

To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

- 3A, *Home Health Service*
- 3G-2, *Private Duty Nursing for Beneficiaries under 21 Years of Age*
- 3D, *Hospice*
- 3H-1, *Home Infusion Therapy*
- 3K-1, *Community Alternatives Program for Children (CAP/C)*
- 5A, *Durable Medical Equipment*
- 8P, *NC Innovations*
- 10D, *Independent Practitioners Respiratory Therapy Services*

1.0 Description of the Procedure, Product, or Service

Private Duty Nursing

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing service that is considered supplemental to the care provided to a beneficiary by the beneficiary's family, foster parents, and delegated caregivers, as applicable. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility; or that requires more continuous care than is available through home health services. PDN must be medically necessary for the beneficiary to be covered by the NC Medicaid.

PDN services are provided:

- a. only in the beneficiary's private primary residence;
- b. under the direction of a written individualized plan of care;
- c. authorized by the beneficiary's primary physician; and
- d. PDN services must be rendered by a registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing (NCBON) and employed by a state licensed and accredited home care agency.

1.1 Definitions

1.1.1 Skilled Nursing

For this policy, nursing services as defined by 10A NCAC 13J.1102 is referred to as "skilled nursing."

Skilled nursing does not include those tasks that can be delegated to unlicensed personnel according to 21 NCAC 36.

1.1.2 Nursing Care Activities

Activities as defined by 21 NCAC 36 .0401. For this policy, Nursing Care Activities are referred to as "tasks."

1.1.3 Substantial

Substantial means there is a need for interrelated nursing assessments and interventions. Interventions not requiring an assessment or judgment by a licensed nurse are not considered substantial.

1.1.4 Complex

Complex means scheduled, hands-on nursing interventions. Observation in case an intervention is required is not considered complex skilled nursing and is not covered by Medicaid as medically necessary PDN services.

1.1.5 Continuous

Continuous means nursing assessments requiring interventions are performed at least every two (2) or three (3) hours during the period Medicaid-covered PDN services are provided.

1.1.6 Significant Change in Condition

Significant change means a change in the beneficiary's status that is not self-limiting, impacts more than one (1) area of functional health status, and requires multidisciplinary review or a revision of the plan of care according to program requirements specified in **Sections 3.0** and **4.0** of this policy.

1.1.7 Primary Caregivers

- a. A **fully available** primary caregiver is one who lives with the beneficiary, is not employed and who is physically and cognitively able to provide care.
- b. A **partially available** primary caregiver is one who lives with the beneficiary and has verified employment or who has been determined by the Social Security Administration to be unable to work due to a disability and the nature of the disability is one that limits the ability of that person to provide care to the PDN beneficiary.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term "General" found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

An eligible Medicaid beneficiary shall be 21 years and older.

Eligibility categories are:

1. Fee-for-Service: Beneficiaries covered by Medicaid are eligible to apply for PDN services.
2. Medicaid for Pregnant Women (MPW): Pregnant women may be eligible to apply for PDN services if the services are medically necessary for a pregnancy-related condition.
3. Medicare Qualified Beneficiaries (MQB): Medicaid beneficiaries who are Medicare-qualified beneficiaries (MQB) are not eligible for PDN.
4. Managed Care: Medicaid beneficiaries participating in a managed care program, such as Medicaid health maintenance organizations and Community Care of North Carolina programs(CCNC), (Carolina ACCESS and ACCESS II/III), must access home services, including PDN, through their primary care physician.

b. NCHC

NCHC beneficiaries are not eligible for Private Duty Nursing (PDN).

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <https://medicaid.ncdhhs.gov/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

NC Medicaid shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the NC Medicaid clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries Under 21 Years of Age

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Medicaid shall cover PDN when:

- a. Eligibility criteria in **Section 2.0** are met;
- b. Health criteria in **Section 3.3** are met;
- c. Provided only in the primary private residence of the beneficiary. The basis for PDN approval is the need for skilled nursing care in the primary private residence to prevent institutionalization. A beneficiary who is authorized to receive PDN services in the primary private residence may make use of the approved hours outside of that setting when normal life activities temporarily take him or her outside that setting. Normal life activities are supported or sheltered work settings, licensed childcare, school and school related activities, and religious services and activities. Normal life activities are not inpatient facilities, outpatient facilities, hospitals, or residential-type medical settings;
- d. PDN services have been requested by (Refer to **Attachment C**) and ordered by the beneficiary's primary physician (MD) or Doctor of Osteopathic Medicine (DO) licensed by the North Carolina Board of Medicine and enrolled with Medicaid) on the CMS-485 (Home Health Certification and Plan of Care Form);
- e. Prior approval has been granted by NC Medicaid according to **Section 5.0 of this policy** (Refer to **Attachment A**); and
- f. The beneficiary has at least one (1) trained primary informal caregiver to provide direct care to the beneficiary during the planned and unplanned absences of PDN staff. It is recommended that there be a second trained informal caregiver for instances when the primary informal caregiver is unavailable due to illness, emergency, or need for respite.

3.2.3 NCHC Additional Criteria Covered

None Apply

3.3 Health Criteria

3.3.1 PDN Level 1 Services

To be eligible for Level 1 PDN services, the beneficiary shall:

- a. be dependent on a ventilator for at least eight (8) hours per day, or
- b. meet at least four (4) of the following criteria:
 1. unable to wean from a tracheostomy;
 2. require nebulizer treatments at least two (2) scheduled times per day and one (1) as needed time per day;
 3. require pulse oximetry readings every nursing shift;
 4. require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency;
 5. require oxygen as needed, also known as pro re nata (PRN) or has PRN rate adjustments at least two (2) times per week;
 6. require tracheal care at least daily;
 7. require PRN tracheal suctioning. Suctioning is defined as tracheal suctioning requiring a suction machine and a flexible catheter; or
 8. at risk for requiring ventilator support.

3.3.2 PDN Level 2 Services

Medicaid beneficiaries who meet ALL the criteria for Level 1 nursing services plus at least one (1) of the criteria below may be eligible for additional PDN services:

- a. use of respiratory pacer;
- b. dementia or other cognitive deficits in an otherwise alert or ambulatory recipient;
- c. infusions, such as through an intravenous, Peripherally Inserted Central Catheter (PICC) or central line;
- d. seizure activity requiring use of PRN use of Diastat, oxygen, or other interventions that require assessment and intervention by a licensed nurse;
- e. primary caregiver who is 80 or more years of age or who has a disability confirmed by the Social Security Administration (SSA) and the disability interferes with caregiving ability; or
- f. determination by Adult Protective Services that additional hours of PDN would help ensure the recipient's health, safety, and welfare.

Note: Level 2 PDN services, in most cases, allows an additional 14 hours per week - as long as that new total does not exceed the program maximum limit of 112 hours per week.

3.4 Amount, Duration, Scope, and Sufficiency of PDN Services

NC Medicaid shall determine the amount, duration, scope, and sufficiency of PDN services – not to exceed 112 hours per week or 16 hours per day - required by the beneficiary based on a comprehensive review of all the documents listed in **Subsection 5.2.3**, along with the following characteristics of the beneficiary:

- a. Primary and secondary diagnosis;
- b. Overall health status;
- c. Level of technology dependency;
- d. Amount and frequency of specialized skilled interventions required;

- e. Amount of caregiver assistance available. Verification of employment hours are conducted annually. Allowances are not for second jobs, overtime, or combination of work and school, when the additional hours cause the policy limit to be exceeded;

Hours are approved on a per-week basis beginning 12:01 a.m. Sunday and ending at 12:00 a.m. Saturday. A Beneficiary may use the hours as he or she chooses. A beneficiary approved for 70 hours per week may use ten hours per day seven (7) days per week, or may use 14 hours per day five (5) days per week. It is the responsibility of the beneficiary and caregiver to schedule time to ensure the health and safety of the beneficiary. Additional hours are not approved because the family planned poorly and ‘ran out’ before the end of the week.

Note: Unused hours of services must not be “banked” for future use or “rolled over” to another week.

Approved hours are determined as follows:

| Informal Caregiver Availability | Standard PDN Services (Refer to Subsection 3.3.1- Level 1 Services) | Expanded PDN Services (Refer to Subsection 3.3.2 Level 2 Services) |
|---|--|--|
| Two or more fully available caregivers | 56 hours per week | 70 hours per week |
| One fully available caregiver, with or without the presence of any other caregivers | 76 hours per week | 90 hours per week |
| Two or more partially available caregivers | 56 hours per week plus time absent for work, up to maximum of 96 hours per week | 70 hours per week plus time absent for work, up to maximum of 110 hours per week |
| One partially available caregiver | 76 hours per week plus time absent for work, up to maximum of 112 hours per week | 90 hours per week plus time absent for work, up to maximum of 112 hours per week |

3.4.1 Short Term Increase in PDN Services for a Significant Change in Condition

A short-term increase in PDN services is limited to a maximum of four (4) calendar weeks. The amount and duration of the short-term increase is based on medical necessity, and approved by NC Medicaid’s PDN Nurse Consultant.

Medicaid shall cover a short-term increase in PDN service when the beneficiary meets ONE of the following significant changes in condition:

- a. Beneficiary with new tracheostomy, ventilator, or other technology need, immediately post discharge, to accommodate the transition and the need for training of informal caregivers. Services generally start at a high number of hours and are weaned down to within normal policy limits over the course of the four (4) weeks.
- b. An acute, temporary change in condition causing increased amount and frequency of nursing interventions.
- c. A family emergency, when the back-up caregiver is in place but requires additional support because of less availability or need for reinforcement of training.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

Medicaid shall not cover PDN if any of the following are true:

- a. the beneficiary is receiving medical care in a hospital, nursing facility, outpatient facility, or residential-type medical setting where licensed personnel are employed;
- b. the beneficiary is a resident of an adult care home, group home, family care home, or nursing facility;
- c. the service is for custodial, companion, respite services (short-term relief for the caregiver) or medical or community transportation services;
- d. the nursing care activities rendered can be delegated to unlicensed personnel (Nurse Aide I or Nurse Aide II), according to 21 NCAC 36.0401 and 21 NCAC 36.0221(b);
- e. the purpose of having a licensed nurse with the beneficiary is for observation or monitoring in case an intervention is required;
- f. the service is for the beneficiary or caregiver to go on vacation or overnight trips away from the beneficiary's private primary residence.
Note: Short-term absences from the primary private residence that allow the beneficiary to receive care in an alternate setting for a short period of time may be allowed as approved by the PDN Nurse Consultant and when not provided for respite, when not provided in an institutional setting, and when provided according to nurse and home care licensure regulations;
- g. services are provided exclusively in the school or home school;
- h. the beneficiary does not have informal caregiver support available as per **Subsection 3.2.2.f**;
- i. the beneficiary is receiving home health nursing services or respiratory therapy treatment (except as allowed under clinical coverage policy 10D, *Independent Practitioners Respiratory Therapy Services*) during the same hours of the day as PDN;

- j. the beneficiary is receiving infusion therapy services as found under the clinical coverage policy 3H-, *Home Infusion Therapy (HIT)* program; or
- k. the beneficiary is receiving hospice services as found under clinical coverage policy 3D, *Hospice Services*, except as those services may apply to children under the Patient Protection and Affordable Care Act. H.R.3590
- l. the beneficiary is receiving services from other formal support programs (such as NC Innovations) during the same hours of the day as PDN.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Medicaid shall require prior approval (PA) before rendering Private Duty Nursing (PDN) Services.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Personnel the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific Criteria

5.2.2.1 Initial Referral Process

The hospital discharge planner or referring medical provider shall refer a potential beneficiary to a PDN service agency to initiate the service review process.

The PDN service agency shall submit the documents (as listed in **Subsection 5.2.2.2**) with an initial request for PDN services.

5.2.2.2 Initial PDN Service Review Documentation Requirements

Specifically, the following documents are required for an eligibility assessment review:

- a. PDN Prior Approval Referral Form DMA-3061 (refer to **Attachment D**);
- b. NC Medicaid Physician's Request form DMA-3075 (refer to **Attachment C**) or a physician signed letter of medical necessity. Either type of physician's request must contain ALL the following:
 1. The current diagnosis(es);
 2. History and date of onset of the illness, injury, or medical condition for which PDN services are requested;
 3. Date(s) of any related surgeries;
 4. The projected date of hospital discharge, if applicable;
 5. A prognosis and the estimated length of time PDN services is required; and
 6. The specific licensed nursing interventions needed and the frequency of those interventions.
- c. Hospital discharge summary (if from hospital discharge) or clinical notes from the last two (2) office visits;
- d. Most recent history and physical;
- e. Signed physician's order from the referring physician or discharging physician must contain the specific skilled nursing interventions and the frequency of those interventions.

Note: If observation and assessment is the only skilled nursing intervention required, then the beneficiary's skilled needs are not sufficient for PDN services; and
- f. Employment Attestation Form for caregiver(s) (refer to **Attachment F**).

Note: PDN service providers shall indicate in their submitted documents the family members and other caregivers who are available to furnish care and that they have been or shall be provided training on the necessary care.

Once all required documents are received, NC Medicaid shall complete a clinical review for PDN services. Incomplete documentation is handled as unable to process or as an incomplete request.

5.2.2.3 Initial Referral Provisional Approval

When all required documents are received by NC Medicaid (refer to **Subsection 5.2.2.4**), NC Medicaid shall conduct a comprehensive clinical review for PDN services. With NC Medicaid approval, the initial provisional request for PDN services is granted for 30 calendar days only. This is a provisional approval pending receipt of final documentation. The physician signed Home Health Certification and Plan of Care Form (CMS 485) and Verification of Employment Form (refer to **Attachment F**), and the provider's consent to treat are due by

day 30. When NC Medicaid receives these documents, PA is granted for the remainder of the six (6) - month certification period.

Note: Beyond the provisional time frame, PA is only granted from the date of documents submission.

5.2.2.4 Initial Referral Continuation Approval

To receive PA for service provision for the remainder of the six (6)-month certification period, the PDN agency shall:

- a. Complete a comprehensive in home assessment within 24 hours of the start of care (SOC).
- b. PDN service providers shall upload, into NC Tracks, the physician signed CMS-485 along with the Employment Verification form and provider's consent to treat as supporting documentation for PA requests by day 30 of the Provisional PA period.
- c. NC Medicaid shall process the continuation approval for PDN services within 15 business days of the receipt of all required information from the PDN service provider.
- d. A letter is sent to the beneficiary, or the beneficiary's representative. The approval letter contains:
 1. the beneficiary's name and MID number;
 2. the name and provider number of the authorized PDN service provider;
 3. the number of hours per week approved for PDN services, beginning with Sunday at 12:01 am; and
 4. the starting and ending dates of the approved certification period, Certification periods are six (6) months.

5.2.2.5 Plan of Care

The physician signed Home Health Certification and Plan of Care Form (CMS-485) must contain:

- a. All pertinent diagnoses, including the beneficiary's mental status;
- b. The type of services, medical supplies, and equipment ordered;
- c. The number of hours of PDN per day and number of days per week, according to 42CFR 409.43 Plan of Care Requirements;
- d. Specific assessments and interventions to be administered by the nurse;
- e. Individualized nursing goals with measurable outcomes;
- f. Verbal order and date, signed by RN if CMS-485 (Locator 23) is not signed by the physician in advance of the recertification period;
- g. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications-indicating new or changed in last 30 calendar days, and treatments;
- h. Teaching and training of caregivers;
- i. Safety measures to protect against injury;
- j. Disaster plan in case of emergency or natural occurrence; and
- k. Discharge plans individualized to the beneficiary.

Note: The PA period is a maximum of six (6)-months, but the physician signed CMS-485 shall be uploaded every 60 days. Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

5.2.2.6 Reauthorization Process

To recertify for PDN services, the PDN service provider shall submit the reauthorization documents to NC Medicaid at least 30 calendar days prior to the end of the current approved certification period. Submitted documents required are: Hourly Nursing Review Criteria form (refer to **Attachment G**), PDN Medical Update/Beneficiary Information Form DMA-3062 (refer to **Attachment E**) and physician signed Home Health Certification and Plan of Care Form (CMS-485) (refer to **Attachment B**).

The CMS-485 must document:

- a. All pertinent diagnoses along with the beneficiary's mental status;
- b. The type of services, medical supplies, and equipment ordered;
- c. The specific number of hours of PDN per day (a range of hours is not acceptable) and number of days per week;
- d. Specific assessments and interventions to be administered by the licensed nurse;
- e. Individualized nursing goals with measurable outcomes;
- f. Verbal order and date, signed by RN if CMS-485 (Locator 23) is not signed by the physician in advance of the recertification period;
- g. The beneficiary's prognosis, rehabilitation potential, functional limitations, permitted activities, nutritional requirements, medications-indicating new or changed in last 30 calendar days, and treatments;
- h. Teaching and training of caregivers;
- i. Safety measures to protect against injury;
- j. Disaster plan in case of emergency or natural occurrence; and
- k. Discharge plans individualized to the beneficiary.

Note: The PA period is a maximum of six (6)-months, but the physician signed CMS-485 shall be uploaded every 60 days. Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

If any of the documents are omitted or incomplete, the request for PA is treated as an incomplete request and NC Medicaid is unable to process.

Note: If the recertification request is received after the beginning of the new certification period, NC Medicaid shall only approve PA from the date of submission of the request.

5.2.2.7 Documentation Required for PDN Service Reauthorization

All the following documents are required for reauthorizations:

- a. A copy of the completed PDN Medical Update/Beneficiary Information Form, which also indicates the date of the last physician visit (refer to **Attachment E**);
- b. A copy of the Home Health Certification and Plan of Care Form CMS-485 (**Attachment B**) signed and dated by the attending physician. The CMS-485 needs to specify: at minimum - skilled nursing care to be provided, recertification dates, frequency and duration of PDN services being requested;
- c. The completed Hourly Nursing Review Criteria (**Attachment G**);
- d. At NC Medicaid's discretion, an in-home assessment may be performed by NC Medicaid;
- e. NC Medicaid reserves the right to verify caregiver's employment schedule annually and as deemed appropriate by NC Medicaid. Verification consists of a statement on employer letterhead signed by a supervisor or representative from the employer's Human Resources Department, detailing the employee's current employment status (such as active or on family medical leave) and typical work schedule. If a caregiver is self-employed or unable to obtain a letter, the Verification of Employment form, **Attachment F**, may be used;
- f. Nurses' notes from the latest certification period as requested by NC Medicaid.

Note: The PA period is a maximum of six (6) months, but the physician signed CMS-485 shall be uploaded every 60 days. Refer to **Attachment B** for an example of the Home Health Certification and Plan of Care Form (CMS-485).

Note: If any of the above documents are omitted or incomplete, the request for PA is treated as incomplete and NC Medicaid is unable to process.

5.2.2.8 Re-Evaluation during the Approved Period

If the beneficiary experiences a significant change of condition, the PDN service provider shall notify NC Medicaid. NC Medicaid shall re-evaluate services at that time.

5.2.3 Requests to Change the Amount, Scope, Frequency, or Duration of Services

Any requests to change the amount, scope, frequency, or duration of services must be ordered by the attending physician and approved by NC Medicaid.

5.2.3.1 Plan of Care Changes

Any request to increase or decrease the amount, scope, frequency or duration of services must be approved by NC Medicaid prior to implementation.

5.2.3.2 Temporary Changes

Requests to decrease the amount, scope, frequency, or duration of services for seven (7) days or less, such as over a holiday when additional family members are available to provide care and services, do not require NC Medicaid approval. Previously approved service levels can resume after the family situation returns to the normal routine. The agency shall document the reason for the decrease in services and supportive information, notifying the physician as appropriate.

5.2.3.3 Emergency Changes

Sudden changes in the amount, scope, frequency or duration of services must be based on true emergent medical necessity of beneficiary. Emergency changes initiated outside of regular business hours must be reported to NC Medicaid the next business day. The written request must contain specific information regarding changes in the beneficiary's medical condition and a documented verbal order supplemental order. A physician signed order must be provided to NC Medicaid within 15 business days.

5.2.4 Termination or Reduction

PDN services may be reduced or terminated by the beneficiary's attending physician, the beneficiary or their legal representative, or NC Medicaid. Upon termination or reduction, NC Medicaid enters information into the fiscal agent's claims system to deny payment for all services provided after the termination date. Important information about the Medicaid Beneficiary Due Process (Appeal Rights) is found at: <https://medicaid.ncdhhs.gov/>

5.2.4.1 Notification of Termination

The termination process is determined by the following:

- a. If the PDN service provider discharges the beneficiary, the service provider shall send a copy of the physician's order to terminate services to NC Medicaid within five (5) business days.
- b. If the PDN service provider discharges the beneficiary from Medicaid coverage because there is another source of nursing care coverage, the service provider shall notify NC Medicaid in writing. The notification must include the last date that PDN services were provided and can be billed to Medicaid and the name of the other source of coverage as applicable.
- c. If the attending physician discharges the beneficiary, the PDN service provider shall provide to NC Medicaid, within five (5) business days, the physician's order to terminate beneficiary services.

- d. If services are terminated as a result of the beneficiary's loss of Medicaid, or if no PDN services are provided during the 30 consecutive days for any reason including hospitalization, then the prior approval process must be initiated once again as outlined in **Subsections 5.2 and 5.3.**

Note: The decision of the beneficiary's attending physician or the PDN service provider to discharge the beneficiary cannot be appealed to NC Medicaid.

5.2.4.2 Notification of Reduction

The reduction process is determined by the following:

- a. If the PDN service provider reduces the PDN services: the service provider shall send NC Medicaid, within five (5) business days, a copy of the physician's order to reduce services.
- b. If the attending physician reduces the PDN services: the PDN service provider shall provide to NC Medicaid, within five (5) business days, the physician's order to reduce beneficiary services.
- c. If NC Medicaid initiates reduction of PDN services because it has determined that the beneficiary no longer meets the administrative requirements and/or medical criteria. NC Medicaid may request additional information from the PDN service provider. In the event the additional information is not provided within 10 business days of the notice of the reduction (or other time frame agreed upon by the provider and NC Medicaid nurse consultant), NC Medicaid shall proceed with the reduction of services.

5.2.5 Changing Service Providers

Requests to change PDN service providers may occur as a result of a beneficiary's exercising freedom of choice.

5.2.5.1 Transfer of Care Between Two Branch Offices of the Same Agency

The new PDN service provider shall facilitate the change by coordinating the transfer of care with the beneficiary's attending physician, the current PDN service provider, and others who are involved in the beneficiary's care. The new PDN service provider is responsible for the following:

- a. Submitting the transfer request to NC Medicaid within five (5) business days of the request;
- b. Obtaining written permission from the beneficiary or legal guardian regarding the request to transfer;
- c. Coordinating the date the new provider assumes beneficiary care, and ensuring that duplication of service is avoided;
- d. Providing, in the written notification, the new provider's name and full mailing address, the new provider's PDN service provider number, the date the new provider plans to initiate services, the name of the person at the previous agency with whom the transfer

was coordinated, the name and telephone number of the new provider's contact person, and the responsible party's contact information;

- e. Ensuring that written and verbal orders are verified and documented according to 10A NCAC 13J, The Licensing of Home Care Agencies; and
- f. Forwarding to NC Medicaid, prior to transfer, written notification of the transfer along with a copy of the attending physician's orders.

5.2.5.2 Transfer of Care Between Two Different Agencies

Follow the same procedure as listed above in **Subsection 5.2.5.1**, but also submit:

- a. the PDN Prior Approval Referral Form DMA-3061 (refer to **Attachment D**)
- b. the physician signed Home Health Certification and Plan of Care Form CMS-485 (physician's orders) (refer to **Attachment B**)
- c. Physician's Request Form for Private Duty Nursing DMA 3075 (refer to **Attachment C**) *or* a letter of medical necessity signed by the physician.

5.2.5.3 Discharge Summary

The former PDN service provider shall forward to NC Medicaid a discharge summary that specifies the last day PDN services were provided to the beneficiary.

5.2.5.4 Approval Process

After all requirements are met, NC Medicaid approves the new PDN service provider and forwards an approval letter, with copies to the beneficiary's attending physician, the beneficiary (and representative if applicable) in accordance with the beneficiary notices procedure.

5.2.6 Coordination of Care

The beneficiary's attending physician and the PDN service provider are responsible for monitoring the beneficiary's care and initiating any appropriate changes in PDN services.

5.2.6.1 Transfers Between Health Care Settings

If a beneficiary is placed in a different health care setting due to a change in his or her medical condition, the PDN service provider shall contact NC Medicaid prior to the beneficiary's discharge to discuss any required changes in PDN services. A history and physical and a discharge summary must be submitted to NC Medicaid.

5.2.6.2 Drug Infusion Therapy

If a beneficiary requires drug infusion therapy, the Durable Medical Equipment (DME) supplier provides the drug infusion equipment, and drugs are provided through Medicaid's or Medicare's Part D pharmacy coverage. The PDN provider is responsible for the administration and caregiver teaching of the infusions.

5.2.6.3 Enteral or Parenteral Nutrition

If a beneficiary requires enteral or parenteral nutrition, the DME supplier provides the equipment, supplies, and nutrients. Home health and Home Infusion would be duplication.

Refer to **Section 4.0** for information on services that are not covered when the beneficiary is receiving PDN services.

5.2.6.4 Home Health Nursing

Home Health nursing services may not be provided concurrently with PDN Services. When a beneficiary requires Home Health medical supplies, the PDN provider shall provide and bill for those supplies. The PDN provider is also expected to handle blood draws, wound care, and other home health nursing tasks for a PDN beneficiary.

5.2.6.5 Medical Supplies

Medical supplies are covered as per the criteria for coverage of medical supplies and use of the miscellaneous procedure code for medical supplies defined in clinical coverage policies 3A, *Home Health Services* and 5A, *Durable Medical Equipment* at <https://medicaid.ncdhhs.gov/>.

An enrolled PDN provider may bill for Medicaid-covered medical supplies as above if provided to a NC Medicaid-approved PDN beneficiary during the provision of PDN services.

Refer to **Subsection 7.2** for documentation requirements.

5.3 Limitations on the Amount, Frequency, and Duration

5.3.1 Unauthorized Hours

PDN services provided in excess of the approved amount (the excess has not been authorized by NC Medicaid) are the financial responsibility of the provider agency.

5.3.2 Transportation

The PDN nurse may not transport the beneficiary. The licensed nurse may accompany the beneficiary if medically necessary as defined in **Subsection 3.2** when his or her normal life activities require that the beneficiary access the community within the NC Medicaid approved time scheduled for PDN services.

5.3.3 Medical Settings

PDN is not covered for a beneficiary in a hospital, nursing facility, outpatient facility, or residential-type medical setting where licensed personnel are employed and have prescribed responsibility for providing care for the designated beneficiary.

5.3.4 Weaning of a Medical Device

NC Medicaid or its designee may authorize PDN services for a brief period after the beneficiary no longer requires the medical device to compensate for loss of a

vital body function. This period shall not exceed two (2) weeks past the weaning of the medical device. The provider agency shall contact the physician to obtain an order to decrease PDN services once a significant change in condition and need for skilled nursing care has occurred.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

PDN services must be provided by home care agencies accredited with Joint Commission, Community Health Accreditation Partner (CHAP), or Accreditation Commission for Health Care (ACHC); and holding a current license from the N.C. Division of Health Service Regulation (DSHR) or as applicable, Eastern Band of Cherokee providers must be a Medicare Certified Home Health Agency. The home care agency shall be an enrolled N.C. Medicaid provider approved by NC Medicaid to provide PDN services. Each office of the home care agency providing services shall have an individual N.C. Medicaid PDN National Provider Identifier (NPI) number.

6.2 PDN Service Provider Responsibilities

The PDN service provider is responsible for:

- a. ensuring that qualified and competent licensed nurses are assigned to provide skilled nursing care as required by the plan of care and the services are provided within the nurses' scope of practice as defined by 21 NCAC 36;
- b. ensuring accreditation with Joint Commission, Community Health Accreditation Partner (CHAP), Accreditation Commission for Health Care (ACHC) or federal law, including the IHCA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136 and Section 5006 of the American Recovery and Reinvestment Act (ARRA) of 2009. as appropriate.
- c. ensuring orientation and competency assessment of skills are sufficient to meet the plan of care requirements before assigning the nurse to the beneficiary's care;
- d. ensuring RNs and LPNs have documented continuing education hours, as per NC Board of Nursing;
- e. developing and providing orientation to licensed nurses for policies and procedures consisting of the following:
 1. organizational chart and line of supervision;
 2. on-call policies;
 3. record keeping and reporting;
 4. confidentiality and privacy of Protected Health Information (PHI);
 5. patient's rights;

6. advance directives;
7. written clinical policies and procedures;
8. training for special populations such as pediatrics, ventilator care, tracheostomy care, wound, infusion care;
9. professional boundaries;
10. supervisory visit requirements to include new and experienced personnel;
11. criminal background checks;
12. Occupational Safety and Health Administration (OSHA) requirements, safety, infection control;
13. orientation to equipment;
14. cardiopulmonary resuscitation training and documentation;
15. incident reporting;
16. cultural diversity and ethnic issues; and
17. translation policy.

Note: Documentation of all training and competency must be retained in the personnel file of each licensed nurse and available to NC Medicaid upon request.

6.3 Provider Relationship to Beneficiary

To provide PDN services reimbursed by Medicaid, the provider agency must not employ:

- a. a member of the beneficiary's immediate family (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step- and in-law relationships); or
- b. a legally responsible person who maintains his or her primary private residence with the beneficiary; or
- c. the nurse shall not live with the beneficiary in any capacity.

6.4 Nurse Supervision Requirements

The PDN nurse supervisor shall have at least two (2) years of Intensive Care Unit, Coronary Care Unit, Neonatal Intensive Care Unit, Pediatric Intensive Care Unit or other experience in other critical care settings or two (2) years' home care experience with medically fragile beneficiaries or a combination of the previous. NC Medicaid prefers additional direct clinical supervisory experience.

6.5 Provider Certifications

None Apply

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Documentation Requirements

7.2.1 Contents of Records

The PDN service provider is responsible for maintaining complete and accurate records of all care, treatment, and interventions that fully document the beneficiary's condition, nursing interventions, and treatment provided. The records must contain:

- a. The date and time the skilled care was provided;
- b. All nursing interventions, to include time, activity, and beneficiary's response;
- c. Certification that all care was provided according to the attending physician's orders, the beneficiary's current individualized plan of care, and NC Medicaid approval;
- d. Signature of beneficiary or caregiver acknowledging time spent and services rendered. This signature shall be obtained daily;
- e. Hourly Nursing Review Criteria (Refer to **Attachment H**).
- f. Indicate place of service, if other than residence (such as school, outings, travel to medical appointments);
- g. Use of medical supplies to support quantities delivered and used;
- h. Document to whom report was given and received from;
- i. indicate present and available caregivers;
- j. Document of caregiver education, competency and learning needs and progress toward teaching goals;
- k. Document safety issues and appropriate interventions;
 - l. Coordination with other homecare services to ensure no duplication of services;
- m. Document other in home services such as Respiratory Therapy, Therapy Services, Habilitation Aides, etc.;
- n. Document a medical update (such as a face-to-face encounter with physician/Non-Physician Provider) and submit to NC Medicaid with each reauthorization; and
- o. Document supervisory visits according to agency policy and licensure rules.

The provider(s) shall submit to NC Medicaid any requested documents that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

7.2.2 Termination of Operations

If an agency ceases operation, NC Medicaid must be notified in writing where the records are stored.

7.3 Verification of Eligibility

The PDN service provider is required to verify the beneficiary's eligibility, Medicaid coverage category, other insurance coverage, and living arrangement before initiating services and during delivery of PDN services.

7.4 Qualified Family and Other Designated Caregivers

7.4.1 Primary Caregiver

The beneficiary shall have at least one trained informal primary caregiver. It is recommended that there also be a second informal caregiver for instances of primary informal caregiver unavailability due to illness or emergency and for occasional respite for the primary caregiver. Both informal caregivers shall be trained and available to provide care in the home during the absence of the PDN nurse and as required by the beneficiary's medical status.

7.4.2 Training

As part of the PDN service, the PDN service provider shall provide and document training and educational needs of the beneficiary (when applicable), family members, and designated caregivers in accordance with the beneficiary's plan of care. In particular, training provided by the PDN provider and by the hospital prior to a beneficiary's beginning PDN services, should be documented.

7.4.3 Documenting Competency

Family members and other designated caregivers shall demonstrate competency in providing the care that the beneficiary will require when the PDN nurse is not present. The PDN service provider is responsible for documenting to NC Medicaid those family members and other designated caregivers who have demonstrated competency in providing the care required by the beneficiary. Documentation of discharge teaching provided by a hospital may be part of documenting competency.

7.4.4 Emergency Plan of Action

An emergency plan of action must be developed, and all family members and caregivers shall know the procedures to take if the beneficiary requires emergency medical care.

7.4.5 Evaluation of Health and Safety

Prior to initiating services and with continuation of PDN services, the PDN service provider is responsible for evaluating the family and home environment in terms of the health, safety, and welfare of the beneficiary and PDN nursing staff, consistent with the agency's policies and licensure requirements.

7.5 Patient Self Determination Act

The Patient Self Determination Act of 1990, Sections 4206 and 4751 of the Omnibus Budget Reconciliation Act of 1990, P.L.101-508 requires that Medicaid-certified hospitals and other health care providers and organizations, give patients information about their right to make their own health decisions, including the right to accept or refuse medical treatment. Providers shall comply with these guidelines. *NCTracks Provider Claims and Billing*

Assistance Guide: <https://www.netracks.nc.gov/content/public/providers/provider-manuals.html>

7.6 Marketing Prohibition

Agencies providing PDN under this Medicaid Program are prohibited from offering gifts or service related inducements of any kind to entice beneficiaries to choose it as their PDN Provider or to entice beneficiaries to change from their current provider.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1988

Revision Information:

| Date | Section Revised | Change |
|------------|------------------------------------|---|
| 12/01/2012 | All sections and attachment(s) | Initial promulgation of coverage from a manual. |
| 12/01/2012 | All sections and attachment(s) | Technical changes to merge Medicaid and NCHC current coverage into one policy. |
| 10/01/2015 | All Sections and Attachments | Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable. |
| 02/01/2016 | Subsection 6.2.1.b | Removed statement, "All current PDN providers shall be fully accredited within 18 months of the effective date of this policy." |
| 03/01/2017 | All Sections and Attachments | Changed name and number to "3G-1 Private Duty Nursing for Beneficiaries Age 21 and Older" |
| 03/01/2017 | All Sections and Attachments | Portions of the policy pertaining to beneficiaries under 21 years of age were removed. |
| 03/01/2017 | Subsection 5.2.2.3 | Added provisional prior approvals for Initial PDN Referrals |
| 03/01/2017 | Various Sections | Changed the certification period from 60 days to 90 days. |
| 03/01/2017 | Various Sections | Removed the experience requirement for PDN nurses |
| 03/01/2017 | Various Sections | Expand the expertise areas for PDN Nursing Supervisors. |
| 05/12/2017 | All Sections and Attachments | Policy posted 05/12/2017 with an Amended Date of 03/01/2017 |
| 11/01/2017 | All Sections and Attachment (s) | Grammar, formatting, and hyperlink updates and corrections |
| 11/01/2017 | All Sections and Attachment (s) | Increased prior authorization (PA) certification period from 60 calendar days to 6 months |
| 11/01/2017 | Sections 5.2.3.3, 5.2.4.1, 5.2.4.2 | Removed text in 5.2.3.3 Emergency Changes, 5.2.4.1 Notification of Termination, and 5.2.4.2 Notification of Reduction, as it was duplicative of already posted Due Process Policies and Procedures. |

| Date | Section Revised | Change |
|-------------|---------------------------------|---|
| 11/01/2017 | All Sections and Attachment (s) | Added 'physician' to clarify need for physician signed CMS 485 for PA approval. |
| 11/01/2017 | Section 3.4 and 4.2.2 | Removed information about CAP/C beneficiaries – transition is complete. Moved information about hours for other formal support programs to Section 4.2.2 |
| 11/01/2017 | Section 5.2.2.5 | Removed 'specific' and 'range of hours not acceptable'. Per 42CFR 409.43 Plan of Care Requirements, the frequency of visits may be stated as a specific range to ensure the most appropriate level of care is provided. |
| 11/21/2017 | All Sections and Attachments | Corrected an error in the document style that was causing some subsection headings to display incorrectly. No change to content or amended date. |
| 03/15/2019 | Table of Contents | Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP." |
| 03/15/2019 | All Sections and Attachments | Updated policy template language. |

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

B. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

| HCPCS Code(s) | Program Description |
|---------------|----------------------|
| T1000 | PDN Nursing Services |

Note: Medical supplies are billed using HCPCS supply codes as indicated on the Home Health Fee Schedule. The Home Health Fee Schedule lists the covered supplies. Refer to NC Medicaid's Web site at <http://dma.ncdhhs.gov/>.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Modifiers are required for billing PDN nursing services as follows: TD for RN care and TE for LPN care.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

1. PDN Services

PDN services are billed in 15-minute units and must not exceed the NC Medicaid authorized number of PDN units per day. The qualifications of the nurse must be specified.

2. Medical Supplies

Medical supplies are paid by item and quantity supplied and according to the Medicaid Home Health Fee Schedule. Refer to **Subsection 5.2.6.5** for coverage criteria.

F. Place of Service

PDN services are provided in the beneficiary's private primary residence. Refer to **Subsection 4.2**

G. Co-payments

For Medicaid refer to Medicaid State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

For NCHC refer to NCHC State Plan:

<https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

H. Reimbursement

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

PDN providers shall bill their usual and customary charges.

Reimbursement is based on the NC Medicaid Home Health and Private Duty Maximum Rate Schedule available at: <https://medicaid.ncdhhs.gov/>

Program Integrity

The Program Integrity Section of NC Medicaid investigates PDN services provided without authorization.

Unit Limitations

The following limits apply:

Billed time cannot exceed the number of units per week authorized by NC Medicaid.

Attachment B: Home Health Certification and Plan of Care Form (CMS-485)

This form is available at: <https://medicaid.ncdhhs.gov/>

| | | | | |
|--|---------------------------|--|--|---|
| 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 <input type="checkbox"/> M <input type="checkbox"/> 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 | | | 18.B. Activities Permitted | |
| 1 <input type="checkbox"/> Amputation 5 <input type="checkbox"/> Paralysis 9 <input type="checkbox"/> Legally Blind 2 <input type="checkbox"/> Bowel/Bladder (Incontinence) 6 <input type="checkbox"/> Endurance A <input type="checkbox"/> Dyspnea With Minimal Exertion 3 <input type="checkbox"/> Contracture 7 <input type="checkbox"/> Ambulation B <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Hearing 8 <input type="checkbox"/> Speech | | | 1 <input type="checkbox"/> Complete Bedrest 6 <input type="checkbox"/> Partial Weight Bearing A <input type="checkbox"/> Wheelchair 2 <input type="checkbox"/> Bedrest BRP 7 <input type="checkbox"/> Independent At Home B <input type="checkbox"/> Walker 3 <input type="checkbox"/> Up As Tolerated 8 <input type="checkbox"/> Crutches C <input type="checkbox"/> No Restrictions 4 <input type="checkbox"/> Transfer Bed/Chair 9 <input type="checkbox"/> Cane D <input type="checkbox"/> Other (Specify) 5 <input type="checkbox"/> Exercises Prescribed | |
| 19. Mental Status | | | 20. Prognosis | |
| 1 <input type="checkbox"/> Oriented 3 <input type="checkbox"/> Forgetful 5 <input type="checkbox"/> Disoriented 7 <input type="checkbox"/> Agitated 2 <input type="checkbox"/> Comatose 4 <input type="checkbox"/> Depressed 6 <input type="checkbox"/> Lethargic 8 <input type="checkbox"/> Other | | | 1 <input type="checkbox"/> Poor 2 <input type="checkbox"/> Guarded 3 <input type="checkbox"/> Fair 4 <input type="checkbox"/> Good 5 <input type="checkbox"/> 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/re-certify 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) | | | | |

Attachment C: Physician's Request Form for Private Duty Nursing

This form is available e at: <https://medicaid.ncdhhs.gov/>.

PHYSICIAN'S REQUEST FORM FOR PRIVATE DUTY NURSING

Requested SOC date: _____ *Complete form within 15 business days of the start of care date and submit to NC DMA.

Name _____ Medicaid ID# _____

Address _____

Telephone Number _____ Date of Birth _____

Diagnosis _____

Prognosis and expectations of specific disease process _____

Date of last physician assessment: _____

Services requested & why _____

Date & name of next MD appointment: _____

Approximate length of time services required: Weeks/Months. Specify length of time _____

Informal Caregivers availability/Training received: _____

TECHNOLOGY REQUIREMENTS & NURSING CARE NEEDS

1. Ventilator dependent: _____ YES _____ NO Type: _____

Hours per day on ventilator _____

2. Oxygen: _____ YES _____ NO Actual liters per minute and hours per day required _____

Continuous prescribed rate _____ or adjusted daily/ more often. _____

Maintain Sats > _____ % Frequent need for adjustments and interventions: _____

3. Non-ventilator dependent tracheostomy _____ YES _____ NO Actual Frequency of Suctioning and results: _____

4. Enteral (Tube) feedings: Sole source of nutrition _____ YES _____ NO

Type of nutrition/frequency/Method of receiving: _____

5. Licensed Skilled Nursing interventions and frequency: _____

6. Medical History: note functional/communication limitations/incontinence: _____

7. Family/Home Dynamics that impact the licensed skilled nursing requirements: _____

8. What Community Based resources have been utilized to assist the above recipient? _____

"I am in agreement that the individual is medically stable except for acute episodes that Private Duty Nursing can manage in the home setting."

Print Physician's name _____

Print Physicians Address & phone number _____

Physician's Signature _____ DATE _____

Attachment D: PDN Prior Approval Referral Form (DMA-3061)

This form is available at: <https://medicaid.ncdhhs.gov/>.

PRIVATE DUTY NURSING (PDN) INITIAL REQUEST PRIOR APPROVAL REFERRAL FORM

N.C. Division of Medical Assistance Home and Community Care Section, HCI Unit
2501 Mail Service Center Raleigh, North Carolina 27699-2502
PHONE: (919) 855-4393 FAX: (919) 715-2859

For initial PDN requests, submit either a) this form along with a DMA 3075 or
b) a physician's letter of medical necessity.

PATIENT INFORMATION

Name _____
Address _____
Phone Number _____
MID # _____ Medicare # _____
Birthdate _____ Sex _____

RESPONSIBLE PARTY/ HEALTH CARE POWER OF ATTORNEY/LEGAL REPRESENTATIVE

Name _____
Address _____
Phone Number _____ Relationship _____
CAREGIVER INFORMATION

Name _____
Address _____
Phone Numbers work _____ home _____
Relationship to Recipient _____
Hours/Day Available to Care for Recipient _____

PHYSICIAN INFORMATION

Community Attending's Name _____
Address _____
Phone Number _____
Names and Phone Numbers of Other Physicians Ordering Care _____

NURSING AGENCY INFORMATION

PDN Agency _____
Address _____
Nursing Contact Person _____
Contact's Phone Number _____
PDN Provider Number 7100 _____

INSURANCE INFORMATION

Insurer's Name _____
Address _____
Contact Person & Phone Number _____
Policy or ID Number _____
Amount of PDN Covered by Insurance _____

MEDICAL INFORMATION

Primary and secondary diagnoses that support the need for PDN _____

Primary nursing interventions and the frequency with which these are performed at home _____

Requested SOC Date: _____ Anticipated Hospital Discharge Date: _____

Physician Orders for Daily Hours and Weeks' Duration _____

Decrease Hours _____

Referred by Name/Agency _____

Phone Number _____

Attachment E: PDN Medical Update/Beneficiary Information Form

North Carolina Division of Medical Assistance Private Duty Nursing—Medical Update/Recipient Information Form

| | |
|---|---------------------------------|
| Recipient Name: | Medicaid Identification Number: |
| Name of Provider Agency: | PDN Provider Number: |
| Does the recipient have insurance in addition to Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Is PDN covered by PRIVATE INSURANCE? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain coverage | |
| Date of Last Approval Period: | |
| Current Attending Physician: | |
| Updated Information—please include summary of nursing documentation for the last certification period (do NOT copy form 485): | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| _____ | |
| Date of last weight (adults) or height & weight (pediatric recipients): _____ | |
| Date of last examination by MD & Name of MD: _____ | |
| Changes in recipient's condition: _____ | |
| _____ | |
| Home visit observations, safety of environment, and caregiver information: _____ | |
| _____ | |
| Critical incidents with the recipient (hospitalizations, falls, infections, etc.): _____ | |
| _____ | |
| Therapies recipient is receiving (such as PT, OT, ST, RT, etc.): _____ | |
| _____ | |
| Emergency plan of care if nurse is not available: _____ | |
| _____ | |
| Training needs: _____ | |
| Education provided, return demonstrations, and identification of ongoing needs: _____ | |
| _____ | |
| _____ | |

Nurse Signature and Title: _____ Date: _____
 DMA-3062 (04/08)

Attachment F: Verification of Employment Form

This form is available: at: <https://medicaid.ncdhhs.gov/>

VERIFICATION OF EMPLOYMENT

Beneficiary's Name: _____

Beneficiary's Medicaid ID Number _____

Caregiver Name _____

This form is to be used only by individuals that are self-employed or are independent contractors

- A. I am self-employed.
 I am an independent contractor.

B. I work as a _____.

- C. I do most of my work outside the home.
 I do most of my work at my home.

- D. If I do most of my work at my home,
 I have a separate, dedicated work space in my home.
 I do not have a separate, dedicated work space in my home.

- E. If I do most of my work at my home,
 I can arrange my hours, interrupt my work, or be otherwise available for care if needed.
 I can not be available for care; I would need to hire a caregiver to supplement the hours that PDN could not provide

F. My typical work hours are (do not include on-call hours):

Monday _____ Thursday _____ Saturday _____
Tuesday _____ Friday _____ Sunday _____
Wednesday _____

- G. My typical work schedule:
 never or rarely varies.
 varies sometimes.
 varies a lot.

- H. My typical work hours are:
 very flexible.
 somewhat flexible.
 not flexible.

I. Please elaborate on any of the above or include any additional relevant information on the back of this form.

An individual who certifies a material and false statement in this assessment will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate professional licensing agency for investigation.

Signature _____ Date _____

Attachment G: Test Document-Hourly Nursing Review Criteria

This form is available at: <https://medicaid.ncdhhs.gov/>

**Test Document – Hourly Nursing Review Criteria –
NC Division of Medical Assistance
Refer to instructions before completion**

| | | |
|-------------------|----------------------------------|---|
| RECIPIENT NAME | RECIPIENT MID | PROGRAM <input type="checkbox"/> PDN <input type="checkbox"/> CAP/C |
| PRIMARY DIAGNOSIS | ADMIT DATE OR CAP EFFECTIVE DATE | DOB |

| TECHNOLOGY NEEDS | | | |
|---------------------------------------|--|------------------------------|--------------------------------|
| ventilator dependent | <input type="checkbox"/> dependent <input type="checkbox"/> needs assistance <input type="checkbox"/> independent <input type="checkbox"/> intervention, continuous <input type="checkbox"/> intervention, intermittent <input type="checkbox"/> monitoring | total 60 | intermittent 50 |
| tracheostomy not ventilator dependent | <input type="checkbox"/> dependent <input type="checkbox"/> needs assistance <input type="checkbox"/> independent <input type="checkbox"/> intervention, continuous <input type="checkbox"/> intervention, intermittent <input type="checkbox"/> monitoring | continuous 50 | passey-muir/cap 40 |
| CPAP/BIPAP not tracheostomy | <input type="checkbox"/> dependent <input type="checkbox"/> needs assistance <input type="checkbox"/> independent <input type="checkbox"/> intervention, continuous <input type="checkbox"/> intervention, intermittent <input type="checkbox"/> monitoring | continuous 40 | intermittent 35 |
| oxygen | <input type="checkbox"/> dependent <input type="checkbox"/> needs assistance <input type="checkbox"/> independent <input type="checkbox"/> intervention, continuous <input type="checkbox"/> intervention, intermittent <input type="checkbox"/> monitoring | unstable 35 | stable 15 |
| hospitalizations | <input type="checkbox"/> greater than three hospitalizations within the last year <input type="checkbox"/> at least one extended (> two months) hospitalization within the last year | related to primary diagnosis | unrelated to primary diagnosis |
| SUBTOTAL TECHNOLOGY NEEDS | | | |

| SKILLED CARE NEEDS | | | | | | | |
|---|---|------------------------|---------------------------|--------------------------------------|--|--|---|
| endotracheal suctioning | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | > QH 10 | Q 2-4 hrs 8 | Q 5-8 H 6 | | | < Q8H 4 |
| sterile dressing | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | QID 8 | TID 6 | BID 4 | | | daily or less 2 |
| nasogastric, gastrostomy, or jejunostomy tube feeds | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | bolus with reflux 8 | bolus without reflux 6 | daily or continuous with reflux 4 | | | daily or continuous without reflux 2 |
| intake and output specialized intervention | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | QID intervention 8 | TID intervention 6 | BID intervention 4 | | | daily intervention 2 |
| intermittent catheterization | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | QID 8 | TID 6 | BID 4 | | | daily or as needed 2 |
| intravenous: fluids or medications or nutrition | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | QID 8 | TID 6 | BID 4 | | | daily or continuous 2 |
| pulse oximetry, CO ₂ levels, nebulizers, chest PT, | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | QID 8 | TID 6 | BID 4 | | | daily or continuous 2 |
| medication | <input type="checkbox"/> dependent <input type="checkbox"/> needs assist <input type="checkbox"/> independent | complex 8 | | moderate 4 | | | simple 2 |
| SUBTOTAL SKILLED CARE NEEDS | | | | | | | |

| ACTIVITIES OF DAILY LIVING NEEDS | | | |
|---|----------------|-------------------|------------------|
| nasoro-pharyngeal suctioning frequency | dependent 2 | needs assist 1 | independent 0 |
| nonsterile dressing/site care | dependent 2 | needs assist 1 | independent 0 |
| oral feeding assistance (N/A for children < 3 yrs of age) | dependent 2 | needs assist 1 | independent 0 |
| recording of intake and output | dependent 2 | needs assist 1 | independent 0 |
| incontinence care (N/A for children < 3 yrs of age) | dependent 2 | needs assist 1 | independent 0 |
| personal care (age inappropriate) (N/A for children < 3 yrs of age) | dependent 2 | needs assist 1 | independent 0 |
| range of motion | dependent 2 | needs assist 1 | independent 0 |
| ambulation assist, transfers, bed mobility | dependent 2 | needs assist 1 | independent 0 |
| SUBTOTAL ACTIVITIES OF DAILY LIVING NEEDS | | | |

| |
|---|
| TOTAL POINTS |
| CURRENT NURSE HOURS |
| CURRENT AIDE HOURS |
| LEVEL OF CARE/ HOURS AUTHORIZED |
| SIGNATURE AND TITLE OF PERSON COMPLETING FORM* |
| DATE |

COMMENTS/HOME ENVIRONMENT/CAREGIVER INFORMATION

*This certifies the signee, and no one else, has completed the above in-home assessment of the client's condition. Falsification: an individual who certifies a material and false statement will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate licensing agency for investigation.

**Test Document – Hourly Nursing Review Criteria Instructions –
NC Division of Medical Assistance**

This is ONE of several submitted documents that is reviewed and utilized for prior approval decisions and/or authorization. All recipients will be scored with the initial assessment and every two months thereafter by the Case Manager or Nurse Supervisor. Forms for PDN recipients should be submitted to DMA with the initial approval and with each 60 day reauthorization. Forms for CAP/C recipients should be submitted to DMA with the initial assessment, with each annual Continued Needs Review, and any time there is a change in the recipient's condition. It is expected that if total points start to decline, indicating that the recipient is improving, that total nursing hours will also decline.

| | | |
|---|---|--|
| RECIPIENT NAME as it is written on the Medicaid card | RECIPIENT MID | PROGRAM <input type="checkbox"/> PDN <input type="checkbox"/> CAP/C |
| PRIMARY DIAGNOSIS should match the primary diagnosis listed on the FL-2 and/or the CMS-485, as applicable | ADMIT DATE OR CAP EFFECTIVE DATE | DOB |

| | |
|--|---|
| TECHNOLOGY NEEDS Scores in the technology section reflect the risk of death or disability if the technology is lost, as well as the degree of licensed skilled nursing assessment/judgment necessary to operate the technology. | |
| ventilator dependent | Recipients using ventilators will not receive additional points for tracheostomy. The need for this technology is included in the points for the ventilator. Total is used for a recipient who is on the ventilator 24 hours per day. Intermittent is used for a recipient who is able to come off of the ventilator for a period of time; e.g., someone who uses the ventilator only during sleep. |
| tracheostomy not ventilator dependent | Recipients with a tracheostomy will not receive additional points for tracheostomy dressing changes. The need for this procedure is included in the points for the tracheostomy. Continuous is scored for a recipient who always breathes through an open tracheostomy. Passy-Muir/cap is scored for a recipient who is able to tolerate the use of a speaking valve or having the tracheostomy capped for a period of time. |
| CPAP/BIPAP not tracheostomy | Continuous Positive Airway Pressure/Bi-level Positive Airway Pressure Continuous is scored for a recipient who is on the CPAP or BiPAP 24 hours per day. Intermittent is scored for a recipient who is able to come off of the CPAP or BiPAP for a period of time; e.g., someone who uses it only during sleep. |
| oxygen | Recipients are eligible to receive the points for unstable oxygen if the recipient has daily desaturations below doctor-ordered parameters AND if those desaturations require a response based on skilled nursing assessment and intervention. Recipients are NOT eligible for the unstable points if the oxygen use is routine and predictable; i.e., a recipient with Chronic Obstructive Pulmonary Disease who requires oxygen when walking would not receive the points for unstable. |
| hospitalizations | Use a rolling twelve month calendar. Emergency room visits without admission do not count. Recipients who have been hospitalized since birth and are just now going home for the first time are eligible to have this item checked. |
| SUBTOTAL TECHNOLOGY NEEDS Recipients must receive ?? or more points in the technology section to qualify for PDN or CAP/C Hospital Level of Care. A score of ?? or greater does not guarantee approval; rather, it is necessary to even be considered for approval for either PDN or CAP/C Hospital Level of Care. | |

| | |
|---|---|
| SKILLED CARE NEEDS Scores in the skilled care needs section reflect the time needed to perform the assessment and intervention. The recipient's nursing documentation, including the nurses' notes, nursing supervisor's reports, and/or case manager's assessment and notes, must support the frequency chosen. The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient with a tracheostomy has an acute respiratory infection, and the need for endotracheal suctioning increases for the duration of the illness, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill. | |
| endotracheal suctioning | If the recipient is able to self-suction at least some of the time, choose the frequency at which the caregiver has to perform the suctioning. |
| sterile dressing | Recipients with a tracheostomy will not receive an additional score for tracheostomy dressing changes. The need for this procedure is included in the score for the tracheostomy. |
| nasogastric, gastrostomy, or jejunostomy tube feeds | A continuous tube feeding is one that is administered over at least eight consecutive hours. If the tube feeding occurs more frequently, it is considered bolus. If the recipient uses a combination of a continuous and bolus feedings, score the feeding as bolus. To receive the points for reflux, the recipient must meet at least ONE of the following criteria: 1) a positive swallowing study performed within the last six months, 2) documented current and ongoing treatment for reflux, i.e., medications such as metoclopramide (Reglan), ranitidine (Zantac), or lansoprazole (Prevacid), 3) documented treatment for aspiration pneumonia within the last twelve months, or 4) a need for suctioning due to reflux at least daily (NOT including suctioning of oral secretions). |
| intake and output specialized intervention | This is intake and output which requires intervention; i.e., the nurse has to make adjustments to feedings or IV fluids based on the intake and output data. If there are no interventions other than recording the data and/or calling the physician, the recipient is ineligible for these points; see intake and output non-specialized monitoring below. |
| intermittent catheterization | If the recipient is able to self-catheterize at least some of the time, choose the frequency at which the caregiver has to perform the catheterization. |
| intravenous: fluids or medications or nutrition | The frequency chosen should be based on the recipient's BASELINE condition; i.e., when a recipient becomes acutely ill and requires a ten-day course of intravenous antibiotics, the frequency determination should not be based on this time period, but on the time period when the recipient was not acutely ill. |
| pulse oximetry, CO ₂ monitoring, nebulizers, chest PT, _____ | Include treatments that are done on a routine basis, whether standing or PRN. If the treatments are done together; i.e., nebulizer treatments (QID) followed by chest physiotherapy (BID), choose the frequency of the one done most often (choose QID). If the treatments are not done together; i.e., chest physiotherapy (BID) and specialized ostomy care (TID), award points based on the total frequency (five times per day). A recipient can not be awarded more than eight points in this category no matter how many treatments he or she receives or how frequently he or she receives them. |

**Test Document – Hourly Nursing Review Criteria Instructions, continued–
NC Division of Medical Assistance**

| | |
|--|---|
| medication | Simple medications include scheduled, routine medications that do not require dosage adjustments, regardless of the number of those medications. Moderate and Complex medication includes medications which are PRN and/or require dosage adjustments by a licensed nurse. Recipients who have one to three such medications ACTUALLY GIVEN by the caregiver within an eight hour period qualify for moderate points. Recipients who have more than three such medications ACTUALLY GIVEN by the caregiver in an eight hour period qualify for complex points. PRN seizure medication; i.e., Diastat, should always be awarded moderate points. Oxygen, nebulizer treatments, and intravenous medications are not scored in this category, as they are scored elsewhere on the form. Please note that there are only three scores to choose from for medications. |
| SUBTOTAL SKILLED CARE NEEDS The total score for the nursing needs section will be used to determine the need for continuous, complex, and substantial skilled nursing care. Not all of the items in this section can be considered substantial, as they fall within the scope of practice for a Nurse Aide according to the regulations of the North Carolina Board of Nursing regarding delegation of tasks to Nurse Aides. | |

| | |
|--|--|
| ACTIVITIES OF DAILY LIVING NEEDS The activities of daily living section has minimal impact on approval, except for those recipients applying for CAP/C Nurse Aide services. These recipients must receive a score on at least two items in this section AND have a primary diagnosis that is medical in order to be considered for the CAP/C program. Meeting these criteria does not guarantee CAP/C approval. Normal age-appropriate care and parental responsibility should be considered; i.e., all 4 year olds need assistance with getting bathed and dressed, therefore 'needs assist' in this category is not scorable as it is an age-appropriate need, not a medical need. | |
| naso-oropharyngeal suctioning | Suctioning of the nose, mouth, or upper throat with a bulb syringe, yankaeur, or suction catheter. Does not include deep, or endotracheal, suctioning. |
| nonsterile dressing/site care | Recipients with a tracheostomy or gastrostomy will not receive an additional score for tracheostomy or gastrostomy dressing changes. The need for this procedure is included in the score for the tracheostomy or gastrostomy. |
| oral feeding assistance (N/A for children < 3 yrs of age) | Does not include meal/formula preparation. Does include hands-on assist with feeding and supervision during feeding. |
| recording of intake and output | Normal daily measurement of intake and output without the need to assess for fluid replacement or restriction. If such assessment is required, see intake and output specialized monitoring, above. |
| incontinence care (N/A for children < 3 yrs of age) | Cleaning after an incontinence episode, changing incontinence devices such as diapers and chux, emptying a foley catheter or colostomy. |
| personal care (age inappropriate) (N/A for children < 3 yrs of age) | Includes bathing, dressing, and grooming, and application of orthotics and prosthetics. |
| range of motion | |
| ambulation assist, transfers, bed mobility | Moving around within the recipient's residence with or without the use of an assistive device such as a walker, wheelchair, Hoyer lift, or trapeze. |
| SUBTOTAL ACTIVITIES OF DAILY LIVING NEEDS | |

| |
|--|
| TOTAL POINTS Total of technology, skilled care needs, and activities of daily living needs. |
| CURRENT NURSE HOURS Record as number of hours per day and number of days per week; i.e., for a recipient who gets 18 hours 5 days per week and 10 hours 2 days per week, write as 18X5 & 10X2. |
| CURRENT AIDE HOURS Record as number of hours per day and number of days per week; i.e., for a recipient who gets 18 hours 5 days per week and 10 hours 2 days per week, write as 18X5 & 10X2. |
| LEVEL OF CARE/ HOURS AUTHORIZED Level of Care for CAP/C recipients, Hours Authorized for PDN recipients. |
| SIGNATURE AND TITLE OF PERSON COMPLETING FORM Case Manager or Nurse Supervisor |
| DATE The date the form was COMPLETED, not the date it was submitted. |

COMMENTS/HOME ENVIRONMENT/CAREGIVER INFORMATION

Include any special home environment needs or special caregiver needs in this section; i.e., a primary caregiver with health issues, multiple home-care recipients in the home, other stressors, other programs, other needs not identified above.

*This certifies the signee, and no one else, has completed the above in-home assessment of the client's condition. Falsification: an individual who certifies a material and false statement will be subject to investigation for Medicaid fraud and, if applicable, will be referred to the appropriate licensing agency for investigation.

Submit the form to :
North Carolina Department of Health and Human Services
Division of Medical Assistance
Facility and Community Care
Home Care Initiatives Unit
2501 Mail Service Center
Raleigh, NC 27699-2501
Fax: 919 715 9025
Phone: 919 855 4380

Attachment H: Employment Attestation Form

This form is available at <https://medicaid.ncdhhs.gov/>

Private Duty Nursing Employment Attestation Form

This Attestation of Employment Form services to provide information about employment status for the purpose of determining Medicaid Private Duty Nursing benefits.

Beneficiary: _____ MID# _____
DOB: _____

Primary Caregiver Attestation

On this date, I _____ (Print Name), certify that I am:

- Employed
- Not currently employed
- attend an institution of higher education part time
- attend an institution of higher education full time

If employed or attending institution of higher education provide daily schedule:

Secondary Caregiver Attestation

On this date, I _____ (Print Name), certify that I am:

- Employed
- Not currently employed
- attend an institution of higher education part time
- attend an institution of higher education full time

If employed or attending institution of higher education provide daily schedule:

I attest that, to the best of my knowledge, the above information can be supported by documentation.

Primary Caregiver (print) _____ Date: _____
Signature (required) _____

Secondary Caregiver (print) _____ Date: _____
Signature (required) _____