

Private Duty Nursing Reconsideration Process

Objective:

To provide the opportunity to request and receive a reconsideration of a private duty nursing utilization review denial determination or modified approval for any beneficiary/parent or legal guardian, provider or physician who disagrees with the determination.

Performed By:

Denial/Reconsideration Coordinator (DRC), Medical Director (MD), Physician Advisors(PA)

Policy:

HSM notifies the beneficiary/parent or legal guardian, provider, and attending physician in writing of all denial determinations or modified approvals. HSM will only phone-notify the requesting party. Any party who receives a denial notice and disagrees with the determination may request a reconsideration of the determination.

The request may be submitted to HSM by mail or fax, within thirty (30) calendar days of the date of the denial notice. HSM has developed a Reconsideration Request form for PDN agencies and physicians to use for this purpose. The beneficiary may submit any type of written request for reconsideration.

HSM will conduct the reconsideration review for all timely requests and will make a decision to perform reconsideration review on a case-by-case basis for untimely requests. Any additional information you wish to be considered must accompany the request for reconsideration. Reconsiderations will be performed whether or not additional information is submitted.

If the beneficiary/parent or legal guardian, physician, or PDN agency choose not to exercise the option for a reconsideration, benefits for private duty nursing services will be discontinued thirty (30) calendar days from the date of the denial notice. If a reconsideration request is received by HSM, benefits will continue while the reconsideration process is being completed.

HSM will ensure that the Physician Advisor (PA) performing the reconsideration meets the terms of its contract with DOM and is not the PA who originally reviewed and denied the review request.

HSM will complete the review within thirty (30) calendar days of receipt of the request. The beneficiary parent or legal guardian, physician, and PDN agency will be notified in writing of the reconsideration determination. The requestor will be notified by phone notified of the determination.

Procedure:

1. Upon receipt of a request for reconsideration, the Denial/Reconsideration Coordinator (DRC) will determine if the request is timely, and ascertain whether additional (clinical) information was included in the request.
2. Untimely requests will be logged, and written notification (Notice of Untimely Request for Reconsideration) indicating the reason(s) why the reconsideration will not be performed will be sent to the requestor(s).
3. Each timely request for reconsideration will be processed. The reconsideration review will be performed by the Medical Director/Associate Medical Director or a PA selected by the Medical Director/Associate Medical Director or a PA who is:
 - Not associated with the original denial
 - Not related to the beneficiary
 - Not responsible for the care of the beneficiary
 - Is a physician licensed in Mississippi who is board certified in the specialty consistent with the type of care under review
 - Has active admitting privileges at one or more hospitals in Mississippi
 - Is not the subordinate of the physician who made the initial denial determination
4. The PA will review the information that led to the denial determination, the complete HSM case file, and any additional information submitted. The PA may contact the attending physician by telephone to discuss the case.
5. Reconsideration determinations will be made within thirty (30) calendar days after receipt of a timely request for reconsideration and all necessary information.
6. The beneficiary/parent or legal guardian, physician, and PDN agency will be notified of the results of the reconsideration (i.e., denial was upheld, reversed or modified) in writing within one (1) business day of the determination.

Written notification includes information to advise the Medicaid beneficiary/parent or legal guardian of the right to request an Administrative Appeal from the Division of Medicaid (DOM) within fifteen (15) calendar days of notification if the original denial was upheld or modified. Directions for how to request such an appeal are also provided. If the beneficiary/parent or legal guardian chooses not to exercise the option for an Administrative Appeal, benefits for private duty nurses will discontinue fifteen (15) calendar days from the date of the appeal notice. If an Administrative Appeal is requested, benefits will continue while the Administrative Appeal process is being completed. The requestor is notified verbally by telephone of the appeal determination.