

## ***Precertification and Concurrent Review of Private Duty Nursing Services***

### ***Objective:***

Establish a process for reviewing requests for private duty nursing services that will ensure timely access to quality care for Medicaid beneficiaries.

### ***Performed By:***

Utilization Review Coordinator (URC), Medical Director (MD), Physician Advisor (PA)

### ***Policy:***

All private duty nursing (PDN) services requested for Mississippi Medicaid beneficiaries under the age of twenty-one (21), through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, must be precertified by HSM. These services are available only to EPSDT beneficiaries. Intermittent home health agency skilled nursing and aide visits will be considered a duplication of services. Private Duty agencies should be aware that services such as respite, hospice, or some other waiver services might be considered a duplication of service by the Division of Medicaid. Cases should be evaluated individually.

Requests for precertification may be submitted by mail or fax using request forms provided by HSM. Precertification requests must be submitted at least two (2) weeks (ten business days) prior to initiation of planned services. An on-site evaluation by the PDN agency is required with the physician and agency's Plan of Care Forms. Notification is issued within one (1) business day of the PA's determination.

Concurrent certification requests must be submitted by mail or fax within seven (7) business days prior to the last day certified. New Plan of Care forms are required to accompany each review request.

HSM will issue written notification sixty (60) days prior to a beneficiary reaching the age of twenty-one (21). This notification informs all involved parties that HSM is not authorized by DOM to accept review for PDN services after the beneficiary's twenty-first (21<sup>st</sup>) birthday. Approved benefits will continue through the last day of the beneficiary's birth month.

HSM will complete precertification and concurrent PDN review requests within two (2) weeks (10 business days) of receipt of all necessary information. Written notification is issued within one business day of the review determination.

The beneficiary/parent or legal guardian, nursing agency and physician have a right to a reconsideration of any denial or modified (approval of hours less than requested) decision. The request for reconsideration must be submitted by fax or mail to HSM within thirty (30) calendar days of the date on the denial notice. Refer to the Private Duty Nursing Reconsideration Process Policy and Procedure section of this manual for additional information.

**Procedure: Precertification Review**

1. Nursing Agencies must submit a request for precertification utilizing the HealthSystems of Mississippi Private Duty Nursing (PDN) Agency Plan of Care Form and a copy of the agency's home and social assessment. A HealthSystems of Mississippi Private Duty Nursing Initial Certification of Medical Necessity Physician Plan of Care Form must also accompany the request for certification. The request must be received two (2) weeks (10 business days) prior to initiation of PDN services. If the request is not submitted to HSM two (2) weeks (10 business days) prior to the proposed service date, HSM may not be able to complete a certification determination by the proposed service date. This request may be submitted by fax or mail. To expedite the certification process, agencies/physicians should attach/include all required information, including physician's treatment plans signed by the physician.
2. The initial plan of care must include at least the following:
  - Beneficiary's diagnosis(es)
  - Skilled teaching/instruction to be provided to family/caregiver
  - Treatment plan/Physician's orders (specify each skill to be performed)
  - Expected duration of service
  - Level of service
  - Identification of types of other homecare services to be provided (i.e., case management, physical therapy, speech therapy, occupational therapy, respiratory therapy, respite, hospice, home health, personal care attendant, etc.) and the hours, days, and times of the day these services are to be provided
  - Homebound status
  - Plan for reducing and/or discontinuing PDN services
  - When applicable, a plan to transition the beneficiary to the most appropriate setting when PDN services are no longer required
  - Physician's signature
  - Agency's Registered Nurse's signature
3. The agency must submit a copy of the agency's home and social assessment with the initial plan of care.
4. Upon receiving the requested plan of care forms from the agency and physician and also the agency's home and social assessment, the request is forwarded to HSM's URC.
5. The URC verifies beneficiary eligibility. Nursing agency and attending physician identification is also verified, including telephone and fax numbers. If the beneficiary is not eligible, the URC notifies the agency via telephone with written follow-up (Notice of

Receipt of Certification Request - Non-Medicaid Beneficiary) and ends the review process.

6. Once eligibility is verified, the URC assesses the case to determine if there is sufficient clinical information to make a determination. If not, the additional information is requested via telephone. The additional information must be submitted to HSM within twenty-four (24) hours (or one business day) of the request.
7. If the requested information is not received within the timeframe afforded, the URC will close the case. A Notice of Incomplete Information - Certification Review Suspended will be sent to the agency and attending physician informing each party that the case has been closed.
8. When the needed information is received, the URC will:
  - Screen all information collected against DOM's Private Duty Nursing Criteria provided in the Criteria section of this manual (Section II in this manual)
  - Apply appropriate quality screens according to HSM's Quality Assurance and Utilization Review Section
9. The URC documents whether PDN criteria is met or not, whether a quality screen is failed or not and forwards the recommendation for number of daily hours, days of the week, and number of days per week to the Physician Advisor for review determination.
10. The PA reviews the case and all available information and, if necessary, contacts the attending physician to discuss the case (peer-to-peer discussion). If additional information is required, twenty-four (24) hours (or one business day) are allowed for submission of the information. The PA and/or the URC request the information from the physician and, when appropriate, from the nursing agency via telephone.
11. If the requested information is not received within twenty-four (24) hours (or one business day), the URC will close the case. A Notice of Incomplete Information - Certification Review Suspended will be sent to the agency/attending physician informing each party that the case has been closed. When the needed information is received, PA review continues.
12. The PA makes a determination based on practice standards, and his/her clinical experience and judgment.

If the PA's initial determination is to deny or modify, verbal notification to the agency and/or the physician is made. PAs call the attending physician two (2) times prior to issuance of written denial determination. If no contact occurs because the physician is not available, HSM proceeds with issuance of the denial/modification notification letter. During attempted telephone contacts, the PA provides verbal instructions and contact information to the receptionist or nurse at the physician's office, affording the attending physician an

opportunity to call the PA to discuss the case (peer-to-peer conversation). HSM makes every attempt to arrange a peer-to-peer conversation within one (1) business day of a request with the same PA making the initial determination or as soon as possible.

**NOTE: A peer-to-peer conversation that occurs following issuance of the denial or modification determination notification in no way may change the PA's initial denial determination. If the attending physician continues to disagree with the PA's determination following the peer-to-peer conversation, the attending physician may submit a request for reconsideration to HSM. Please refer to the Private Duty Nursing Reconsideration Policy and Procedure for detailed information on this process.**

13. A review determination is rendered within two weeks (10 business days) of receipt of complete information. Written notification of the review determination is sent to the parent or legal guardian, the nursing agency and the attending physician within one (1) business day of the determination.

14. **Notices of certification, denial or modification, will include the following information:**

- Date of notice
- Date(s) of service being denied/modified
- Timeframe within which services will be discontinued
- The process and timeframe for submitting a reconsideration and additional information to be considered on reconsideration

15. The beneficiary/parent or legal guardian, the agency and physician have a right to a reconsideration of any denial or modified decision. Refer to the Private Duty Nursing Reconsideration Process Policy and Procedure section of this manual for additional information.

16. If the case is approved, the URC assigns a Treatment Authorization Number (TAN) and notifies the nursing agency via telephone within one (1) business day of the determination. Written notification is sent to the agency, the parent or legal guardian, and the attending physician within one (1) business day of the determination.

17. **Notices of certification approval will include the following information:**

- Date of notice
- Services being approved, frequency of visits and number of hours certified for each visit [i.e., RN 8 hours per day x 5 days per week (Monday – Friday)]
- The Treatment Authorization Number (TAN)
- Date(s) of service being approved (service start and end dates)
- HCPCS code

18. If the PA confirms a quality issue, the URC forwards the case to a QRN following data entry and notification of utilization review determination. The QRN issues a Quality Issue Notification to the identified source of problem. Refer to the Quality Review Policy and Procedure for additional information on this process.
19. If a quality issue is confirmed, the agency and physician have a right to request a quality re-review. Refer to the Quality Re-review Policy and Procedure section of this manual for additional information.

***Procedure: Concurrent Review***

**NOTE: New plan of care forms are required with each request for certification and continued certifications. This plan of care is due seven (7) business days prior to the last date certified.**

1. For approved (precertified) cases, the URC requests that the nursing agency submit a copy of all nursing progress notes for the previous review period, a complete and signed PDN agency plan of care, monthly summary, and a concurrent certification of medical necessity physician plan of care form within seven (7) business days prior to the last day certified.

NOTE: Use of HSM's Monthly Summary Form is optional. Monthly summary forms approved by PDN agencies are acceptable for submission to HSM with concurrent review requests. However, a monthly summary report(s) is required to accompany all concurrent review certification requests submitted to HSM.

2. HSM notifies the PDN agency 5 business days prior to the certification expiration in writing.
3. The URC evaluates the review request, all attached documents, any changes in the beneficiary's condition or needs. The URC screens the current information against criteria, and reapplies quality screens. The URC assesses whether enough clinical information has been submitted to make a review determination. If not, the additional information is requested via telephone. The additional information must be submitted to HSM within twenty-four (24) hours (or one business day) of the request.
4. If the requested information is not received within twenty-four (24) hours (or one business day), the URC will close the case. A Notice of Incomplete Information - Certification Review Suspended will be sent to the agency/attending physician informing each party that the case has been closed. When the needed information is received, URC review continues.

5. The URC documents whether PDN criteria is met or not, whether a quality screen is failed or not and forwards the recommendation for the number of daily hours, days of the week, and number of days per week to the Physician Advisor for review determination. I
6. The PA reviews the case and all available information and, if necessary, contacts the attending physician to discuss the case (peer-to-peer discussion). If additional information is required, twenty-four (24) hours are allowed for submission of the information. The PA or the URC (if not requested by the PA) requests the information from the physician and, when appropriate, from the nursing agency via telephone.
7. If the requested information is not received within twenty-four (24) hours, the URC will close the case. A Notice of Incomplete Information - Certification Review Suspended will be sent to the agency/attending physician informing each party that the case has been closed. When the needed information is received, PA review continues.
8. The PA makes a determination based on practice standards, and his/her clinical experience and judgment.
9. If continuing PDN services are approved, the URC assigns the existing Treatment Authorization Number (TAN), so the entire episode of care remains linked. The URC notifies the nursing agency via telephone within one (1) business day of the determination. Written notification is sent to the agency, the parent or legal guardian, and the attending physician within one (1) business day of the determination.
10. If the PA's initial determination is to deny or modify the requested services, verbal notification to the agency and/or the physician is made. PAs call the attending physician two (2) times prior to issuance of written denial or modification determination. If no contact occurs because the physician is not available, HSM proceeds with issuance of the denial or modification notification letter. During attempted telephone contacts the PA provides verbal instructions and contact information to the receptionist or nurse at the physician's office, affording the attending physician an opportunity to call the PA to discuss the case (peer-to-peer conversation). HSM makes every attempt to arrange a peer-to-peer conversation within one (1) business day of a request with the same PA making the initial determination or as soon as possible.

**NOTE: A peer-to-peer conversation that occurs following issuance of the denial or modification determination notification in no way may change the PA's initial denial or modification determination. If the attending physician continues to disagree with the PA's determination following the peer-to-peer conversation, the attending physician may submit a request for a reconsideration to HSM. Please refer to the Private Duty Nursing Services Reconsideration Policy and Procedure for detailed information on this process.**

11. A review determination is rendered within two weeks (10 business days) of receipt of complete information. Written notification of the review determination is sent to the parent or legal guardian, the nursing agency and the attending physician within one (1) business day of the determination.
12. The beneficiary/parent or legal guardian, the agency and the physician have a right to a reconsideration of any denial or modified decision. Refer to the Private Duty Nursing Reconsideration Process Policy and Procedure section of this manual for additional information.
13. If a quality issue is confirmed by the PA, the URC forwards the case to the QRN after entering utilization determination results and issuing notification. The QRN issues a Quality Issue Notification to the identified source of problem. Refer to the Quality Review Policy and Procedure for additional information on this process.
14. If a quality issue is confirmed, the agency and the physician have a right to request a quality re-review. Refer to the Quality Re-review Policy and Procedure section of this manual for additional information.