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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV GENERAL INFORMATION AND COVERED SERVICES

FREEDOM OF CHOICE

Medicaid eligible individuals are federally required to be offered the choice of service provider(s). Freedom of choice must be documented in the individual file of the recipient.

In addition to their freedom of choice of service providers, recipients have a choice regarding where services are offered. Those choices consist of either the home or institutional setting.

GENERAL INFORMATION

This chapter describes the Technology Assisted Waiver services available under the Commonwealth of Virginia's *State Plan for Medical Assistance* (Medicaid). Technology Assisted Waiver services are provided in accordance with the requirements of 12VAC30-80-90; 12VAC30-120-90; and 12VAC30-120-110 and are available to all categorically and medically needy individuals determined to be eligible for assistance. Technology Assisted Waiver services under Virginia Medicaid must not be of any less or greater duration, scope, or quality than that provided recipients not receiving state and/or federal assistance for those services covered by Virginia Medicaid.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management Program that enables Medicaid recipients to select their personal Primary Care Physicians (PCPs) who are responsible for providing and/or coordinating the services necessary to meet all of the recipient's health care needs. MEDALLION promotes the physician/patient relationship, preventive care and patient education while reducing the inappropriate use of medical services. The PCP serves as a care coordinator for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. Please refer to the MEDALLION section of this manual for further details on the program.

MEDALLION II

In areas where the Medallion II program is available, many Medicaid recipients receive primary and acute care through mandatory enrollment in managed care organizations

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(MCOs). You will be able to identify recipients enrolled in a Medallion II MCO by their MCO Member Identification Card or by using the various Medicaid eligibility verification systems. Medicaid recipients enrolled in the traditional Medicaid program or MEDALLION program will have a regular Medicaid card. Except for family planning and emergency services, Medallion II recipients must utilize providers that participate within the MCO's provider network. Additionally, providers must adhere to the MCO's requirements regarding referrals and Prior Authorization, otherwise, payment for services may be denied. Providers may not bill the recipient for Medicaid covered services, including in those instances where a provider fails to follow the MCO's established guidelines.

Reference the section titled "Medallion II" in Chapter I of this manual for further details regarding individuals who are enrolled in Medallion II.

HOME- AND COMMUNITY-BASED CARE

Medicaid-funded home- and community-based care is an alternative to institutional placement, which must be approved under special waiver authority by the United States Secretary of Health and Human Services. Approval of Virginia's Home- and Community-Based Care Waivers is also contingent upon projections, for each year of the waiver, of the number of recipients the Commonwealth expects to receive waiver services and the average per capita expenditures projected for waiver services.

Virginia offers Medicaid reimbursement for Home- and Community-Based Care services through several waivers granted by the Centers for Medicare and Medicaid Services (CMS). CMS may waive certain statutory requirements in order to allow states to offer those Home- and Community-Based Care services that prevent institutionalization of Medicaid eligible individuals. Continued federal approval for waiver programs is contingent upon the state's ability to document that the population targeted to receive waiver services was, in fact, a population that would otherwise have required institutional care and that the cost of Home- and Community-Based Care services is equal to or less than the cost of such institutional care. Individuals must be preauthorized to receive services through one of the approved waivers. An individual cannot receive services from more than one waiver program at a time or receive waiver services if these services would duplicate other care the individual receives.

Virginia has several Home- and Community-Based Care Waivers, which require the Pre-Admission Screening Program (PAS) as the prior assessment and authorization for receipt of waiver services.

ASSESSMENT PROCESS

Hospitalized Recipients/Nursing Facility Residents

For Technology Assisted Waiver referrals, the discharge planning staff must complete the objective scoring criteria to ensure that the individual meets the minimum nursing needs (a score of 50).

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For Technology Assisted Waiver referrals over the age of 21 years, the discharge planning staff must evaluate the individual for eligibility of nursing services using the Technology Waiver criteria for individuals 21 years of age or older.

For EPSDT referrals, the discharge planning staff must evaluate the individual for eligibility of nursing services using the EPSDT Private Duty Nursing criteria. The staff is then responsible for completing the pre-admission screening process. A Uniform Assessment Instrument (UAI) and, if appropriate, a level II screening must be completed on all referrals over the age of 21 years. The staff must have the parent or legally responsible person sign a Consent for Release of Information form. The forms are then sent to the appropriate staff at DMAS.

Once all of the information is received, the DMAS staff will review the packet and, if it is determined the individual is eligible, will schedule a home visit with the parents or caregivers. A home visit is required before an individual can begin services.

Persons Residing in the Community

For individual under 21 years old, an assessment is completed by an LCSW and a medical professional (either an RN or physician) when he or she resides in a nursing facility or medical institution. If the child is at home when requesting waiver services, the HCC will make a home visit to complete the assessment and determine if the individual meets eligibility criteria. If the recipient meets eligibility criteria, the nursing and respite services are authorized by the HCC.

For both hospitalized recipients and those at home, a Care Coordination Team will assess the individual's need for services and develop a plan of care based on the supports available and the needs of the individual. As part of the development of the plan of care, the DMAS staff will contact the nursing provider chosen by the individual or individual's family to provide orientation to the needs of the individual to facilitate a smooth transition to nursing services. The DMAS staff will continuously monitor the individual's status and the provision of nursing services by telephone contact with the nursing provider and review of documentation routinely submitted by the nursing provider.

DMAS-122 FORM

The DMAS staff is responsible for notifying the city or county Department of Social Services (DSS) in which the individual resides, via a DMAS-122 form, of all admissions to or discharges from the technology assisted waiver program. The DSS eligibility worker must complete the DMAS-122 form and return it to the DMAS staff who then sends a copy to the private duty nursing provider in the event the individual has a patient pay requirement.

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DEFINITION OF PRIVATE DUTY NURSING SERVICES

Private duty nursing is defined as skilled, in-home nursing care provided by a registered nurse or a licensed practical nurse under the supervision of a registered nurse. These services are rendered according to a plan of care authorized by DMAS and have been certified by a physician as medically necessary to enable the individual to remain at home, rather than in a hospital or nursing facility. Private duty nursing may be provided only to individuals living in the community who have been authorized to receive certain Home- and Community-Based Care Waiver or Early Periodic Screening, Diagnosis and Treatment (EPSDT) services as an alternative to institutional care.

Private duty nursing may be offered to individuals as either:

1. Continuous private duty nursing service required to supplement care rendered by a primary caregiver, or,
2. Respite care services offered as episodic relief to the caregiver of a technology assisted waiver recipient.

The policies in this manual apply to the provision of private duty nursing care rendered as either private duty nursing (continuous nursing care) or as respite care services. See “Respite Care” in this chapter for additional information regarding respite care.

Private duty nursing is available through:

1. A waiver for technology assisted individuals offered to individuals who would otherwise require hospital (for individuals under 21) or specialized care nursing facility (for those over 21) level of care; and
2. The Early Periodic Screening, Diagnosis and Treatment (EPSDT) private duty nursing care program.

PROGRAM CRITERIA

Technology Assisted Waiver

The individual authorized for private duty nursing through the technology assisted waiver program must have a primary caregiver who accepts responsibility for the individual's health, safety, and welfare. The primary caregiver must be responsible for a minimum of eight (8) hours of the individual's care in a 24-hour period. Private duty nursing may be authorized through the technology assisted waiver for individuals who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and substantial and ongoing nursing care to avert death or further disability. The technology-assisted population may include one or more of the following categories:

1. The technology assisted individual who is younger than 21 years of age will be determined to need a medical device and ongoing nursing care when the individual meets categories A, B, or C and category D:

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- A. Individuals depending on mechanical ventilators at least part of the day; or
 - B. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis; or
 - C. Individuals having daily dependence on other device-based respiratory or nutritional support, including tracheostomy tube care, oxygen support, or tube feeding; and
 - D. Individuals who have been determined to need substantial and ongoing nursing care as indicated by a score of a minimum of 50 points on the objective scoring criteria (see Appendix B).
2. The technology-assisted individual who is 21 years of age or older will be determined to need a medical device when the individual meets one or more of the following categories:
- A. Individuals depending on mechanical ventilators at least part of each day; or
 - B. Individuals requiring prolonged intravenous administration of nutritional substances or drugs or requiring ongoing peritoneal dialysis.
3. In addition, regardless of age, individuals authorized for technology assisted waiver services must be individuals:
- A. Who are not residents of hospitals, nursing facilities, or board and care facilities;
 - B. Who are financially eligible for Medicaid;
 - C. For whom an appropriate and cost effective plan of care can be established;
 - D. For whom there are no other or insufficient community resources to meet the individual's needs; and
 - E. For whom the individual's attending physician has certified the need for this level of care, which must include the need for private duty nursing.

Individuals can be either hospital confined, in a nursing facility, or in the community at the time of assessment for technology assisted waiver services. However, to be eligible for these services, an individual in the community or hospital at the time of assessment must be:

- 1. No longer eligible for private insurance coverage for alternative institutional placement. If an individual or an individual's legally responsible party voluntarily cancels any insurance plan which would have provided coverage for institutional services in order to become eligible for waiver services within one

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year prior to the date waiver services are requested, eligibility for the waiver shall be denied; and

2. At risk of a hospitalization covered by Medicaid.

EPSDT Private Duty Nursing

Individuals are eligible for EPSDT covered services until they are twenty-one (21) years of age. Once an individual reaches his or her twenty-first birthday, EPSDT services will end. Children with third party health insurance are not excluded from receiving coverage through EPSDT for private duty nursing services. For MEDALLION recipients, a referral from the recipient's primary care physician is required for EPSDT PDN services. For Medallion II recipients, the HMO is responsible for providing EPSDT private duty nursing services. All of the following criteria must be met:

1. The individual must be chronically ill or severely impaired;
2. The individual must require individual and continuous skilled nursing care to correct or ameliorate a medical condition;
3. The individual is Medicaid eligible;
4. All third party coverage of in-home nursing services is exhausted; and
5. A safe and appropriate plan of care can be developed and is medically necessary as indicated by a physician; for MEDALLION recipients, this physician must be the recipient's primary care physician (PCP).

COVERED SERVICES

ENVIRONMENTAL MODIFICATIONS

Service Definition

Environmental modifications are physical adaptations to an individual's home or place of residence, which provide direct medical or remedial benefit to the individual. These adaptations are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home.

All services shall be provided in accordance with applicable state or local building codes.

Activities

The modifications and activities are:

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1. Physical adaptations to a house or place of residence necessary to ensure an individual's health or safety (installation of specialized electric and plumbing systems to accommodate medical equipment and supplies, etc.);
2. Physical adaptations to a house or place of residence that enable an individual to live in a non-institutional setting and to function with greater independence i.e. grab-bars, widening of doorways, modifications of bathroom facilities, etc.);

Criteria

This service is available to individuals who are receiving at least one other Technology Assisted Waiver service.

In order to qualify for these services, the individual shall have a demonstrated need for equipment or modifications of a remedial or medical benefit offered primarily in an individual's home to specifically improve the individual's personal functioning. This service shall encompass those items not otherwise covered in the *State Plan for Medical Assistance* or through another program.

The provider and recipient could possibly work with four different types of providers in order to complete one modification, for example:

1. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and subsequently act as project manager, assuring functionality of the environmental modification through quality assurance inspections once the project is finished. Alternatively, the Rehabilitation Engineer may actually design and personally complete the modification. A Physical Therapist, Speech Therapist or Occupational Therapist, available through the *State Plan for Medical Assistance* or DD Waiver Therapeutic Consultation, may also be utilized to evaluate the needs for environmental modifications. (NOTE: Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be preauthorized through the DMAS PA Contractor if more than 5 visits have been provided to the individual. Visits are recipient-specific, not provider-specific.);
2. A building contractor may design and complete the structural modification;
3. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor or Rehabilitation Engineer; or
4. A durable medical equipment provider enrolled with DMAS may be used to bill for modifications.

A Rehabilitation Engineer might be required if (for example):

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- The environmental modification involves combinations of systems which are not designed to go together; or
- The structural modification requires a project manager to assure that design and functionality meet ADA accessibility guidelines.

Service Units and Service Limitations.

The maximum Medicaid-funded expenditure is \$5,000 per calendar year. Costs for environmental modifications cannot be carried over from calendar year to the next, and each modification must be preauthorized.

Modifications may not be used to bring a substandard dwelling up to minimum habitation standards. This service does not include those adaptations or improvements to the home, which are of general utility and are not direct medical or remedial benefit to the individual (i.e. carpeting, roof repair, central air conditioning, etc.). Adaptations, which add to the total square footage of the home, are not allowable expenditures. Also excluded are modifications that are reasonable accommodation requirements of the Americans with Disabilities Act, Virginians with Disabilities Act, and the Rehabilitation Act.

Environmental Modifications will be covered in the least expensive, most cost effective manner.

Any request for a change in cost (increase or decrease) requires justification, supporting documentation of medical need and a revision to the PA approved by the DMAS PA contractor.

Provider Documentation Requirements

The requirements are:

1. Supporting documentation, must document the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the evaluation, design, labor, and supplies or materials, or both. The supporting documentation must include documentation of the reason that a Rehabilitation Engineer is needed, if one is to be involved;
2. Documentation of the date services are rendered and the amount of services and supplies;
3. Any other relevant information regarding the modification;
4. Documentation of notification by the individual or individual's representative of satisfactory completion of the service;

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5. Instructions regarding any warranty, repairs, complaints, and servicing that may be needed; and
6. More than one cost estimate may be required.

ASSISTIVE TECHNOLOGY

Service Definition

Assistive Technology is specialized medical equipment, and supplies, devices, controls, and appliances, not available under the *State Plan for Medical Assistance*, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. Assistive technology devices must be portable.

Activities

The equipment and activities are:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support not available under the *State Plan for Medical Assistance*;
2. Durable or non-durable medical equipment and supplies (DME) not available under the *State Plan for Medical Assistance*;
3. Adaptive devices, appliances, and controls not available under the *State Plan for Medical Assistance* which enable an individual to be more independent in areas of personal care and activities of daily living; and
4. Equipment and devices not available under the *State Plan for Medical Assistance*, which enable an individual to communicate more effectively.

Criteria

This service is available to individuals who are receiving at least one other Technology Assisted Waiver service.

Items will not be approved for purposes of convenience of the caregiver or restraint of the individual. Assistive technology shall be covered in the least expensive, most cost-effective manner.

Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under Tech Waiver Assistive Technology. A copy of the Durable Medical Equipment and Supplies list is available from DMAS and should be used to ascertain whether an item is covered through the *State Plan for Medical Assistance* before requesting it through the Tech Waiver. All questionable items should be verified with the DMAS

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HELPLINE (800-552-8627 or 800-852-6080). DME information can also be found on the DMAS web site by reviewing the *DME Provider Manual* at www.dmas.virginia.gov.

Equipment and supplies must be purchased and each assistive technology item must be recommended and determined appropriate to meet the individual's needs by the following professionals, prior to approval by the PA Contractor:

Examples of Assistive Technology Devices (not a comprehensive list)	Professional Assessment Required
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Computer/Software or Communication Device	Speech Language Pathologist or Occupational Therapist
Orthotics, such as braces	Physical Therapist or Physician
Writing Orthotics	Occupational Therapist or Speech Language Pathologist
Support Chairs	Physical Therapist or Occupational Therapist
Specialized Toilets	Occupational Therapist or Physical Therapist
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Behavioral Consultant, Psychologist, Psychiatrist, Physical Therapist, or Occupational Therapist; depending on the device or equipment
Specially Designed Utensils for Eating	Occupational Therapist or Speech Language Pathologist
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist, Psychologist, or Behavioral Consultant

For items not included above or for a specific request, contact DMAS for assistance with determining the appropriate professional making the recommendation. Items such as furniture will not be approved if they are of general utility and are not of direct medical benefit.

A Rehabilitation Engineer may be utilized if, for example:

- The Assistive Technology will be initiated in combination with Environmental Modifications involving systems which are not designed to go together; or
- An existing device must be modified or a specialized device must be designed and fabricated.

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Service Units and Service Limitations

The service unit is the total cost of the item and any supplies, or hourly for Rehabilitation Engineering.

The maximum Medicaid funded expenditure is \$5,000.00 per calendar year. Assistive Technology shall be covered in the least expensive, most cost effective manner. The cost for Assistive Technology cannot be carried over from calendar year to the next, and each item must be pre-authorized.

Provider cannot be spouses or parents of the individuals requesting the services.

Any request for a change in cost (increase or decrease) requires justification, supporting documentation of medical need and a revision to the PA approved by the DMAS PA contractor.

Provider Documentation Requirements

The document requirements are:

1. Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, supplies, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if disability expertise is required that a general contractor will not have;
2. Written documentation regarding the process and results of ensuring that the item is not covered by the *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies and that is not available from a DME provider when purchased elsewhere;
3. Documentation of the date services are rendered and the amount of service needed;
4. Any other relevant information regarding the device or modification;
5. Documentation in the record of notification by the designated individual or individual's representative of satisfactory completion of the service;
6. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed; and
7. More than one cost estimate may be required.

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AUTHORIZATION FOR MEDICAID PAYMENT OF PRIVATE DUTY NURSING SERVICES

Prior authorization for the Technology Assisted Waiver or EPSDT Services is handled through DMAS or the DMAS PA Contractor depending on the service being requested. Please refer to the PA Chapter of this manual (Appendix D) for details regarding the prior authorization process.

Medicaid will not pay for any private duty nursing services delivered prior to the effective date of the individual's plan of care approved by DMAS. The date of this authorization cannot be made prior to the date on which the assessment is completed and DMAS makes a decision.

Medicaid will assume payment responsibility for private duty nursing services only after the Department of Social Services (DSS) has determined that the individual is Medicaid-eligible for medical assistance for the dates services are to be provided.

For recipients enrolled in the Medallion II HMO program, the HMO will coordinate and authorize PDN services with the recipient's health care team.

PRIVATE DUTY NURSING AGENCY RESPONSE TO REFERRAL

The provider agency shall not begin services for which it expects Medicaid reimbursement until the admission package (the assessment and plan of care) is received from the Health Care Coordination Team or before the date of authorization. The authorization date is shown on the Technology Assisted Services Plan of Care form.

Upon receipt of a referral and prior to the delivery of private duty nursing services, the registered nurse supervisor of the provider agency must make an evaluation visit to the recipient's home. During this initial home visit, the registered nurse supervisor is responsible for the following activities:

- Introduction of the nurse(s) to be assigned to the recipient - If the nurse to be assigned to the recipient has previously been oriented to that recipient's care or has rendered care to another recipient with the same needs as the newly assigned recipient, the nurse supervisor does not have to introduce the regularly assigned nurse at the time of services initiation. The nurse's skills checklist (DMAS 259) maintained in the personnel file must indicate previous orientation to the recipient's needs. If the nurse to be regularly assigned is not introduced to the recipient at the time of the nurse supervisor's initial home visit and the nurse has not been previously oriented to the care needs of that recipient, or a like recipient, the nurse supervisor must make a return visit with the regularly assigned nurse; and
- Discussion of the recipient's needs and reviewing the treatment plan with the recipient or recipient's primary caregiver and the private duty nurse(s) to ensure that there is complete understanding of the services that will be provided. A copy of the treatment plan must be kept in the recipient's home. The nurse(s)

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should be instructed to use the treatment plan as a guide for daily service provision. The nurse must chart private duty nursing tasks, which are not included in the recipient's treatment plan if the recipient has a need for the task to be done. The nurse must note why this task was performed and whether the need for this task continues to exist. It is then the responsibility of the RN supervisor who must review nursing notes to determine whether there is a need for the task to be included in the treatment plan on an ongoing basis and to make whatever changes are appropriate.

The evaluation visit must be documented in the Nursing Status Report as an initial assessment. This initial assessment should document the following:

- Introduction of the nurse to the recipient - The RN supervisor must note when the nurse(s) was oriented to the recipient's needs and when the review of the plan of care and documentation needs was conducted;
- Review of the recipient's treatment plan with nursing staff and recipient; and
- Completion of an assessment, to include the recipient's current functioning status, current medications, social support system, and other community services rendered to the recipient, and condition of the recipient's environment. When any special medical care (e.g., ventilator care) is to be provided by the private duty nurse, the RN supervisor must indicate in the initial Nursing Status Report what care the nurse is providing, what instructions the nurse has received from the RN supervisor regarding this care, and the RN supervisor's observation of the nurse's demonstration of the correct techniques involved in this care.

It is the private duty nursing provider's responsibility to determine whether the agency can adequately provide services to an individual prior to accepting a referral for services from a Health Care Coordination Team. There may be instances in which the provider is unaware of a problem, which will prohibit service delivery until the RN supervisor completes the initial assessment.

If, during the initial assessment, the RN supervisor determines that the recipient is not appropriate for private duty nursing services because of health, safety, or welfare reasons or because the provider is unable to staff the case, the agency should not open the case to private duty nursing. The provider RN should contact the DMAS staff to discuss the situation. If the provider agency decides not to accept the referral, the RN must notify the recipient and DMAS staff of this decision and the reason for the decision.

For EPSDT MEDALLION recipients, the private duty-nursing provider must send copies of all assessments and copies of all care plans to the recipient's primary care physician.

PROVISION OF PRIVATE DUTY NURSING SERVICES

First 30-Day Period – Technology Assisted Waiver

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For recipients under 21 years of age, during the first thirty (30) days of an individual's entry into the technology assisted waiver program, private duty nursing may be offered and reimbursed by Medicaid for up to 24 hours per day if needed and appropriate to assist the family in adjustment to the care of the individual at home. If the individual is entering the program from the community, it is assumed the primary caretaker is already familiar with the care of a technology assisted individual and would require less than 24 hours of private duty nursing per 24-hour period for the initial 30 days.

First 30-Day Period – EPSDT PDN

For EPSDT recipients, the number of hours authorized will be based upon medical necessity and cost-effectiveness.

Subsequent Private Duty Nursing Services Provision for the Technology Assisted Waiver

After the first thirty (30) days, DMAS will reimburse for a maximum of 16 hours per 24-hour period per household for private duty nursing. For individuals over the age of 21 years, whether living separately or congregately, private duty nursing shall be reimbursed for a maximum of 16 hours within a 24-hour period per household, provided that the cost effectiveness standard is not exceeded for the individual's care.

In no instance will DMAS approve an ongoing plan of care or multiple plans of care per household which result in approval of more than 16 hours of private duty nursing in a 24-hour period per household.

The DMAS staff has the authority to approve or deny a private duty nursing provider's request for a change in the amount or type of nursing care.

In order to ensure the health, safety, and welfare of the individual, a maximum of 16 hours of care can be provided by the same nurse within a 24-hour period.

Congregate Private Duty Nursing

Congregate private duty nursing must be provided when more than one technology assisted waiver/EPSDT recipient resides in the same home. Congregate private duty nursing shall be limited to a maximum ratio of one private duty nurse to two waiver/EPSDT recipients. When three or more waiver/EPSDT recipients share a home, ratios will be determined by the combined needs of the recipients.

Transportation of Medicaid recipients

Nurses should not transport technology assisted waiver/EPSDT recipients. These recipients are receiving nursing services because they are at risk of death or permanent disability without continuous nursing service. It is impossible to provide nursing services to a person while the nurse is driving a car. DMAS will reimburse for necessary transportation to medical appointments; however, transportation to school, babysitters, or other locales is the responsibility of the primary caregiver. DMAS may not be billed for any time a nurse spends driving a recipient.

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Personal assistance services for Technology Assisted Waiver recipients:

Provided that the cost effectiveness standard will not be exceeded, personal assistance services can be covered for individuals over the age of 21 who require some assistance with activities of living and instrumental activities of daily living but also are able to do without skilled interventions for portions of their day. Personal assistance services must be rendered by a provider who has a DMAS agreement to provide private duty nursing. At a minimum, the staff providing personal assistance must have been certified through coursework as either personal care aides, home health aides, homemakers, personal care attendants, or registered or certified respiratory therapists. These services are billed under the private duty nursing provider number.

PLAN OF CARE REVISIONS

The DMAS staff is responsible for authorizing any change in the amount or type of nursing care. The nursing supervisor can request an increase or decrease in nursing hours by writing or telephoning the DMAS staff. The DMAS staff will authorize the change by signing and dating the Private Duty Nursing Plan of Care form and sending a copy to the nursing agency. This copy must be retained in the recipient's file. The DMAS staff will notify the individual by letter of the change in hours and his or her right to appeal.

TERMINATION OF PRIVATE DUTY NURSING SERVICES

Since the definition of the technology assisted population includes the individual's need for a medical device to compensate for the loss of a vital body function, the weaning of an individual from such a device will necessitate the individual's termination from waiver services. Weaning may be a process which occurs over a period of weeks and should be accompanied by a concurrent tapering off of private duty nursing. DMAS will determine that the individual has been weaned according to the date the attending physician certifies that the individual no longer requires the medical device to avert death or further disability. DMAS may allow the individual to continue to receive some private duty nursing for a brief period not to exceed two weeks past this date for medical monitoring. A recipient will be discharged from private duty nursing services when he or she no longer meets a minimum score of 50 on the objective scoring criteria.

EPSDT recipients will be discharged from private duty nursing services when they no longer meet the program criteria as previously defined in this Chapter.

Providers should give a minimum of five (5) days' notice to caregivers when discharging recipients from services if discharge is not due to health, safety, or welfare issues.

TRANSFER OF PRIVATE DUTY NURSING Services

The private duty nursing agency must transfer a recipient's care to another private duty nursing agency whenever the agency is no longer able to sufficiently staff the recipient's care or the recipient requests a transfer to another agency.

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When this occurs, the private duty nursing provider is instructed to contact the DMAS staff to inform of the need to transfer the recipient, the provider chosen to accept the transfer, and the effective date of the transfer. The transferring private duty nursing provider must send to the accepting private duty nursing provider a letter stating the last date of service to be rendered by the transferring provider and the reason for the transfer, along with a copy of the current plan of care, the individual's waiver assessment, authorization package, the most recent monthly nursing assessment, and the number of respite hours used within the current year. A copy of the letter must be sent to the DMAS staff.

RESPITE CARE

Respite care is the provision of skilled nursing care to a technology assisted individual for short period(s) of time (a maximum of 15 days or 360 hours per 12-month period), as a supplement to the daily plan of care. Caregivers are strongly encouraged to use respite carefully and reserve some time for use in case of emergencies. Respite care must be provided in the home of the individual's family or caretaker.

The purposes of respite care are:

- To relieve the family of the care of the waiver recipient;
- To meet planned or emergency family needs; and
- To provide the restoration or maintenance of the physical and mental well being of the recipient and the family.

The focus of services offered under respite care is on the need of the caregiver for temporary relief. This focus on the caregiver and the temporary relief needed differentiates respite care from programs which focus on the dependent or disabled care receiver.

Although the recipient of respite care services must meet the same long-term care criteria for respite care as for private duty nursing, the need for private duty nursing services must be continuous, whereas the need for respite care is periodic. Also, respite care can only be authorized when there is a primary caregiver living in the home with the individual.

At the time that respite care services are needed for a specific reason, authorization may be requested. The type of authorization will depend upon the individual circumstances of the caregiver and care receiver. In all instances where authorization of respite care is given, clear documentation of the need for the amount and type of respite care authorized must be provided.

Respite care provided by a private duty nurse must follow the same policies and procedures as those established for private duty nursing in this manual.

Note: Respite care is not a covered service under EPSDT Private Duty Nursing.

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APPROPRIATE USE OF HOME HEALTH VERSUS WAIVER SERVICES

Home health providers must determine whether an individual referred for home health skilled nursing or homemaker home health aide services has been screened and authorized for services under one of the waiver programs. DMAS does not consider skilled nursing and home health aide services under the Medicaid home health program to be reasonable and necessary for reimbursement purposes in those instances where the individual qualifies for the comparable service(s) available under one of the Home- and Community-Based Waivers. While individuals may qualify for services under more than one program category, it is essential to the well being of recipients and the cost effectiveness and integrity of the programs that recipients are directed to the best possible alternatives.

Home health services are services provided by a certified home health agency on a part-time or intermittent basis to a patient. The services must be reasonable and necessary for the diagnosis or treatment of an illness or injury or to establish a program to restore or maintain functions which have been lost or reduced by illness or injury. Home health aide services are intended to assist the patient or caregiver during a period of time that the patient or caregiver is adjusting to a change in the patient's ability to conduct his or her activities of daily living.

Private duty nursing, personal care, and respite care are services delivered by Medicaid-approved providers on an ongoing basis to individuals who qualify for technology assisted waiver services. When an individual has **ongoing** skilled nursing or aide service needs which are available under a Medicaid waiver program, and the individual meets the criteria, the nursing or aide services must be provided through the waiver rather than through the home health program.

If the individual has been authorized to receive waiver services, and the home health provider receives a request for nursing or aide services, the home health provider must refer the individual to the DMAS staff to discuss the nursing care which is needed but not already provided by the private duty nursing staff in the home. Home health services are not appropriate for reimbursement for an individual who receives a comparable technology assisted waiver service.

The Home- and Community-Based Waiver provider and the Pre-Admission Screening Team are responsible for determining whether an individual is receiving services through home health at the time that waiver services are initiated. If the provider or Pre-Admission Screening Team is made aware that an individual receives home health services which are comparable to services available under the waiver, the provider or Pre-Admission Screening Team must notify the home health provider and facilitate transfer of the nursing or aide services to the available waiver service program.

TRANSFER TO NURSING FACILITY LEVEL OF CARE

An individual entering a nursing facility who anticipates Medicaid payment by DMAS for a bed must first be screened to determine whether that person meets established Medicaid criteria. Please refer to the DMAS Pre-Admission Screening Manual for further details. This manual is available for review on the DMAS website (www.dmas.virginia.gov).

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RIGHT OF APPEAL

Individuals must be informed in writing of actions taken that affect their receipt of services. Any adverse action may be appealed. Adverse actions include denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed.

If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the client will be expected to repay DMAS for all services received during the appeal period. For this reason, the client may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable.

Appeals must be requested in writing within 30 days of receipt of the notice of adverse action. The client or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services or by calling (804-371-8488).

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the :

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
Appeal request may also be faxed to:
(804) 371-8491