered therapies.

Fourth, §§5.1.1 and 5.2.1 merit review. These sections only refer to prior authorization by the Delaware Medical Assistance Program (DMAP) through a DMMA nurse. We assume it should also refer to an MCO nurse since the standards cover both DMMA-authorized PDN and MCO-authorized PDN. See §§5.1.2, 5.2.7 and §1.0.

**Agency Response:** DMMA respectfully disagrees with the Councils' suggestion to include references to an MCO nurse and MCO-authorized PDN in this section. Although the MCOs are required to provide, at a minimum, coverage of services described in this manual, it is still a DMAP manual and not an MCO manual.

Fifth, we assume that references to "DMAP" (e.g. §§5.2.4, 5.2.6) are generic and are intended to cover both DMMA and MCO decision-making. However, the reference to "DMMA" in §5.2.2 is "under inclusive" since it would not cover an MCO. The reference could be amended to refer to "DMAP" or "DMMA or an MCO".

**Agency Response:** DMMA agrees with the Councils' suggestion to change DMMA to DMAP in this instance. Section 5.2.2 will be revised as follows:

The on-going need for PDN care is routinely/periodically re-evaluated. DMAP may determine that PDN hours may be increased based on medical necessity or reduced based on medical necessity accompanied by a change in circumstances or other good causes.

Sixth, the requirement in §5.2.1 that an initial nursing assessment be "face to face" is being deleted. Perhaps this change is in recognition of the expanded authorization for telemedicine. Otherwise, we suspect a face to face assessment may be "best practice" and generally more valid than a "paper" review.

**Agency Response:** DMMA thanks the Councils for their comment.

Seventh, §5.2.3 merits reconsideration based on concerns reflected in the attached August 26, 2015 letter, Section 5. Consider the following:

A. The section categorically presumes that everyone qualifying for PDN will need a caregiver during non-authorized PDN hours. Some individuals may be capable of self-care during such periods and not require a caregiver.

B. The section omits the concept or expectation that an MCO or provider will include a backup component in the plan of care akin to the PAS Service Specifications.

C. The section is "at odds" with §5.3.5 which contemplates home health personnel covering non-PDN hours as juxtaposed to exclusive reliance on a caregiver.

**Agency Response:** DMMA thanks the Councils for these comments. We would like to offer the following update/clarification to this section of the proposed policy in response:

*PDN services will only be authorized when there is at least one caregiver willing and able to accept responsibility for the individual's care when the nurse is not available. PDN is only authorized for the provision of skilled care (i.e. G-tube feeds, trach care, etc.) and is not primarily for home health aide (HHA) or certified nursing assistant (CNA) services, safety and supervision. Therefore, DMAP expects that caregivers be willing and capable to accept responsibility for their individual's care. If the caregiver cannot or will not accept responsibility for the individual's care when PDN services are not authorized or available, the individual is deemed not to be in a safe environment and PDN services will not be authorized.*

Eighth, §5.2.6 indicates that a parent's consent to an IEP which includes PDN equates to parental consent to use of Medicaid to fund PDN. There are two problems with this approach.

A. Some students qualifying for Medicaid-funded PDN may not yet have an IEP. They may have an IFSP (Title 16 Del.C. §214.215) or be awaiting IEP development. For example, a student incurring a sports injury or involved in an auto accident may qualify for PDN but be in the evaluation phase of the Individuals with Disabilities Education Act (IDEA) special education eligibility or, having been determined eligible, be awaiting development of an IEP.

B. Parental consent to an IEP does not equate to consent to utilize Medicaid or private insurance benefits for a child. Indeed, IEPs do not typically include sources of payment for services. Moreover, there is no requirement that a parent "consent" to an IEP.

Explicit parental consent to "tap" Medicaid should be required. See attached federal guidance referring to a "consent form" and requirement that "parental consent" must be obtained "each time that access to public benefits or insurance is sought". Characterizing consent to an annual IEP as consent to accessing Medicaid for PDN does not conform to this federal guidance. Even on a practical level, PDN can change more frequently than an annual IEP (§5.2.2).

**Agency Response:** DMMA thanks the Councils for these comments and offers the following revision to this section of policy in response:

*PDN services may be authorized during the school day with parental consent and when DMAP determines that it is medically necessary for school age children. This may include accompanying the children during the transport to and from school and providing medically necessary care during school hours.*

Ninth, §5.2.6 contains an incorrect legal standard for eligibility to use Medicaid to fund school-based services. The standard refers to a determination that "a school is unable to meet the medical needs of school age children who are technology dependent or for whom DMAP has determined these services to be otherwise medically necessary". [emphasis supplied]. There are two problems with the underlined provision.

A. A child could qualify for PDN for reasons apart from technological dependency.

B. Medicaid is expected to routinely fund qualifying services in schools. A school is not required to demonstrate that it cannot meet a child's needs without resorting to Medicaid funding. See attached In re A.G., DCIS No. 5000703852 (DHSS June 22, 2000); U.S. DOE Memorandum OSEP 00-7 (January 13, 2000), at 5 ["The law clearly states that the State Medicaid agency, as well as other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or State agency)"].

**Agency Response:** DMMA has considered Councils' comments and believes that the proposed revision to §5.2.6 cited in item 8 above should satisfactorily address these concerns.

#### FINDINGS OF FACT:

The Department finds that the proposed changes as set forth in the October 2015 *Register of Regulations* should be adopted.

THEREFORE, IT IS ORDERED, that the proposed regulation to amend the Title XIX Medicaid State Plan and the Delaware Medical Assistance Program Provider Specific Policy Manual to revise and clarify Private Duty Nursing (PDN) services, specifically, *service requirements, coverage criteria, provider qualifications, service limitations and reimbursement methodology*, is adopted and shall be final effective December 10, 2015.

Rita M. Landgraf, Secretary, DHSS

#### DMMA FINAL ORDER REGULATION #15-25a REVISIONS:

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#### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE: DELAWARE

#### METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR PRIVATE DUTY NURSING SERVICES 42 CFR 440.80

#### ~~DELAWARE RATES FOR PRIVATE DUTY NURSING~~

Private duty nursing (PDN) services provided to eligible Delaware Medical Assistance Program (DMAP) clients individuals are reimbursed using prospectively determined rates. The unit of service for agency providers is one (1) hour. ~~and for self-employed nurses is 15 minutes.~~ A weekly maximum limit is established for each client individual by the DMAP based on the authorized services.

Rates for agency services are reviewed annually. The rate will relate to the lowest prevailing usual and customary charge, as determined by a survey of all private duty nursing service agencies. Agencies will be reimbursed the lower of their usual and customary charges or the maximum rate.

~~Rates for self-employed nurses will be individually negotiated, but will not exceed a predetermined percentage of the agency rate. Self-employed nurses agree to rates that do not exceed 60% of the agency rate for LPNs and 70% of the agency rate for RNs. Rates may not be renegotiated more than once annually except in extenuating circumstances. Increases will be limited to the normal medical inflation used by DMAP. Self-employed nurses will be reimbursed the lower of their usual and customary charges or the maximum rate. DMAP assures that both public and private providers are paid the same rates.~~

Providers are not required to submit cost reports to the DMAP. There are no retrospective settlements on claims paid.

The baseline PDN reimbursement rate will normally represent services provided by one nurse to one ~~client~~ individual. An adjusted reimbursement rate per ~~client~~ individual will be established for medically ~~appropriate~~ necessary PDN services provided by a single nurse for up to three (3) clients. Maximum rates are established according to the following table:

One <del>client</del> individual:	Rate for One =	100% of established baseline rate
Two <del>clients</del> individuals:	Rate for Each =	50% of 143% of baseline rate
Three <del>clients</del> individuals:	Rate for Each =	33% of 214% of baseline rate

~~For example, if the baseline rate for one client is \$21.00 per hour, the reimbursement rate for multiple client settings is as follows:~~

<del>One Client:</del>	<del>Rate for each individual =</del>	<del>\$21.00 per hour (Baseline)</del>
<del>Two Clients:</del>	<del>Rate for each individual =</del>	<del>\$15.00 per hour</del>
<del>Three Clients:</del>	<del>Rate for each individual =</del>	<del>\$15.00 per hour</del>

The fee schedule and any annual/periodic adjustments to the fee schedule and effective dates are available on the Delaware Medical Assistance Program (DMAP) website at: <http://www.dmap.state.de.us/downloads/feeschedules.html>

The rates of service were set as of October 2, 2015 and are effective for services provided on or after that date.

Except as otherwise noted in the plan, payment for these services is based on State-developed fee schedule rates, which are the same for both governmental and private providers of private duty nursing services.

## **DMMA FINAL ORDER REGULATION #15-25b**

### **REVISIONS:**

### **DELAWARE MEDICAL ASSISTANCE PROGRAM Private Duty Nursing Program Provider Specific Policy**

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##### **1.0 Overview**

~~Private Duty Nursing (PDN) services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). Effective July 1, 2007, all PDN services are included in the MCO benefits package. All Medicaid clients who are~~

enrolled with an MCO must receive PDN services through the MCO. Medicaid clients age 21 years and over are eligible for up to eight hours of PDN daily. Children under age 21 are covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program and may exceed this limit if medically necessary.

Effective July 1, 2007, Private Duty Nursing (PDN) services are provided to the majority of Medicaid individuals through a Managed Care Organization (MCO). MCOs are required to provide, at a minimum, coverage of services described in this provider specific policy manual. The MCO's contract with the Division of Medicaid and Medical Assistance (DMMA) may include additional obligations. Services provided to individuals enrolled in an MCO are not billed to the Delaware Medical Assistance Program (DMAP). The provider shall provide services only under arrangement with the MCO.

Providers shall refer to the Managed Care section of the General Policy Manual for the required forms and procedures related to Diamond State Partners (DSP) additional information related to PDN services.

This manual reflects the policies as they relate to:

- Medicaid ~~clients~~ individuals who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy Manual).
- Medicaid ~~clients~~ individuals whose medical need requires private duty nursing services in a non-institutional setting.
- Medical Necessity as defined in Appendix H of the General Policy Manual.

### **1.1 Service Definition**

1.1.1 PDN services are available through the DMAP for ~~clients~~ individuals who require more individual and continuous skilled care than as defined in 42 CFR 440.70, Home Health Services.

1.1.2 PDN services may be provided by a single nurse to an individual or to multiple ~~clients~~ individuals in a non-institutional group setting as described above. The nurse-client ratio will not exceed ~~3~~ three (3) ~~clients~~ individuals per nurse unless authorized by the Medical Review Team.

1.1.3 Arrangements for multiple ~~clients~~ individuals in non-institutional settings may be considered if such arrangements are medically appropriate and advantageous to both the ~~client~~ individual and to DMAP.

1.1.4 PDN services are provided to Medicaid ~~clients~~ individuals in their home or other DMAP approved community setting as an alternative to more expensive institutional care. Generally, the total cost of PDN services shall not exceed the cost of care provided in an institutional setting.

### **1.2 Technology Dependent Definition**

1.2.1 Technology Dependent means an individual who has a chronic disability which requires the routine use of a specific medical device to compensate for the loss of a life-sustaining body function and requires daily, ongoing care or monitoring by trained personnel.

## **2.0 Qualified Providers**

### **2.1 General Criteria**

2.1.1 Private duty nursing may be provided by any registered nurse (RN), licensed practical nurse (LPN) or ~~certified registered nurse practitioner (CRNP) advance practice registered nurse (APRN)]~~ who has a professional license from the State to provide nursing services.

2.1.2 Home health agencies that employ and provide qualified nursing staff as described above ~~or self-employed qualified nursing staff~~ are considered qualified providers and may enroll as PDN providers.

2.1.2.1 Individual nurses, either employed by an agency or self-employed may provide no more than 16 hours of PDN services in a 24-hour period except in an emergency situation which will be reviewed by the Medical Review Team. The maximum number of hours provided by an individual nurse will be restricted to a level that can safely and reasonably be provided. No individual nurse will be authorized to work more than a sixteen (16) hour shift per day except in an emergency situation which will be reviewed and then approved or denied by the Medical Review Team.

## **3.0 Documentation**

### **3.1 Provider Requirements**

3.1.1 The private duty nursing provider is required to keep the following documentation in the patient's record:

3.1.1.1 Documentation of orientation to client's care needs and demonstration of nursing skills necessary to deliver prescribed care.

3.1.1.2 A written plan of care that is established, signed and dated by the ~~attending~~ **[attending]** practitioner which includes orders for medications, treatments, nutritional requirements, activities permitted, special equipment and other ordered therapies.

3.1.1.3 Orders renewed, signed and dated at least once every ~~60~~ sixty (60) days or sooner as the severity of the ~~client's~~ individual's conditions requires.

3.1.1.4 Documentation that the nurse promptly alerts the practitioner to any changes that suggest a need to alter the plan of care.

3.1.1.5 Adequate documentation dated and signed by the nurse performing the service.

## 4.0 Reimbursement

### 4.1 Methodology

4.1.1 Private duty nursing services provided to eligible DMAP ~~clients~~ individuals are reimbursed using prospectively determined rates. The unit of service for agency providers is one (1) hour, ~~and for self-employed nurses is 15 minutes. A weekly maximum limit is established for each client by the DMAP based on the authorized services. The number of weekly hours of PDN services authorized for each individual will be based on the individual's needs and documented in the plan of care.~~

4.1.2 Rates for agency services are reviewed annually. The rate will relate to the lowest prevailing usual and customary charge, as determined by a survey of all private duty nursing service agencies. Agencies will be reimbursed the lower of their usual and customary charges or the maximum rate.

~~4.1.3 Rates for self-employed nurses will be individually negotiated, but will not exceed a predetermined percentage of the agency rate. Rates may not be renegotiated more than once annually except in extenuating circumstances. Increases will be limited to the normal medical inflation used by DMAP. Self-employed nurses will be reimbursed the lower of their usual and customary charges or the maximum rate.~~

4.1.4 ~~4.1.3~~ Providers are not required to submit cost reports to the DMAP. There are no retrospective settlements on claims paid.

4.1.5 ~~4.1.4~~ The baseline PDN reimbursement rate will normally represent services provided by one nurse to one ~~client~~ individual. An adjusted reimbursement rate per ~~client~~ individual will be established for medically appropriate PDN services provided by a single nurse for up to three (3) ~~clients~~ individuals. Maximum rates are established according to the following table:

One <del>client</del> individual:	Rate for One =	100% of established baseline rate
Two <del>clients</del> individuals:	Rate for Each =	50% of 143% of baseline rate
Three <del>clients</del> individuals:	Rate for Each =	33% of 214% of baseline rate

~~For example, if the baseline rate for one individual is \$21.00 per hour, the reimbursement rate for multiple individual settings is as follows:~~

One Individual:	Rate for each individual =	\$21.00 per hour (Baseline)
Two Individuals:	Rate for each individual =	\$15.00 per hour
Three Individuals:	Rate for each individual =	\$15.00 per hour

### 4.2 Counting of 15-Minute Increments

~~4.2.1 Visits are to be rounded to the nearest 15-minute increment. The following chart is to be used to assist providers in determining the number of units to be billed:~~

<del>1 unit</del>	<del>1 minute to &lt;23 minutes</del>
<del>2 units</del>	<del>&gt;23 minutes to &lt;38 minutes</del>
<del>3 units</del>	<del>&gt;38 minutes to &lt;53 minutes</del>
<del>4 units</del>	<del>&gt;53 minutes to &lt;68 minutes</del>
<del>5 units</del>	<del>&gt;68 minutes to &lt;83 minutes</del>
<del>6 units</del>	<del>&gt;83 minutes to &lt;98 minutes</del>
<del>7 units</del>	<del>&gt;98 minutes to &lt;113 minutes</del>
<del>8 units</del>	<del>&gt;113 minutes to &lt;128 minutes</del>

~~NOTE: Unless prior authorized, providers cannot exceed the limited number of units assigned to each private duty nursing service.~~

## 5.0 Prior Authorization

### 5.1 Requirements

5.1.1 Private duty nursing services must be prior authorized by DMAP before the services are rendered.

~~5.1.2 Private duty nursing services for clients who are eligible for the Elderly and Disabled HCBS Waiver program, the Assisted Living Medicaid Waiver program, or the Acquired Brain Injury Medicaid Waiver, must be prior authorized by the nursing staff of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD). See the Index in back of General Policy for the appropriate address and telephone number.~~

5.1.3 All other requests for prior authorization should be directed to the Medical Prior Authorization Units. The

New Castle County unit is located in the Robscott Building and the Kent/Sussex County unit is located in Georgetown (see the Index section in the back of General Policy for the address and telephone number of each Prior Authorization Unit).

5.1.2 For individuals not enrolled in an MCO, prior authorization requests for PDN services should be directed to the appropriate Medicaid office (Robscott Building in Newark for New Castle County and Thurman Adams State Service Center in Georgetown for Kent and Sussex Counties). Contact information for these offices may be found in the Index of the General Policy Manual.

5.1.4 The maximum number of hours provided by an individual nurse will be restricted to a level that can safely and reasonably be provided. No individual nurse will be authorized to work more than a 16-hour shift per day except in an emergency situation which will be reviewed by the Medical Review Team.

5.1.5 5.1.3 PDN hours must be used for the period of time in which they are authorized. If the authorized hours are not used they the unused hours cannot be carried over into another time period.

5.1.4 Prior approval of services does not guarantee that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and must determine if Medicaid beneficiaries have other health insurance.

## **5.2 General Guidelines for Private Duty Nursing Services Authorization**

5.2.1 Initially, a Division of Medicaid and Medical Assistance (DMMA) Medical Services Nurse completes a face-to-face medical assessment. The client individual will receive a written notice of approval or non-approval for PDN services.

5.2.2 The on-going need for PDN care is routinely/periodically re-evaluated. DMMA may determine that because of parent/caregiver work schedule, stability of the patient, and other factors, that PDN hours may be reduced or increased. [DMMA DMAP] may determine that PDN hours may be increased based on medical necessity or reduced based on medical necessity accompanied by a change in circumstances or other good causes.

5.2.3 PDN will only be authorized when there is at least one caregiver willing and able to accept responsibility for the client's care when the nurse is not available. DMMA expects that parents/caregivers be willing and capable to accept responsibility for their relative/child's care. If the parent/caregiver cannot or will not accept responsibility for the client's care when PDN is not authorized or available, the client is deemed not to be in a safe environment and PDN will not be authorized.

PDN services will only be authorized when there is at least one caregiver willing and able to accept responsibility for the individual's care when the nurse is not available. [PDN is only authorized for the provision of skilled care (i.e. G-tube feeds, trach care, etc.) and is not primarily for home health aide (HHA) or certified nursing assistant (CNA) services, safety and supervision. Therefore,] DMAP expects that caregivers be willing and capable to accept responsibility for their individual's care. If the caregiver cannot or will not accept responsibility for the individual's care when PDN services are not authorized or available, the individual is deemed not to be in a safe environment and PDN services will not be authorized.

5.2.4 DMMA DMAP cannot guarantee that PDN services will be available from a specific provider.

5.2.5 DMMA DMAP reimburses for medically necessary transportation through a Medicaid transportation broker. DMMA expects the parent/caregiver to accompany the client in transport. If, because of employment or school, the parent/caregiver cannot accompany the client, the prior authorized PDN may accompany the client. If the client is transported to a medical appointment or the hospital with the PDN, as soon as the parent/caregiver arrives, the PDN service is no longer required. PDN will not be authorized for a nurse to accompany a client to a medical appointment or hospital stay when the parent/caregiver is available. PDN services will be authorized for transportation when medically necessary, as determined on an individualized basis.

5.2.6 PDN may be approved to accompany school-age children with a compromised airway or other DMAP approved high-risk condition in transport to school and to provide medically necessary care during school hours. PDN services may be authorized during the school day [with parental consent, as indicated by the agreement with the child's Individual Education Plan (IEP), if DMAP determines that a school is unable to meet the medical needs of school-age children who are technology dependent or for whom DMAP has determined these services to be otherwise with parental consent and when DMAP determines that it is] medically necessary [for school-age children]. This may include accompanying the children during the transport to and from school and providing medically necessary care during school hours.

5.2.7 DMMA may approve PDN services may be approved when a child is home sick with a cold, virus or normal childhood disease or there are unplanned school closures or inclement weather days. However, additional hours must be prior authorized. Home health agencies may not be able to provide "on demand or same day service." Families Parents/caregivers should contact DMMA or their MCO as soon as they know about an unplanned school closure, etc. and find a willing and available provider.

5.2.8 DMMA may approve PDN services may be approved to cover summer vacation as well as scheduled school year holiday vacations for school age children if the parent/caregiver requests coverage timely it is determined that services are medically necessary. Absence of parents/guardian from the home for employment or work-related education reasons must be documented.

5.2.9 DMMA projects a sufficient amount of hours per day. If the hours authorized are not used on a particular day, the hours do not carry over to the next day or weekend nor can the hours be "banked" to be used at a later time.

### 5.3 Determination of Hours Needed

5.3.1 ~~DMMA does not approve 24 hour on-going PDN services. DMMA may approve 24 hours PDN for 3-4 days (trach and vent child/adult) to help parents/caregivers adjust and ensure all equipment is functioning. PDN reduces to 20 hours for 1-2 days. PDN then reduces to 18 hours then reduces to 16 hours, the maximum number of hours a day authorized for children (8 hours for adults). PDN services may be approved for up to twenty-four (24) hours per day for up to three to four (3-4) days when medically necessary to help caregivers adjust and ensure all equipment is functioning following a transition or discharge from hospital or other facility to the community. Once the transition is successfully accomplished, PDN services will be gradually reduced based upon individually assessed medical necessity.~~

5.3.2 ~~PDN may be reduced further by school enrollment or attendance at a Prescribed Pediatric Extended Care (PPEC) facility. A home health aid or Certified Nursing Assistant (CAN) may be approved for some clients in lieu of PDN when appropriate and cost effective.~~

5.3.3 ~~An increase in hours may be approved if additional hours will avoid hospitalization or institutional placement as a cost effective measure. This will depend on the medical necessity, the amount of additional hours needed and the letter of medical necessity from the admitting individual's primary care physician (PCP).~~

5.3.4 ~~If a parent/caregiver needs hours for sleep and skilled care is required for a client with a compromised airway (trach/vent) or other DMAP approved high risk condition during this sleep time, PDN is approved for a maximum of up to eight hours, generally eight hours within the range of 10pm through 8am. During those hours when a parent/caregiver needs to sleep, and a high risk or technology dependent individual continues to require skilled care, PDN services may be approved for a maximum of eight (8) additional hours.~~

5.3.5 ~~PDN services is may be adjusted to cover work and travel time of the parent/caregiver or to cover education (class schedule) and travel time of the parent, if there is not another parent/caregiver in the home. PDN is authorized for up to 40 hours per week plus an additional five hours for travel to and from work or school. Parent/guardian work hours/schedule must be verified. PDN for education is for employment related classes, vo tech, GED, high school, college, etc. and must be documented. based on the availability of the parent/caregiver as determined by DMAP. "Availability" is individually determined based on a totality of circumstances. DMAP requires that documentation of parent/caregiver unavailability be provided annually, or when/if changes occur.~~

5.3.6 ~~If medical care is needed, but it is less than skilled care, DMMA may authorize a CAN or home health aid to provide medically necessary care if it is deemed to be the most appropriate and cost effective.~~

5.3.5 ~~PDN services may be reduced by the introduction of a Home Health Aide (HHA), Certified Nursing Assistant (CNA) or Personal Attendant and may be approved for some individuals in lieu of PDN services when appropriate and cost effective.~~

*(Break in Continuity of Sections)*

## 7.0 Appendix B – HCPCS Procedure Codes

The PDN provider must use the following procedure codes when billing the DMAP for private duty nursing services effective for dates of services on and after 7/1/02.

<b>Codes</b>	<b>Description</b>
T1000	Private duty/independent nursing service(s) licensed, up to 15 minutes
S9123	Nursing care, in the home, by registered nurse, per hour
S9124	Nursing care, in the home, by licensed practical nurse, per hour

19 DE Reg. 507 (12/01/15) (Final)