Nursing Services Provider Policy Manual

2017

Office of Health Services
MDH-Division of Nursing Services

MARYLAND
Department of Health

Nursing Services Program Policy
Revision Table

Revision Dates	Section(s) Revised	Description

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Nursing Services Program Policy

I. Overview

Medicaid State Plan Services

Nursing is an available State Plan service for Medicaid participants under the age of 21. These services are typically provided in the home (rather than an institution). Services authorized must be medically necessary and may include care rendered by a registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant (CNA) or home health aide (HHA)* also certified as a medication technician (CMT).

Rare and Expensive Case Management (REM) Program and Model Waiver

Medicaid adults enrolled in the REM and Model Waiver programs are also provided medically necessary nursing services. Adult Medicaid participants must meet eligibility for REM or Model Waiver in order to receive nursing services.

Eligibility for REM

A. An individual is eligible to participate in the REM program if the individual:

(1) Has one or more of the specified diagnoses in accordance with COMAR 10.09.69.

Eligibility for Model Waiver

A. To be eligible for the Model Waiver several conditions must be met. These conditions are:

1. Admission must be completed before the individual becomes 22 years old.

2. The individual must meet the definition of a disabled child at the time application for Model Waiver services is made. The term "disabled child" means "a chronically ill or severely impaired child, younger than 22 years old, whose illness or disability may not require 24-hour inpatient care, but which, in the absence of home care services, may precipitate admission to or prolong stay in a hospital, nursing facility, or other long-term facility" (COMAR 10.09.27).

***Please see the following Maryland Board of Nursing link: http://mbon.maryland.gov/Pages/cna-info.aspx. HHAs are required to work in licensed home health agencies.**

3. The individual must be certified as in need of a hospital or nursing facility level of care. This level of care is determined by a state contracted reviewer using information supplied by the referring physician.

4. The individual's medically necessary and appropriate community based medical services must be cost neutral. That is, the cost of the community-based services must not exceed the cost of institutional care.

Under the Model Waiver, the parents' income and assets are waived during the financial eligibility process. This means that the child is considered an eligibility unit of one even though he or she will live in the community with the parent(s).

Service Definition

Nursing Services are authorized through the Division of Nursing Services (DONS) for participants who require more individual and continuous skilled care than as defined in 42 CFR 440.70, Home Health Services.

Nursing Services may be provided by a single nurse to an individual in the individual's home or to multiple participants in a non-institutional group setting. The nurse-participant ratio will not exceed 2 participants per nurse unless authorized by the Department.

Nursing Services are provided to Medicaid participants in their home or other appropriate community setting as an alternative to institutional care.

II. Provider Enrollment

I. General Criteria

<u>Prerequisites</u>

- **Prior to submitting an application for enrollment as a Maryland Medicaid provider, applicants must successfully obtain licensure as a Residential Service Agency (RSA) or Home Health Agency via the Office of Healthcare Quality (OHCQ). All questions regarding the RSA or Home Health licensure application process should be directed to 410-402-8267, or applicants may visit the OHCQ *website at http://dhmh.maryland.gov/ohcq*.**

- **After obtaining Maryland licensure, applicants may submit an application packet to enroll as a Maryland Medicaid provider to the Provider Enrollment Unit. All questions regarding the application or the process should be directed to 410-767-5340.**

Step 1 – Receipt of Application

- **After the Maryland Medicaid Provider Enrollment Unit has processed a completed application packet, staff will forward the application packet to the Division of Nursing Services (DONS).**
- **Upon receipt of the Provider Application packet from the Provider Enrollment Unit, the DONS staff will log the application in and send the applicant a letter informing them that they must attend a Provider Applicant Training session.**
- **The Provider Applicant Training is geared to assist and familiarize applicants with the requirements for enrollment. Applicants are strongly encouraged to review the regulations prior to attending the training.**

Step 2 – Agency's Credentials Review

- **Upon successful completion of the Provider Agency Training, agencies are informed that they may continue with the application process by submitting the credentials and all applicable documentation required pursuant to COMAR 10.09.53 within the specified timeframe.**
- **Upon timely receipt of this documentation, the DONS staff will review the agency's RN Supervisor's credentials and other required documentation for appropriateness and compliance with COMAR 10.09.53 to include:**
  - **Agency's employment application completed by RN Supervisor**
  - **RN Supervisor's resume**
  - **RN Supervisor's skills checklist meeting requirements in COMAR**
  - **Criminal background check documentation**
  - **Valid, non-temporary license documentation**
  - **CPR certification**
  - **Appropriate references**
- **If the credentials and documentation received are incomplete or do not comply with COMAR, the applicant will be notified of the discrepancies in**

writing. The agency will be given a specified timeframe to make corrections.

- **Once the credentials are deemed acceptable, the DONS sends a letter to the applicant requesting the applicant to forward copies of its policies and procedures for review. If credentials do not comply with COMAR, the application is denied.**

If the required information has not been received by the DONS within the specified timeframe, and the agency has not contacted the DONS, the application will be denied.

Step 3 – Policies & Procedures Reviewed

- **The agency's policies are reviewed to ensure their compliance with COMAR. If they do not meet the requisite standards, a letter denying their application is sent to the agency. The DONS staff will also notify the Provider Enrollment Unit of the denial.**
- **If, however, the applicant requires only limited revisions to their policies, a findings letter noting the appropriate corrections and/or revisions to be made is sent and an inspection date is scheduled.**

Step 4 – Inspection

- **The DONS staff will conduct an inspection at the agency's office location or at the DONS office. During this inspection a review will be completed of all requisite revisions made to the agency's policies and procedures. If the inspection is completed at the applicant's office, the DONS will review the agency's personnel files to ensure their security and confidentiality.**
- **If the agency is determined to be in compliance with regulations a provider education session is scheduled.**

Step 5 – Provider Applicant Final Education Session

- **A provider education session is conducted for all provider applicants who have met the requirements for enrollment as a Medicaid provider. This**

session provides information regarding regulations, preauthorization requirements and other Medicaid policies.

- **Successful applicants are scheduled to attend this session prior to final approval of their application.**

Step 6 – Maryland Medicaid Provider Number Activated

- **At this final step, the DONS staff will submit a request to the Provider Enrollment Unit to activate the agency's provider number in the Maryland Medicaid Information System.**
- **A form letter notifying the provider applicant of its active status is then generated and sent by the Provider Enrollment Unit.**

II. Provider Conditions of Participation

The provider must be licensed as a Residential service agency (COMAR 10.07.05) or a licensed home health agency (COMAR 10.07.10) and meet the general Medical Assistance provider requirements as specified in COMAR 10.09.36.

1 Registered Supervisory Nurse Responsibilities

The provider must have on staff at least one registered nurse supervisor who:

(1) Provides and documents initial direction to the participant's caregivers and assigned nurse, CNA, or HHA regarding the provision of nursing services to the participant;
(2) Completes a skills checklist* and demonstration of competency on an annual basis that was observed, documented and verified by the RN supervisor (or an RN designated by the supervisor) for each assigned nurse, CNA, or HHA providing home care services;**
(3) Conducts and documents a monthly review of the progress notes to assure adequacy and quality of care;
(4) Makes supervisory visits in the participant's home or another site where the participant is receiving nursing, CNA or HHA services and regularly evaluates the assigned staff's performance of the nursing services in accordance with COMAR 10.27.09, 10.27.10, and 10.27.11 as applicable;

(5) Completes a note after each supervisory visit that becomes part of the participant's file;

(6) Provides and documents training to the participant's caregiver or caregivers and the individual or individuals providing backup to the caregiver or caregivers; and

(7) Develops an initial nursing care plan which is reevaluated 30 days after the initial assessment and modified as necessary to meet the participant's nursing needs.

***** The RN Supervisor must also have a skills checklist completed annually by a registered nurse.**

2 Provider Responsibilities

The provider ensures that each nurse, CNA, or HHA rendering services to a participant:

(1) Has a valid, nontemporary, nursing license or certification to provide nursing, CNA, or HHA services in the jurisdiction in which services are rendered;

(2) Demonstrates to the provider's nurse supervisor, on a continuing basis, the ability to carry out competently the services specified in a participant's care plan, subject to review by the Department or its designee;

(4) Participates in the multidisciplinary team process, if appropriate, including attending team meetings, for children receiving home and community-based services under COMAR 10.09.27, and renders services in accordance with the plan of care recommended by the team and approved by the Department or its designee, including any subsequent revisions to that plan;

(5) Is currently certified in cardiopulmonary resuscitation (CPR) at the time services are rendered;

(6) Provides care and services in accordance with generally accepted nursing practices;

(7) Knows how to contact the provider and the registered nurse supervisor; and

(8) If a CNA or HHA, has completed the training and been certified by the Maryland Board of Nursing as a CMT.

3 Provider Policies and Procedures

The provider develops policies for the delivery of services to participants in accordance with COMAR 10.09.53.

4 Personnel Documentation Requirements

The provider maintains a personnel folder at the agency's business office for each nurse, CNA, and HHA which shall include the following:

(1) Verification of current nursing license or certification;

(2) A copy of the current CPR certification;

(3) Documentation related to:

(a) The face-to-face interview;

(b) Verification that any nurse who serves a participant younger than 19 years old has past employment which shall include at least 1 year of clinical experience which includes pediatric direct patient care within the last 3 years; and

I Verification of the CNA or HHA's past employment which shall include at least 1 year of clinical experience within the last 3 years;

(d) Documented efforts at verification of past employment history

(4) Written verification of a criminal background check (A criminal background check to include, when caring for a child, an application for a child care criminal history record check to the Criminal Justice Information System Central Repository, Department of Public Safety and Correctional Services, in accordance with Family Law Article, §5-561, Annotated Code of Maryland); and

(5) Documentation of a completed skills checklist signed and dated by the registered nurse supervisor or the registered nurse supervisor designee and the assigned nurse, CNA, or HHA.

5 Provider Contact Notification to Participants

The provider ensures the participant or the participant's caregiver is provided the following written information:

(1) Name and phone number of the provider's contact person; and

(2) Name of each nurse, CNA, or HHA assigned by the provider to render services to the participant

6 Complaint Investigation

The provider ensures there is a mechanism for the timely investigation of written complaints such that:

(1) Disruption of service does not result from the filing of a complaint;

(2) Complete files are maintained on the source, category, and disposition of the complaint;

(3) A summary report of the complaint investigation is made available to the Department or the Department's designee;

(4) A summary report of the complaint investigation is made available for public inspection, upon request; and

(5) When a complaint investigation is not conducted, reasons are documented and forwarded with the complaint to the Department or the Department's designee.

7 Backup Services

- **The provider plans for back-up services when the assigned nurse, CNA, or HHA is unable to provide the services.**
- **Family primary caregivers are also encouraged to plan for and establish family/friend backup care for emergent circumstances.**
- **The Program cannot guarantee that nursing services will be available from the provider chosen by the participant and/or caregiver(s).**

8 Termination of Services

The provider ensures the participant or the participant's representative is provided with:

(1) At least 14 days written notice of termination of services when it is the provider's decision to terminate and the medical condition remains unchanged; and

(2) A copy of a developed discharge plan if the participant, the participant's representative, or the provider elects to discontinue the provider's services to the participant.

9 Provider Appeal/Reconsideration Process

Appeal Process

In accordance with 10.09.36, a provider may file an appeal from a proposed Program adverse action of the following:

- **suspension or removal from the Program,**
- **recovery or denial of payment, and**
- **disqualification from future participation in the Program.**

An appeal must be filed in writing within 30 days of the date of the notice of action. The hearing request (appeal) is forwarded to an independent agency, the Office of Administrative Hearings (OAH). The OAH will notify the provider of the date, time and place of the hearing.

Reconsideration Process

If a provider disagrees with the Program's determination of any adverse action as noted above, the provider may also request that the Program reconsider its decision. A reconsideration request must be filed in writing within 30 days of the date of the notice of action to the Division of Nursing Services (DONS). The request should include any supporting documentation. The DONS will review the documentation and provide a prompt response. If the provider disagrees with the response, the provider may request a face-to-face meeting with the Chief and/or Deputy Director.

The provider may withdraw a request for appeal or reconsideration at any time.

IV. Documentation

1 Maintenance of Records

The provider is required to maintain adequate records for a minimum of 6 years and make them available, upon request, to the Department or its designee.

The provider ensures that each nurse, CNA, or HHA rendering services to a participant:

(1) Completes a progress note for each shift which becomes part of the participant's permanent record;

(2) Is providing services which follow the participant's care plan; and

(3) Is providing services ordered by the participant's primary medical provider before the start of care and renewed every 60 days as indicated by the participant's primary medical provider's signed and dated orders; and

(4) Maintains sufficient documentation to demonstrate that the requirements of COMAR 10.09.53 are met.

2 Initial Assessment by Registered Nurse

The initial assessment of a participant must be completed and documented by a registered nurse.

3 Written Plan of Care

A written plan of care developed by the primary medical provider and registered nurse that includes:

(1) Prognosis;

(2) Diagnoses;

(3) Treatment;

(4) Treatment goals;

(5) Services required, including specific nursing procedures;

(6) Frequency of visits (that is, hours of nursing care ordered for each day);

(7) Duration of treatment;

(8) Functional limitations;

(9) Permitted and prohibited activities;

(10) Diet;

(11) Medications;

(12) Mental status;

(13) A list of medical supplies related to each nursing procedure and how these are to be used in the participant's care:

(14) A list of durable medical equipment related to each nursing procedure and how the equipment is to be used in the participant's care;

(15) Safety measures to protect against injury;

(16) Emergency plan;

(17) Contingency plan for back-up coverage;

(18) Nurse's role in including the family in the provision of care;

(19) Plan to decrease services when the participant's condition improves or as the caregivers become better able to meet the participant's needs; and

(20) Other appropriate items.

4 Physician Orders (Form 485)

Orders renewed, signed and dated at least once every 60 days on Form 485 or similar document which includes the required information.

<u>Verbal Orders:</u> Verbal orders must be completed in accordance with the provider's own policies and procedures.

Standard practices include but are not limited to the following:

- **A registered nurse (RN) must confer with a physician for the order.**

- **The RN must sign and date the order on the date it is obtained and document the name of the physician providing the order.**
- **Signatures must be handwritten—stamped or typewritten names are not acceptable.**

5 Progress Notes

Adequate progress notes dated and signed by staff performing the service.

V. Reimbursement

Fee schedule is published annually at:
https://mmcp.dhmh.maryland.gov/Pages/Provider-Information.aspx

1 Methodology

Units and Flat Rates

Payment to a provider of nursing services may not exceed the published fee schedule. The unit of service for providers is 15 minutes with the exception of the following:

(1) A flat rate for the initial assessment of up to 3 hours, if this is not covered by another Medical Assistance or insurance program; and

(2) A flat rate per visit for a registered nurse supervisory visit of a nurse, CNA, or HHA.

2 Payment

Payment to a provider of nursing services may not exceed the lesser of:

(1) The rates established in the most recently published fee schedule; and

(2) The provider's customary charge to the general public unless the service is free to individuals not covered by Medicaid.

If the service is free to individuals not covered by Medicaid:

(1) The provider:

(a) May charge the Program; and

(b) Shall be reimbursed in accordance with the most recently published fee schedule; and

(2) The provider's reimbursement is not limited to the provider's customary charge.

Effective July 1 of each year, subject to the limitations of the State budget, the fee schedule rates shall be adjusted annually by the percentage of the annual increase in the previous July Consumer Price Index for All Urban Consumers, medical care component, Washington-Baltimore, from the U.S. Department of Labor, Bureau of Labor Statistics.

VI. Preauthorization

1 General Criteria

Services authorized must be medically necessary and may include care rendered by a registered nurse (RN), licensed practical nurse (LPN), a certified nursing assistant (CNA) and/or medication technician (CMT) who has a professional license or certification from the State to provide services.

2 Requirements

Nursing services must be authorized by the DONS before the services are rendered. Since preauthorization does not guarantee Program eligibility, the provider is responsible for confirming Program eligibility on the date of service via the Eligibility Verification System (EVS).

3 HealthChoice (Maryland Medicaid's Managed Care Program)

Nursing services for participants enrolled in the HealthChoice program, Maryland Medicaid's Managed Care program, must be prior authorized by the participant's managed care organization (MCO). (See Appendix B)

4 Staffing Hours

Individual nurses, certified nursing assistants/medication technicians or home health aides may provide no more than a total of 60 hours per week or 16 consecutive hours and the individual must be off 8 or more hours before starting another shift unless otherwise authorized by the Department.

VII. General Guidelines for Nursing Services Authorization

1 Initial Assessment/Preauthorization Procedures

Prior to rendering services, the provider's registered nurse completes an initial assessment. The provider then follows the procedures for preauthorization. (See Appendix C)

If applicable, the participant will receive a written notice of denial for nursing services.

2 Reviews for Continuation of Services

The review for medical necessity of nursing services for Medicaid participants is periodically reevaluated. The DONS may determine that nursing services may be adjusted, reduced or terminated based upon a review of the participant's medical condition as well as factors such as a change in the parent/caregiver work or school schedule, services obtained by the participant which may duplicate or supplant nursing services, change in eligibility status and other applicable factors.

3 "Willing and able" Caregiver Requirement

"Caregiver" means a willing and able individual who is trained in providing care to the participant.

When a caregiver is unable or not willing to provide care to the participant (in the absence of a nurse or CNA), the participant's environment is considered unsafe.

4 Transportation

Please be advised that under no circumstance should a nurse or home health aide/certified nursing assistant take a minor recipient to a medical appointment in lieu of the participant's parent/guardian. In such an instance, the nurse/aide/assistant is providing transportation service not nursing or aide care. This policy also applies to those recipients 21 years old and older in receipt of these services. Specifically, the nurse/aide/assistant may accompany the adult to the medical appointment; however, it is necessary that the adult's caregiver or other resource provide transportation to the appointment. (See Appendix D memo)

Nursing services may be authorized to accompany school-age children with transport to school and to provide medically necessary care during school hours.

5 School Absences and Closures

The DONS may authorize nursing services when the participant requires medically necessary nursing services and is unable to attend school for illness or there are unplanned school closures due to inclement weather, etc. However, additional hours must be prior authorized. Families should contact the participant's case manager as soon as they know about an unplanned school closure, etc. and find a willing and available provider.

6 Vacations/Out-of-state Services

When the participant requires medically necessary nursing service, the DONS may authorize hours to cover summer vacation as well as scheduled school year holidays for school age children if the parent/caregiver requests coverage timely. Absence of parents/guardian from the home for employment or education must be documented. The Program does not cover respite care.

Nursing services rendered out-of-state must meet the following criteria:

- **RN or LPN assigned is licensed and legally authorized to practice or deliver services in the state in which the service is provided or services must be rendered in a compact state.**
  (See Maryland Board of Nursing (MBON) website: http://mbon.maryland.gov/Pages/msl-compact-states.aspx)
- **The provider must continue to comply with COMAR (i.e. complete required monthly supervisory visits, Nurse Practice Act, etc.).**

7 Banked Hours

The DONS authorizes a predetermined amount of hours per day. If the hours authorized are not used on a particular day, the hours do not carry over to the next day or weekend nor can the hours be "banked" to be used at a later time, unless otherwise authorized by the Department.

VIII Determination of Nursing Services Hours

1 Ongoing 24/7 Services

The DONS does not authorize 24/7 on-going 1:1 nursing services. The DONS may authorize 24 hours of nursing services for a short-term (trach and vent child/adult) to help parents/caregivers adjust and ensure all equipment is

functioning. Nursing services are then weaned to "up to 10 hours per day, 5 days" per week for caregivers employed or attending school and/or "awake and overnight care, 8-12 hours per night" when determined medically necessary.

The DONS may authorize 24/7 *shared* ongoing nursing services when determined medically necessary for participants residing in alternative living units such as adult group homes.

2 Duplicate Services

Nursing services may be reduced based on school enrollment or attendance at a Day Habilitation program. Nursing Services may not duplicate or supplant services rendered by the participant's family caregivers or primary caregivers as well as other insurance, privilege, entitlement, or program services that the recipient receives or is eligible to receive.

3 Overnight Hours

When a participant requires medically necessary services overnight (i.e. skilled care for respiratory system function such as tracheostomy and/or invasive ventilator care or other high risk condition during sleep time), nursing services may be approved to allow for necessary sleep for parents/caregivers for up to eight hours per night. Routinely eight hours are scheduled within the range of 10 pm through 8 am. Additional overnight hours may be approved for younger children (toddlers/infants).

4 Work/School Hours

Frequency of nursing services is adjusted to cover work and commute time of the parent/caregiver or to cover education (class schedule) and commute time of the parent (s). Nursing services are authorized for up to 40 hours per week plus additional travel time for commuting up to 2 hours round trip per day for 5 days. Parent/guardian work hours/schedule must be verified. Nursing services for education is for employment related classes, vo-tech, GED, high school, college, etc. and must be documented.

5 Referrals

If medical care is needed, but it is less than skilled care or delegated nursing care, the Department may refer participants to other appropriate Medicaid programs.

Nursing Services Procedure Codes

Appendix A Procedure Codes

Service	Procedure Code
Assessment	T1001
Registered nurse supervisory visit	W1002
Registered nurse/ 1 recipient	T1002
Registered nurse/ 2 or more recipients	T1030
Licensed practical nurse/ 1 recipient	T1003
Licensed practical nurse/ 2 or more recipients	T1031
Certified nursing assistant or Home health aide/ 1 recipient **(EPSDT: must also be a Certified Medicine Technician)**	W1000
Certified nursing assistant or Home health aide/ 2 or more recipients **(EPSDT: must also be a Certified Medicine Technician)**	T1021
Certified nursing assistant or Home health aide/ 1 recipient	T1004
Certified nursing assistant or Home health aide/ 2 or more recipients	T1004 (TT Modifier)

HealthChoice, Managed Care Program and the Eligibility Verification System (EVS)

Appendix B List of Managed Care Organizations (MCOs)

There are currently 8 MCOs participating in HealthChoice:

- **AMERIGROUP Community Care –www.amerigroupcorp.com 800-600-4441**
- **Jai Medical Systems –http://www.jaimedicalsystems.com/ 888-524-1999**
- **Kaiser Permanente-http://www.kp.org/medicaid/md 855-249-5019**
- **Maryland Physicians Care –www.marylandphysicianscare.com/ 800-953-8854**
- **MedStar Family Choice –www.medstarfamilychoice.net 888-404-3549 or 410-581-0708**
- **Priority Partners – www.ppmco.org/ 800-654-9728**
- **University of Maryland Health Partners (formerly Riverside Health) 800-730-8530 or 410-779-9369**
- **UnitedHealthcare – www.uhccommunityplan.com 800-318-8821**

Information on any or all of the MCOs may be obtained by calling the member services lines of the managed care organizations.

If participants have questions about coverage, please refer them to the HealthChoice Enrollee Help Line at 1-800-284-4510.

ELIGIBILITY VERIFICATION SYSTEMS (EVS) INFORMATION

EVS is a system available to allow verification of Maryland Medicaid recipient eligibility status. DHMH has a few EVS applications:

- **IVR – Telephone inquiry/response system: EVS IVR User Guide**
- **WebEVS – Web-based EVS application available for provider's with access to eMedicaid**

Appendix C Preauthorization Procedures

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

Division of Nursing Services Preauthorization Process

A. **New requests for PDN**

1. The agency/discharge planner faxes the request to the attention of the **assigned reviewer (see attached)**.
2. The agency/discharge planner contacts DONS to verify receipt of the faxed request.
3. The DONS nurse assigned to the referral contacts the agency/discharge planner to confirm the records needed for review. **(See page 4 for documentation checklist)**
4. Once a decision is made the DONS nurse notifies the agency/discharge planner of the decision.
5. The agency faxes the preauthorization form to the DONS **only** after they receive email notification of a decision.
6. The agency must fax the completed preauthorization form to the DONS nurse reviewer who approved the request within **3 business days** of the date of email notification.

The hospital's discharge planner will complete **Steps 1-4** when the patient has never required Medicaid nursing services or has been hospitalized for over 72 hours. **(See "Hospitalizations" below.)**

- **NOTE: For new requests when the participant is hospitalized, notify DONS at least 3 business days prior to discharge to ensure timely processing of the request.**

B. **Hospitalizations**

If there is an existing preauthorization, it will remain in effect unless the participant is hospitalized for more than 72 hours.

If the participant is hospitalized for more than 72 hours, the agency:

1. Ends the preauthorization on the date of admission

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2. When the participant is ready for discharge the hospital discharge planner will contact the assigned reviewer at 410-767-1448 and fax updated medical information; allow 3 business days for a decision when requesting additional hours. **(See page 4 for documentation checklist)**
3. Once the medical information is reviewed, the assigned DONS reviewer will notify the agency/discharge planner with the nursing hours that are approved.
4. The agency sends the preauthorization request form to the assigned reviewer within 3 business days of approval notification.

C. **Requests for additional nursing hours**

1. The Case Manager will send the request to the assigned reviewer to initiate the process. **(See page 4 for documentation checklist)**
2. The assigned DONS reviewer will contact the agency to confirm that the request is received and notify the agency once a decision is made.
3. If additional nursing hours are approved, the agency will fax the preauthorization with the approved hours to the assigned DONS reviewer **within 3 business days** of approval notification.

In the case of an emergency, in the absence of the assigned reviewer, requests may be sent to the Division Chief or designee.

201 W. Preston Street – Baltimore, Maryland 21201
Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov

D. **Transfer Cases**

1. The agency faxes the agency transfer form to the **assigned reviewer**.
2. The agency verifies the receipt of the fax by calling DONS to confirm receipt of the transfer form.
3. DONS will contact the agency to confirm the start date after notifying the existing agency. Please allow at least 3 business days.
4. The agency faxes the preauthorization form to DONS on or before the start date.
5. ***If the agency does not send the preauthorization form to DONS on or before the start date, the preauthorization request may be denied.***

E. **Routine Preauthorization Requests (Renewals)**

1. The agency faxes all **preauthorization renewal requests** to Laurence Phillip **30 days prior to the start date of the authorization period.**
2. The nursing agency is responsible for keeping the fax transmission receipt confirmation that the fax was successfully transmitted to DONS from the agency.
3. Place the following information on the fax cover sheet: **name of participant, MA#, dates of preauthorization request.**

❖ **Please fax multiple routine requests with one cover sheet instead of individually.**

F. **Obtaining Preauthorization Numbers**

If the nursing agency has not received the preauthorization number 3 days after the start of the preauthorization period, the agency may fax a request for the preauthorization number with the following information on the cover sheet along with a copy of the initial fax confirmation page: **name of the recipient, MA#, start date of the authorization.**

❖ **NOTE: Please do not call DONS to request preauthorization numbers.**

G. **Procedure for obtaining preauthorization when DONS has not received the original preauthorization request**

1. If the preauthorization period has not started, refax the preauthorization request
2. If the preauthorization period has started, refax the preauthorization request with the fax confirmation from the agency verifying that the fax was successfully transmitted to DONS.
3. If the agency cannot provide verification that the preauthorization was successfully transmitted to DONS, the preauthorization request may be denied and a new preauthorization start date will be given.

H. **Primary Insurance**

Medical Assistance is the payer of last resort. In general, the primary insurance must be exhausted before nursing services are authorized. Please submit the authorization/denial letter from the primary insurance when submitting a request for PDN.

I. **Short term authorization**

The DONS may approve a short term authorization under the following circumstances:

- When the caregiver provides documentation of emergency circumstances, additional nursing services may be approved up to 60 days.
- When the medical information is insufficient to determine medical necessity, the DONS may preauthorize nursing on a short term basis.

J. **Factors that may delay a preauthorization request:**

- **Eligibility of the participant**
- **Incorrect information on the preauthorization form**
- **Authorization requests received after the start date of the authorization period**
- **Sending the information to the incorrect reviewer/DONS staff**
- **Missing information or lack of documentation**

NOTE:

- The nursing agency is responsible for ensuring that the nursing hours that are approved are used as authorized. For example, if the authorization covers a caregiver work or school schedule, then the agency is responsible for ensuring that the participant understands that the agency can only staff the case during the work or school hours. It is the responsibility of the agency to obtain the schedule from the caregiver, particularly if global hours have been approved to cover the work or school schedule.
    - The agency must notify DONS and the case manager when there are changes in the work or school schedule so that modifications can be made in the authorization.

❖ **Note: All preauthorization approvals are for 60 days unless otherwise specified.**

❖ **NOTE: Nursing services provided prior to requesting and receiving preauthorization are not covered and therefore not reimbursed under the Medical Assistance Program.**

Attention: _____ **FAX: 410-333-5085**

Documentation Checklist

(Please forward this Checklist with all new requests, changes in plans of care or requests for additional hours.)

Upon discharge from a hospital/new case:

- Current history and physical from the hospital discharge planner, agency, or physician's office;
- Discharge summary and hospital records/progress notes;
- Also, confirms training of primary caregiver and obtains the name of a trained back-up caregiver (if no back-up caregiver, refer to CM for follow up);
- Most recent (1-2 months) PCP or Specialists' office notes may be requested for those recipients with little or no PDN history;
- REM PDN assessment (if applicable) and
- Additional information as noted below, if applicable.

Request for additional hours/change in POC:

- Most recent Physician's Orders and Plans of Care;
- Nursing Notes;
- RN Supervisory Notes;
- MARS and Treatment Records;
- A letter from the caregiver's employer/school verifying work/school schedule on letterhead*** (if requesting covered hours for work/school) to include date and signature of supervisor or designee; and
- Additional information, if applicable.

Comments:_____
_____
_____

Revised DONS 01/2017

Division of Nursing Services (DONS)

Nurse Reviewers

REM/FFS 19 and under

- A-N: Claudette Matthews
- O-Z: Myrna Pimentel

Model Waiver

- A-Z: Shelly P. Moore

REM Optional (age 21 and over)

- A-Z: Tamara McDuffie

REM Optional (age 20)

- A-Z: Toby Cornish

Revised DONS 01/2017

Appendix D **Medical Appointments/Transportation Memo**

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

To: EPSDT - Private Duty Nursing Providers
Model Waiver Providers
Rare and Expensive Case Management (REM) Program Providers

From: Dawnn Willliams

Re: Medical Appointments/Nurse Accompaniment

Date: February 8, 2011

The Division of Nursing Services (DONS) is amending the policy concerning the provision of private duty nursing/shift home health aide/certified nursing assistant services to Medicaid clients while they attend medical appointments.

The current policy requires that when the need for the nurse/aide/assistant to accompany a parent/guardian and the recipient to medical appointments is necessary, the DONS requests documentation supporting the medical necessity for assistance in transporting the recipient to a medical appointment. Based on a review of the documentation, the DONS' staff then approves or denies the authorization requests.

Effective immediately, prior authorization is no longer required for the nurse/aide/assistant to accompany a parent/guardian and the recipient to medical appointments if the medical appointment is scheduled during the recipient's current authorized nursing hours. Requests for additional nursing hours beyond the recipient's current authorized plan of care always require prior authorization. Please be advised that **under no circumstance should a nurse or home health aide/certified nursing assistant take a minor recipient to a medical appointment in lieu of the client's parent/guardian.** In such an instance, the nurse/aide/assistant is providing transportation service not nursing or aide care.

This policy also applies to those recipients 21 years old and older in receipt of these services. Specifically, the nurse/aide/assistant may accompany the adult to the medical appointment; however, it is necessary that the adult's caregiver or other resource provide transportation to the appointment.

If you have any questions regarding this issue, please call the staff of the Division of Nursing Services at 410-767-1448. Thank you.

cc: Mark Leeds, Director
Sandra Brownell, Deputy Director
Toby Cornish, RN
Mike Berman, RN

STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

MEMORANDUM

TO: Nursing Services Program Providers (Type 53)
The Coordinating Center (TCC)

FROM: Dawnn Williams, Chief
Division of Nursing Services (DONS)

RE: Medical Appointments for Nursing Services Participants (under age 21) Residing in Group Homes

DATE: May 2, 2016

This memorandum serves as notice of operational procedures pertaining to preauthorization requests for Medicaid enrolled nursing providers (Provider Type 53) serving children (under age 21) residing in group homes. The Division of Nursing Services (DONS) will approve *up to 4 hours of nursing services per day* for each medical appointment (up to 2 medical appointments per day) scheduled and attended for children in group homes requiring the following medical interventions:

(1) Tracheostomy and ventilator care; or
(2) Other conditions assessed as medically necessary, as determined by the Department.

Prior authorization is required when nursing services are needed for scheduled medical appointments. The following information must be submitted to the DONS for review:

- Nursing Assessment completed by the participant's case manager (The Coordinating Center)
- Verification of the most recent 6 months of medical appointments, if applicable; and
- Letter of medical necessity and/or other medical documentation (i.e. nursing notes, etc.).

Upon approval, the nursing agency must submit a renewal request every 30 days unless otherwise authorized by the Department. Attached to the request, please include:

- Verification of the participant's attendance for the previous month's appointment(s); and
- Documentation of scheduled future appointments.

If you have any questions regarding this memorandum, please direct them to staff of the DONS at 410-767-1448 or 1-877-4MD-DHMH.

Cc: DONS staff
File

201 W. Preston Street – Baltimore, Maryland 21201
Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: www.dhmh.maryland.gov

Appendix E **Personnel Review Memo**

STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MEMORANDUM

TO: Private Duty Nursing Program Providers

FROM: Dawnn Williams, Chief
Division of Nursing Services

RE: Review of Agency Staff Personnel

DATE: December 13, 2013

This memorandum serves as notice of operational procedures pertaining to preauthorization requests for Medicaid enrolled private duty nursing providers (Provider Type 53). Before processing a preauthorization request, the Division of Nursing Services (DONS) may complete a review of all agencies' staff personnel documentation when:

(1) The agency has not rendered private duty nursing services to any Medical Assistance recipient within the last 12 months; or
(2) Previous reviews/audits indicate non-compliance and the noted deficiencies are not resolved.

The DONS performs this review to ensure that all agency staff are in compliance with the requirements of COMAR 10.09.53 before the preauthorization request submitted will be processed.

If you have any questions regarding this memorandum, please direct them to staff of the DONS at 410-767-1448 or 1-877-4MD-DHMHx1448.

DW/st
Cc: DONS staff Files

Toll Free 1-877-4MD-DHMH – TTY/Maryland Relay Service 1-800-735-2258
Web Site: http://dhmh.maryland.gov

RESERVED

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0357

HOME HEALTH CERTIFICATION AND PLAN OF CARE

1. Patient's HI Claim No.	2. Start Of Care Date	3. Certification Period From: To:	4. Medical Record No.	5. Provider No.

6. Patient's Name and Address	7. Provider's Name, Address and Telephone Number

8. Date of Birth	9. Sex ☐M ☐F	10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis	Date
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses	Date

14. DME and Supplies	15. Safety Measures

16. Nutritional Req.	17. Allergies

18.A. Functional Limitations

1 ☐ Amputation	5 ☐ Paralysis	9 ☐ Legally Blind			
2 ☐ Bowel/Bladder (Incontinance)	6 ☐ Endurance	A ☐ Dyspnea With Minimal Exertion			
3 ☐ Contracture	7 ☐ Ambulation	B ☐ Other (Specify)			
4 ☐ Hearing	8 ☐ Speech				

18.B. Activities Permitted

1 ☐ Complete Bedrest	6 ☐ Partial Weight Bearing	A ☐ Wheelchair			
2 ☐ Bedrest BRP	7 ☐ Independent At Home	B ☐ Walker			
3 ☐ Up As Tolerated	8 ☐ Crutches	C ☐ No Restrictions			
4 ☐ Transfer Bed/Chair	9 ☐ Cane	D ☐ Other (Specify)			
5 ☐ Exercises Prescribed					

19. Mental Status	1 ☐ Oriented	3 ☐ Forgetful	5 ☐ Disoriented	7 ☐ Agitated
	2 ☐ Comatose	4 ☐ Depressed	6 ☐ Lethargic	8 ☐ Other

20. Prognosis	1 ☐ Poor	2 ☐ Guarded	3 ☐ Fair	4 ☐ Good	5 ☐ Excellent

21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

22. Goals/Rehabilitation Potential/Discharge Plans

23. Nurse's Signature and Date of Verbal SOC Where Applicable:	25. Date of HHA Received Signed POT

24. Physician's Name and Address	26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.
27. Attending Physician's Signature and Date Signed	28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (12-14) (Formerly HCFA-485) (Print Aligned)

****TECHNOLOGY ASSISTED WAIVER/EPSDT**
NURSING SERVICES PROVIDER
SKILLS CHECKLIST FOR INDIVIDUALS CARING FOR TRACHEOSTOMIZED AND/OR VENTILATOR ASSISTED CHILDREN AND ADULTS
Agency Name _____
Name of Nurse Providing Service _____
ASSESSMENTS

	Experience		Date of Most Recent Experience
	Yes	No	
Breath Sounds – Auscultation:			
Before Suction			
After Suction			
Need for Aerosol			
Signs & Symptoms:			
Respiratory Distress			
Hypoxia			
Side Effects of Medications			
Fluid Retention			
PROCEDURES			
Chest Physical Therapy			
Suctioning:			
Positioning for			
Nasopharyngeal			
Trachea			
Trach Care:			
Clean Trach Site			
Change Trach Ties			
Change Trach Tube			
Cleaning of Inner Cannula			
Place on Trach Collar			
Manual Resuscitation Device Application:			
Via Trach			
Via Mouth			
Emergency Protocol/Procedure:			
Knowledge of Individualized Plan			
Monitoring & Equipment:			
Vital Signs			
Skin Care			
Oral Hygiene			
Use of Apnea/Bradycardia Monitor			
Placement on Oxygen Delivery Device/Trach Collar			
DMAS 259 Page 2 of 3 Pages			
Experience Date of Most			
Yes No Recent Experience			
Monitoring & Equipment (Continued):			
Placement on Ventilator			
Calibrate Oxygen Analyzer			
Check Oxygen Level/Liter Flow/Tank			

Level			
Check/Calibrate Ventilator Settings			
IMV			
PEEP			
Pressure Units			
Tidal Volume			
Systematic Troubleshooting of Ventilator			
Use of Respirometer			
Humidity System:			
Check Water Level			
Check Temperature			
Filling Procedure			
Draining Water from Tubing			
Cleaning of Humidity Bottles/Cascade			
Check Compressor Operation			
Clean Compressor Unit Screen			
Assess Suction Machine Pressure			
Clean Suction Machine			
Clean Suction Catheters			
Clean Corrugated Tubing			
Clean Manual Resuscitation			
Device (Reservoir Bag & Assoc. Equip)			
Clean Trach Collar			
Clean Trach Tubes			
Disposable			
Metal			
Medication Administration:			
Administration Technique (as appropriate)			
Installation of Normal Saline			
Administration of Aerosol Treatments			

Additional Individualized Assessments/Skills:

I (Supervisor/Designee) _____, have in serviced the individual designated as Orientee regarding assessments and skills listed above.

Print Name (Supervisor/Designee) _____

Title _____

Organization _____

(Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.)

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

Print Name (Orientee) _____

*Please indicate N/A when nonapplicable

****SKILLS CHECKLIST FOR NURSES CARING FOR INDIVIDUALS WITH NUTRITIONAL NEEDS**

Agency Name _____

Name of Nurse Providing Service _____

ASSESSMENTS:

	Date Described/Observed	Date Demonstrated
Assess and Record Intake and Output		
Assess Signs and Symptoms:		
Dehydration		
Fluid Retention		
Procedures/Techniques:		
Weight		
Skin Care:		
GT Site		
NG Site		
PO (By Mouth) Feeding:		
Preparation of Special Formula/Feeding		
Nasogastric Feeding:		
Preparation of Special Formula/Feeding		
Insert NG Tube		
Check NG Placement		
Check NG Residual		
Bolus Feed		
Use of Feeding Pump		
Gastrostomy Feeding:		
Insert GT Tube		
Check Placement of GT Tube		
Bolus Feed		
Use of Feeding Pump		
Hyperalimentation (As Per Physicians Orders):		
Reading/Checking Hyperalimentation Prescription		
Operation of Infusion Pump		
Troubleshooting of Infusion		
Placement/Care of Infusion Line		

I (Supervisor/Designee) _____, have in serviced the individual designated as Orientee regarding assessments and skills listed above.

Print Name (Supervisor/Designee) _____

Title _____

Organization _____

(Initial and Date indicates procedure has been described and/or demonstrated in a competent manner.)

I (Orientee) _____, understand all assessments and skills listed above and am able to perform same in a competent and confident manner.

Print Name (Orientee) _____

*Please indicate N/A when nonapplicable

**** FORM PROVIDED BY VIRGINIA MEDICAID'S DIVISION OF AGING & DISABILITY SERVICES TECHNOLOGY WAIVER**

PDN PREAUTHORIZATION INTAKE SHEET

DATE: _____
TIME: _____

CALLER: _____

PHONE: _____

PROVIDER: _____ **PROVIDER NO: _ _____**

RECIP. NAME: _____ **RECIP. NO: _____**

Dr. NAME: _____ **Dr. PHONE: _____**

PRESCRIBING PROV. NO: _____

PA: __ _____NEW

_____RENEWAL

DATES OF SERVICE FROM: _____ **THRU: _____**

PARTICIPANTS: _____MW
_____ REM
_____ FFS

PROC. CODE: _____ **UNITS: _____**

_____ **_____**

_____ **_____**

NO. DAYS: _____ **MAX HOURS PER DAY: _____**

COMMENTS: (PLAN OF CARE)
_____

_____

STATUS: _____

RSN: _____

MMIS ENTRY: _____

PA #:_____

Examples of forms are provided for illustration purposes only. Providers may develop similar forms with the required information. If the examples are used, please be sure to adjust the forms (as needed) to ensure compliance with applicable Code of Maryland Regulations (COMAR).