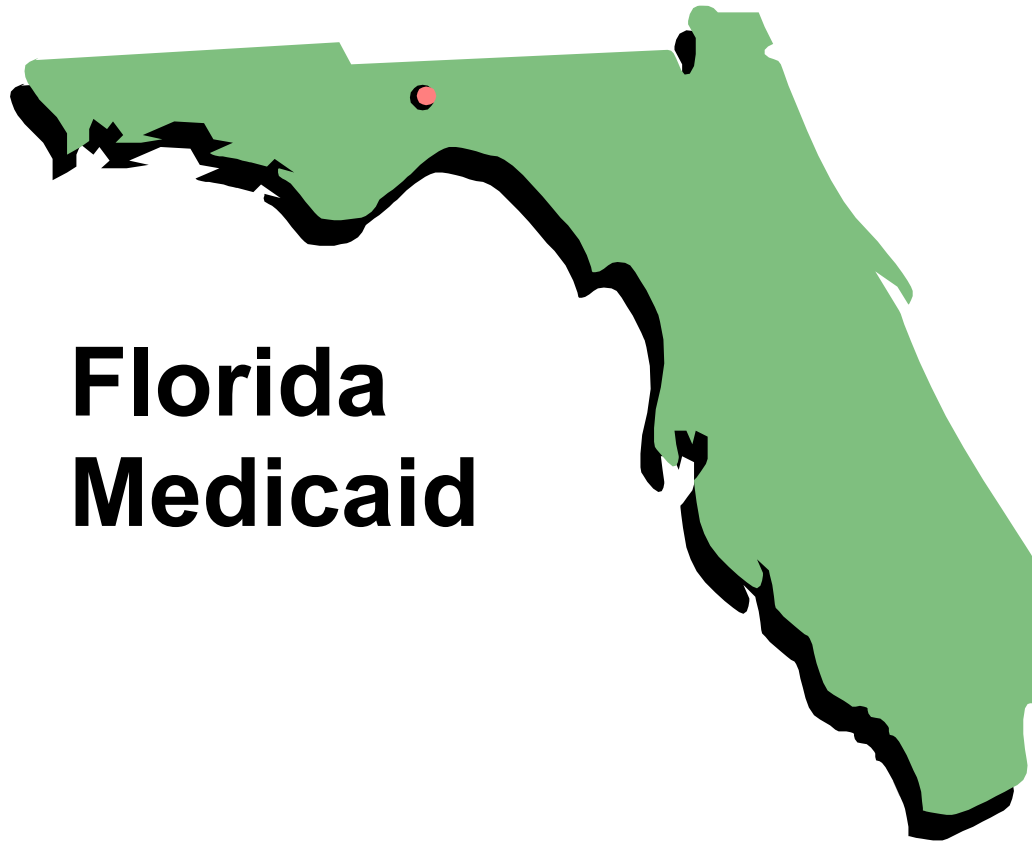




**Private Duty Nursing and Family Home Health
Aide Services
Coverage Policy**

Agency for Health Care Administration

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1.0 Introduction

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

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render private duty nursing and family home health aide services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.4) and any applicable service-specific and claim reimbursement policies with which providers must comply.

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

1.2 Statewide Medicaid Managed Care Plans

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

1.3 Legal Authority

Private duty nursing and family home health aide services are authorized by the following:

- Section 1861 (m) of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), sections 440.60 and 440.80
- Sections 400.4765 and 409.905, Florida Statutes (F.S.)

1.4 Definitions

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

1.4.1 Babysitting

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

1.4.2 Caretaker Relative

As defined in 42 CFR 435.4.

1.4.3 Claim Reimbursement Policy

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

1.4.4 Coverage and Limitations Handbook or Coverage Policy

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

1.4.5 Family Home Health Aide or Home Health Aide for Medically Fragile Children

The term used to describe a related provider, legal guardian or caretaker relative who is employed by a home health agency to provide services to an eligible Florida Medicaid recipient.

1.4.6 General Policies

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

1.4.7 Home Health Services

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

1.4.8 Medically Necessary/Medical Necessity

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

Note: The following condition of the medical necessity definition shall not be applied when determining the medical necessity of private duty nursing and family home health aide services:

- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caregiver, or the provider

All other medical necessity criteria apply and must be met in order to receive reimbursement for Florida Medicaid.

1.4.9 Private Duty Nursing (PDN) Services

As defined in 42 CFR 440.80.

1.4.10 Provider

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

1.4.11 Recipient

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

1.4.12 Related Provider

For the purpose of this coverage policy, the term means an individual who is the aunt, brother, brother-in-law, cousin, daughter, daughter-in-law, father, father-in-law, granddaughter, grandfather, grandmother, grandson, great-grandfather, great-grandmother, half-brother, half-sister, husband, mother, mother-in-law, nephew, niece, sister, sister-in-law, son, son-in-law, stepbrother, stepdaughter, stepfather, stepmother, stepsister, stepson, uncle, or wife of the recipient.

2.0 Eligible Recipient

2.1 General Criteria

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

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

2.2 Who Can Receive

Florida Medicaid recipients under the age of 21 years requiring medically necessary PDN.

- Recipients receiving medically necessary PDN services may receive medically necessary family home health aide services.

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

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

3.0 Eligible Provider

3.1 General Criteria

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

3.2 Who Can Provide

Services must be rendered by one of the following:

- Home health agencies licensed in accordance with sections 400.464 and 408.810, F.S., and Rule Chapters 59A-8 and 59A-35, F.A.C.
- Independent registered nurses (RN) and licensed practical nurses (LPN) licensed in accordance with Chapter 464, F.S.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

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

4.2 Specific Criteria

Florida Medicaid covers up to 24 hours of PDN services per day, per recipient, in accordance with the applicable Florida Medicaid fee schedule, or as specified in this policy, when the recipient meets all of the following criteria:

- Requires more extensive and continual care than can be provided through a home health visit
- Requires services that can be safely provided in their home or the community
- Is under the care of a licensed practitioner in accordance with State law

For recipients requiring less than two hours of PDN services per day, please refer to the Florida Medicaid Home Health Visits Services Coverage Policy.

4.2.1 PDN Provided by a Related Provider, Legal Guardian or Caretaker Relative

Florida Medicaid covers an enrolled home health agency provider for up to 40 hours per week for PDN services per related provider, legal guardian, or caretaker relative, with a valid RN or LPN license in the state of Florida and who is employed by the home health agency.

4.2.2 Family Home Health Aide Services for Recipients Receiving PDN Services

Florida Medicaid covers up to 12 hours of family home health aide services per day and 40 hours per week, per recipient under the age of 21 years receiving PDN services, when the recipient is under the care of a physician and has an order for family home health aide services as outlined in section 409.905(4), F.S.

Forty hours per week per recipient may be exceeded in accordance with section 400.4765, F.S.

Family home health aide services are intended to be provided in conjunction with, but may not duplicate, PDN hours being received. Services must be overseen by a non-related provider, non-legal guardian, or non-caretaker relative RN who is employed by a home health agency and authorized to provide PDN services in accordance with this policy.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a

condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

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

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

5.2 Specific Non-Covered Criteria

Florida Medicaid does not cover the following:

- A skill level other than what is prescribed in the order for services and approved plan of care (POC)
- Babysitting
- Certification of the POC by a physician
- Family home health aide services provided by an independent RN or LPN
- Nursing assessments related to the POC
- Private duty nursing services provided by an independent RN or LPN when the provider is a related provider, legal guardian, or caretaker relative
- Private duty nursing services and family home health aide services provided by the same related provider, legal guardian, or caretaker relative
- Private duty nursing services and family home health aide services provided concurrently
- Professional development training or supervision of home health staff or other home health personnel
- Respite care to facilitate the parent or legal guardian attending to personal matters
- Services funded under section 110 of the Rehabilitation Act of 1973 or under the provisions of the Individuals with Disabilities Educational Act
- Services provided in any of the following locations:
 - Hospitals
 - Intermediate care facilities for individuals with intellectual disabilities
 - Nursing facilities
 - Prescribed pediatric extended care centers
 - Residential facilities or assisted living facilities when the services duplicate those provided by the facility
- Services rendered prior to the development and approval of the POC
- Travel time to or from the recipient's place of residence

Florida Medicaid may cover some services listed in this section through another service benefit.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria

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

- Assessments completed in accordance with 42 CFR 484.55 and 42 CFR 440.70(f)(3)-(4)
- Written orders completed in accordance with section 409.905(4), F.S.
- A POC developed in accordance with 42 CFR 484.60 and section 409.905, F.S.

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

The initial assessment and all subsequent POC recertification assessments for PDN and family home health aide services, must be completed by an RN who is employed by the home health agency provider and who is not a related provider, legal guardian, caretaker relative, or member of the recipient's household.

7.0 Authorization

7.1 General Criteria

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

7.2 Specific Criteria

Providers must obtain authorization from the Medicaid-contracted Quality Improvement Organization (QIO) at least every 180 days, or more frequently if there is a change in the recipient's condition requiring an increase or decrease in authorized services. When PDN and family home health aide services are authorized, providers must document the following:

- Cumulative hours for PDN and family home health aide services do not exceed 24 hours a day
- PDN and family home health aide services do not occur concurrently

7.2.1 Review Criteria

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

7.2.2 Review Process

The QIO assigns a care coordinator who:

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

The multidisciplinary team will develop a service plan recommending the number of PDN or PDN and family home health aide service hours.

7.2.3 Intensified Review

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

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

7.2.4 Monthly Contact

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

8.0 Reimbursement

8.1 General Criteria

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

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

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

8.3.1 Modifiers

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

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

8.4 Diagnosis Code

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

8.5 Rate

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

8.5.1 Rate Adjustment for Multiple Recipients

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

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

Medically complex and technology dependent recipients, living in group homes and sharing a dwelling space, shall be exempt from the rate adjustments for multiple recipients provided in the section.

9.0 Appendix

9.1 Review Criteria for Private Duty Nursing Services

REVIEW CRITERIA FOR PRIVATE DUTY NURSING SERVICES

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

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

1. Service Criteria for First Level Reviewers:

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

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

a. Provider assessment of:

- Home environment
- Care required in the home or community

b. Provider documentation of organ system dysfunction, including:

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

c. Endocrine system

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

d. Gastrointestinal system and nutrition

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

e. Hematologic system

- Administration of injectable anticoagulants

f. Neurologic system

- Seizure precautions and interventions
- Vagal nerve stimulator

g. Musculoskeletal system

- Cast care
- Wound care
- Decubiti and pressure ulcers

h. Respiratory system

- Tracheostomy care
- Technology-dependent child

2. Clinical Indicators for Private Duty Nursing

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

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

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

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

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

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

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