MEDICAL POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Private Duty Nursing-OH MCD-MM-1510	01/01/2024
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Private Duty Nursing

B. Background

Private duty nursing (PDN) is a Medicaid State Plan service that provides in-home skilled nursing care to Medicaid members of any age who require continuous nursing services beyond the Medicaid State Plan Home Health benefit. PDN provides care for members with complex medical needs under the direction of the members' physician if it can be provided safely in a residence. For individuals who have a medical need for part-time, intermittent, and skilled nursing or aide care and therapies, home health services may also be provided. Refer to the *Home Health Services* medical policy for further guidance on intermittent skilled nursing or aide care.

PDN services are covered by the Ohio Department of Medicaid (ODM) when certified as medically necessary and only when continuous skilled care that requires the skills of either a registered nurse (RN) or licensed practical nurse (LPN) under the direction of an RN are performed. A covered PDN visit must meet the conditions imposed in 5160-12-02 of the Administrative Code and all other applicable state regulations. Providers of PDN include a Medicare certified home health agency (MCHHA) that meets the requirements in accordance with rule 5160-12-03 of the Administrative Code, an otherwise accredited agency that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code, and a non-agency nurse that meets the requirements in accordance with rule 5160-12-03.1 of the Administrative Code.

In order for PDN to be covered, providers must:

1. Provide PDN that is appropriate given the member's diagnosis, prognosis, functional limitations, and medical conditions as documented by the member's treating physician, physician's assistant, or advance practice nurse.
2. Provide PDN as specified in the plan of care in accordance with rule 5160-12-03 of the Administrative Code. PDN services not specified in a plan of care are not reimbursable. For individuals enrolled on a home and community-based services (HCBS) waiver, the providers of PDN services must provide the amount, scope, duration, and type of PDN service within the plan of care as:
    a. Documented on the all-services plan that is approved by ODM or its designee when an individual is enrolled on an ODM administered HCBS waiver. PDN services not identified on the all-services plan are not reimbursable; or
    b. Documented on the services plan when an individual is enrolled on an Ohio department of aging (ODA) or an Ohio department of developmental disabilities (DODD) administered HCBS waiver. PDN services not documented on the services plan are not reimbursable.
3. Bill for provided PDN services using an appropriate procedure code and applicable modifiers in accordance with rule 5160-12-06 of the Administrative Code.
4. Bill for provided PDN services in accordance with the visit policy in rule 5160-12-04 of the Administrative Code, except as provided for in paragraph (A) of rule 5160-12-02 of the Administrative Code.

5. Bill after all documentation is completed for services rendered during a visit in accordance with rule 5160-12-03 of the Administrative Code.

The below guidelines identify clinical information that CareSource uses to determine medical necessity and quantity of care for private duty nursing. These guidelines are based on generally accepted standards of practice, review of medical literature, as well as federal and state policies and laws applicable to Medicaid programs.

Providers should consult Chapter 5160-12 of the Ohio Administrative Code for details about coverage, limitations, service conditions, and prior-authorization requirements.

C. Definitions

- **HealthChek Program** – The Ohio-administered version of the early and periodic screening, diagnosis, and treatment (EPSDT) program, which is a federally mandated program of comprehensive preventive health services available to Medicaid-eligible individuals from birth through age 20 years and is administered by the County Department of Job and Family Services (CDJFS).
- **Home Health Agency** – A person or government entity, other than a nursing home, residential care facility, or hospice care program that has a primary function of providing any of the following services to a patient at a place of residence used as the patient's home:
  - skilled nursing care
  - physical therapy
  - speech language pathology
  - occupational therapy
  - medical social services
  - home health aide services
- **Maintenance Care** – Care given to a member for the prevention of deteriorating or worsening medical conditions or the management of stabilized chronic diseases or conditions. Services are considered maintenance care if the member is no longer making significant improvement with a medical condition.
- **Medical Necessity** – Procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition that meet ALL the following conditions:
  - Meets generally accepted standards of medical practice.
  - Is clinically appropriate in its type, frequency, extent, duration, and delivery setting.
  - Is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
  - Is the lowest cost alternative that effectively addresses and treats the medical problem.
  - Provides unique, essential, and appropriate information if it is used for diagnostic purposes.
  - Is not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.

- **Place of Residence** – Wherever the individual lives, whether the residence is the individual's own dwelling, assisted living facility, relative's home, or other type of living arrangement. This does not include a hospital, nursing facility, or intermediate care facility for individuals with intellectual disabilities.
- **Plan of Care** – The medical treatment plan that is established, approved, and signed by a treating physician, advance practice nurse, or physician's assistant in accordance with all applicable federal and state regulations.
- **Skilled Care** – Procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the physical, mental, and emotional needs of the ill or otherwise incapacitated. "Skilled nursing care" includes, but is not limited to, the following:
  - Irrigations, catheterizations, application of dressings, and supervision of special diets.
  - Objective observation of changes in the resident's condition as a means of analyzing and determining the nursing care required and the need for further medical diagnosis and treatment.
  - Special procedures contributing to rehabilitation.
  - Administration of medication by any method ordered by a physician or other licensed health care professional acting within their applicable scope of practice, such as hypodermically, rectally, or orally, including observation of the resident after receipt of the medication.
  - Carrying out other treatments prescribed by the physician or other licensed health care professional acting within their applicable scope of practice, that involve a similar level of complexity and skill in administration.

D. Policy

I. Private duty nursing (PDN) services are provided to any CareSource Ohio Medicaid member when considered medically necessary.

II. This policy is not intended to restrict or contradict EPSDT services.

III. Duplicative services are not covered. If the member is receiving other assistance (e.g., family caregiver, home health services, additional supportive services), this information and the hours involved must be provided to adequately evaluate medical necessity of PDN services.

IV. PDN services must meet ALL the following:
   A. Services performed must be within the nurse's scope of practice as defined in Chapter 4723. Of the Revised Code and rules adopted there under.
   B. Services provided must be documented in accordance with the individual's plan of care.
   C. Services must be medically necessary to care for the individual's condition, illness, or injury.
   D. Be provided in person in the individual's place of residence unless it is medically necessary for a nurse to accompany the individual in the community. The place

of service in the community cannot include the business location of the provider of PDN. The place of service in the community cannot include the residence of the provider of PDN unless it is the same as the individual.

V. PDN services do not include any of the following:
   A. services provided for the provision of habilitative care
   B. RN assessment services
   C. RN consultation services

VI. Individuals who receive PDN must meet ALL the following:
   A. Be under the supervision of a treating physician, physician's assistant, or advance practice nurse who is providing care and treatment to the individual. The treating physician, physician's assistant, or advance practice nurse is not a physician, physician's assistant, or advance practice nurse not only signs and authorizes plans of care, but are also directly involved in the care or treatment of the individual. A treating physician, physician's assistant or advance practice nurse may also substitute temporarily on behalf of a treating physician.
   B. Participate in the development of a plan of care with the treating physician, physician's assistant, or advance practice nurse and the MCHHA, other accredited agencies, or non-agency registered nurse. An authorized representative may participate in the development of the plan of care in lieu of the individual.
   C. Access PDN in accordance with the program for the all-inclusive care of the elderly (PACE) if the individual participates in the PACE program.
   D. Access PDN in accordance with the individual's provider of hospice services if the individual has elected hospice.
   E. Access PDN in accordance with the individual's managed care plan's process if the individual is enrolled in a Medicaid managed care plan.

VII. Post hospital PDN
   A. Any individual receiving Medicaid, whether adult or child, may receive PDN services up to 56 hours per week and up to 60 consecutive days from the date of discharge from an inpatient hospital stay of 3 or more covered days in accordance with rule 5160-2-03 of the Administrative Code. For purposes of this rule, a covered inpatient hospital stay is considered one hospital stay when an individual is transferred from one hospital to another hospital, either within the same building or to another location.
      1. The 60 days will begin when the individual is discharged from the hospital to the individual's place of residence from the most recent inpatient stay in an inpatient hospital or inpatient rehabilitation unit of a hospital.
      2. The 60 days will begin when the individual is discharged from a hospital to a nursing facility. PDN is not available while residing in a nursing facility.
   B. The treating physician, physician's assistant, or advance practice nurse will certify the medical necessity of PDN services using the ODM 07137 "Certificate of Medical Necessity for Home Health Services and Private Duty Nursing

Services" (rev. 7/2014). PDN is available to individuals only with a medical need comparable to a skilled level of care as evidenced by a medical condition that temporarily reflects the skilled level of care as defined in rule 5160-3-08 of the Administrative Code. In no instance do these requirements constitute the determination of a level of care for waiver eligibility purposes or admission into a Medicaid covered long-term care institution.

VIII. Children may qualify for additional PDN services beyond the post-hospitalization service when the following criteria are met:
   A. The individual is under age 21 years and requires services for treatment in accordance with the HealthChek program.
   B. Needs, as ordered by the treating physician, physician's assistant, or advance practice nurse, continuous nursing services, including the provision of on-going maintenance care (services for habilitative care are inappropriate).
   C. Has a comparable level of care as evidenced by either:
      1. Enrollment on a HCBS waiver
      2. For a child not enrolled on a HCBS waiver, a comparable institutional level of care, including a nursing facility-based level of care pursuant to rule 5160-3-08 of the Administrative Code or an ICF-IID level of care pursuant to 5123:2-8-01 of the Administrative Code, as evaluated initially and annually by ODM or its designee.
   D. The provider of PDN services ensures and documents the child meets all requirements for PDN services prior to providing and billing for the services.
   E. The child has a PDN authorization obtained in accordance with rule 5160-12-02.3 of the Administrative Code to establish medical necessity and the child's comparable level of care. A request for additional, recertification, and/or a change of PDN authorization is made as follows:
      1. For a child not enrolled on a HCBS waiver, the provider of PDN shall submit the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity shall be provided by the provider of PDN services. ODM or its designee will notify the provider of the amount, scope and duration of services authorized.
      2. For a child enrolled on a DODD administered waiver, the provider of PDN must submit the request to the case manager of the HCBS waiver, who will forward the request to DODD. Any documentation required by DODD for the review of medical necessity shall be provided by the provider of PDN services. DODD will notify the provider and the case manager of the amount, scope and duration of services authorized.
      3. For a child enrolled on an ODM administered waiver, the ODM case manager will authorize PDN services through the person-centered services plan.

IX. Adults may qualify for additional PDN services beyond the post-hospitalization service when the following criteria are met:
   A. The adult is age 21 years or older.

B. The adult needs, as ordered by the treating physician, physician's assistant, or advance practice nurse, continuous nursing services, including the provision of on-going maintenance care (services for habilitative care are inappropriate).
C. The adult has a comparable level of care as evidenced by either:
    1. Enrollment on a HCBS waiver.
    2. A comparable institutional level of care, including a nursing facility-based level of care as evaluated initially and annually by ODM or its designee for an adult not enrolled on a HCBS waiver. The criteria for a nursing facility-based level of care are defined in rule 5160-3-08 of the Administrative Code or ICF-IID level of care as defined in rule 5123-8-01 of the Administrative Code.
D. The provider of PDN services ensures and documents that the adult meets all requirements for PDN services prior to providing and billing for services.
E. The adult must have a PDN authorization obtained in accordance with rule 5160-12-02.3 of the Administrative Code and approved by ODM or its designee to establish medical necessity and the adult's level of care. A request for additional, recertification, and/or a change of PDN authorization is made as follows:
    1. For an adult not enrolled on a HCBS waiver, the provider of PDN shall submit the request to ODM or its designee. Any documentation required by ODM or its designee for the review of medical necessity shall be provided by the provider of PDN services. ODM or its designee will notify the provider of the amount, scope, and duration of services authorized.
    2. For an adult enrolled on a DODD administered waiver, the provider of PDN must submit the request to the county board of DD, who will forward the request to DODD. Any documentation required by DODD for the review of medical necessity shall be provided by the provider of PDN services. DODD will notify the provider and the county board of DD of the amount, scope, and duration of services authorized.
    3. For an adult enrolled on an ODM administered waiver, the case manager will authorize PDN services through the person-centered services plan.

X. Additional PDN services beyond what ODM or its designee has authorized may be provided to an individual in an emergency when the provider has an existing PDN authorization to provide PDN services to that individual. For the purposes of this rule, emergency services are provided outside of normal state of Ohio office hours when prior authorization cannot be obtained.
    A. PDN services may be delivered in an emergency and a new PDN authorization obtained after the delivery of services. The PDN services must be medically necessary in accordance with rule 5160-1-01 of the Administrative Code, and the services must be necessary to protect the health and welfare of the individual.
    B. The provider shall notify ODM, or the ODA case manager, as applicable, in writing using the ODM 02374, or the county board SSA for individuals enrolled on a DODD administered waiver when emergency PDN services are delivered. Notification shall be immediate, or no later than the first business day following the emergency provision of PDN services.

XI. For billing information, refer to Rule 5160-12-06 of the Ohio Administrative Code.

XII. The PDN acuity scale is intended to be used in conjunction with the assessment tool and the clinical and professional judgement of the nurse completing the tool. It is not intended to be the sole determinant of all the skilled nursing needs of the individual. Normal age-appropriate care and parental responsibility should be considered, i.e., all 3-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 and not a medical need.

A. Skilled nursing care acuity guidelines

1. Mechanical ventilation: acuity measurement is based on number of hours used per day.
   - 1.0 point is scored when the ventilator is listed as standby (e.g., "just in case" it would be needed).
   - 2.5 points are scored when the member requires a ventilator 12 hours or less per day (e.g., while sleeping).
   - 5.0 points are scored when the member requires a ventilator for greater than 12 hours per day.
2. CPAP/BiPAP: acuity measurement is based on number of hours used per day.
   - 2.0 points are scored when the member is on CPAP or BiPAP 12 hours or less per day.
   - 4.0 points are scored when the member is on CPAP or BiPAP for greater than 12 hours per day.
3. Tracheostomy: acuity measurement is used to indicate special care needed for tracheostomy (note: dressing changes are included in the below).
   - 1.5 points are scored when the member is able to tolerate the use of a speaking valve, or having the tracheostomy capped for a period of time and/or receives routine care.
   - 3.0 points are scored when the member breathes continuously through an open tracheostomy and requires special care (e.g., frequent tube changes, current infection at trach site, irritation, mucous plugs requiring intervention, mucosal bleeding).
4. Oxygen: acuity measurement is based on the order for administration, either continuous or determined by pulse oximeter.
   - 1.0 point is scored when the member's oxygen use is routine and predictable (i.e., member has COPD and requires oxygen whenever necessary when walking or upon exertion).
   - 3.0 points are scored when the member's oxygen use is unpredictable (e.g., unstable airways).
5. Tracheal suctioning: acuity measurement is based on frequency the skilled nurse performs this service and is only applicable when the member be unable to self-suction.
   - 1.0 point is scored when the member requires suctioning once per day.

- 2.0 points are scored when the member requires suctioning 2 – 10 times per day.
- 3.0 points are scored when the member requires suctioning 11 – 20 times per day.
- 4.0 points are scored when the member requires suctioning more than 20 times per day.

6. Humidification: acuity measurement is based upon the need for humidification treatment: 0.5 points is scored when humidification is performed and completed by skilled nurse.
7. Pulse oximetry monitoring: acuity measure is based on treatment that is done on a routine basis.
   - 1.0 point is scored if monitoring is completed by the nurse ≤ 3 times per day.
   - 2.0 points are scored if monitoring is completed by the nurse > 3 times per day or continuous.
8. Injectable medications: acuity measurement is based on number of injections per day on medication that is routinely ordered or as needed (PRN) only when the skilled nurse has administered the injectable. Insulin/subcutaneous injections are not included in this scoring.
   - 1.0 point is scored if 1 injection is administered per day.
   - 2.0 points is scored if more than 1 injection is administered per day.
9. Medication schedule: acuity measurement is based on the complexity of the medication.
   - 1.0 point is scored for routine medication schedule. This includes medications that do not require dosage adjustments, regardless of the number of medications.
   - 2.0 points are scored for complex medication schedule. This includes medications which are PRN and/or require dosage adjustments by a skilled nurse. Members who have more than 3 medications which are PRN and/or require adjustment delivered within an 8-hour window by a skilled nurse would qualify for complex.
10. CPT/vest/nebulizer treatments: include treatment that is done on a routine basis, whether there is a standing or PRN order. If the treatments are done together (i.e., nebulizer treatments followed by chest physiotherapy, and/or vest therapy), consider points based on the therapy provided at the highest frequency (e.g., if nebulizer 2 times per day and pulmonary vest 3 times per day, count as therapy 3 times per day).
    - 1.0 point is scored when CPT/vest/nebulizer (PRN).
    - 2.0 points are scored when CPT/vest/nebulizer 1 – 2 times per day.
    - 3.0 points are scored when CPT/vest/nebulizer 3 – 4 times per day.
    - 4.0 points are scored when CPT/vest/nebulizer ≥ 5 times per day.
11. Blood draws: acuity measurement is based upon the number of blood draws per week.

- 1.0 point is scored for peripheral blood draw routinely performed by skilled nurse during the week.
- 1.5 points are scored for central line blood draw routinely performed by skilled nurse during the week.

12. Blood products: acuity measurement is based upon the number of times per month it was documented that the member received any blood products provided by the skilled nurse during the PDN visit.
    - 1.0 point is scored for blood products administered once per month.
    - 1.5 points are scored for blood products administered 2 – 3 times per month.
    - 2.0 points are scored for blood products administered more than 3 times per month.
13. Nasogastric (N/G), gastrostomy (G), or jejunostomy (J/J) tube feedings: acuity measurement is based upon the complexity of the enteral feeding and the associated care needed from the nurse.
    - 2.0 point is scored for G/J and N/G tube bolus or continuous.
    - 3.0 points are scored for G/J and N/G tube combination (bolus and continuous).
    - 4.0 points are scored for G/J and N/G tube complicated. In order to score for complicated, there must be required residual checks, aspiration precautions, postural changes, and frequent rate adjustments or formula changes.
14. Special diet, prolonged feedings: 1.0 point is scored if there is a threat of aspiration and it requires the assessment, observations, and interventions of a skilled nurse. Documentation of how long it took to feed the member must be present in the nurse's notes. This is not applicable for tube feedings.
15. Reflux, dysphagia, aspiration: to receive points for Reflux, the member must meet at least one of the following criteria: 1) a positive swallowing study performed within the last 12 months; 2) documented current and ongoing treatment for reflux (e.g., medications such as Reglan, Zantac, or Prevacid); 3) documented treatment for aspiration pneumonia within the last 12 months; or 4) a need for suctions due to reflux at minimum daily (this does not include suctioning of oral secretions). Must also have the diagnosis of dysphagia or difficulty swallowing, and documentation in the medical record on how the member is progressing. Aspiration precautions should be noted in the clinical record by the skilled nurse, as well as the interventions done to prevent aspiration.
    - 1.0 point is scored for aspiration precautions.
    - 1.5 points are scored for reflux or dysphagia.
16. Seizures: acuity measurement is based upon the frequency of the seizure activity, the severity of the seizure activity, and intervention(s) required. In all instances, seizure monitoring must be recorded in the nurses' notes and/or maintained in a seizure logbook. The description of the seizure should be addressed (i.e., type, duration, intervention). There must also be seizure

medications that are scored on a routine basis. The number of seizures per day, week, month, etc. must be documented and the average number occurring should be known.
- 0.0 points are scored if there is a seizure diagnosis or history of seizures, but there is no active seizure activity.
- 1.0 point is scored if there is observation/monitoring only, but no skilled nursing intervention.
- 2.0 points are scored if there are moderate interventions required, no injury, and Diastat has to be administered.
- 3.0 points are scored if there is an injury, Diastat has to be administered, and apnea is present.

17. General assessments: acuity measurement is based on the frequency a complete nursing assessment is being performed and documented in the nurse's notes. This does not include general statements (e.g., sleeping soundly, respirations quiet, restless), but may be a targeted assessment if there is a concern (e.g., respiratory assessment, neurological checks). Points are not considered under this section if just vital signs are taken, but if targeted vital signs are taken (e.g., temperature), as well as the targeted assessment, then points could be scored under this assessment.
    - 1.0 point is scored if the assessment is completed and documented in the nurse's notes at least once per shift.
    - 1.5 points are scored if the assessment is completed and documented in the nurse's notes every 4 hours.
18. Vital signs: acuity measurement is based on complete sets of vitals being taken at specific frequencies (otherwise use the general assessment section above).
    - 1.5 points are scored if a complete set of vital signs are taken 2 – 3 times per shift AND documented in the clinical record.
    - 2.0 points are scored if a complete set of vital signs are taken ≥ 4 times per shift AND documented in the clinical record.
19. Peripheral intravenous therapy (PIV)
    - 1.0 point is scored when peripheral IV infuses less than 4 hours.
    - 2.0 points are scored when there is IV therapy ordered and the skilled nurse gives the IV solution while on the visit and the IV infuses for 4 – 8 hours
    - 3.0 points are scored when there is IV therapy ordered and the skilled nurse gives the IV solution while on the visit and the IV infuses for greater than 8 hours.
20. Total parenteral nutrition (TPN), central line care, chemotherapy, IV pain control
    - 2.0 points are scored if there is a physician order for chemotherapy and it's administered by the skilled nurse during the visit.
    - 2.0 points are scored if there is a physician order for IV pain meds and the skilled nurse gives the IV medication during the visit.

- 2.5 points are scored if only central line care is scored and no IV is infusing.
- 3.0 points are scored if TPN is ordered by a physician and it's administered by the skilled nurse during the visit.

21. Blood sugar checks
    - 1.0 point is scored when the blood sugar is checked by the skilled nurse and there is no insulin scored. It does not matter how many times it is checked.
    - 2.0 points are scored when the blood sugar is checked by the skilled nurse and insulin is administered by the nurse. It does not matter how many times it is scored.
22. Medicated skin treatment: 1.0 point is scored when medicated skin treatment is scored by the nurse. This does not include lotions, powders, nonmedicated creams, etc.
23. Stoma/wound care: acuity measurement includes dressing changes. Members with a tracheostomy or gastrostomy will not receive additional points for tracheostomy or gastrostomy dressing changes, as this task is included in the score for the tracheostomy or gastrostomy.
    - 1.5 points are scored when the member has general stoma/wound care and care is documented in the nurse's notes once per day, noting condition of the wound/stoma.
    - 2.0 points are scored when the member has the above performed greater than once per day.
24. Decubitus care: 3.0 points are scored when the member has an order for decubitus care and it is performed by the nurse during the home visit. The member would not also receive points for wound/stoma care/medicated skin treatment in addition to this score if they just have a decubitus.
25. Complex dressing changes/burn care: 3.0 points are scored when the member has an order for burn care/complex dressing change and it is performed by the nurse during the home visit. The member would not also receive points for wound/stoma care/medicated skin treatment in addition to this score.
26. Catheter, in-dwelling and intermittent
    - 1.5 points are scored when the member has an in-dwelling catheter and catheter care is performed by the nurse during the home visit.
    - 2.5 points are scored when the member has an in-dwelling catheter and the care is performed by the nurse during the home visit. This would include more complex/complicated care, (e.g., flushes, insertion of catheter, etc.).
    - 1.0 point is scored if there is an order for a straight catheter AND the skilled nurse completes the task during the home visit AND it is no more than once per 8-hour shift AND it is documented in the nurse's notes.

- 2.0 points are scored if there is an order for a straight catheter AND the skilled nurse completes the task during the home visit AND it is more than once per 8-hour shift AND it is documented in the nurse's notes.

27. Peritoneal dialysis: 2.0 points are scored if peritoneal dialysis is performed by the skilled nurse during the home visit.
28. Hemodialysis: 4.0 points are scored if hemodialysis is performed by the skilled nurse during the home visit.
29. Strict intake and output (I&O): 1.0 point is scored when the I&O requires interventions (i.e., the skilled nurse has to make adjustments to feedings or IV fluids based on the intake and output data).
30. Acute care episodes
    - 1.5 points are scored if the member has had bone surgery in the last 45 days from the time of assessment.
    - 2.0 points are scored if the member has a new or revised trach within the last 30 days from the assessment date.
    - 2.0 points are scored if the member has had abdominal/thoracic surgery with the last 45 days from the date of assessment.
    - 2.5 points are scored if member has had a ventriculoperitoneal (VP) shunt new or revised within the last 30 days.
    - 3.0 points are scored if the member has acute/post-procedure hospitalization at least 3 times per year one year from the date of assessment (this does not include admissions for testing or ER visits). For long-term hospitalizations (over 1 month), this section may be counted if the member is admitted for at least 3 months (e.g., premature infants).
    - 2.0 points are scored if the member has had an acute/post-procedure hospitalization (does not include admissions for testing or ER visits) within the last 30 days from time of assessment.
    - 1.0 point is scored if the member has been discharged from an ECF within the last 30 days.
    - 2.0 points are scored if the member has had documented by the physician at least 2 episodes of any respiratory issue (to include apnea, respiratory distress, etc.) within the last year from the date of the assessment.

B. Non-skilled nursing care: can be used if the member does not meet for PDN based on the skilled score alone, but there are extenuating psychosocial circumstances. The score from this section is added to the skilled nursing care score for the total number of hours that the member would need per day/week.
    1. Caregiver availability: acuity measurement requires documented evidence of the employment and/or school status of the primary caregivers before this is scored.
        - 1.0 point is scored when there are 2 caregivers and neither is employed or attends school.

- 2.0 points are scored when there are 2 caregivers and at least one is employed or attends school.
- 2.5 points are scored when there is only 1 caregiver and the caregiver is not employed or attends school.
- 3.5 points are scored when there is only 1 caregiver and the caregiver is employed or attends school.
- 8.0 points are scored when there is no caregiver that lives in the home with the member. This does not mean that the consumer lives with an individual who takes primary responsibility for the consumer but refuses to deliver any care. An example of this would be a member that assumes responsibility for their own care and lives alone or is on a waiver and has supplemental staffing from agencies and independent providers.

2. Sleeping status: acuity measurement is based on the amount of time the member is awake during the night. Nurse/caregiver waking the member over the course of the night is not scored.
   - 1.0 point is scored if the member is awake 1 – 3 times per night.
   - 1.5 points are scored if the member is awake 4 or more times per night.
   - 1.5 points are scored if the member sleeps less than 5 hours consecutively.
   - 2.0 points are scored if the member sleeps less than 3 hours consecutively.
3. Number of dependents: acuity measurement takes into consideration the number and ages of dependents the caregiver is directly responsible for and does not include episodic visits.
   - 1.0 point is scored if the caregiver is directly responsible for 1 – 2 dependents at least 5 years old.
   - 1.5 points are scored if the caregiver is directly responsible for 1 – 2 dependents under 5 years old.
   - 2.0 points are scored if the caregiver is directly responsible for 3 or more dependents.
4. Communication ability: acuity measurement is based on the cognitive ability of the member to communicate or make their needs known.
   - 1.0 point is scored if the member has a limited ability to communicate their needs.
   - 2.0 points are scored if the member is unable to communicate their needs.
5. Orientation/cognition impairment (N/A for children under age 3 years): acuity measurement is based on the member's ability to be oriented in all 3 spheres (person, time, place). Members with episodic confusion requiring reminders and members with cognitive impairment who are completely dependent on the caregiver may be scored here.
   - 0.5 points are scored for members who do not meet all 3 spheres of orientation.

- 1.0 point is scored if the member experiences confusion requiring reminders.
- 1.5 points are scored if the member has cognitive impairment and is dependent upon the caregiver.

6. Personal care/activities of daily living (ADL) (N/A for children under 3 years): 2.0 points are scored if the member requires assistance with personal care/ADLs including bathing, dressing, and grooming.
7. Oral feedings/assist/supervision (N/A for children under 3 years): 1.5 points are scored if the member requires assistance and supervision with oral feeds. Documentation in the clinical record on how the member tolerated the feeding should be recorded.
8. Weight/transfers: acuity measurement is based on the member's weight and their ability to transfer from one surface to another, with 1 – 2 persons, and/or Hoyer lift/trapeze.
   - 0.5 points are scored if the member weighs less than 65 pounds and requires no or partial lift with 1 person.
   - 1.0 point is scored if the member weighs at least 65 pounds and requires no or partial lift with 1 person.
   - 1.0 point is scored if the member weighs less than 55 pounds and requires a total lift with 1 person.
   - 2.0 points are scored if the member weighs at least 55 pounds and requires a total lift with a Hoyer and/or 2 persons.
   - 2.5 points are scored if the member weighs greater than 125 pounds and requires partial lift with 1 person.
   - 3.5 points are scored if the member weighs greater than 125 pounds and requires a total lift with a Hoyer and/or 2 persons.
9. Spasticity or tremors, quadriplegia, paraplegia, hemiplegia, dysfunctional limbs: select a maximum of one of the below when applicable.
   - 1.0 point is scored if the member has spasticity or tremors.
   - 1.5 points are scored if the member has hemiplegia.
   - 1.5 points are scored if the member has a dysfunctional limb.
   - 2.0 points are scored if the member has paraplegia.
   - 2.5 points are scored if the member has quadriplegia.
10. AFO/splint/orthotics application: 0.5 points are scored if there is a physician order for the device and the skilled nurse applies them to the member during the visit, which is documented in the clinical notes.
11. Range of motion: 1.0 point is scored if range of motion is ordered by the physician and is documented as being performed by the nurse in the clinical record.
12. Wheelchair/walker dependent: 2.0 points are scored if the member does not have the ability to walk unaided and is either wheelchair- or walker-dependent.

13. Turn every 2 hours: 1.5 points are scored if there is a physician order and the nurse performs during the visit. Skin assessment should be documented by the nurse in the clinical record.
14. Ambulation/assists: 1.0 point is scored if the member requires hand-in-hand assist or guidance with turning a wheelchair/walker.
15. Weakness/fall risk: 1.0 point is scored if the member has weakness and/or is a fall risk. There must be a protocol in place to decrease the fall risk of the member which is monitored by the nurse.
16. Recording of I&O: 0.5 points are scored if normal daily measurement of intake and output is recorded by the nurse without the need to assess for fluid replacement or restriction.
17. Oral suctioning: 1.0 point is scored if suctioning of the nose, mouth, or upper throat with a bulb syringe, yankaeur, or suction catheter.
18. Ostomy care: 1.0 point is scored if the member has an ileostomy, vesicostomy, or colostomy.
19. Impairments
    - 0.5 points are scored for visual impairments not correctable by glasses or another assistive device.
    - 0.5 points are scored for auditory impairments not correctable by hearing aid or another assistive device.
    - 0.5 points are scored for tactile impairments (e.g., member has the need to put everything in their mouth or has an aversion to different touch stimuli).
    - 1.0 point is scored if the member if blind and there is no modification they have used to compensate.
    - 1.0 point is scored if the member is deaf and there is no modification they have used to compensate.
20. Behaviors/developmentally delay
    - 1.0 point is scored if the member demonstrates self-abusive behavior with no injury.
    - 1.5 points are scored if the member demonstrates self-abusive behavior with moderate injury.
    - 2.0 points are scored if the member demonstrates with severe injury.
    - 1.5 points are scored if the member demonstrates combative behavior.
    - 0.5 points are scored if the member requires occasional redirection.
    - 1.0 point is scored if the member requires frequent redirection.
21. Global delays: acuity measurement is scored as documented by the physician on the member's care plan.
    - 1.0 point is scored if the member's current age is age 4 years or under and has documentation of global delays.
    - 2.0 points are scored if the member's current age is over age 4 years and has documentation of global delays.
22. Incontinence, toilet program (N/A for children under age 3 years)
    - 0.5 points are scored if the member experiences occasional incontinence.

- 1.5 points are scored if the member experiences daily incontinence.
- 1.0 point is scored if the member has a toilet program documented in the clinical record.

C. The following point / care guideline may be adjusted based on a case-by-case review:
   1. 15-24 points equate to 4 to 8 hours of care per day, or less than 56 hours per week.
   2. 25-34 points equate to 8 to 12 hours of care per day, or between 56 and 84 hours per week.
   3. 35-40 points equate to 12 to 14 hours of care per day, or between 85 and 98 hours per week.
   4. 40+ points equate up to 16 hours of care per day, or between 99 and 112 hours per week.
   5. PDN may be extended beyond 112 hours per week if there is an emergent short-term need for additional care.

E. Conditions of Coverage

NA

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	07/19/2023	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2024	
Date Archived		

H. References

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This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.

Independent medical review – July 2023

Approved by ODM 09/28/2023

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.