Benefit Guideline: Home Care Nursing Service (HCN)

Service: Home Care Nursing Service (formerly known as Private Duty Nursing or PDN)
Effective: 9/1/2014

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

Definition of Service:
Home Care Nursing (HCN) Services, also known as hourly nursing, are nursing services ordered by a physician, for a member whose illness, injury, physical or mental condition requires more individual and continuous care by a registered nurse (RN) or licensed practical nurse (LPN) than can be provided in a single or twice daily skilled nurse visit and requires greater skill than a home health aide (HHA) or personal care attendant (PCA) can provide. HCN nursing services can be provided to a member in or outside their home when normal life activities take the person outside the home with such services based on an assessment of the medical/health care needs of the member.
HCN services can be classified regular or complex.

1. Regular HCN care is provided to a member who is not ventilator dependent and does not require an intensive level of care. Services include, but are not limited to:
   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 to determine appropriate interventions to maintain or improve the member’s health status.

2. Complex HCN care is provided to members who are either ventilator dependent or who require an intensive level of care.
   a. Ventilator dependent- Nursing for a member dependent on mechanical ventilation for life support for at least six hours a day and who is expected to be or has been dependent for at least 30 consecutive days
   b. Members whose medical needs require complex nursing assessments and interventions in response to life-threatening episodes of instability. The interventions are:
      i. Needed immediately based on anticipated or unanticipated changes in the health status of the person.
      ii. Ordered by a physician

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
- 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
- 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 #2.
3. Contact an in-network HCN provider 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 Operations 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
- To use an out of network HCN provider

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 $12,842 and a maximum of 39 units of HCN/day. This means all MA home care services must fit within this monthly cap 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
DHS PCA Enhanced Rate
Minnesota Health Care Programs (MHCP) Provider Manual
Community Based Service Manual (CBSM)