

# **Private Duty Nursing** Policy Manual

eMedNY New York State Medicaid Provider Policy



**Department  
of Health**

**Office of  
Health Insurance  
Programs**

## **New York State Medicaid**

Office of Health Insurance  
Department of Health

### **CONTACTS:**

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#### **(914) 995-6676**

PDN case in Westchester County

#### **(800) 342-3005**

#### **(518) 474-8161**

[OHIPMEDPA@health.ny.gov](mailto:OHIPMEDPA@health.ny.gov)

PDN Prior Approval at Bureau of Medical Review

#### **(800) 343-9000**

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## Table of Contents

1.0 Document Control Properties.....	5
2.0 Definitions.....	5
3.0 Overview of Private Duty Nursing.....	7
3.1 Overview.....	7
3.2 Intention.....	7
3.3 Family Responsibilities.....	7
4.0 Written Order Required.....	7
4.1 Maintain Documentation.....	7
4.2 Orders.....	7
5.0 Physician Plan of Care.....	7
5.1 Skilled Nursing Tasks.....	7
6.0 Prior Approval Requirements.....	9
6.1 Documentation Chart.....	9
6.2 Additional Information.....	12
6.3 Determination in Writing.....	12
6.4 Requests.....	12
6.5 ePACES.....	12
6.6 Approval Period.....	12
6.7 Shared Cases.....	12
6.8 Physician Order for Nursing Services.....	12
6.9 Independent Contractors.....	13
6.10 Assessment or Physician Visit.....	13
6.11 Home Evaluation.....	13
6.12 Psychosocial and Home information.....	13
6.13 Backup Caregiver Training and Responsibility.....	14
6.14 Case Management.....	14
6.15 Managed Care.....	14
6.16 Primary Insurance.....	14
6.17 Improvement in Member’s Condition.....	15
6.18 Recommendation for PDN Services.....	15
6.19 PDN During School Hours.....	15
6.20 Day Program Information.....	15
6.21 Consumer Directed Personal Assistance Program (CDPAP).....	15

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7.0	New Cases .....	15
7.1	Definition .....	15
7.2	Eligibility .....	15
7.3	Submission .....	15
8.0	Renewal Cases.....	15
8.1	Re-evaluation .....	15
9.0	Prior Approval Changes.....	16
9.1	Change Requests .....	16
9.2	Replacement PA .....	16
9.3	Additional Procedure Code .....	17
9.4	Non-School Hours.....	17
9.5	Transfer of Hours .....	17
9.6	Increase of Hours .....	18
9.7	Adding or Removing a Billing Provider to Existing PA (Agency or Independent Nurse).....	18
9.8	End Date on Existing Prior Approval Number .....	19
10.0	Retroactive / Emergency Cases.....	19
10.1	PA Before Services Commence .....	19
10.2	Notify Director.....	19
10.3	Retrospective PA.....	19
10.4	Changes in Coverage.....	19
11.0	Place of Service.....	19
11.1	Home and Community .....	19
11.2	School / Pre-School .....	20
11.3	Day Program.....	20
11.4	Residential Habilitation .....	20
11.5	Travel Away from Home.....	21
12.0	Provider .....	22
12.1	Coverage.....	22
12.2	Medicaid Enrollment.....	22
12.3	NYS Registered LPN or RN .....	22
12.4	Ending Nursing Services by Provider .....	22
13.0	PDN in Combination with Other Services and Programs .....	22
13.1	Consumer Directed Personal Assistance Program (CDPAP) .....	22
14.0	Record Keeping .....	23
14.1	Clinical Record Requirements.....	23

# PDN Manual

eMedNY > Private Duty Nursing Provider Policy



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15.0	Billing for Services.....	24
15.1	Billing Medicaid for PDN Services.....	24
16.0	Unacceptable Practices.....	25
16.1	Additional References.....	25
16.2	Prohibited.....	25

## 1.0 Document Control Properties

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Document Name	<b>Private Duty Nursing Manual</b>
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## 2.0 Definitions

As used in Medicaid Fee-For-Service Private Duty Nursing:

Case (Care) Management – a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the client's health and human service needs

Certified Home Health Agency (CHHA) – an entity certified or otherwise authorized to provide home health services [See NYS PHL §3602(3)]

Consumer Directed Personal Assistance Program (CDPAP) – a statewide Medicaid program that provides an alternative way of receiving home care services

Department of Health (Department) – the New York State Department of Health

Electronic PA – a prior approval request submitted using a 278 form via the ePACES system

ePACES – an internet-based program available to enrolled Medicaid providers

HHA – a Home Health Aide

HRA – is the New York City Human Resources Administration

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Licensed Home Care Services Agency (LHCSA) – an entity licensed by the Department to provide home care services. [See NYS PHL §3602(13)]

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Licensed Practical Nurse (LPN) – an individual licensed and currently registered to practice the profession of nursing as an LPN pursuant to Article 139 of New York State Education Law

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LDSS – the Local Department of Social Services

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Medicaid – the New York State Medicaid Program

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Member – an eligible member of Medicaid

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New York State Education Department (NYSED) – the entity responsible for licensing of the four distinct nursing professions in New York State: Registered Professional Nurse, Clinical Nurse Specialist, Licensed Practical Nurse and Nurse Practitioner

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Paper PA – Prior Approval requests mailed to eMedNY with form (EMEDNY-361502)

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PCA – Personal Care Aide

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Private Duty Nursing (PDN) – the provision of skilled nursing services on a continuous basis to a specific individual

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PA – a prior approval for private duty nursing services

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Provider – a LHCSA or privately practicing LPN or RN enrolled with Medicaid to provide nursing services

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Registered Professional Nurse (RN) – an individual licensed and currently registered to practice the profession of nursing as an RN pursuant to Article 139 of New York State Education Law

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## 3.0 Overview of Private Duty Nursing

### 3.1 Overview

Private duty nursing services are nursing services for Medicaid members who require more individual and continuous skilled nursing care than is available from a certified home health agency (“CHHA”). A CHHA may provide nursing services only on a part-time or intermittent basis, generally fewer than two hours per service authorization. A Medicaid member may be appropriate for private duty nursing services if he or she requires nursing services that exceed the amount and scope of nursing services that a CHHA may provide. Private duty nursing services are not warranted for non-skilled tasks such as, but not limited to, turning and positioning, ambulation, transferring, bathing, toileting, oral feeding, dressing, and household chores.

### 3.2 Intention

The intention of PDN services is to support – not replace – the skilled care provided to a member by parents, family, and other responsible caregivers. Commitment by the family and community are necessary to meet the member’s needs and to ensure the member can remain safely at home.

### 3.3 Family Responsibilities

Backup caregivers will need to be identified for use when a nurse is not available. Family and other caregivers should routinely provide hands on care to maintain their general care skills, and assure they are competent in providing backup care when the nurse is unavailable.

## 4.0 Written Order Required

### 4.1 Maintain Documentation

PDN services may be rendered only under the direction of a physician as part of a comprehensive program of care. Each nursing provider is required to maintain written physician’s orders in their clinical documentation prior to the provision of such services.

### 4.2 Orders

Orders may also be written by certified nurse practitioners who are currently registered by the NYSED and enrolled in the NYS Medicaid Program.

## 5.0 Physician Plan of Care

### 5.1 Skilled Nursing Tasks

Approval of PDN services requires documentation from the ordering provider of all skilled nursing tasks necessary for the care of the member. Complete documentation of the skilled tasks will allow NYSDOH staff to accurately assess the number of hours necessary for the nursing care required.

The signed and dated Physician Plan of Care should include the following information, if applicable to the member:



- A.** Diagnoses
- B.** Orders for all skilled tasks with frequency and time of day performed including, but not limited to the following:
  - a) Scheduled and as needed medication orders: name, dose, route, and frequency
  - b) Nebulizer treatments: name, dose, and frequency
  - c) Intravenous medication: name, dose, frequency, time of administration, length of infusion
  - d) Total Parenteral Nutrition: volume, rate, and time of administration
  - e) Enteral orders: route (G-tube, J-tube, NG-tube, other), formula, rate, (bolus, continuous, or combination), volume, frequency, time of administration
  - f) Tracheostomy care: frequency. If removed, decannulation date and care of stoma
  - g) Suctioning: type (nasal, oral, trach) and frequency
  - h) Oxygen: rate, schedule (continuous, frequency, pulse oximetry- based), route (nasal cannula, mask, direct trach), parameters and intervention
  - i) Pulse Oximeter Monitoring: frequency, parameters and intervention
  - j) Ventilator: all settings, PEEP, backup rate, tidal volume or rate, hours per day, time of day, weaning schedule
  - k) BIPAP/BIPAP-ST/CPAP: all settings, PEEP, backup rate, hours per day, time of day, weaning schedule
  - l) Chest therapy type: (Physiotherapy, vest, cough assistance), frequency
  - m) Glucose monitoring – frequency
  - n) Seizures – type, number per day, intervention
  - o) Dressing Changes/Wound Care/Ostomy Care – frequency, location, stage, standard dressings or specialized dressings. For extensive wound care, indicate the time frame required for dressing change.
  - p) Urinary Catheter – type; for intermittent catheterizations frequency and time of day
  - q) Bowel Regimen – procedure, frequency, duration

## 6.0 Prior Approval Requirements

### 6.1 Documentation Chart

Prior approval for all PDN services is required before the start of providing services and the request must be submitted by a Medicaid enrolled PDN provider. There are two categories of prior approvals: New Case and Renewal/Reevaluation prior approvals. Prior approval requests are reviewed in the order in which they are received by the Department. It is the provider's responsibility to obtain all necessary paperwork and submit those requests prior to the start of providing services.

The following chart summarizes the documentation requirements for each approval interval. Requirements needing additional explanation will be discussed in more detail in other sections of the manual.

All required documentation must be dated within 6 months of the PA start date.

Information Required	New Cases	Every 6 Months	Every 12 Months
<p><b>Physician's Order for Nursing Services, including:</b></p> <ul style="list-style-type: none"> <li>- RN or LPN level of care</li> <li>- Statement justifying RN level of care (annually, if applicable)</li> <li>- Number of PDN hours requested (per day or per week) and distribution of hours (daytime, nighttime, flexible use hours)</li> </ul> <p>See section <a href="#">6.8</a> for more information</p>	✓	✓	✓
<p><b>Physician Plan of Care/Skilled Nursing Tasks:</b></p> <ul style="list-style-type: none"> <li>- Documentation of the skilled nursing needs and physician plan of care for the member.</li> </ul> <p>See Section <a href="#">5.1</a> for detailed requirements</p>	✓	✓	✓
<p><b>Independent Nursing Contractors:</b></p> <ul style="list-style-type: none"> <li>- Physician statement that he/she will provide oversight of the LPN(s) providing nursing care to the member</li> <li>- Names and NPI numbers for all independent nurses providing care to the member</li> </ul> <p>See section <a href="#">6.9</a> for more information</p>	✓	✓	✓
<p><b>Assessment from Community Based Organizations or Physician Visit:</b></p> <ul style="list-style-type: none"> <li>- Assessment may be performed by a CHHA, LHCSA, or local department of social services OR</li> <li>- Annual history and physical exam including the current medical status performed by a physician or nurse practitioner</li> <li>- Annual assessments must have been completed within six (6) months of the PA start date</li> </ul> <p>See section <a href="#">6.10</a> for more information</p>	✓		✓

Information Required	New Cases	Every 6 Months	Every 12 Months
<p><b>Home Evaluation:</b></p> <ul style="list-style-type: none"> <li>- Performed by a healthcare professional or Social Worker to include home safety and adequacy for member's care.</li> <li>- Ventilator members: the home safety evaluation must be performed by a Respiratory Therapist</li> </ul> <p>See section <a href="#">6.11</a> for more information</p>	✓		If change in home location
<p><b>Psychosocial and Home Information:</b></p> <ul style="list-style-type: none"> <li>- Persons living in the home environment, including ages of minors, member's school schedule, including pick up and drop off transportation times</li> <li>- Names and ages of all backup caregivers and their college schedules (on college letterhead) and work schedules (with work hours and days of the week, including travel time, on company letterhead, signed/dated by the employer)</li> </ul> <p>See section <a href="#">6.12</a> for more information</p>	✓		✓
<p><b>Backup Caregiver:</b></p> <ul style="list-style-type: none"> <li>- Training Statement signed and dated by all backup caregivers stating that they are fully trained in all skilled tasks, and willing to care for the member.</li> </ul> <p>See section <a href="#">6.13</a> for more information</p>	✓		✓
<p><b>School Information:</b> (if applicable)</p> <ul style="list-style-type: none"> <li>- If the member is considered school age and does not attend school, please submit a statement that the member does not attend a public or private school outside the home</li> <li>- The school district is responsible for providing nursing services to the member during transportation and school hours</li> </ul> <p>See section <a href="#">11.2</a> for more information</p>	✓		If change in school status
<p><b>Day Program Information:</b> (if applicable)</p> <ul style="list-style-type: none"> <li>- If the member attends a day program, submit program schedule with transportation times</li> <li>- If Medicaid PDN services are requested to accompany the member, also submit the name of the program, contact information, and letter from the day program</li> </ul> <p>See section <a href="#">11.3</a> for more information</p>	✓		✓

Information Required	New Cases	Every 6 Months	Every 12 Months
<p><b>Other Personal Healthcare Services:</b> (CDPAP, PCA, or HHA)</p> <ul style="list-style-type: none"> <li>- Submit the approval and plan of care from the authorizing program showing the specific service(s) authorized, and the hours per day, days per week, and times of day these other services are approved for</li> <li>- If services have been discontinued, submit a statement from the authorizing program indicating the date of service termination</li> </ul> <p>See section <a href="#">13.1</a> for more information</p>	✓		✓
<p><b>Primary Insurance Information:</b></p> <ul style="list-style-type: none"> <li>- Submit request for PDN to the primary insurance first</li> <li>- Submit response from primary insurer (Explanation of Benefits (EOB), denial, claim response)</li> </ul> <p>See sections <a href="#">6.16</a>, <a href="#">10.4</a>, <a href="#">12.1</a> and <a href="#">15.1</a> for more information</p>	✓		✓
<p><b>Managed Care Information:</b></p> <ul style="list-style-type: none"> <li>- Only required when the member is leaving a managed care plan and returning to Fee for Service Medicaid as a new case</li> <li>- Submit the most recent Managed Care Person Centered Service Plan (PCSP) or Plan of Care (POC)</li> </ul> <p>See sections <a href="#">6.15</a> and <a href="#">10.4</a> for more information</p>	✓		
<p><b>Case Management Information:</b> (if applicable)</p> <ul style="list-style-type: none"> <li>- Submit the name, telephone, and mail/e-mail address of both the case management company and the direct case manager</li> </ul> <p>See section <a href="#">6.14</a> for more information</p>	✓		✓

## 6.2 Additional Information

Based on the information submitted, additional information may be requested by review staff to make a final determination. PDN hours and level of care are re-evaluated and may be changed (decreased or denied) based on medical necessity and skilled nursing needs at the time of prior approval review.

## 6.3 Determination in Writing

Upon receipt of a complete package, a determination will be given in writing.

## 6.4 Requests

Prior approval requests can be completed via paper prior approval forms with attachments or in ePACES with mailed documentation or PDF attachments.

Paper prior approval request forms (form number eMedNY-361502) may also be submitted, with appropriate attachments, to:

eMedNY  
PO Box 4600  
Rensselaer, NY 12144-4600

A supply of paper prior approval forms is available by contacting eMedNY at 1(800)-343-9000.

## 6.5 ePACES

For instructions on using ePACES or completing the paper prior approval form please see the manuals on the eMedNY website (<https://www.emedny.org>). When submitting an electronic PA through ePACES a reference number will be returned to your ePACES screen, which can be later used to check the approval status on ePACES. For information about enrolling in ePACES or questions about how to submit an electronic 278 prior approval, contact eMedNY at (800) 343-9000 or visit <https://www.emedny.org> for more information.

## 6.6 Approval Period

Approval of PDN services will be for a period of six (6) months but may be for a lesser or greater period if determined by the Medical Bureau Director or his/her designee.

One prior approval number will be issued for each approval period. Agency and independent nurses will have access to the number of approved hours for the member and should work to make sure the approved hours are not exceeded. The provider submitting the prior approval is responsible for submitting all the required documentation.

## 6.7 Shared Cases

Cases where one nurse is responsible for the care of multiple members during the same hours at the same location (shared cases); must have a PA submitted for each member using the TT modifier. TT modifier must be on the PA line used for shared hours. The one to one (1:1) hours do not require the TT modifier. All shared PAs must be submitted at the same time.

## 6.8 Physician Order for Nursing Services

The ordering physician request should indicate the level of care (LPN or RN) and number of hours requested.

Approval for PDN services will be at the LPN level unless the required skills are outside the scope of practice for an LPN as determined by the NYSED. If RN level of care is requested, the physician needs to provide justification for the higher level of care. In this case, the Medical Bureau Director of local designee must agree.

## 6.9 Independent Contractors

LPN Oversight as required by New York State Education Law. In the instance that PDN services are to be provided wholly or in part by an independently enrolled LPN the ordering physician must certify the following in writing:

- A. The ordering physician will be responsible for oversight of the independent nurse to ensure adherence to the prescribed treatment plan.
- B. The ordering physician will be available to consult with the independent nurse should the member's medical condition change or treatment plan needs updating.
- C. The ordering physician will provide, or arrange, appropriate direction to any independently enrolled LPN working the case in accordance with State Education Law.
- D. This letter should state, "I am aware there are independently enrolled LPN's staffing this case and I am willing to provide oversight to them." This must accompany the prior approval request along with a list of all Independent Providers servicing the case and their National Provider Identification Number (NPI).

## 6.10 Assessment or Physician Visit

Examples of assessment tools, such as, but not limited to: Uniform Assessment System (UAS), M27R form, Medical Assessment Abstract (DSM1 form), Pediatric Patient Review Instrument (PPRI), Home Assessment Abstract, Outcome & Assessment Information Set (OASIS), or another equivalent may be used.

If no current assessment is available, you may substitute the last annual history and physical exam.

Annual assessments must have been completed within six (6) months of the PA start date.

## 6.11 Home Evaluation

The home evaluation is to verify the safety of the member's home environment. They must be completed by, but not limited to, a Licensed Nursing Agency, Public Health Nurse (PHN), CHHA, or Social Worker. If the member is ventilator dependent a respiratory company must complete the evaluation. This is required for new cases or when the home environment has changed because of moving to a new location.

## 6.12 Psychosocial and Home information

Information on other members in the household should be submitted to assist in determining accessibility to the home and the member's schedule. Information should include the following:

- A. Who resides in the household with the member (include ages of any children);
- B. If applicable, member's school schedule, including pick up and drop off transportation time;
- C. Backup caregiver(s) work schedules on employer's letterhead, including days of the week and start/end times of the work day. It must be signed and dated by the employer;
- D. Length of commute to and from workplace for backup caregiver;
- E. If backup caregiver is attending college, submit course schedule on college letterhead

## 6.13 Backup Caregiver Training and Responsibility

At least one (1) trained backup caregiver must be identified for the member. It is recommended that there be a second caregiver identified for instances where the backup caregiver is unavailable because of: illness, emergency, or occasional respite for the backup caregiver. Caregivers must be trained and available to provide care in the home during the absence of the private duty nurse and as required by the member's medical status.

Members who are birth through 17 years of age must reside with a responsible adult who is either trained to provide nursing care or can initiate an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

A backup caregiver cannot be a nursing provider who is servicing the member's case. If the backup caregiver is no longer able to function in this capacity for any reason (illness, travel, work, emergency) a training statement should be submitted to the Department for any new backup caregiver.

- A.** The backup/training statement signed and dated by the backup caregiver should read: "In the event a nursing shift is not covered, I \_\_\_\_\_(name), the \_\_\_\_\_(relation to the member) of the member, will be responsible for taking care of \_\_\_\_\_( the member's name) as the backup caregiver and have been fully trained in all skilled tasks."
- B.** For members over the age of 18 and residing independently, the physician must submit an annual statement that they are aware the member resides alone, a backup caregiver does not live in the residence, and he/she feels this is a safe plan of care.

## 6.14 Case Management

If a case manager has been identified for the member, please provide contact information for assistance in getting additional information for a prior approval determination. A HIPAA release form may be required for communication. Authorization for Release of Health Information Pursuant to HIPAA can be found here:

[http://www.nycourts.gov/forms/hipaa\\_fillable.pdf](http://www.nycourts.gov/forms/hipaa_fillable.pdf)

## 6.15 Managed Care

If a member was enrolled in a Medicaid Managed Care Plan in the previous 30 days, please submit the most recent Managed Care Person Centered Service Plan (PCSP) or Plan of Care (POC). This will allow assessment for continuity of services during the transition.

## 6.16 Primary Insurance

Full disclosure of primary insurance must be made to Medicaid. Provider must submit for prior authorization/prior approval to the primary insurance before requesting PDN hours from Medicaid. Submit the response from the primary insurance (Explanation of Benefits (EOB), denial, claim response) with the PDN request. A copy of the member's benefit booklet is not acceptable evidence of primary insurance denial for PDN services. This documentation must be submitted annually. See Section [15.1](#) for additional information.

For Medicaid approval in addition to nursing hours approved by the Primary Insurance; submit documentation from the primary insurance that indicates the approved nursing hours and the hours that they denied.

For retrospective approval due to the primary insurance exhaustion or denial, see section [10.4](#).

## 6.17 Improvement in Member's Condition

When there has been an improvement in the member's medical condition (i.e. decannulation, discontinuation of G-tube feedings or TPN, ventilator weaning, etc.), or there has been a change in the social environment (i.e. member attending school/day program, a change in caregiver status, etc.), the provider is responsible for calling the Department as soon as possible to speak with a nurse reviewer for further guidance.

## 6.18 Recommendation for PDN Services

The Department will take into consideration the recommendation for PDN services from Certified Home Health Agencies, Case Managers, or the Local Department of Social Services (LDSS), however it is ultimately the responsibility of the ordering physician to order nursing services.

## 6.19 PDN During School Hours

See Place of Service Section [11.2](#)

## 6.20 Day Program Information

See Place of Service Section [11.3](#)

## 6.21 Consumer Directed Personal Assistance Program (CDPAP)

See Section [13.1](#) for more information

## 7.0 New Cases

### 7.1 Definition

A "New Case" refers to a member who has never received a prior approval number from Medicaid for Private Duty Nursing Services OR there has been a lapse in service for the member (no Medicaid PDN approved services in the last 6 months).

### 7.2 Eligibility

The member must be Fee for Service (FFS) Medicaid Eligible, as determined by the member's Local Department of Social Services (LDSS), prior to requesting PDN services.

### 7.3 Submission

All new cases must be submitted by an enrolled servicing provider (independent nurse or agency) through ePACES or a paper prior approval as described in Section [6.4](#) and [6.5](#)

## 8.0 Renewal Cases

### 8.1 Re-evaluation

Approval for continued PDN care beyond the initial new case determination must be re-evaluated at regular intervals. Please see the chart in Section [6.1](#) for the documentation to be submitted at each interval.

- A. Prior approval requests should be submitted a minimum of six (6) weeks prior to the expiration date of the current PA.



- B.** When, at any time, the Medical Bureau Director, or his/her designee determines that PDN services are being decreased or denied based on medical necessity and the member continues to request nursing care, the member will be advised of the determination and of their right to request a Fair Hearing.
- C.** When the determination to discontinue PDN services is made, the Medical Director may authorize continuation of the nursing services for a period of time sufficient to permit the member's caregivers and his/her medical team time to implement an alternate treatment plan.

## 9.0 Prior Approval Changes

### 9.1 Change Requests

Change Requests (CR) are changes that are being requested to a prior approval number in response to changes in the member's medical condition, servicing providers, availability of backup caregivers, level of skilled nursing services or the member's schedule or home environment. This includes, but is not limited to:

- A.** Adding a procedure code
- B.** Adding or removing a provider
- C.** Request for increase, decrease or discontinuance of PDN hours
- D.** Transfer of hours between procedure codes
- E.** Non-school day hours
- F.** Correction to a rejected paper PA
- G.** Miscellaneous: updated member information

Change requests should include the name and contact information of the requestor. For requests that do not contain all the required information, the provider will be notified that the request cannot be processed.

Completed forms and supporting documentation should be faxed to the number or mailed to the address found on the form. Change request forms are available at <https://www.emedny.org/info/phase2/paper.aspx>

### 9.2 Replacement PA

Change requests cannot be processed for all changes to a prior approval and may require a replacement PA. A replacement PA must indicate the PA number that it is replacing and must include all supporting documentation for the requested change. Please note: in order to avoid system delay, all electronic 278 submissions must have at least one attachment stating it is a replacement PA and the reason.

A replacement paper PA submission or electronic 278 submission is required for the following changes:

- A.** Replacing the servicing provider who submitted the original PA;

- B. Replacing the Ordering Physician on the original PA. This requires submission of new physician orders and independent LPN oversight agreement, if applicable, from the new ordering physician
- C. Adding a procedure code
- D. Adding a modifier (TT)
- E. Correction to a rejected PA

### 9.3 Additional Procedure Code

Requesting an additional procedure code is for paper PAs only. Electronically submitted PAs (ePACES) require a replacement PA in order to add a procedure code, See Section [9.2](#)

If there is an approved PA for S9124 (LPN) or S9123 (RN) and a different procedure code is requested on the existing PA (RN or LPN), then the following information is required for the Change Request:

- A. Number of hours being requested (and new code) for the additional level of service;
- B. Updated PDN order:
- C. Letter of medical necessity for a higher level of service, if applicable;
- D. If independently enrolled providers are being added to the case, submit the list of provider names and NPI numbers. For independently enrolled LPNs, the physician letter of oversight must be submitted if not already on file.

The Department will determine if the higher level of service is medically appropriate.

### 9.4 Non-School Hours

Adding Non-School day hours to an existing prior approval number that has a current Department approval for additional hours on non-school days:

- A. Change Requests for sick days must only be submitted once per month for the previous months' hours. The request must include the days and hours that the member was absent from school.
- B. Change Requests for school vacation days should be accompanied by the current school year calendar and/or the summer school calendar, if applicable.
- C. Change Requests for inclement weather (i.e. snow day) or other unplanned event (i.e. power outage, medical appointment) must clearly indicate the reason the child was off from school with the days and the number of hours needed.

### 9.5 Transfer of Hours

Transfer of approved hours can be between nursing procedure codes. Requests for transfer of hours should only be submitted one time per month unless the Approved Quantity is near exhaustion or has been completely exhausted. One nurse should be designated on each case to coordinate and communicate to other nurses and agencies the total number of hours to be transferred before making the transfer request.

Transfer requests should include the number of hours that need to be transferred from one procedure code to another.

## 9.6 Increase of Hours

All increases to hours on an existing prior approval number, require prior approval and if possible, should be requested at least six weeks in advance of the dates of service. Retroactive increases, with the exception of emergency services which occur when the Department is closed (i.e. evenings/nights or weekends), are at the discretion of the review staff. For more information on emergency services see the "Retroactive / Emergency Services" Section [10.0](#)

Increases in hours are considered for parent, guardian, or caregiver respite, increase in member medical acuity, temporary absence or limitation of the backup caregiver or other instances where the member would need additional hours of service.

See Travel Away from Home for additional information Section [11.5](#).

The following documentation for an increase in PDN hours is required:

**A.** Reason for the increase, such as:

- a) Unavailability of the Primary Caregiver; for example: temporary hospitalization, surgery, or another event. Documentation of medical issue is required from the caregiver's physician; including expected timeframe of restriction.
- b) Intermittent, limited travel required by the Primary Caregiver; such as temporary work travel. Documentation of travel is required from employer on corporate letterhead.
- c) Primary Caregiver Respite Travel (See section [11.5](#) for additional information.)

**B.** Letter of medical necessity to include:

- a) The change in medical condition or social circumstances that warrant the increase;
- b) Number of hours requested;
- c) Time period covered by the request;

**C.** Backup care giver statement from the individual who will be assuming this responsibility showing that they have been fully trained in all skills and care of member

## 9.7 Adding or Removing a Billing Provider to Existing PA (Agency or Independent Nurse)

The provider must submit a change request form indicating that they want to be added to or removed from the prior approval number. If the provider who submitted the PA is being removed, a replacement PA must be submitted. See Section [9.2](#) If there is an active PA on file, then no additional physician orders need to be submitted.

For Independent Nurses, a list of nurse's names and NPI numbers must be submitted.

Independent LPN's must submit a physician oversight statement if not already on file.

## 9.8 End Date on Existing Prior Approval Number

A Prior Approval number should be end dated for the following reasons:

- A. Members death;
- B. Member has entered a skilled nursing facility or group home;
- C. Discontinuance of PDN hours

If the Ordering Provider is discontinuing PDN services, then submit a discontinue order.

Send the exact date you want the prior approval number to end, along with the reason.

## 10.0 Retroactive / Emergency Cases

### 10.1 PA Before Services Commence

Prior approvals must be obtained before services commence except in cases of emergency. In that instance, no more than two days will be approved retrospectively, and approval is dependent on a detailed explanation for the delay. The explanation must be provided to the prior approval office on the next business day.

### 10.2 Notify Director

In cases where services are provided on an emergency basis, the Medical Bureau Director or his/her designee must be notified on the next business day.

### 10.3 Retrospective PA

In limited circumstances, prior approval may be granted retrospectively at the discretion of the Medical Director, or his/her designee, providing the prior approval request is received by the Medical Director or his/her designee within ninety (90) days of the date service was provided.

### 10.4 Changes in Coverage

The provider is responsible for verifying eligibility whenever services are to be provided to the member. The provider is strongly encouraged to access the Medicaid eligibility system frequently while providing services to the member. If there is a change in eligibility from Medicaid Fee for Service to Medicaid Managed Care or a change in third party liability, a new request for prior approval needs to be submitted to Medicaid within 30 days of being notified of the change in coverage in order to receive retroactive approval.

For primary insurance exhaustion or denial of PDN services, submit documentation from the primary insurance that indicates the nursing hours on the last date of their approval and the first date PDN services were denied or exhausted.

For members with approved PDN services through Medicaid Managed Care with a change in eligibility to Medicaid Fee for Service, submit documentation from the managed care company that indicates the approved nursing hours on the last date of their approval.

## 11.0 Place of Service

### 11.1 Home and Community

PDN services may be provided to a member in their home, or usual and customary community environment. A member's "usual and customary community environment" is considered any place – not otherwise specified in this

manual – outside the member’s home where any person would normally perform activities (i.e., shopping, dining out, visiting friends and family, community functions, etc.). [See Section [16.0](#) “Unacceptable Practices” for further information.]

## 11.2 School / Pre-School

The Individuals with Disabilities Education Act (IDEA) requires that free appropriate public education (FAPE) be made available to students with disabilities through the provision of special education and related services, including school health services and school nurse services. For some students, nursing services, including the assignment of a full-day (continuous) one-to-one nurse, may be a required related service for the student to receive FAPE. Additionally, students may need nursing services to attend school in accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act.

If it is determined that school health services and/or school nurse services, including assignment of a full-day (continuous) one-to-one nurse, are required related services for a student with a disability, those services must be provided by the school district at no cost to the parents and are the fiscal and programmatic responsibility of the school district of residence.

New York State Department of Education January 2019 memo special: Guidelines for Determining a student with a Disability’s Need for a One-to-One Nurse: <http://www.p12.nysed.gov/publications/documents/guidelines-for-determining-a-student-with-a-disability-need-for-a-1-1-nurse.pdf>

New York State Department of Education January 7, 2019 memo: Provision of Nursing Services in School Settings – Including One-to-One Nursing Services to Students with Special Needs: <http://www.p12.nysed.gov/sss/documents/OnetoOneNSGQAFINAL1.7.19.pdf>

For additional information regarding intermittent Medicaid reimbursement for nursing services in school/pre-school through the School Supportive Health Program (SSHP), see: [http://www.oms.nysed.gov/medicaid/handbook/sshsp\\_handbook\\_9\\_march\\_21\\_2018\\_final.pdf](http://www.oms.nysed.gov/medicaid/handbook/sshsp_handbook_9_march_21_2018_final.pdf)

## 11.3 Day Program

If the Medicaid Nurse is requested to attend a Day Program with the Member, then the Day Program provider must submit a letter documenting the following:

- A. Inclusion/exclusion of nursing services as part of their reimbursement rate;
- B. The nurse to member ratio providing nursing services;
- C. Justification for requesting that PDN services be provided to the member during program hours (if nursing services are included in the reimbursement rate).

## 11.4 Residential Habilitation

PDN services may not be provided in a Residential Habilitation Program that provides services as part of its routine operation. Residential habilitation services are provided to individuals living in the following certified locations:

- A. Supervised Individualized Residential Alternatives (Supervised IRAs);
- B. Supportive Residential Alternatives (Supportive IRAs);

- C. Family Care Residences;
- D. Intermediate Care Facility (ICF).

Nursing services included in the residential habilitation rate for these settings are as follows:

- A. Nursing supervision of direct care staff;
- B. Coordination of residents' health care needs, including prescriptions, medication administration and medication;
- C. Administration training and oversight;
- D. Coordinating needed medical appointments;
- E. Follow-up reports from medical appointments;
- F. Follow-up and interface with hospital staff regarding Emergency Room visits and other hospitalizations.

PDN services of a Registered Nurse or Licensed Practical Nurse, delivered in the residence, may be approved through Medicaid under the following conditions:

- A. The service is ordered by a physician and prior approved by the Department of Health based upon the health care needs of the person that cannot be met with residential staffing alone (both Direct Support Professionals & clinicians who work for the Residential Habilitation service provider); and
- B. The Registered Nurse or Licensed Practical Nurse who delivers the approved PDN services are not employed by the agency providing the Residential Habilitation service to the person.

## 11.5 Travel Away from Home

In the event that a NYS Medicaid member who is temporarily residing outside NYS requires PDN services, they may be provided only by nurses who meet the certification requirements of the state in which they are practicing and who are enrolled in the NYS Medicaid Program. Out-of-state nurses who wish to provide services within NYS must possess a license and current registration from the New York State Education Department (NYSED). PDN services, whether rendered or ordered by an out-of-state provider, must conform to the prior approval requirements outlined in this Manual.

For PDN services requested for intermittent out of state travel, New York State Medicaid must authorize these services on an individual per trip basis. PDN service providers must have the appropriate licensure for the states in which they will provide the PDN services. A letter from the ordering physician must be submitted acknowledging that they are aware that the member will be traveling out of NYS. For more information regarding the provision of out-of-state medical care and services, please refer to the Information for All Providers, General Policy manual.

[https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information\\_for\\_All\\_Providers-General\\_Policy.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Policy.pdf)

Additional hours for primary caregiver respite may be requested through the Change Request process. See section [9.6](#) for additional information. A maximum of two weeks per calendar year (14 days) can be requested. Requests need to be submitted six (6) weeks prior to the start date of the respite to allow time for review.

## 12.0 Provider

### 12.1 Coverage

It is the provider's responsibility to determine the type of coverage (Medicare, Medicaid, or private insurance) that the member is eligible to receive. Medicaid is the payor of last resort and all Medicare and third-party coverage must be exhausted before payment for nursing services by Medicaid.

See the following regulation for more information: <https://regs.health.ny.gov/content/section-5406-billing-medical-assistance>.

To verify member Medicaid eligibility please use the ePACES Member Eligibility Verification System (EMEVS). Instructions can be found at the following link: <https://www.emedny.org/selfhelp/ePACES/ePACESRefSheets.aspx>

See sections [6.16](#), [10.4](#) and [15.1](#) for more information.

### 12.2 Medicaid Enrollment

Nursing providers must be enrolled with Medicaid prior to the start of providing services. All nursing providers must be either a Licensed Home Care Services Agency (LHCSA) or independently practicing LPN or RN enrolled with Medicaid to provide nursing services.

For information on enrolling as a Medicaid Provider please see the information on our website at the following link: <https://www.emedny.org/info/ProviderEnrollment/index.aspx>

### 12.3 NYS Registered LPN or RN

All nurses providing PDN services must possess a current LPN or RN registration with the New York State Department of Education. Independent enrollment with Medicaid and any approval for PDN services does not constitute an exception to, or expansion of, any scope of practice defined by New York State Education Law. PDN services provided by an independently enrolled LPN must be overseen by a licensed physician.

A list of Medicaid enrolled private duty nursing services providers can be obtained by calling the Prior Approval Call Center at 1-800-342-3005 or by emailing; [ohipmedpa@health.ny.gov](mailto:ohipmedpa@health.ny.gov)

### 12.4 Ending Nursing Services by Provider

If the nursing provider can no longer provide nursing care for the member they must notify the member or member's backup caregiver in writing at least 48 hours prior to stopping nursing services. The nursing provider should coordinate with the member or member's backup caregiver to ensure a safe discharge plan is in place. Notification should also be sent to the member's physician and the PDN approval unit.

## 13.0 PDN in Combination with Other Services and Programs

### 13.1 Consumer Directed Personal Assistance Program (CDPAP)

This Medicaid program provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. Nothing precludes the provision of CDPAP services in combination with other services, such as PDN services, when a combination of services can appropriately

and adequately meet the consumer's needs; provided, however, that no duplication of Medicaid funded services would result. See Department regulations at <https://regs.health.ny.gov/volume-c-title-18/1383001753/section-50528-consumer-directed-personal-assistance-program> for additional information and program requirements.

If the member will be receiving PCA, HHA, or CDPAP services, then submit documentation for the specific service authorized and plan of care to include the number of hours/days of week serviced. This document can be obtained from the local DSS or NYC HRA.

## 14.0 Record Keeping

### 14.1 Clinical Record Requirements:

- A. A clinical record of the member's care must be maintained in the member's home containing documentation of PDN services provided during each nursing shift.
- B. Documentation must be in the form of generally accepted professional nursing notes, detailing all skilled nursing tasks provided, as well as any assessments, teaching, planning, and evaluations performed of the member or family needs and their responses to the nursing care.
- C. The clinical record must contain detailed documentation to enable another medical professional to reconstruct what transpired during each hour of nursing service billed to Medicaid.
- D. The clinical record must include, at a minimum:
  - a) The physician / nurse practitioner's current written orders and treatment plan; both of which will be revised as the needs of the member dictate.
  - b) The beginning and ending shift times, signed and dated by the nurse.
  - c) The dates and times of PDN care provided, with the identity of the nurse providing the care.
  - d) The member's status as observed, measured, and evaluated by the nurse providing the care (nursing progress notes).
  - e) Medication administration and other treatment records, including the member's response(s).
  - f) A record of other therapies provided, and the observed functioning and adequacy of the supporting medical therapies and equipment.
  - g) A copy of the Medicaid PDN prior approval
- E. Corrections to any record should be made using the generally accepted standard of a single strike-through with date, time, and initials of the individual making the correction. A record should never contain scribbled or blackened out information, nor be corrected using "white-out".
- F. The clinical record must be submitted to the Department upon request, according to Department/Medicaid policy and regulation.



- G. Periodic written documentation of the member's progress should be given by the Provider to the PDN ordering physician/nurse practitioner on a regularly scheduled basis, as agreed upon by the parties and as part of the medical orders for PDN services. A copy of this documentation should be included in the member's clinical record.
- H. Immediate notification to physician/nurse practitioner is required when there is any significant change in the member's condition.

## 15.0 Billing for Services

### 15.1 Billing Medicaid for PDN Services

- A. PDN services billable to Medicaid include skilled nursing care rendered directly to the member and instructions to his/her family in the procedures necessary for the member's care. All PDN services must be in accordance with, and conform to, the ordering physician's treatment plan.
- B. A valid prior approval (PA) for PDN is required before a Provider may bill Medicaid for PDN services. A Provider servicing a PDN case without a valid PA may be at financial risk should the PA be approved with modifications or denied.
- C. The name of the Ordering Provider (physician or nurse practitioner) on the paper or electronic PA must be the same as the provider, or a provider in the same practice, that signed the written order / Plan of Treatment and must be an enrolled Medicaid provider.
- D. Reimbursement for PDN will be at hourly rates not to exceed those negotiated by Local Department of Social Services (LDSS) Commissioners on behalf of their respective counties and approved by the Department. Approval for LPN/RN services will be at the approved county rate unless the member meets the criteria for a high-tech rate. The high-tech rate is approved for members on ventilator life support.
- E. If PDN services are provided in increments other than a full hour, the Provider's claim should be rounded up or down to the nearest full hour. Justification for services rendered for less than a full hour should be noted in the clinical record when documenting shift hours. Routine rounding claims to the nearest hour is not encouraged and may cause claims to be pended for additional review.
- F. Under federal law, the Medicaid program is the payer of last resort. All third-party obligations must be exhausted before claims can be submitted to Medicaid. It is the responsibility of the member (family) and Provider to investigate and exhaust all other insurance sources prior to billing Medicaid.
- G. All PDN providers are responsible for submitting claims to the primary insurance first before submitting claims to Medicaid. The Department will continue to request a copy of current insurance claim response (denial or proof of payment) annually.

See manual sections [6.16](#) and [10.4](#) for more information.

## 16.0 Unacceptable Practices

### 16.1 Additional References:

- A. Information for All Providers, General Providers  
[https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information\\_for\\_All\\_Providers-General\\_Billing.pdf](https://www.emedny.org/ProviderManuals/AllProviders/PDFS/Information_for_All_Providers-General_Billing.pdf)
- B. New York State [Regulation 18 NYCRR 515.2](#), Unacceptable practices under the medical assistance program

### 16.2 Prohibited

Providers are specifically prohibited from engaging in practices considered unacceptable including, but not limited to:

- A. Offering cash payments to a physician/nurse practitioner;
- B. Entering into agreements or arrangements of any kind with any practitioner or representative of a health facility whereby any benefit, financial or otherwise accrue to the parties of such agreement;
- C. Billing for services available free of charge to the general public;
- D. Billing for services not properly ordered by a qualified or otherwise legally authorized physician/nurse practitioner;
- E. Nursing services provided by an individual nurse exceeding sixteen (16) hours in a 24-hour period;
- F. Billing for services not provided to the member;
- G. Billing for services provided by the member's legally responsible relative (i.e., parent, spouse or guardian). Nothing prohibits nursing services to be provided by other relatives that hold the required nursing degree and are an enrolled provider in NYS Medicaid;
- H. Billing for services while the member is receiving comparable or duplicative services in a physician's office, clinic, hospital or other medical facility;
- I. Billing for or providing services for components of all dialysis or dialysis time;
- J. Billing for services that are the legal responsibility of a school district (See Section [11.2](#) for further information);
- K. Billing for services covered by other insurance;
- L. Operating a motor vehicle, chauffeuring, or otherwise facilitating transportation of the member while the nurse is purported to be providing nursing services; a nurse may accompany the member, but may not drive, chauffeur, or otherwise facilitate transporting the member;
- M. Billing for services provided to the member in the nurse's home;
- N. Billing for time caring for other individuals during time scheduled to be providing skilled nursing care to the member;

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- O. Performing tasks that are not skilled nursing in nature including, but not limited to cooking, cleaning and other, household chores (washing dishes, laundry).