wisconsin Medicaid update
department of health and family services
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POH 1648

To:
FQHCs
HMOs and Other Managed Care Programs
Home Health Agencies
Nurse practitioners
Nurses who provide private duty nursing services

Wisconsin Medicaid revises private duty nursing prior authorization guideline

This Update clarifies the prior authorization (PA) requirements for private duty nursing (PDN). Included with this Update are copies of:

- Revised Private Duty Nursing Prior Authorization Guideline.
- Private Duty Nursing Prior Authorization Acknowledgement.
- A brochure explaining PDN suitable for agencies and independent nurses to photocopy and distribute to Medicaid recipients and their families.

The prior authorization information here applies to fee-for-service Medicaid providers only. If you are a Medicaid managed care provider, contact your managed care organization for information about their procedures. However, coverage is the same for Medicaid recipients in both fee-for-service and managed care programs.

The revised guidelines allowed for more flexibility in the use of Medicaid coverage of skilled nursing services.

Revised Prior Authorization Guideline

On October 7, 1997, Wisconsin Medicaid issued revised PA guidelines for PDN services in response to suggestions from consumers of PDN. The revised guidelines allowed for more flexibility in the use of Medicaid coverage of skilled nursing services.

Although the number of hours continued to be authorized on a daily and weekly basis, the primary change in the guidelines allowed recipients to use their authorized daily hours of PDN care flexibly over periods of time up to 8 weeks in length.

This was not a change in Medicaid policy regarding criteria for PDN eligibility or determination of authorized hours of care. Each request for PA still requires information describing the recipient's case to allow the Medicaid consultants to make informed decisions. Each request is still reviewed individually.

Additional Changes

Based on comments made by PDN recipients and their families, Medicaid PDN providers, and interested members of the Legislature and the public who reviewed the guidelines, two additional procedures were added to improve the PA process:

- The recipient for whom PDN services are requested or the recipient's parent, guardian, or legal representative will be required to sign a statement (enclosed) that they have read the PA Request and Plan of Treatment before submitting it for review.
- Wisconsin Medicaid will provide a brochure for providers to use to help them explain the PDN benefit to recipients and their families.

Private Duty Nursing Prior Authorization Acknowledgement

For all prior authorization requests submitted on and after May 1, 1999, Wisconsin Medicaid will require the recipient, or the recipient's parent, guardian, or legal representative to sign a statement verifying he/she has read the PA Request and the Plan of Treatment. This statement is included on the enclosed Private Duty Nursing Prior Authorization Acknowledgement. Providers are to photocopy the acknowledgement form for future use.

Providers are required to complete the acknowledgement form as follows:

1. Allow the recipient or member of the recipient's family to read the Plan of Treatment and PA Request and answer any questions.
2. Have the recipient or member of the recipient's family sign the acknowledgement.
3. Attach the acknowledgement form to the to PA Request or amendment (only for PDN services).
5. Send all forms to the Medicaid fiscal agent as part of the PA Request.

PDN Brochure

Included with this letter is a copy of *"Wisconsin Medicaid Private Duty Nursing—A Guide for Medicaid Recipients and their Families,"* The brochure is written for Medicaid recipients and their families. The purpose of the brochure is to help providers to explain:

- The extent and limitations of the private duty nursing benefit.
- The Medicaid prior authorization process.
- The rights and responsibilities of PDN recipients and their families.
- The remedies available to recipients and their families who are dissatisfied with Medicaid private duty nursing.

Providers are strongly encouraged to photocopy the brochure and use it for *all* recipients and their families to explain the Medicaid PDN benefit. (The brochure is intended to be folded in thirds.)

For all prior authorization requests submitted on and after May 1, 1999, Wisconsin Medicaid will require the recipient, or the recipient's parent, guardian, or legal representative to sign a statement verifying he/she has read the PA Request and the Plan of Treatment.

The Wisconsin Medicaid Update is the first source for provider information including Medicaid policy and billing information.

Wisconsin Medicaid is administered by the Division of Health Care Financing, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701-0309.

For provider questions, call the Medicaid fiscal agent at (800) 947-9627 or (608) 221-9883 or visit our web site at: www.dhfs.state.wi.us/medicaid.

WISCONSIN MEDICAID
Private Duty Nursing
Prior Authorization Acknowledgement

Recipient Name: _____

P.A. # __ __ __ __ __ __ __

I have read the attached Plan of Treatment and the Prior Authorization Request.

Signed: _____
Recipient or recipient's parent, guardian, or legal representative

Relationship: _____
If other than recipient

Date: __ __ / __ __ / __ __ __ __

Instructions to PDN Provider: Return this signed and dated statement with the Prior Authorization Request (PA/RF) or the Prior Authorization Amendment.

Questions and Answers about PDN

Is it possible to appeal a prior authorization decision?

- You may appeal a prior authorization decision by requesting a fair hearing before an independent administrative hearing officer.
- Before beginning the appeal process, you should discuss the decision with your provider to make sure that the provider submitted all the necessary information in the prior authorization request.
- If additional information or corrections are needed, the provider may submit the prior authorization request for reconsideration.

What if changes occur in your needs or the family's ability to provide care after the PDN services are approved?

- If changes occur, inform your PDN provider, who will then notify your physician and Wisconsin Medicaid.
- The Plan of Treatment can be modified and the PA Request may be amended with the approval of the Medicaid consultants.
- The Plan of Treatment must be re-evaluated and signed by your physician every 62 days, even if no changes occur.

Are there limits on how many hours of PDN care a recipient may receive?

Yes. PDN only covers the time spent by a licensed nurse performing skilled nursing tasks. If additional health care is authorized, family and PDN care may be supplemented by home health aides and personal care workers. Together, you, your family, and the PDN provider(s) should discuss how these hours will be coordinated.

Can PDN recipients use their authorized hours flexibly?

Yes. You may use your authorized PDN hours flexibly over periods of time up to eight weeks in length. If you choose flexible scheduling, the provider(s) will indicate this preference in the prior authorization request or in an amendment to the existing prior authorization.

Flexible use of PDN hours allows most recipients to accommodate changes in family schedules, unscheduled provider absences, hospitalizations, or other unforeseen needs.

What if a provider cannot meet a recipient's need for flexible hours?

If an agency or individual provider is unable to meet your needs for flexibility, you may wish to work with additional PDN providers to ensure coverage of all the PDN hours authorized. Providers should include a provision regarding flexible time in your service agreement with them.

Where can recipients get more information or voice any concerns they may have about their PDN care?

You can contact Medicaid Recipient Services by calling 1-800-362-3002 toll-free or 608-221-5720. Medicaid Recipient Services can:

- Answer questions about Medicaid coverage.
- Refer you to Medicaid-certified providers in your area.
- Refer you to state agencies that regulate the performance of home health care professionals.

Wisconsin Department of Health and Family Services
Division of Health Care Financing
POH 1122
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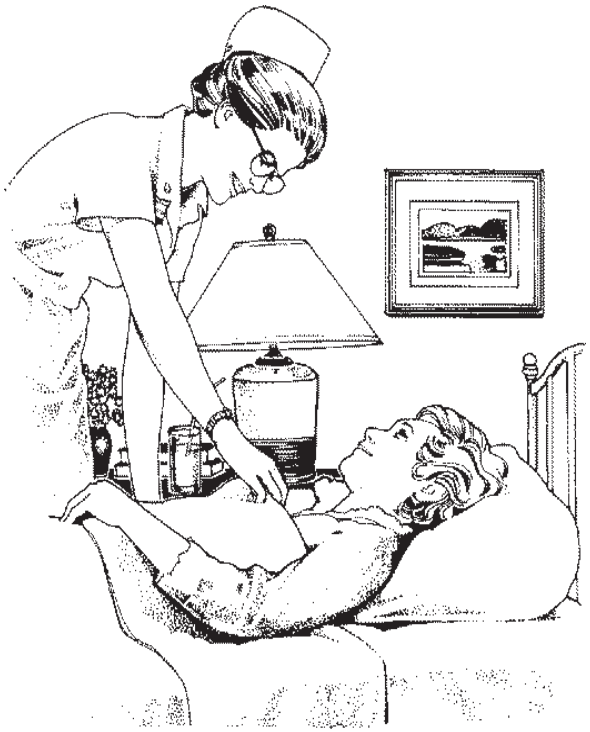
WISCONSIN MEDICAID



Private Duty Nursing

A GUIDE FOR
WISCONSIN MEDICAID RECIPIENTS AND
THEIR FAMILIES

About Wisconsin Medicaid Private Duty Nursing

Wisconsin Medicaid covers private duty nursing (PDN) for recipients with medical conditions that require eight or more hours of skilled nursing care in a 24-hour period.

- PDN supplements the care families and other health professionals are able to provide in the home.
- PDN services are generally provided in a recipient's home. However, PDN may also be provided outside the home if the recipient's normal activities, like school or work, require him/her to leave home.
- Recipients may use their authorized daily hours of PDN care flexibly over periods of time up to 8 weeks in length.
- The number of PDN hours covered daily is based on medical need and must be prior authorized by Wisconsin Medicaid medical consultants.
- Only Medicaid-certified home health agencies or independent nurses may provide Medicaid PDN.

Guiding recipients through the process

If it appears that you, the Medicaid recipient, may qualify for PDN services, the PDN provider will work with you and your physician to help you get the care you need.

If you do not require eight or more hours of skilled nursing care in a day, the PDN provider can refer you to providers of part-time intermittent skilled nursing care.

Plan of Treatment

The PDN provider will work with you and your physician to develop a Plan of Treatment, sometimes called a Plan of Care. A Plan of Treatment includes:

- A medical assessment.
- Medication and treatment orders.
- Treatment goals.
- Methods of care to be used.
- Plan for care coordination by nurses and other health professionals.

Family Support

The PDN provider will ask questions about your family support needs, including:

- Your family's ability to provide medical care.
- Daily schedules — including hours of work, school, sleep, and care for other family dependents.

Guiding recipients through the process *(cont.)*

Request for Prior Authorization

Based on the Plan of Treatment and the family support information, the provider will:

- Prepare a written prior authorization request.
- Obtain a signed statement from you or a responsible family member saying that you or he/she has read both the Plan of Treatment and the Prior Authorization Request.
- Submit the Prior Authorization Request and the Plan of Treatment to the Medicaid medical consultants who will review the request.

Approval of PDN

Medicaid medical consultants will review a request for prior authorization of PDN services within two weeks after it is received.

- If the information is not complete, the Prior Authorization Request will be returned to the provider.
- If the information is complete, the request will be approved, modified, or denied.
- If the request is modified or denied, you will receive a letter explaining the reason for the decision and what further steps you may take.

CATEGORY OF SERVICE	PROVIDER TYPE(S) AFFECTED	GUIDELINE EFFECTIVE DATE
Private Duty Nursing	24, 33, 44, 45	Revised: 05/01/99 Revised: 07/14/97 Revised: 08/01/94 Revised: 01/92

PROCEDURE/SERVICE

Private Duty Nursing (LPN)/Ventilator Dependent	W9041* (TOS 1)
Private Duty Nursing (RN)/Ventilator Dependent	W9042* (TOS 1)
Private Duty Nursing (LPN)	W9045 (TOS 1)
Private Duty Nursing (RN)	W9046 (TOS 1)
Private Duty Nursing (LPN) (Provider Type 44 only)	W9030 (TOS 1)
Private Duty Nursing (RN) (Provider Type 44 only)	W9031 (TOS 1)

*W9041 and W9042 are also subject to the prior authorization guidelines for respiratory care services.

ADMINISTRATIVE RULES

1. The rule provisions from the following citations must be considered in adjudicating every PA request received:

   Wisconsin Administrative Code HFS 107.02(3)(a) through (i) provides the Department with authority to require PA for covered services, procedures for PA documentation, and Departmental review criteria used to authorize coverage and reimbursement.

   In addition, Wisconsin Administrative Code HFS 106.02(9)(a) through (g) requires providers to prepare and maintain medical and financial record keeping and documentation for all services provided recipients, and to provide such record keeping and documentation as requested by the Department in order to determine Wisconsin Medicaid coverage and reimbursement.

   Effective Date: 06/95 **Reference:** HFS 107.02
HFS 106.02

2. Prior authorization is required for all private duty nursing (PDN) services.

   Effective Date: 06/95 **Reference:** HFS 107.12

3. Private duty nursing is skilled nursing provided for recipients with medical conditions requiring more continuous skilled care than can be provided on a part-time, intermittent basis. Only a recipient who requires 8 or more hours of skilled nursing care in a 24-hour period is authorized to receive these services in the home setting or may make use of the approved hours outside of that setting during those hours when normal life activities take him or her outside of that setting. PDN may be provided according to the requirements under ss. HFS 105.16 and 105.19 when the written plan of care specifies the medical necessity for this type of service.

PDN services provided by a certified registered nurse (RN) in independent practice are those services prescribed by a physician which comprise the practice of professional nursing as described under s. 441.11 (3), Stats., and s. N 6.03. PDN services provided by a certified licensed practical nurse (LPN) are those services which comprise the practice of practical nursing under s. 441.11 (4), Stats., and s. N 6.04.

An LPN may provide PDN services delegated by a RN as delegated nursing acts under the requirements of ch. N 6 and guidelines established by the state board of nursing.

Services may be provided only when prescribed by a physician and the prescription calls for a level of care which the nurse is licensed and competent to provide.

Effective Date: 05/95 **Reference:** HFS 107.12

4. Patient rights. A nurse shall provide a written statement of the rights of the recipient for whom services are provided to the recipient or guardian or any interested party prior to the provision of services. The recipient or guardian shall acknowledge receipt of the statement in writing. The nurse shall promote and protect the exercise of these rights and keep written documentation of compliance with this subsection. Each recipient receiving care shall have the following rights:

   a. To be fully informed of all rules and regulations affecting the recipient;

   b. To be fully informed of services to be provided by the nurse and of related charges, including any charges for services for which the recipient may be responsible;

   c. To be fully informed of one's own health condition, unless medically contraindicated, and to be afforded the opportunity to participate in the planning of services, including referral to a health care institution or other agency;

   d. To refuse treatment to the extent permitted by law and to be informed of the medical consequences of that refusal;

   e. To confidential treatment of personal and medical records and to approve or refuse their release to any individual, except in the case of transfer to a health care facility;

   f. To be taught, and have the family or other persons living with the recipient taught, the treatment required, so that the recipient can, to the extent possible, help himself or herself, and the family or other party designated by the recipient can understand and help the recipient;

   g. To have one's property treated with respect; and

   h. To complain about care that was provided or not provided, and to seek resolution of the complaint without fear of recrimination.

Effective Date: 05/95 **Reference:** HFS 105.16(10)(b)

5. Physician's prescription. Services may be provided only when prescribed by a physician and the prescription calls for a level of care which the nurse is licensed and competent to provide.

Effective Date: 07/97 **Reference:** HSF 107.12 (1)(c)

6. Plan of Care (POC). For purposes of ss. HFS 105.16, 105.19, 107.11, 107.113 and 107.12, a written plan of care for a recipient must be prescribed and periodically reviewed by a physician and developed in consultation with the agency staff which covers:

   a. All pertinent diagnoses;

   b. Mental status;

   c. Type of services and equipment required;

   d. Frequency of visits;

   e. Prognosis;

   f. Rehabilitation potential;

   g. Functional limitations;

   h. Activities permitted;

   i. Nutritional requirements;

   j. Medications and treatments;

   k. Any safety measures to protect against injury;

   l. Instructions for timely discharge or referral; and

   m. Any other appropriate items.

   If a physician refers a patient under a POC that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

   Effective Date: 06/95 **Reference:** HFS 101.03 (124m)

7. Medically necessary. A medical assistance service under ch. HFS 107 that:

   a. Is required to prevent, identify or treat a recipient's illness, injury or disability; and

   b. Meets the following criteria:

(1) Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

(2) Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

(3) Is appropriate with regard to generally accepted standards of medical practice;

(4) Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

(5) Is of proven medical value or usefulness and, consistent with s. HFS 107.035, is not experimental in nature;

(6) Is not duplicative with respect to other services being provided to the recipient;

(7) Is not solely for the convenience of the recipient, the recipient's family or a provider;

(8) With respect to PA of a service and to other prospective coverage determinations made by the Department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

(9) Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Effective Date: 06/95 **Reference:** HFS 101.03 (96m)

8. "Department review criteria." In determining whether to approve or disapprove a request for prior authorization, the department shall consider:

a. The medical necessity of the service;

b. The appropriateness of the service;

c. The cost of the service;

d. The frequency of furnishing the service;

e. The quality and timeliness of the service;

f. The extent to which less expensive alternative services are available;

g. The effective and appropriate use of available services;

h. The misutilization practices of providers and recipients;

i. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines;

j. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;

k. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and

l. The professional acceptability of unproven or experimental care as determined by consultants to the Department.

Effective Date: 07/97 **Reference:** HSF 107.02 (3)(e)

CONSIDERATIONS/DISPOSITION OF PA REQUEST

Special Consideration

1. All requests must be referred by the fiscal agent to the Division of Health Care Financing nurse and physician consultants for review.

2. Physician's prescription:

   a. All requests must be accompanied by a physician's prescription or physician's POC, signed and dated within three months of receipt by the fiscal agent.

   b. If a physician's prescription for "PRN visits/hours" does not state the number of hours prescribed, the request will be returned to the provider.

   c. If the provider is requesting backdating, the physician's prescription must apply to dates of service requested.

3. The written POC must indicate the diagnosis, specific medical orders, specific services required, and the intensity and duration of services to be provided.

4. If the information on the request does not clearly portray the recipient's clinical picture, return the request for further documentation.

5. If the request for PA does not include a statement, signed by the recipient or the recipient's guardian, that says the signer has read the Plan of Treatment and the Prior Authorization Request or the Prior Authorization Amendment Request, return the request to the provider for completion.

6. PDN cases that meet the criteria to enroll in the voluntary Health Care Connections (HCC) case management program should be informed of the opportunity to permit recipient and caregiver optimum coordination and quality of care.

7 If two or more providers are sharing a case, this information must be included on the PA/RF, e.g., "We are sharing this case with ACME agency."

8. Amendments:

   a. When a request for amendment is received and is incomplete, return the request to the provider, attaching a Prior Authorization Request Form (PA/RF) Amendment Instruction Sheet and the Amendment Information Form, noting the omitted/erroneous item(s).

   b. In the event that unexpected circumstances require additional PDN hours, PA amendments allowing extended care may be backdated up to two weeks, (e.g. illness of primary care giver requires additional hours of PDN coverage that cannot be addressed solely with flexibility).

   c. In the event that the recipient's condition improves to the point that fewer hours of PDN coverage are appropriate, the provider must submit an amendment reflecting that reduced need.

9. If the provider is requesting that an authorization be backdated, rationale for backdating must be included in the request (PA/RF form). Backdating is allowed on the initial PA request only under limited circumstances.

10. If the request is for PDN services for a nursing home or inpatient hospital recipient, return the request for clarification of start date for care and plan of care.

11. If the request is received more than 8 weeks prior to the requested grant date, return the request to the provider for clarification.

12. If a visit is not rounded to the nearest 1/2 hour increment on the request, return the request to the provider for correction.

13. An independent PDN may provide no more than 12 hours care in a 24 hour period, nor more than 60 hours care in a calendar week, all Medicaid recipients combined.

Approval Criteria

1. The request must include a diagnosis and associated ICD-9-CM code.

2. The services requested must be skilled nursing care.

3. A request for LPN services must indicate a supervising RN or physician.

4. The recipient does not have to be confined to the residence to receive PDN service. Services may be provided outside the place of residence, i.e., school, medical appointments, other.

5. The service(s) requested must be equal to or less than that prescribed by the physician. If the services requested are less than the hours prescribed, the POC must indicate who will provide the balance of care.

6. One POC must be used for the recipient for each provider type, regardless of the number of providers.

7. The request must indicate the extent to which family/caregivers are capable (physically, emotionally, intellectually) of providing medical cares and that the provider is helping recipients and their families assume greater responsibilities for care by providing instruction, counseling and guidance.

8. The PA must be adjudicated consistent with the following Departmental review criteria as set forth in the administrative rules quoted above:

    a. The medical necessity of the service;

    b. The appropriateness of the service;

    c. The cost of the service;

    d. The frequency of furnishing the service;

    e. The quality and timeliness of the service;

    f. The extent to which less expensive alternative services are available;

    g. The effective and appropriate use of available services;

    h. The misutilization practices of providers and recipients;

    i. The limitations imposed by pertinent federal or state statutes, rules, regulations or interpretations, including Medicare, or private insurance guidelines;

    j. The need to ensure that there is closer professional scrutiny for care which is of unacceptable quality;

    k. The flagrant or continuing disregard of established state and federal policies, standards, fees or procedures; and

    l. The professional acceptability of unproven or experimental care as determined by consultants to the Department.

Denial Criteria

1. The request does not meet one or more of the Approval Criteria.

2. The requested care does not require a skilled nurse.

3. The recipient resides in a hospital or nursing home.

Disposition

1. All PA dispositions must respect the singular characteristics of the in-home circumstances as well as be reasonable, logical, consistent and predictable.

2. The number of hours of PDN care allowed is determined by the type, character, timing and intensity of medically necessary and appropriate skilled services, the stability and predictability of the recipients clinical course and the availability/capability of the family/caregivers.

3. The number of daily hours authorized should reflect the daily care needs of the recipient. Recipients may use the authorized hours flexibly over an 8-week period.

4. If the request states that care will be performed by either RN or LPN, grant the identical quantity for each to allow the agency to bill for either RN or LPN, or both, and write on PA request "not to exceed _____ hours" (total number of services allowed for RN or LPN).

5. To determine the hours of PDN care for children, consider the extent to which family/caregivers are capable of providing medical cares:

    a. 24 hours/day PDN care is permitted in the following circumstances:

        (1) Short-term, after institutional discharge or after in-home exacerbations with significant changes, to allow time to teach family/caregivers and to stabilize child and develop routine care techniques.

        (2) Short-term, if single family/caregiver is hospitalized or if one family/caregiver is hospitalized and the other is not capable of providing any cares. 24 hours/ day PDN can fill gap until other caregivers can be taught cares, or until usual family/caregiver can resume them.

        (3) If family/caregivers are not capable of providing any needed cares.

    b. Cover family/caregiver work-time:

        (1) If family/caregiver works at home, medically necessary PDN/services depend on several factors, including the amount of care and direct monitoring the child needs, the location of family/caregiver work, etc.

        (2) If family/caregiver works outside the home, a reasonable number of hours of PDN should be allowed to account for family/caregiver absence from cares for work and commuting to work.

    c. Cover family/caregiver sleep time if overnight PDN is medically necessary:

(1) PDN may be covered for the night shift so that the family/caregiver can sleep.

(2) Sleep time may be during the day if family/caregiver works nights. An overall schedule of child's school time, family/caregiver work schedule and other pertinent information is considered in determining the required hours of PDN care.

d. Cover time for family or other similar responsibilities of family/caregiver.

e. Cover child's school hours when it is medically necessary for PDN to accompany child to school:

(1) In many cases, the child meets Medicaid's eligibility criteria for PDN, but is cared for at school by nurses' aides or laypersons, with a school RN available as needed. Some other PDN-eligible children do not attend school due to risk of infections. But many have the PDN accompany them to school.

6. If the request meets the Approval Criteria #1-8, approval can be granted up to, but not to exceed, 12 months.

7. If the request meets any of the Denial Criteria, the request will be denied, with documentation of the reason for denial on the request form.

8. If the number of hours requested must be reduced to meet the Approval Criteria, the Nurse Consultant will modify the PA and inform the provider. The provider should notify the recipient or family/caregiver of that reduction. (Recipient will also receive notice from the Department of the reduction and of their appeal rights.)

9. If the provider agrees to modify the request by reducing the number of hours, the provider must inform the recipient or family/caregiver of that change prior to the submission of the request. The provider is also required to document that communication.