Medica

Benefit Guideline: Home Care Nursing Service (HCN)

Service: Home Care Nursing Service (formerly known as Private Duty Nursing or PDN)
Effective: 9/1/2014
Reviewed: 2/15/21, 12/13/2021

Products: Medica DUAL Solution® (Minnesota Senior Health Options, or MSHO), Medica Choice Care℠ (Minnesota Senior Care Plus, or MSC+)

Note: Home Care Nursing is a medical assistance state plan service and for members under 65 years of age it is not covered through the health plan. Members on Special Needs Basic Care access this benefit through fee for service.

Definition of Service:
Home Care Nursing (HCN) Services are professional nursing services provide to a member who requires more continuous care than a skilled nurse visit (SNV) and beyond the scope of what personal care assistance (PCA) and home health aide (HHA) services can provide. HCN services are based on an assessment of the member's medical/health care needs and are provided in the member's place of residence or outside of the home during hours when normal life activities take them outside their home. All HCN services must be ordered by a physician, advance practice registered nurse (APRN) or physician assistant (PA). HCN services have two levels of care:

1. ***Regular HCN*** covers the following activities:
   a. Regular HCN assessments and interventions for members who are considered stable but have episodes of instability not immediately life threatening
   b. Nursing observation, monitoring, and assessment and evaluation to determine appropriate interventions that will maintain or improve the member's health status.
2. ***Complex HCN*** covers all the regular HCN activities and require life-sustaining interventions to reduce the risk of long-term injury or death for people who meet at least one of the following requirements:
   a. The member is dependent on a ventilator for life support for at least six hours a day and is expected to be or has been dependent for at least 30 consecutive days.
   b. The member requires life-sustaining interventions to reduce the risk of long-term injury or death.

Covered:
- When authorized by the care coordinator
- When a recipient needs more individual and continuous skilled nursing care than can be provided in a single, or twice daily skilled nurse visit
- When the care needed is outside the scope of services provided by a HHA or PCA
- When provided under a plan of care or service plan approved by the physician
- When ordered by the recipient's physician, APRN, or PA
- When provided by an RN or LPN
- When provided by an RN or LPN with a hardship waiver who is one of the following: spouse or non-corporate legal guardian.
- When used as a service to support a members transitioned into the community from a hospital,

nursing facility (NF), or intermediate care facility (ICF).

Not Covered:

- HCN visits for the sole purpose of providing household tasks, transportation, companionship, or socialization
- Services that are not medically necessary
- Services that are not ordered by a physician, APRN, or PA
- Services provided in a hospital, nursing facility (NF), or intermediate care facility (ICF)

Process:

1. The Care Coordinator (CC) will complete a Health Risk Assessment (HRA) Medica encourages using DHS 3428 Minnesota Long Term Care Consultation form (LTCC) for all members utilizing HCN, due to the complexity of member's needs.

2. Determine if nursing needs exceed what a skilled nurse visit (SNV) can accomplish in once a day or twice daily SNVs. If yes, proceed to #3

3. Contact an in-network home health care provider that provides HCN and request they complete a HCN Assessment and submit completed assessment to Care Coordinator to review. At a minimum, the HCN Provider should complete the Minnesota Department of Human Services (DHS) HCN Assessment form (DHS-4071A). The care coordinator should remind the HCN provider that the following details will be needed on the completed assessment:
   a. Documentation regarding if regular or complex HCN is needed.
   b. Identification of the HCN home care rating the member falls in, per the DHS HCN Service Decision Tree (DHS-4071C). This will also indicate the number of maximum number of HCN units/day allowed.
   c. Identification of all other home care services that the HCN provider would recommend be provided along with HCN (all MA home care services must fit within the HCN home care rating cost cap refer to DHS 3945). If the member is on Elderly Waiver (EW), all home care services including HCN and waiver services are within the members EW case mix cap.

4. Once the care coordinator receives the completed assessment, they will review to ensure services recommended do not duplicate other services in place and to make sure that the findings on the assessment are consistent with the level of need the care coordinator has identified. Using the DHS 3945, the Care Coordinator (CC) assures the providers requested authorization of services are within the DHS home care rating limits, or if on EW within the case mix cap limits. The CC applies the DHS rates for RN and LPN HCN services to verify services are within limits. If findings on the assessment are not consistent with the level of care needs or the cost of services is within guidelines, the care coordinator should call the HCN provider to discuss case until agreement is reached on what services are needed

5. The care coordinator completes the Medica Referral Request Form (RRF) and sends into Medica support specialist for a HCN authorization to be entered into the system. Authorization not to exceed 365 days.
   a. On the Referral Request form (RRF):

i. Indicate for each HCPC code and applicable modifier (refer to DHS 3945) a line on the RRF.
ii. Include number of hours or units per day or month for each HCPC code
iii. Also include "Flex" for each HCPC code if requested by the provider
iv. The "cost" is the DHS Medical Assistance home care rate for each HCPC with applicable modifier.

b. Submit with the RRF, the DHS-4071A and DHS-4071C obtained from the HCN provider. Include in documentation the members home care rating, the members case mix if on EW, and any other home care services the member is receiving. If the member is receiving PCA, also note the daily units of PCA authorized. If the member is on EW, include the cost cap tool.
c. Please note, the requested information will be reviewed before an authorization will be completed to ensure DHS limits are met. If the required information is not included with the RRF, there may be a delay processing the authorization. Reassessments must be completed before the end of the authorization and within the assessment 365 day requirements. It is recommended the authorization end date line up with when the annual assessment is due.

When to Submit a Request for a Benefit Exception:

- When the Care Coordinator feels more HCN is needed than is allowed per the HCN Home care rating.
- When the member has a need for waiver services, meets eligibility for HCN but the cost of all the state plan services do not fit within the EW cap

Considerations:

- If a member is determined eligible for HCN services and expresses an interest in living in the community, the care coordinator will follow the above outlined process to support the member through the transition process.
  - Any risks identified with using HCN should be managed through a care plan risk management plan.
  - For members on Elderly Waiver, home care nursing is medical assistance home care and must be included in the member's waiver case mix budget.
- Due to the complex health needs of members receiving home care nursing services, Medica prefers that members be assigned to a nurse care coordinator. If the care coordinator is not a nurse, the care coordinator should consult a nurse within their agency at least annually with assessments and with any changes in member's condition or plan of care. If the care coordination delegate assigned to the member does not have nurse care coordinators, Medica requires that the care coordinator consult with the Clinical Liaison. For all questions and for consultations, please contact the Clinical Liaison, MedicaCCSupport@Medica.com.
- Frequently HCN and PCA are used as a service combination and the HCN Provider may recommend this as part of the HCN Assessment. In this instance, a PCA Assessment still should be completed though the amount of PCA that can be provided must fit within the monthly maximum limit for HCN as determined by DHS's continuing care administration. See monthly limits for HCN using the DHS 3945.
  - For example, a member assessed as eligible under the MA home care rating of PD/HC (HCN Nursing Facility Level) is eligible for a monthly maximum of $13,354 and a maximum of 39

units of HCN/day. This means all MA home care services must fit within the financial limits and HCN unit daily limits regardless of how much PCA is recommended by the PCA assessment. We look to the HCN provider to make recommendations as to the amount of PCA and HCN needed for that member when both services are needed.

- EN Home Care Rating is ventilator dependence which is defined as a person that's receiving mechanical ventilation for life support at least 6 hours per day and is expected to be or has been dependent on a ventilator for at least 30 consecutive days.
- When a member is not ventilator dependent, the HCN cost cap has priority over the PCA assessment tools PCA recommendation.
- Members who meet the definition of ventilator dependent and the EN Home care rating and utilize a combination of home care services are limited to a total of 24 hours of home care services per day. Additional hours may be authorized when a recipient's assessment indicates a need for two staff to perform activities and must be documented on the PCA Assessment (additional time is limited to 4 hours/day of PCA services, not 4 additional hours of HCN services).
- When a member is receiving HCN, if the member has an EN home care rating and is also receiving PCA services, the member meets criteria for the complex PCA (T1019 TG). The PCA providing the services must meet DHS criteria and the CC will include that rate to apply towards budget limits for those PCA's that meet the requirements. The provider is responsible for submitting claims accordingly. See DHS PCA Enhanced Rate reference below.
- Medica will honor a HCN out of network provider for up to 120 days from the member's enrollment date with Medica if member is currently receiving services from an out of network provider. CC's can utilize the provider search on Medica.com or contact MedicaCCSupport@Medica.com for a list of in network providers.
- Contact MedicaCCSupport@Medica.com if you have questions or to consult regarding home care nursing service.

References:

DHS-4071 C
DHS-4071 A
DHS-3945
§ 256B.0654
§ 256B.0652
§ 256B. 0651
Minnesota Health Care Programs (MHCP) Provider Manual
Community Based Service Manual (CBSM)
Link: DHS PCA Enhanced Rate

This Medica Benefit Guideline for Care Coordination Products is intended to guide service plan development. This reflects current interpretation of the product benefit set and/or parameters for obtaining services. Medica staff should be consulted for further guidance or to vary from these recommendations.

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