

Home Health Shift Care / Private Duty Nursing (PDN) Services Utilization Management (UM) Criteria- Medi-Cal, Including Members Under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit Under the Age of 21

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Utilization Management Criteria Statement

This document includes criteria that supports utilization review of certain provider requested health care services. Refer to the NCAL UM Criteria List.

Utilization review occurs when a qualified physician other than the treating clinician reviews the treating clinician's request against utilization review criteria. The qualified physician is in the position to approve, deny, delay, or modify the service request based on a determination of medical necessity. These criteria are consistent with professional standards of practice and provided for your reference.

If you are in a treatment relationship with a member, then your clinical recommendations are not subject to these criteria. Your treatment recommendations are guided by your professional judgment and informed, where applicable, by clinical practice guidelines and clinical support tools found in the UM Criteria References section, below.

Principles

The Permanente Medical Group, Inc. (“TPMG”) and Southern California Permanente Medical Group (“SCPMG”) provides Private Duty Nursing services when medically necessary.

Kaiser Foundation Health Plan, Inc. covers Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services, as required by law for Medi-Cal managed care plan (MCP) members under age 21, when determined to be medically necessary based upon the following medical necessity criteria and the member’s current clinical condition to correct or ameliorate defects and physical and mental illnesses or conditions. Services must also be provided when medically necessary to prevent disease, disability, and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.

Service/s need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered under EPSDT because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child.

Medical necessity decisions are individualized. Flat limits or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements. Therefore, MCPs are prohibited from imposing service limitations on any EPSDT benefit other than medical necessity. The determination of whether a service is medically necessary or a medical necessity for an individual child must be made on a case-by-case basis, taking into account the particular needs of the child.

In the situations where a member has more than one coverage or program eligibility offering, such as Commercial, Self-Funded, Federal, Medicare, California Children Services (CCS), and other lines of coverage not listed above, the PDN benefit under EPSDT is effective only when the other coverage benefits, or program eligibility is exhausted or has not been met.

Note on care coordination: If the managed Medi-Cal care plan (MCP) approves the private duty nursing (PDN) services, then the MCP is responsible for providing case management to arrange for all approved PDN hours. If another entity (such as CCS) has authorized all or a portion of the PDN hours, the MCP still must coordinate the case management as necessary. This includes, when at the member’s request, arranging the services with home health agencies and individual nurse providers.

Scope of Services

- Private Duty Nursing services are intended to support, not supplant, the natural supports supplied by the primary caregiver.
- There must be a primary caregiver in the home who is proficient in the tasks.
- In-home supplemental services may include a combination of assistance with ADLs, nursing services, or other supportive services provided by professional providers.

Eligibility, Ineligibility and Redetermination

- **To be eligible for PDN services, Medi-Cal members under the age of 21 must meet the following criteria:** Medi-Cal beneficiary and is covered by a Medi-Cal Managed Care plan.
- Reside in a home setting.
- Be capable of being safely served in a home setting. The space in the home setting is adequate to accommodate needed equipment, supplies, and personnel.

Private Duty Nursing services are required by the patient in the home setting at a skilled level that could be safely and effectively performed by unlicensed family member(s) or other layperson(s) with appropriate training and supervision. Family member(s) or layperson(s) are willing, able, and available as determined by the Home Health Continuous Hourly Care Committee.

KFHP is responsible for coordinating the provision of services with other entities, including but not limited to Regional Centers and County Mental Health plans,

Ineligibility for services can be based on meeting the following criteria:

- Resides in a hospital, school, subacute facility, nursing facility, intermediate care facility for the developmental delayed, residential facility or other institution.
- Is not safely served in a home setting as described above.

Redetermination:

The Home Health Continuous Hourly Care Committee shall re- determine a child's eligibility for Private Duty Nursing services using the UM criteria at a minimum of every year, or as the child's skilled nursing needs have changed.

Clinical Review

Service Levels: The Home Health Continuous Hourly Care Committee shall base the average monthly service hours as determined by authorizing physician in the Plan of Care using the criteria outlined below.

Skilled Nursing Needs:

The intensity of medical/skilled nursing care required is such that in the absence of in-home services, the individual would be placed in a facility. Services are the health care services needed by a person less than 21 years of age who uses a medical technology that compensates for the loss of a vital bodily function. Medical necessity for services shall be substantiated by any of the following items in (1) through (3) below:

1. A tracheostomy with dependence on mechanical ventilation for a minimum of six hours each day.

2. Dependence on tracheostomy care requiring suctioning at least every six hours, and room air mist or oxygen as needed, and dependence on one of the three treatment procedures listed in (a) through (c) below:
 1. Dependence on continuous intravenous therapy including administration of therapeutic agents necessary for hydration or intravenous pharmaceuticals; or intravenous pharmaceutical administration of more than one agent, via a peripheral or central line, without continuous infusion.
 2. Dependence on peritoneal dialysis treatments requiring at least four exchanges every 24 hours.
 3. Dependence on tube feeding, nasogastric or gastrostomy tube.
3. Dependence on skilled nursing care in the administration of any two of the three treatment procedures listed in (2) (a) through (c) above.

Medical necessity for care shall be further substantiated by all the following conditions:

1. The intensity of medical/skilled nursing care required by the patient shall be such that the continuous availability of a licensed nurse is medically necessary to meet the patient's healthcare needs.
2. The patient's medical condition has stabilized such that the immediate availability of the services of an acute care hospital, including daily physician visits, is not medically necessary.
3. The intensity of medical/skilled nursing care required by the patient is such that, in the absence of a facility providing services, the only other medically necessary inpatient care appropriate to meet the patient's health care needs under the Medi-Cal program is in an acute care licensed hospital bed.

Criteria for Continuous Hourly Care - 8 hours or greater for a transitional period of time

The purpose of a transitional period is to assist family member(s) or other layperson caregiver(s) with the completion of training to assume 24-hour responsibility for the patient's care in the home setting. Continuous Hourly Care is required for a transitional period of time to accomplish the training noted above.

For authorization of continuous hourly care for a transitional period, all 3 criteria below must be met:

1. There is evidence that the family member(s) or other layperson caregiver(s) require further teaching, observation, and/or monitoring to perform the services the patient requires to safely and effectively remain in the home setting.:
2. Continuous Hourly Care is required for a defined temporary period of time that has a specified start and end date
3. A transition plan must be developed that specifies a continuous and gradual reduction in hours over a defined period of time to less than 8 hours per day.

Contributors / Clinical Experts

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Approving Bodies

Home Health Continuous Hourly Care Advisory Committee	06/05/2020 07/09/2021 10/20/2022
Resource Management Committee (RMC)	04/10/2013 06/02/2020 08/24/2021 06/28/2022 07/25/2023, 07/23/2024
Quality Oversight Committee (QOC)	04/10/2013 07/08/2020 08/25/2021 10/13/2021 07/13/22

References

- Centers for Medicare and Medicaid Services (CMS), titled *EPSDT — A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents* (June 2014)
- Department of Health Care Services, All Plan Letter 19-010 (Supersedes APL 18-007 and 07-008)
- Title 42, United States Code, Section 1396(d)(r)
- Social Security Act (SSA), Section 1905
- WIC Section 14059.5