

**Table of Contents**

1.0 Description of the Procedure, Product, or Service..... 1  
1.1 Private Duty Nursing ..... 1  
1.2 Definitions ..... 1  
1.2.1 Skilled Nursing..... 1  
1.2.2 Substantial ..... 1  
1.2.3 Complex ..... 1  
1.2.4 Continuous ..... 1  
1.2.5 Significant Change in Condition ..... 1  
2.0 Eligibility Requirements ..... 2  
2.1 Provisions..... 2  
2.1.1 General ..... 2  
2.1.2 Specific..... 2  
2.2 Special Provisions..... 2  
2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid  
Beneficiary under 21 Years of Age ..... 2  
2.2.2 EPSDT does not apply to NCHC beneficiaries ..... 3  
2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6  
through 18 years of age ..... 3  
2.3 Medicaid Eligibility Categories ..... 4  
2.3.1 Fee-for-Service Medicaid Categories..... 4  
2.3.2 Medicaid for Pregnant Women (MPW) ..... 4  
2.3.3 Medicare Qualified Beneficiaries (MQB)..... 4  
2.3.4 Managed Care ..... 4  
3.0 When the Procedure, Product, or Service Is Covered..... 4  
3.1 General Criteria Covered ..... 4  
3.2 Specific Criteria Covered..... 4  
3.2.1 Specific criteria covered by both Medicaid and NCHC ..... 4  
3.2.2 Medicaid Additional Criteria Covered ..... 4  
3.3 Health Criteria..... 5  
3.3.1 Standard PDN Services ..... 5  
3.3.2 Expanded PDN Services ..... 5  
3.3.3 PDN During Significant Change In Condition..... 6  
3.3.4 NCHC Additional Criteria Covered ..... 6  
4.0 When the Procedure, Product, or Service Is Not Covered..... 6  
4.1 General Criteria Not Covered ..... 6  
4.2 Specific Criteria Not Covered..... 6  
4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC ..... 6  
4.2.2 Medicaid Additional Criteria Not Covered ..... 6  
4.2.3 NCHC Additional Criteria Not Covered ..... 7  
5.0 Requirements for and Limitations on Coverage ..... 7  
5.1 Prior Approval ..... 7  
5.2 Prior Approval Requirements ..... 8

5.2.1	General .....	8
5.2.2	Initial Prior Approval .....	8
5.2.3	Prior Approval of Reauthorization .....	9
5.3	Additional Limitation or Requirements .....	10
5.3.1	Re-evaluation during the Approved Period.....	10
5.3.2	Verbal Orders .....	10
5.3.3	Plan of Care .....	11
5.3.4	Retroactive Coverage .....	11
5.3.5	PDN in Schools .....	11
5.3.6	Determining the Amount, Duration, Scope, and Sufficiency of Services .....	12
5.3.7	Requests to Change the Amount, Scope, Frequency, or Duration of Services .....	14
5.3.7.1	Plan of Care Changes .....	14
5.3.7.2	Temporary Changes .....	14
5.3.7.3	Emergency Changes .....	14
5.3.8	Termination or Reduction .....	14
5.3.8.1	Notification of Termination.....	15
5.3.8.2	Notification of Reduction.....	15
5.3.9	Changing Service Providers .....	16
5.3.9.1	Transfer of Care Between Two Branch offices of the Same Agency .....	16
5.3.9.2	Transfer of Care Between Two Different Agencies.....	17
5.3.9.3	Discharge Summary .....	17
5.3.9.4	Approval Process.....	17
5.3.10	Limitations on the Amount, Frequency, and Duration.....	17
5.3.10.1	Unused Service Hours.....	17
5.3.10.2	Unauthorized Hours .....	17
5.3.10.3	Transportation .....	17
5.3.10.4	Medical Settings .....	17
5.3.10.5	Weaning of a Medical Device .....	18
5.3.11	Coordination of Care.....	18
5.3.11.1	Transfers between Health Care Settings .....	18
5.3.11.2	Drug Infusion Therapy .....	18
5.3.11.3	Enteral or Parenteral Nutrition .....	18
5.3.11.4	Home Health Nursing.....	18
5.3.11.5	Medical Supplies .....	18
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service .....	19
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	19
6.1.1	Agency Type .....	19
6.1.2	Agency Responsibilities.....	19
6.1.3	Provider Relationship to Beneficiary .....	20
6.1.4	Nurse Supervision Requirements .....	20
7.0	Additional Requirements .....	20
7.1	Compliance .....	20
7.2	Documentation Requirements.....	21
7.2.1	Contents of Records .....	21
7.2.2	Termination of Operations .....	21

7.3	Verification of Eligibility.....	21
7.4	Qualified Family and Other Designated Caregivers.....	22
7.4.1	Primary Caregiver.....	22
7.4.2	Training.....	22
7.4.3	Documenting Competency.....	22
7.4.4	Emergency Plan of Action.....	22
7.4.5	Evaluation of Health and Safety.....	22
7.5	Patient Self Determination Act.....	22
7.6	Marketing Prohibition.....	23
8.0	Policy Implementation/Revision Information.....	23
Attachment A: Claims-Related Information.....		24
A.	Claim Type.....	24
B.	International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10- CM) and Procedural Coding System (PCS).....	24
C.	Code(s).....	24
D.	Modifiers.....	25
E.	Billing Units.....	25
F.	Place of service.....	25
G.	Co-payments.....	25
H.	Reimbursement.....	25
I.	The Program Integrity.....	25
J.	Unit Limitations.....	25
Attachment B: Sample Home Health Certification and Plan of Care Form (CMS-485).....		26
Attachment C: Physician’s Request Form for Private Duty Nursing.....		27
Attachment D: PDN Prior Approval Referral Form (DMA-3061).....		28
Attachment E: PDN Medical Update/Beneficiary Information Form.....		29
Attachment F: Medical Update and Patient Information Form (HCFA-486).....		30
Attachment H: Hourly Nursing Review Criteria.....		32

## **1.0 Description of the Procedure, Product, or Service**

### **1.1 Private Duty Nursing**

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing service that require more individual and continuous care than is available from a visiting nurse or is routinely provided by the nursing staff of a hospital or skilled nursing facility. PDN must be medically necessary for the beneficiary to be covered by NC Medicaid (Medicaid).

PDN services are provided only in the beneficiary's private primary residence under the direction of a written individualized plan of care by the beneficiary's attending physician. PDN services must be rendered by a licensed registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing (NCBON) and employed by a licensed home care agency.

### **1.2 Definitions**

#### **1.2.1 Skilled Nursing**

Skilled nursing is as defined by 10A NCAC 13J.1102. Skilled nursing does not include those tasks that can be delegated to unlicensed personnel pursuant to 21 NCAC 36.

#### **1.2.2 Substantial**

Substantial means there is a need for interrelated nursing assessments and interventions. Interventions which do not require assessment or judgment by a licensed nurse are not considered substantial.

#### **1.2.3 Complex**

Complex means that there are scheduled, hands-on nursing interventions. Observation in case an intervention is required is not considered complex skilled nursing and shall not be covered by Medicaid as medically necessary PDN services.

#### **1.2.4 Continuous**

Continuous means nursing assessments requiring interventions to be performed at least every two or three hours during the period Medicaid-covered PDN services are provided.

#### **1.2.5 Significant Change in Condition**

Significant change is defined as a change in the beneficiary's status that is not self-limiting, impacts more than one area of functional health status, and requires multidisciplinary review or a revision of the plan of care in accordance with program requirements specified in **Sections 3.0** and **4.0** of this policy.

## 2.0 Eligibility Requirements

### 2.1 Provisions

#### 2.1.1 General

*(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)*

- a. An eligible beneficiary shall be enrolled in either:
  1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
  2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

#### 2.1.2 Specific

*(The term “Specific” found throughout this policy only applies to this policy)*

- a. **Medicaid**  
None Apply.
- b. **NCHC**  
NCHC beneficiaries are not eligible for Private Duty Nursing (PDN). The services included in the PDN policy are not covered for NCHC beneficiaries.

### 2.2 Special Provisions

#### 2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service

requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

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

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**b. EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

*NCTracks Provider Claims and Billing Assistance Guide:*

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

**2.2.2 EPSDT does not apply to NCHC beneficiaries**

**2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age**

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

## **2.3 Medicaid Eligibility Categories**

### **2.3.1 Fee-for-Service Medicaid Categories**

Beneficiaries covered by regular Medicaid are eligible to apply for PDN services.

### **2.3.2 Medicaid for Pregnant Women (MPW)**

Pregnant women are eligible to apply for PDN services if the services are medically necessary for a pregnancy-related condition.

### **2.3.3 Medicare Qualified Beneficiaries (MQB)**

Medicaid beneficiaries who are Medicare-qualified beneficiaries (MQB) are not eligible for PDN.

### **2.3.4 Managed Care**

Medicaid beneficiaries participating in a managed care program, including Medicaid health maintenance organizations and Community Care of North Carolina programs(CCNC), (Carolina ACCESS and ACCESS II/III), must access home services, including PDN, through their primary care physician.

## **3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries Under 21 Years of Age*

### **3.1 General Criteria Covered**

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

### **3.2 Specific Criteria Covered**

#### **3.2.1 Specific criteria covered by both Medicaid and NCHC**

None Apply.

#### **3.2.2 Medicaid Additional Criteria Covered**

Medicaid covers PDN when:

- a. Eligibility criteria in **Section 2.0** are met;
- b. Provided in the private residence of the beneficiary. The basis for PDN approval is based on the need for skilled nursing care in the home. A beneficiary who is authorized to receive PDN services in the home may make use of the approved hours outside of that setting when normal life activities temporarily take him or her outside that setting. Normal life activities include supported or sheltered work settings, licensed child care,

- school and school related activities, and religious services and activities. Normal life activities do not include inpatient facilities, outpatient facilities, hospitals, physicians' offices, or other medical settings;
- c. PDN services must be requested by (Refer to **Attachment C**) and ordered by the beneficiary's attending physician (MD or DO licensed by the North Carolina Board of Medicine and enrolled with Medicaid) on the CMS-485;
  - d. Prior approved by DMA in accordance with **Section 5.0** (Refer to **Attachment D**); and
  - e. The beneficiary has at least one trained primary informal caregiver to provide direct care to the beneficiary during the planned and unplanned absences of PDN staff. It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.

### 3.3 Health Criteria

#### 3.3.1 Standard PDN Services

To be eligible for standard PDN services, the beneficiary shall:

- a. be dependent on a ventilator for at least eight hours per day, or
- b. meet at least four of the following criteria:
  1. unable to wean from a tracheostomy;
  2. require nebulizer treatments at least two scheduled times per day and one as needed time per day;
  3. require pulse oximetry readings every nursing shift;
  4. require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency;
  5. need pro re nata (PRN) oxygen or has PRN rate adjustments at least two times per week;
  6. require tracheal care at least daily;
  7. require PRN tracheal suctioning. Suctioning is defined as tracheal suctioning requiring a suction machine and a flexible catheter; or
  8. at risk for requiring ventilator support.

#### 3.3.2 Expanded PDN Services

Beneficiaries who meet all of the criteria for standard nursing services plus at least one of the criteria below may be eligible for expanded PDN services:

- a. use of respiratory pacer;
- b. dementia or other cognitive deficits in an otherwise alert or ambulatory recipient;
- c. infusions, such as through an intravenous, PICC, or central line;
- d. seizure activity requiring use of PRN use of Diastat, oxygen, or other interventions that require assessment and intervention by a licensed nurse;
- e. primary caregiver who is 80 or more years of age or who had disability confirmed by the Social Security Administration and disability interferes with caregiving ability; or
- f. determination by Child Protective Services or Adult Protective Services that additional hours of PDN would help ensure the recipient's health, safety, and welfare.

Expanded PDN services in most cases allows an additional 14 hours per week - as long as that new total does not exceed the program maximum limit of 112 hours per week.

### **3.3.3 PDN During Significant Change In Condition**

Beneficiaries who meet one of the following criteria may be eligible for a short-term increase in service. The amount and duration of the increase is based on medical necessity and approved by the PDN Nurse Consultant. No short-term increase may last more than four calendar weeks.

- a. beneficiary with new tracheostomy, ventilator, or other technology need, immediately post discharge, to accommodate the transition and the need for training of informal caregivers. Services will generally start at a high number of hours and be weaned down to within normal policy limits over the course of the four weeks.
- b. an acute, temporary change in condition causing increased amount and frequency of nursing interventions.
- c. a family emergency, when the back-up caregiver is in place but requires additional support because of less availability or need for reinforcement of training.

### **3.3.4 NCHC Additional Criteria Covered**

None Apply.

## **4.0 When the Procedure, Product, or Service Is Not Covered**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.*

### **4.1 General Criteria Not Covered**

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### **4.2 Specific Criteria Not Covered**

#### **4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC**

None Apply.

#### **4.2.2 Medicaid Additional Criteria Not Covered**

PDN is not covered if any of the following are true:

- a. the beneficiary is receiving medical care in a hospital, nursing facility, or other setting where licensed personnel are employed;
- b. the beneficiary is a resident of an adult care home, group home, family care home, or nursing facility;

- c. the service is for custodial, companion, or respite services (short-term relief for the caregiver) or medical or community transportation services;
- d. the nursing care rendered can be delegated to unlicensed personnel (Nurse Aide I or Nurse Aide II), in accordance with 21 NCAC 36.0401 and 21 NCAC 36.0221(b);
- e. the purpose of having a licensed nurse with the beneficiary is for observation or monitoring in case an intervention is required;
- f. the service is for the beneficiary or caregiver to go on vacation or overnight trips away from the beneficiary's private primary residence. Note: Short-term absences from the home that allow the beneficiary to receive care in an alternate setting for a short period of time may be allowed as approved by the PDN Nurse Consultant and when not provided for respite, when not provided in an institutional setting, and when provided according to nurse and home care licensure regulations;
- g. services are provided exclusively in the school or home school;
- h. the beneficiary does not have informal caregiver support available as per **Subsection 3.2e**;
- i. the beneficiary is receiving home health nursing services or respiratory therapy treatment (except as allowed under Policy 10D Independent Practitioners Respiratory Therapy Services) during the same hours of the day as PDN;
- j. the beneficiary is receiving infusion therapy services provided under the Medicaid Home Infusion Therapy (HIT) program, or nursing services provided under the Community Alternatives Program for Children (CAP/C); or
- k. the beneficiary is receiving Hospice Services, except as those services may apply to children under the Affordable Care Act.

#### **4.2.3 NCHC Additional Criteria Not Covered**

- a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
  - 1. No services for long-term care.
  - 2. No nonemergency medical transportation.
  - 3. No EPSDT.
  - 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

## **5.0 Requirements for and Limitations on Coverage**

### **5.1 Prior Approval**

Medicaid shall not require prior approval for Private Duty Nursing. The provider shall obtain prior approval before rendering Private Duty Nursing.

## 5.2 Prior Approval Requirements

### 5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

### 5.2.2 Initial Prior Approval

Specifically, the following documents are required for an initial prior approval:

- a. PDN Prior Approval Referral Form (refer to **Attachment D**).
- b. A physician's request. The physician's request consists of either:
  1. Physician's Request Form for PDN Services (refer to **Attachment C**), or
  2. a letter of medical necessity.

Either type of physician's request should include:

1. The current diagnosis(es);
  2. History of the illness, injury, or medical condition requiring PDN services;
  3. Date of onset and date(s) of any related surgeries;
  4. The projected date of hospital discharge, if applicable;
  5. A prognosis that identifies the specific expectations for the beneficiary's recovery from the illness, injury, or medical condition requiring the PDN hours;
  6. The specific licensed nursing interventions requested, the frequency of those interventions, and the estimated length of time PDN will be required; and
  7. The family members and other caregivers available to furnish care and the training they have been or will be provided.
- c. Verification of caregiver employment schedule. Verification consists of a statement on employer letterhead signed by a supervisor or representative from the employer's Human Resources Department, detailing the employee's current status of employment (such as active or on family medical leave) and typical work schedule. If a caregiver is self employed or unable to obtain a letter, the Verification of Employment form, **Attachment G**, may be used.
  - d. Home Health Certification and Plan of Care form (CMS-485); refer to **Attachment B** for an example.

A complete request for initial prior approval contains the following information:

- a. beneficiary's name, address, date of birth and Medicaid Identification Number MID ;
- b. the specific number of hours per day requested;
- c. the name, address, and phone number, and provider number of the PDN provider chosen by the beneficiary;
- d. requested start of care date for PDN;
- e. diagnosis and skilled interventions required;
- f. if applicable, recent hospital admission and discharge summaries;
- g. third party insurance coverage;

- h. caregiver availability and teaching required; and
- i. the name of the beneficiary's attending physician who will be signing the plan of care.

Documentation that is submitted without this information will be treated as unable to process or as an incomplete request per Medicaid due process procedures.

**Note:** Per the current due process procedures, an initial request is defined as a request that the beneficiary was not authorized to receive on the day immediately preceding the date of the receipt of the request.

If DMA or its designee approves the initial request for PDN services, DMA will send the PDN service provider a notification letter within 15 business days of the receipt of all required information. Required information includes notification of the start of care date and the unsigned orders from the agency. A copy of the letter will be sent to the beneficiary's attending physician, the beneficiary, or the beneficiary's representative. The approval letter includes:

- a. the beneficiary's name and MID number;
- b. the name and provider number of the authorized PDN service provider;
- c. the number of hours per week approved for PDN services, beginning with Sunday at 12:01 am; and
- d. the starting and ending dates of the approved period, usually 30 to 60 calendar days, depending on the beneficiary's medical condition.

### 5.2.3 Prior Approval of Reauthorization

The following documents are required for reauthorizations:

- a. The clinical medical record as per **Subsection 7.2** and in accordance with 10A NCAC 13J.1401 and 10A NCAC 13J.1402;
- b. A copy of the completed PDN Medical Update/Beneficiary Information Form, which also indicates the date of the last physician visit (refer to **Attachment E**) or  
A copy of the Medical Update and Patient Information Form (CMS-486) (for a copy of a completed example, refer to **Attachment F**);
- c. A copy of the Home Health Certification and Plan of Care Form (CMS-485) (for a copy of a completed example, refer to **Attachment B**), signed and dated by the attending physician and indicating specific recertification dates, frequency, and duration of PDN services being requested. A verbal order is acceptable in order to have the CMS-485 submitted within ten calendar days prior to the recertification date and receive a verbal authorization for services; however, the physician-signed form must be submitted to DMA before final written approval is granted;
- d. The completed HNRC (**Attachment H**);
- e. At DMA's discretion, an in-home assessment may be performed by DMA or its designee;
- f. Verification of caregiver's employment schedule annually and with any changes. Verification consists of a statement on employer letterhead signed by a supervisor or representative from the employer's Human Resources Department, detailing the employee's current status of employment (such as

- active or on family medical leave) and typical work schedule. If a caregiver is self employed or unable to obtain a letter, the Verification of Employment form, **Attachment G**, may be used; and
- g. Nurses notes from the latest certification period as requested by Consultant.

Documentation that is submitted without this information will be treated as unable to process or as an incomplete request per Medicaid due process procedures.

To receive approval for continuation of PDN services beyond the approved period, the PDN service provider shall submit the reassessment information to DMA at least 10 calendar days PRIOR to the end date of the recertification period (current approved period). Authorization will be finalized upon receipt of all requested information, including signed physician order.

**Note:** If the request is received by DMA's Home Care Initiatives HCI Unit MORE than one day after the end of the current authorization period, the request will be treated as an Initial Request (see **Subsection 5.2.1.**).

If the reauthorization of PDN services is approved, DMA:

- a. forwards a written notification to the PDN service provider in accordance with the current beneficiary notices procedure;
- b. forwards a copy of the authorization for services to the beneficiary (and the beneficiary's representative, if applicable); and
- c. once the signed physician order is received, enters the required information into the Medicaid fiscal agent's claims system to allow payment of claims submitted for the approved services.

**Note:** Payment of claims for approved services will not be generated until the physician signed CMS 485 is submitted to DMA for the current certification period.

### **5.3 Additional Limitation or Requirements**

#### **5.3.1 Re-evaluation during the Approved Period**

If the beneficiary experiences a significant change of condition, the PDN service provider shall notify DMA or its designee of the need either to increase or decrease the number of PDN hours required to meet the beneficiary's needs or to terminate PDN, based on physician's orders. Services will be re-evaluated at that time.

#### **5.3.2 Verbal Orders**

If the physician requests that PDN services begin before the service provider receives written orders, the PDN service provider may act on the physician's verbal orders subject to DMA approval. A licensed nurse or other appropriate home care professional shall record the verbal orders on the Home Health Certification and Plan of Care Form (CMS-485) and in accordance with 10A NCAC 13J, *The Licensing of Home Care Agencies*. The verbal order must be submitted to DMA HCI office, with 10 days prior to recertification end date. The

verbal order shall include recertification dates, frequency and duration of request PDN hours.

### 5.3.3 Plan of Care

The plan of care must have:

- a. All pertinent diagnoses, including the beneficiary's mental status;
- b. The type of services, medical supplies, and equipment ordered;
- c. The specific number of hours of PDN per day (a range of hours is not acceptable) and number of days per week;
- d. Specific assessments and interventions to be administered by the nurse;
- e. individualized nursing goals with measurable outcomes;
- f. Verbal order, date, signed by RN if CMS-485 (Locator 23) is not signed by the physician in advance of the recertification period;
- g. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications-indicating new or changed in last 30 calendar days, and treatments;
- h. Teaching and training of caregivers;
- i. Safety measures to protect against injury;
- j. Disaster plan in case of emergency or natural occurrence;
- k. Discharge plans individualized to the beneficiary; and
- l. The POC recertification period is a maximum of 60 days unless otherwise authorized by DMA.

**Note:** Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

### 5.3.4 Retroactive Coverage

Retroactive coverage for Initial Requests PDN services may be requested for up to five business days prior to the initial request of PDN coverage. If the request is not received within five business days, services are not eligible for reimbursement. This only applies to initial requests; not ongoing recertifications where coverage has lapsed due to failure to submit in accordance with due process procedures.

### 5.3.5 PDN in Schools

Individuals and caregivers are responsible for determining if the beneficiary is receiving the appropriate nursing benefit in the school system and formulating the child's Individualized Education Plan (IEP) to include nursing coverage in the school system. If any nursing hours are approved for school coverage, these hours are included in the total hours approved by DMA.

The nurse shall document the hours and specific place of service when care is rendered in a school, included how transported to school (bus, parent vehicle, etc). All other PDN requirements must be met; for example, there must be a CMS-485 in addition to the IEP and it must be signed only by a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO).

### 5.3.6 Determining the Amount, Duration, Scope, and Sufficiency of Services

DMA or its designee determines the amount, duration, scope, and sufficiency of PDN services required by the beneficiary after reviewing the recommendations of the beneficiary's attending physician and the following characteristics of the beneficiary:

- a. Primary and secondary diagnoses.
- b. Overall health status.
- c. Level of technology dependency.
- d. Current and updated individualized plan of care (refer to **Attachment B**).
- e. Need for specific medical care and services provided under the Medicaid PDN services benefit.
- f. Clinical health care record as per **Subsection 7.2**.
- g. Amount of family assistance available. Verification of employment hours will be conducted annually. Allowances will not be made for second jobs, overtime, or combination of work and school, when the additional hours will cause the policy limit to be exceeded.
- h. PDN services are authorized in the amounts that are medically necessary based on the medical condition of the beneficiary, amount of caregiver assistance available and.

i. Approved hours are determined as follows:

Informal Caregiver Availability	Standard PDN Services (Refer to Subsection 3.3.1)	Expanded PDN Services (Refer to Subsection 3.3.2)
Two or more fully available caregivers	56 hours per week	70 hours per week
One fully available caregiver, with or without the presence of any other caregivers	76 hours per week	90 hours per week
Two or more partially available caregivers	56 hours per week plus time absent for work, up to maximum of 96 hours per week	70 hours per week plus time absent for work, up to maximum of 110 hours per week
One partially available caregiver	76 hours per week plus time absent for work, up to maximum of 112 hours per week	90 hours per week plus time absent for work, up to maximum of 112 hours per week
A fully available caregiver is one who lives with the beneficiary, is not employed and who is physically and cognitively able to provide care. A partially available caregiver is one who lives with the beneficiary and has verified employment or who has been determined by the Social Security Administration to be unable to work due to disability and the nature of the disability is one that interferes with the ability of that person to provide care to the PDN beneficiary.		
Approved hours for other formal support programs (including Community Alternatives Program for Individuals with Intellectual/Developmental Disabilities) apply toward the maximum limit.		
Hours are approved on a per-week basis beginning 12:01 AM Sunday and ending at 12:00 AM Saturday. Beneficiaries may use the hours as they choose. For example, a beneficiary approved for 70 hours per week may use ten hours per day seven days per week, or may use 14 hours per day five days per week. It is the responsibility of the beneficiary and caregiver to schedule time to ensure the health and safety of the beneficiary. Additional hours cannot be approved because the family planned poorly and 'ran out' before the end of the week.		
The maximum number of hours per week any beneficiary can be approved for is 112.		
Unused hours of services shall not be "banked" for future use or "rolled over" to another week.		

- j. Individuals who are PDN beneficiaries on the date this policy takes effect, and who are receiving greater than 112 hours per week, may continue to receive those hours until such time as either their need for nursing interventions decreases, the availability of informal supports increases, or they are disenrolled from the program including for a hospitalization exceeding 30 days.
- k. Individuals who are PDN beneficiaries on the date this policy takes effect, and who are receiving 112 hours per week or less, but whose current hours exceed the above parameters, or who do not meet the clinical coverage criteria in **Section 3.3.1**, will have one year from the date this policy takes effect to decrease their hours to within the new limits.
- 1. **Refer to Subsection 2.2.1 for EPSDT.**

### **5.3.7 Requests to Change the Amount, Scope, Frequency, or Duration of Services**

Any requests to change the amount, scope, frequency, or duration of services must be ordered by the attending physician and approved by DMA or its designee.

#### **5.3.7.1 Plan of Care Changes**

Any request to increase or decrease the amount, scope, frequency or duration of services must be approved by DMA prior to implementation. Any changes in approved services are entered into the fiscal agent's claim system to allow claims to be paid according to the approved changes.

#### **5.3.7.2 Temporary Changes**

Requests to decrease the amount, scope, frequency, or duration of services for seven days or less, such as over a holiday when additional family members are available to provide care and services, do not require DMA approval. Previously approved service levels can resume after the family situation returns to the normal routine. The agency shall document the reason for the decrease in services and supportive information, notifying the physician as appropriate.

#### **5.3.7.3 Emergency Changes**

Sudden changes in the amount, scope, frequency or duration of services shall be based on true emergent medical necessity of beneficiary. Emergency changes initiated outside of regular business hours shall be reported to DMA the next business day by facsimile. The written request must include specific information regarding changes in the beneficiary's medical condition and a documented verbal order supplemental order. A physician signed order must be provided to DMA within 15 business days.

**Note:** Written follow-up reports shall be requested.

If the requested service change is approved, the notification letter specifies the amount, scope, frequency, and duration of services approved. A copy of the notification letter is sent to the beneficiary's attending physician, the beneficiary, and/or representative. A decision on the requested services will not be made until all required information is provided. Should a decision to deny, reduce, or terminate services be made, notification to the beneficiary will be sent in accordance with the current beneficiary notices procedure. The procedure is available on the Web site at <http://www.ncdhhs.gov/dma>.

### **5.3.8 Termination or Reduction**

The PDN service provider, the beneficiary's attending physician, the beneficiary or representative, or DMA may terminate or reduce PDN services. Upon termination or reduction, DMA enters information into the fiscal agent's claims system to deny payment for all services provided after the termination date.

### 5.3.8.1 Notification of Termination

The termination process is determined by the following:

- a. If the PDN service provider discharges the beneficiary, the service provider shall send a copy of the physician's order to terminate services to DMA within five business days.
- b. If the PDN service provider discharges the beneficiary from Medicaid coverage because there is another source of nursing care coverage, the service shall notify DMA in writing. The notification must include the last date that PDN services were provided and can be billed to Medicaid and the name of the other source of coverage as applicable. DMA sends a letter to the agency confirming receipt of the information and the ending date for PDN services. Refer to **Subsection 5.3.10** regarding transfer of care.
- c. If the attending physician discharges the beneficiary, the PDN service provider shall provide to DMA, within five business days, the physician's order to terminate beneficiary services. DMA forwards to the PDN service provider a letter confirming receipt of the information and the ending date for PDN services.
- d. If DMA initiates termination because it has determined that the beneficiary no longer meets the administrative requirements and/or medical criteria, based on a review of the beneficiary's clinical medical record as provided by the PDN service provider, DMA forwards a written notification of termination to the beneficiary, the PDN service provider, and the beneficiary's attending physician in accordance with the current beneficiary notices procedure.
- e. If services are terminated as a result of the beneficiary's losing Medicaid or if no PDN services are provided during the 30 consecutive days for any reason including hospitalization, then the prior approval process must be initiated once again as outlined in **Subsections 5.1 and 5.2.**

**Note:** The decision of the beneficiary's attending physician and/or the PDN service provider to discharge the beneficiary cannot be appealed to DMA.

### 5.3.8.2 Notification of Reduction

The reduction process is determined by the following:

- a. If the **PDN service provider** reduces the PDN services, the service provider shall send DMA within five business days a copy of the physician's order to reduce services.  
DMA replies to the PDN service provider, attending physician, and beneficiary or representative with a letter confirming receipt of the information and the date of the reduction of PDN services.

- b. If the attending physician reduces the PDN services, the PDN service provider shall provide to DMA, within five business days, the physician's order to reduce beneficiary services. DMA replies to the PDN service provider, attending physician, and beneficiary or representative with a letter confirming receipt of the information and the date of the reduction of PDN services.
- c. DMA may request additional information from the PDN service provider. If DMA initiates reduction of PDN services because it has determined that the beneficiary no longer meets the administrative requirements and/or medical criteria, based on a review of the beneficiary's clinical medical record and Medicaid eligibility, DMA may request additional information from the PDN service provider. In the event the additional information is not provided within 10 business days of the notice of the reduction (or other time frame agreed upon by the provider and DMA nurse consultant), DMA forwards a written notification of the reduction of PDN services to the beneficiary and beneficiary's attending physician in accordance with the current beneficiary notices procedure.

### **5.3.9 Changing Service Providers**

Requests to change PDN service providers may occur as a result of a beneficiary's exercising freedom of choice.

#### **5.3.9.1 Transfer of Care Between Two Branch offices of the Same Agency**

The new PDN service provider shall facilitate the change by coordinating the transfer of care with the beneficiary's attending physician, the current PDN service provider, and others who are involved in the beneficiary's care. The new PDN service provider is responsible for the following:

- a. Submitting the transfer request to DMA within five business days of the request;
- b. Obtaining written permission from the beneficiary or legal guardian regarding the request to transfer;
- c. Coordinating the date the new provider will assume beneficiary care and ensuring that duplication of service is avoided;
- d. Obtaining a signed CMS 485 or, if necessary, verbal physician orders that contain the estimated amount, duration, and scope of the skilled nursing interventions to be provided and the expected frequency of each skilled nursing intervention;
- e. Ensuring that written and verbal orders are verified and documented according to 10A NCAC 13J, The Licensing of Home Care Agencies;
- f. Forwarding to DMA, prior to transfer, written notification of the transfer along with a copy of the attending physician's orders; and

- g. Providing, in the written notification, the provider's name and full mailing address, the provider's PDN service provider number, the date the new provider plans to initiate services, the name of the person at the previous agency with whom the transfer was coordinated, the name and telephone number of the new provider's contact person, and the responsible party's contact information.

#### **5.3.9.2 Transfer of Care Between Two Different Agencies**

Follow the same procedure as listed above in **Subsection 5.3.10.1**, but also submit:

- a. the prior approval form
- b. the letter of medical necessity

#### **5.3.9.3 Discharge Summary**

The former PDN service provider shall forward to DMA a discharge summary that specifies the last day PDN services were provided to the beneficiary.

#### **5.3.9.4 Approval Process**

After all requirements are met, DMA approves the new PDN service provider and forwards an approval letter to the new PDN service provider, with copies to the beneficiary's attending physician and the beneficiary (and representative if applicable) in accordance with the beneficiary notices procedure.

### **5.3.10 Limitations on the Amount, Frequency, and Duration**

#### **5.3.10.1 Unused Service Hours**

The beneficiary of PDN services cannot bank, save, or otherwise accumulate unused prior authorized hours.

#### **5.3.10.2 Unauthorized Hours**

PDN services provided in excess of the approved amount (the excess has not been authorized by DMA) are the financial responsibility of the provider agency.

#### **5.3.10.3 Transportation**

The PDN nurse may not transport the beneficiary. The licensed nurse may accompany the beneficiary if medically necessary as defined in **Subsection 3.2** when his or her normal life activities require that he or she access the community within the DMA approved time scheduled for PDN services.

#### **5.3.10.4 Medical Settings**

PDN is not covered for beneficiaries in a medical setting where licensed personnel are employed and have prescribed responsibility for providing care for the designated beneficiary.

### **5.3.10.5 Weaning of a Medical Device**

DMA or its designee may authorize PDN services for a brief period after the beneficiary no longer requires the medical device to compensate for loss of a vital body function. This period shall not exceed two weeks past the weaning of the medical device. The provider agency shall contact the physician to obtain an order to decrease PDN services once a significant change in condition and need for skilled nursing care has occurred.

### **5.3.11 Coordination of Care**

The beneficiary's attending physician and the PDN service provider are responsible for monitoring the beneficiary's care and initiating any appropriate changes in PDN services.

#### **5.3.11.1 Transfers between Health Care Settings**

If a beneficiary is placed in a different health care setting due to a change in his or her medical condition, the PDN service provider shall contact DMA prior to the beneficiary's discharge to discuss any required changes in PDN services. A history and physical and a discharge summary shall be submitted to DMA.

#### **5.3.11.2 Drug Infusion Therapy**

If a beneficiary requires drug infusion therapy, the Durable Medical Equipment DME supplier provides the drug infusion equipment, and drugs are provided through Medicaid's or Medicare's Part D pharmacy coverage. The PDN provider is responsible for the administration and caregiver teaching of the infusions.

#### **5.3.11.3 Enteral or Parenteral Nutrition**

If a beneficiary requires enteral or parenteral nutrition, the DME supplier provides the equipment, supplies, and nutrients. Home health and Home Infusion would be duplication.

Refer to **Section 4.0** for information on services that are not covered when the beneficiary is receiving PDN services.

#### **5.3.11.4 Home Health Nursing**

Home Health nursing services may not be provided concurrently with PDN Services. When a beneficiary requires Home Health medical supplies, the PDN provider shall provide and bill for those supplies. The PDN provider is also expected to handle blood draws, wound care, and other home health nursing tasks for PDN beneficiaries.

#### **5.3.11.5 Medical Supplies**

Medical supplies are covered as per the criteria for coverage of medical supplies and use of the miscellaneous procedure code for medical supplies defined in clinical coverage policy 3A, *Home Health Services*, on DMA's website at <http://www.ncdhhs.gov/dma/mp/>.

An enrolled PDN provider may bill for Medicaid-covered medical supplies as above if provided to a DMA-approved PDN beneficiary during the provision of PDN services.

Refer to **Subsection 7.2** for documentation requirements.

## **6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

### **6.1 Provider Qualifications and Occupational Licensing Entity Regulations**

#### **6.1.1 Agency Type**

PDN services are provided by home care agencies licensed by the N.C. Division of Health Service Regulation. The home care agency shall be an enrolled N.C. Medicaid provider approved by DMA to provide PDN services. Each office of the home care agency providing services shall have an individual N.C. Medicaid PDN provider number.

#### **6.1.2 Agency Responsibilities**

The PDN service provider is responsible for:

- a. ensuring that qualified and competent licensed nurses are assigned to provide skilled nursing care as required by the plan of care and the services are provided within the nurses' scope of practice as defined by 21 NCAC 36.
- b. be accredited with JCAHO, CHAP, or ACHC. All current PDN providers shall be fully accredited within 18 months of the effective date of this policy.
- c. ensuring RNs and LPNs have appropriate combination of experience and training: a minimum of 12 months recent (within the last five years) experience in acute care or in home care related to care of medically fragile beneficiaries.
- d. education, training, and experience are verified prior to employment.
- e. ensuring orientation and competency assessment of skills are sufficient to meet the plan of care requirements before assigning the nurse to the beneficiary's care.
- f. ensuring RNs and LPNs have documented continuing education hours, as per Board of Nursing.

- g. developing and providing orientation for policies and procedures to include the following:
  - 1. organizational chart and line of supervision.
  - 2. on call policies.
  - 3. record keeping and reporting.
  - 4. confidentiality and privacy of Protected Health Information (PHI).
  - 5. patient's rights.
  - 6. advance directives.
  - 7. written clinical policies and procedures.
  - 8. training for special populations such as pediatrics, ventilator care, tracheostomy care, wound, infusion care.
  - 9. professional boundaries.
  - 10. supervisory visit requirements to include new and experienced personnel.
  - 11. criminal background checks.
  - 12. Occupational Safety and Health Administration (OSHA) requirements, safety, infection control.
  - 13. orientation to equipment.
  - 14. cardiopulmonary resuscitation training and documentation.
  - 15. incident reporting.
  - 16. cultural diversity and ethnic issues.
  - 17. translation policy.

**Note:** Documentation of all training and competency must be retained in the personnel file and available to DMA upon request.

### **6.1.3 Provider Relationship to Beneficiary**

To provide PDN services reimbursed by Medicaid, the provider agency may not employ:

- a. a member of the beneficiary's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step- and in-law relationships); or
- b. a legally responsible person who maintains his or her primary residence with the beneficiary; or
- c. the nurse shall not live with the beneficiary in any capacity.

### **6.1.4 Nurse Supervision Requirements**

The PDN nurse supervisor shall have at least two years of home care experience with medically fragile beneficiaries. Additional direct clinical supervisory experience is preferred.

## **7.0 Additional Requirements**

*Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.*

### **7.1 Compliance**

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and

- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

## 7.2 Documentation Requirements

### 7.2.1 Contents of Records

The PDN service provider is responsible for maintaining complete and accurate records of all care, treatment, and interventions that fully document the beneficiary's condition, nursing interventions, and treatment provided, including, but not limited to, the following:

- a. The date and time the skilled care was provided;
- b. All nursing interventions, to include time, activity, and beneficiary's response;
- c. Certification that all care was provided according to the attending physician's orders, the beneficiary's current individualized plan of care, and DMA approval;
- d. Signature of beneficiary or caregiver acknowledging time spent and services rendered. This signature shall be obtained daily;
- e. Hourly Nursing Review Criteria (HNRC) (Refer to **Attachment H**).
- f. Indicate place of service, if other than residence (such as school, outings, travel to medical appointments);
- g. Use of medical supplies to support quantities delivered and used;
- h. Document to whom report was given and received from;
- i. indicate present and available caregivers;
- j. Document of caregiver education, competency and learning needs and progress toward teaching goals;
- k. Document safety issues and appropriate interventions;
- l. Coordination with other homecare services to ensure no duplication of services;
- m. Document other in home services such as Respiratory Therapy, Therapy Services, Habilitation Aides, etc.;
- n. Document a medical update (including face-to-face encounter with physician/NPP) and submit to DMA or its designee with each reauthorization; and
- o. Document supervisory visits according to agency policy and licensure rules.

**Note:** The PDN service provider shall furnish any documentation of care, treatment, and interventions requested by DMA, in accordance with the current beneficiary notices procedure.

### 7.2.2 Termination of Operations

If an agency ceases operation, DMA shall be notified in writing where the records will be stored.

## 7.3 Verification of Eligibility

The PDN service provider is required to verify the beneficiary's eligibility, Medicaid coverage category, other insurance coverage, and living arrangement before initiating services and during delivery of PDN services.

## **7.4 Qualified Family and Other Designated Caregivers**

### **7.4.1 Primary Caregiver**

The beneficiary shall have at least one trained informal primary caregiver. It is recommended that there also be a second informal caregiver for instances of primary informal caregiver unavailability due to illness or emergency and for occasional respite for the primary caregiver. Both informal caregivers shall be trained and available to provide care in the home during the absence of the PDN nurse and as required by the beneficiary's medical status.

### **7.4.2 Training**

As part of the PDN service, the PDN service provider shall provide and document training and educational needs of the beneficiary (when applicable), family members, and designated caregivers in accordance with the beneficiary's plan of care. In particular, training provided by the PDN provider and by the hospital prior to a beneficiary's beginning PDN services, should be documented.

### **7.4.3 Documenting Competency**

Family members and other designated caregivers shall demonstrate competency in providing the care that the beneficiary will require when the PDN nurse is not present. The PDN service provider is responsible for documenting to DMA those family members and other designated caregivers who have demonstrated competency in providing the care required by the beneficiary. Documentation of discharge teaching provided by a hospital may be part of documenting competency.

### **7.4.4 Emergency Plan of Action**

An emergency plan of action must be developed, and all family members and caregivers shall know the procedures to take if the beneficiary requires emergency medical care.

### **7.4.5 Evaluation of Health and Safety**

Prior to initiating services and with continuation of PDN services, the PDN service provider is responsible for evaluating the family and home environment in terms of the health, safety, and welfare of the beneficiary and PDN nursing staff, consistent with the agency's policies and licensure requirements.

## **7.5 Patient Self Determination Act**

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. Providers shall comply with these guidelines. *NCTracks Provider Claims and Billing Assistance Guide*:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

## 7.6 Marketing Prohibition

Agencies providing PDN under this Medicaid Program are prohibited from offering gifts or service related inducements of any kind to entice beneficiaries to choose it as their PDN Provider or to entice beneficiaries to change from their current provider.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** July 1, 1988

### Revision Information:

<b>Date</b>	<b>Section Revised</b>	<b>Change</b>
12/01/2012	All sections and attachment(s)	Initial promulgation of coverage from a manual.
12/01/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

## Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

**A. Claim Type**

Professional (CMS-1500/837P transaction)

**B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)**

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

**C. Code(s)**

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Code(s)	Description	Program Description
T1000	Private duty/independent nursing service(s) - licensed, up to 15 minutes Note: Supervisory visits cannot be billed.	PDN Nursing Services

**Note:** Medical supplies are billed using HCPCS supply codes as indicated on the Home Health Fee Schedule. The Home Health Fee Schedule lists the covered supplies. Refer to DMA’s Web site at <http://www.ncdhhs.gov/dma/provider/>.

**Unlisted Procedure or Service**

**CPT:** The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

**HCPCS:** The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

#### **D. Modifiers**

Provider(s) shall follow applicable modifier guidelines.

Modifiers are required for billing PDN nursing services as follows: TD for RN care and TE for LPN care.

#### **E. Billing Units**

Provider(s) shall report the appropriate procedure code(s) used which determines the billing unit(s).

1. PDN Services

PDN services are billed in 15-minute units and must not exceed the DMA authorized number of PDN units per day. The qualifications of the nurse must be specified.

2. Medical Supplies

Medical supplies are paid by item and quantity supplied and according to the Medicaid Home Health Fee Schedule. Refer to **Subsection 5.3.12.5** for coverage criteria.

#### **F. Place of service**

PDN services are provided in the beneficiary's private primary residence. Refer to **Subsection 4.2**.

#### **G. Co-payments**

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at

<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at

[http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter\\_108A/GS\\_108A-70.21.html](http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html)

#### **H. Reimbursement**

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

PDN providers shall bill their usual and customary charges.

Reimbursement is based on the DMA Home Health and Private Duty Maximum Rate Schedule available at: <http://www.ncdhhs.gov/dma/fee/>

#### **I. The Program Integrity**

The Program Integrity Section of DMA will investigate PDN services provided without authorization.

#### **J. Unit Limitations**

The following limits apply:

1. Billed time cannot exceed the number of units per week authorized by DMA.

## Attachment B: Sample Home Health Certification and Plan of Care Form (CMS-485)

This form is available on DMA's Web site at:  
<http://www.ncdhhs.gov/dma/provider/forms.htm>

Department of Health and Human Services Centers for Medicare & Medicaid Services		Form Approved OMB No. 0938-0357			
HOME HEALTH CERTIFICATION AND PLAN OF CARE					
1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: _____ To: _____	4. Medical Record No.	5. Provider No.	
6. Patient's Name and Address			7. Provider's Name, Address and Telephone Number		
8. Date of Birth		9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged		
11. ICD-9-CM	Principal Diagnosis	Date			
12. ICD-9-CM	Surgical Procedure	Date			
13. ICD-9-CM	Other Pertinent Diagnoses	Date			
14. DME and Supplies			15. Safety Measures:		
16. Nutritional Req.			17. Allergies:		
18.A. Functional Limitations			18.B. Activities Permitted		
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair
2 <input type="checkbox"/> Bowel/Bladder (Incontinence)	6 <input type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker
3 <input type="checkbox"/> Contracture	7 <input type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	3 <input type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		4 <input type="checkbox"/> Transfer Bed/Chair	9 <input type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)
			5 <input type="checkbox"/> Exercises Prescribed		
19. Mental Status:			5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated	
	1 <input type="checkbox"/> Oriented	3 <input type="checkbox"/> Forgetful	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other	
	2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed			
20. Prognosis:			3 <input type="checkbox"/> Fair	4 <input type="checkbox"/> Good	5 <input type="checkbox"/> Excellent
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)					
22. Goals/Rehabilitation Potential/Discharge Plans					
23. Nurse's Signature and Date of Verbal SOC Where Applicable:			25. Date HHA Received Signed POT		
24. Physician's Name and Address			26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized the services on this plan of care and will periodically review the plan.		
27. Attending Physician's Signature and Date Signed			28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.		
Form CMS-485 (C-3) (02-94) (Formerly HCFA-485) (Print Aligned)					

## Attachment C: Physician's Request Form for Private Duty Nursing

This form is available on DMA's Web site at:

<http://www.ncdhhs.gov/dma/provider/forms.htm>.

### PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

Requested SOC date: \_\_\_\_\_ \*Complete form within 15 business days of the start of care date and submit to NC DMA.

Name \_\_\_\_\_ Medicaid ID# \_\_\_\_\_

Address \_\_\_\_\_

Telephone Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Diagnosis \_\_\_\_\_

Prognosis and expectations of specific disease process \_\_\_\_\_

Date of last physician assessment: \_\_\_\_\_

Services requested & why \_\_\_\_\_

Date & name of next MD appointment: \_\_\_\_\_

Approximate length of time services required: Weeks/Months. Specify length of time \_\_\_\_\_

Informal Caregivers availability/Training received: \_\_\_\_\_

#### TECHNOLOGY REQUIREMENTS & NURSING CARE NEEDS

1. Ventilator dependent: \_\_\_\_\_ YES \_\_\_\_\_ NO Type: \_\_\_\_\_

Hours per day on ventilator \_\_\_\_\_

2. Oxygen: \_\_\_\_\_ YES \_\_\_\_\_ NO Actual liters per minute and hours per day required \_\_\_\_\_

Continuous prescribed rate \_\_\_\_\_ or adjusted daily/ more often. \_\_\_\_\_

Maintain Sats > \_\_\_\_\_ % Frequent need for adjustments and interventions: \_\_\_\_\_

3. Non-ventilator dependent tracheostomy \_\_\_\_\_ YES \_\_\_\_\_ NO Actual Frequency of Suctioning and results: \_\_\_\_\_

4. Enteral (Tube) feedings: Sole source of nutrition \_\_\_\_\_ YES \_\_\_\_\_ NO

Type of nutrition/frequency/Method of receiving: \_\_\_\_\_

5. Licensed Skilled Nursing interventions and frequency: \_\_\_\_\_

6. Medical History: note functional/communication limitations/incontinence: \_\_\_\_\_

7. Family/Home Dynamics that impact the licensed skilled nursing requirements: \_\_\_\_\_

8. What Community Based resources have been utilized to assist the above recipient? \_\_\_\_\_

"I am in agreement that the individual is medically stable except for acute episodes that Private Duty Nursing can manage in the home setting."

Print Physician's name \_\_\_\_\_

Print Physicians Address & phone number \_\_\_\_\_

Physician's Signature \_\_\_\_\_ DATE \_\_\_\_\_

DMA-3075 9/2008

## Attachment D: PDN Prior Approval Referral Form (DMA-3061)

This form is available on DMA's Web site at:

<http://www.ncdhhs.gov/dma/provider/forms.htm>.

### PRIVATE DUTY NURSING (PDN) INITIAL REQUEST PRIOR APPROVAL REFERRAL FORM

N.C. Division of Medical Assistance Home and Community Care Section, HCI Unit  
2501 Mail Service Center Raleigh, North Carolina 27699-2502  
PHONE: (919) 855-4393 FAX: (919) 715-2859

For initial PDN requests, submit either a) this form along with a DMA 3075 or  
b) a physician's letter of medical necessity.

#### PATIENT INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_  
MID # \_\_\_\_\_ Medicare # \_\_\_\_\_  
Birthdate \_\_\_\_\_ Sex \_\_\_\_\_

#### RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_  
CAREGIVER INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Numbers work \_\_\_\_\_ home \_\_\_\_\_  
Relationship to Recipient \_\_\_\_\_  
Hours/Day Available to Care for Recipient \_\_\_\_\_

#### PHYSICIAN INFORMATION

Community Attending's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Names and Phone Numbers of Other Physicians Ordering Care \_\_\_\_\_

#### NURSING AGENCY INFORMATION

PDN Agency \_\_\_\_\_  
Address \_\_\_\_\_  
Nursing Contact Person \_\_\_\_\_  
Contact's Phone Number \_\_\_\_\_  
PDN Provider Number 7100 \_\_\_\_\_

#### INSURANCE INFORMATION

Insurer's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Contact Person & Phone Number \_\_\_\_\_  
Policy or ID Number \_\_\_\_\_  
Amount of PDN Covered by Insurance \_\_\_\_\_

#### MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN \_\_\_\_\_

Primary nursing interventions and the frequency with which these are performed at home \_\_\_\_\_

Requested SOC Date: \_\_\_\_\_ Anticipated Hospital Discharge Date: \_\_\_\_\_  
Physician Orders for Daily Hours and Weeks' Duration \_\_\_\_\_

Decrease Hours \_\_\_\_\_  
Referred by Name/Agency \_\_\_\_\_  
Phone Number \_\_\_\_\_

### Attachment E: PDN Medical Update/Beneficiary Information Form

North Carolina Division of Medical Assistance Private Duty Nursing—Medical Update/Recipient Information Form	
Recipient Name:	Medicaid Identification Number:
Name of Provider Agency:	PDN Provider Number:
Does the recipient have insurance in addition to Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is PDN covered by PRIVATE INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, explain coverage	
Date of Last Approval Period:	
Current Attending Physician:	
Updated Information—please include summary of nursing documentation for the last certification period (do NOT copy form 485):	
_____	
_____	
_____	
_____	
_____	
Date of last weight (adults) or height & weight (pediatric recipients): _____	
Date of last examination by MD & Name of MD: _____	
Changes in recipient's condition: _____	
_____	
Home visit observations, safety of environment, and caregiver information: _____	
_____	
Critical incidents with the recipient (hospitalizations, falls, infections, etc.): _____	
_____	
Therapies recipient is receiving (such as PT, OT, ST, RT, etc.): _____	
_____	
Emergency plan of care if nurse is not available: _____	
_____	
Training needs: _____	
Education provided, return demonstrations, and identification of ongoing needs: _____	
_____	
_____	
Nurse Signature and Title: _____ Date: _____	
DMA-3062 (04/08)	

**Attachment F: Medical Update and Patient Information Form (HCFA-486)**

This form is available on DMA's Website at <http://www.ncdhhs.gov/dma/provider/forms.htm>

Department Of Health and Human Services Health Care Financing Administration		Form Approved CMB No. 0938-0357		
MEDICAL UPDATE AND PATIENT INFORMATION				
1. Patient's HI Claim No.	2. SOC Date	3. Certification Period From: To:		4. Medical Record No.
6. Patient's Name and Address			5. Provider No.	
8. Medicare Covered: <input type="checkbox"/> Y <input type="checkbox"/> N			7. Provider's Name	
9. Date Physician Last Saw Patient:		10. Date Last Contacted Physician:		
11. Is the Patient Receiving Care in an 1861 (J)(1) Skilled Nursing Facility or Equivalent?: <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Do Not Know		12. <input type="checkbox"/> Certification <input type="checkbox"/> Recertification <input type="checkbox"/> Modified		
13. Dates of Last Inpatient Stay: Admission Discharge		14. Type of Facility:		
Updated Information: New Orders/Treatment/Clinical Facts/Summary from Each Discipline:				
16. Functional Limitations (Expand Form 485 and Level of ADL) Reason Homebound/Prior Functional Status				
17. Supplementary Plan of Care of File from Physician Other than Referring Physician: <input type="checkbox"/> Y <input type="checkbox"/> N (If Yes, Please Specify Giving Goals/Rehab. Potential/Discharge Plan)				
18. Unusual Home/Social Environment				
19. Indicate Any Time When the Home Health Agency Made a Visit And Patient was Not Home and Reason Why if Ascertainable			20. Specify Any Known Medical and/or Non-Medical Reasons the Patient Regularly Leaves Home and Frequency of Occurrence	
21. Nurse or Therapist Completing or Reviewing Form			Date (Mo., Day, Yr.)	
<b>PROVIDER</b>				
Form HCFA-486 (C3) (02-94)				

Attachment G: Verification of Employment Form

This form is available on DMA's Website: at: <http://www.ncdhhs.gov/dma/provider/forms.htm>

VERIFICATION OF EMPLOYMENT

Beneficiary's Name: \_\_\_\_\_

Beneficiary's Medicaid ID Number \_\_\_\_\_

Caregiver Name \_\_\_\_\_

This form is to be used only when verification of employment by the employer is unavailable.

- A.  I am self-employed.  
 I am an independent contractor.  
 I am an employee of \_\_\_\_\_.

B. I work as a \_\_\_\_\_.

- C.  I do most of my work outside the home.  
 I do most of my work at my home.

- D. If I do most of my work at my home,  
 I have a separate, dedicated work space in my home.  
 I do not have a separate, dedicated work space in my home.

- E. If I do most of my work at my home,  
 I can arrange my hours, interrupt my work, or be otherwise available for care if needed.  
 I can not be available for care; I would need to hire a caregiver to supplement the hours that PDN could not provide

F. My typical work hours are (do not include on-call hours):  
Monday \_\_\_\_\_ Thursday \_\_\_\_\_ Saturday \_\_\_\_\_  
Tuesday \_\_\_\_\_ Friday \_\_\_\_\_ Sunday \_\_\_\_\_  
Wednesday \_\_\_\_\_

- G. My typical work schedule:  
 never or rarely varies.  
 varies sometimes.  
 varies a lot.

- H. My typical work hours are:  
 very flexible.  
 somewhat flexible.  
 not flexible.

I. Please elaborate on any of the above or include any additional relevant information on the back of this form.

**An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate professional licensing agency for investigation.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Attachment H: Hourly Nursing Review Criteria

This form is available on DMA's Web site at: <http://www.ncdhhs.gov/dma/provider/forms.htm>

### Hourly Nursing Review Criteria N.C. Division of Medical Assistance/Private Duty Nursing

This document should be completed by the Registered Nurse for PDN recipients and submitted along with requests for authorizations to  
Division of Medical Assistance  
Facility and Community Care  
Home Care Initiatives Unit, Attn: PDN  
2501 Mail Service Center  
Raleigh NC 27699-2501  
Fax: 919 715 2859 Phone: 919 855 4380

<b>Recipient Name</b>		<b>Recipient MID #</b>	
<b>Primary Diagnosis</b>		<b>Admit Date</b>	<b>DOB</b>
<b>Height</b>		<b>Weight</b>	
<b>TECHNOLOGY NEEDS</b>			
Points in the technology section reflect the risk of death or disability if the technology is lost, as well as the degree of licensed skilled nursing assessment/judgment necessary and interventions to perform the task.			
<b>Check and circle the appropriate intervention/points and total at the bottom.</b>			
<b>Ventilator with tracheostomy</b>	<input type="checkbox"/> Intervention QH <input type="checkbox"/> Intervention Q2-4H <input type="checkbox"/> Intervention less than Q4H <input type="checkbox"/> monitoring	24 hours per day <b>60</b>	Less than 24 hours per day <b>60</b>
<b>Tracheostomy only, no ventilator</b>	<input type="checkbox"/> Intervention QH <input type="checkbox"/> Intervention Q2-4H <input type="checkbox"/> Intervention less than Q4H <input type="checkbox"/> monitoring	Continuous <b>50</b>	Passy-Muir/cap for at least part of day <b>40</b>
<b>CPAP/BIPAP, no tracheostomy</b>	<input type="checkbox"/> Intervention QH <input type="checkbox"/> Intervention Q2-4H <input type="checkbox"/> Intervention less than Q4H <input type="checkbox"/> monitoring	24 hours per day <b>40</b>	Less than 24 hours per day <b>35</b>
<b>Oxygen</b>	<input type="checkbox"/> Intervention QH <input type="checkbox"/> Intervention Q2-4H <input type="checkbox"/> Intervention less than Q4H <input type="checkbox"/> monitoring	Daily desaturations requiring nursing assessment and intervention <b>20</b>	Routine and predictable oxygen use <b>10</b>
		<b>TOTAL POINTS =</b>	
<b>Hospitalizations</b>	<input type="checkbox"/> Greater than three hospitalizations within the last year <input type="checkbox"/> At least one extended (> 2 months) hospitalization within the last year	Related to primary diagnosis	Unrelated to primary diagnosis

<b>SKILLED INTERVENTIONS</b>				
If the recipient needs assistance all or part of the time with an activity listed below, <b>circle</b> the frequency at which the caregiver needs to perform the task. The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient has an acute respiratory infection and requires more frequent suctioning, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill. The recipient's nursing documentation, including the nurses' notes, nursing supervisor's reports, and any home documentation must support the frequency chosen.				
<b>Circle the appropriate frequency for each task.</b>				
<b>Endotracheal suctioning</b> <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent	≥ QH	Q 2-4 hrs	Q 5-8 H	< Q8H
<b>Naso-opharyngeal suctioning</b> suctioning of the nose, mouth, or upper throat with a bulb syringe, yankauer, or suction catheter; does not include endotracheal suctioning	≥ QH	Q 2-4 hrs	Q 5-8 H	< Q8H
<b>Sterile dressing, not tracheostomy site</b> central line care/wound vac	≥ QID	TID	BID	≤ Daily
<b>Nonsterile dressing/site care, not feeding tube site</b>	≥ QID	TID	BID	≤ Daily
<b>Intake and output, specialized intervention</b> intake and output which requires intervention; i.e., the nurse has to make adjustments to feedings or IV fluids based on the intake and output data.	≥ QID intervention	TID intervention	BID intervention	≤ daily intervention
<b>Intravenous:</b> IV fluids, flushes, medications, or hyperalimentation (TPN)	≥ QID	TID	BID	≤ Daily, or continuous

Hourly Nursing Review Criteria—continued

Recipient Name		MID #			
<b>Intermittent catheterization</b>		Spot checks frequency & reason	Continuous during sleeping or eating only	Continuous always	PRN only
<b>Pulse oximetry , CO<sub>2</sub> levels, nebulizers, chest PT, blood sugars</b> Include treatments that are done on a routine basis, whether standing or PRN. If the treatments are done together—for example, nebulizer treatments (QID) followed by chest physiotherapy (BID)—choose the frequency of the one done most often (choose QID). If the treatments are not done together—such as chest physiotherapy (BID) and specialized ostomy care (TID)—select the total frequency (five times per day).		≥QID	TID	BID	≤ Daily, or continuous
<b>Medication</b> excluding nebulizer treatments, IV medication, PRN seizure medication, and oxygen  <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent	Complex More than 3 medications, which are PRN or require dosage adjustment or administration by a licensed nurse, actually administered during an 8-hour period	Moderate 1-3 medications, which are PRN or require dosage adjustment or administration by a licensed nurse, actually administered during an 8-hour period	Simple Scheduled, routine medications without dosage adjustments, regardless of the number of medications		
<b>Seizure Activity</b>	PRN use of medication or oxygen during acute seizures, actually administered at least monthly	PRN medication or oxygen for acute seizures, actually administered less than once per month	Safety/monitoring for acute seizures, swiping of VNS magnet during acute seizures		
<b>Enteral Feedings</b> <input type="checkbox"/> GT <input type="checkbox"/> JT <input type="checkbox"/> NG <input type="checkbox"/> DT <input type="checkbox"/> reflux precautions	Continuous and bolus	Bolus	Continuous (over at least 8 hours)		
<b>Elimination</b> <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent	<input type="checkbox"/> Intermittent Catheterization <input type="checkbox"/> Foley Catheter	Ostomy			

FAMILY AND HOME ENVIRONMENT	
<input type="checkbox"/> Single caregiver <input type="checkbox"/> All caregivers unavailable due to work/school <input type="checkbox"/> Disabled child has many siblings, # _____ <input type="checkbox"/> Unsafe physical environment	<input type="checkbox"/> Caregiver health issues <input type="checkbox"/> Caregiver responsible for another disabled person in the home <input type="checkbox"/> Recipient/caregiver is not legal guardian
Please describe the items checked above and /or any other considerations not listed above.	

- Current physician's order
- Primary & backup caregivers identified and trained
- If caregivers work, employment verification on file

SIGNATURE AND TITLE OF PERSON COMPLETING FORM
This certifies that the signer, and no one else, has completed the above assessment of the recipient's condition. An individual who certifies a material and false statement will be subject to investigation for Medicaid fraud, and, if applicable, will be referred to the appropriate licensing agency for investigation.
Signature/Title _____
Nurse Supervisor/Director of Nursing Services
Date Completed _____