

High-Tech Nursing Program PROVIDER MANUAL



VERMONT

AGENCY OF HUMAN SERVICES

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PURPOSE

This manual supplements the [Department of Vermont Health Access Provider Manual](#)¹. The High-Tech Nursing (HTN) program is an intensive home care program, with the pediatric services administered by Children with Special Health Needs (CSHN), part of the Maternal Child Health Division of Vermont Department of Health (VDH), and the adult services administered by the Department of Disabilities, Aging and Independent Living (DAIL).

Section 7412 of the Medicaid Covered Services Manual applies to High-Tech Nursing. This rule defines services, eligibility, and covered services. The administrative rule can be found electronically at http://healthvermont.gov/reg/documents/nursing_high_tech_services_dvha_sec7412.pdf.

The HTN program operates as an authorized Vermont Medicaid benefit for those eligible individuals dependent upon medical technology in order to live, or whose illness, injury, or physical condition requires more individual and continuous care by a Registered (RN) or Licensed Practical Nurse (LPN) than can be provided in a skilled nursing visit and requires greater skill than a Home Health Aide (HHA) or Personal Care Assistant (PCA) can provide. The intent of the program is to assist the non-institutionalized client with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize recipient health status and outcomes. This benefit is not intended to replace caregiving responsibility of parents, guardians or other responsible parties, but to promote patient/family-centered, community based care that enables the recipient to remain safely at home rather than in an acute or long-term care facility.

SCOPE

The scope, quantity, and duration of HTN services are defined by physician's orders according to specific treatment goals and caregiver training needs.

¹ <http://vtmedicaid.com/Downloads/manuals.html>

GOALS

- ✓ Enhance the quality of life
- ✓ Reduce morbidity
- ✓ Improve physiologic function
- ✓ Achieve normal growth and development
- ✓ Reduce hospitalization
- ✓ Reduce overall health care cost

DEFINITIONS AND ACRONYMS

This document uses the following definitions:

Child/Adolescent: People who are less than 21 years of age

Adult: People who are 21 years of age or greater

Agency: A Medicaid-approved Visiting Nurse Association or Home Health Agency that is contracted with DVHA to provide direct care services to the client.

Medically Necessary: Per [Medicaid Rule](#)², medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the client's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and

- Help restore or maintain the client's health
- Prevent deterioration or palliate the client's condition
- Prevent the reasonably likely onset of a health problem or detect an incipient problem

Additionally, for EPSDT-eligible beneficiaries, medically necessary includes a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition.

Notice of Decision: Notifies the client and referring provider of services authorized or denied once prior authorization has been completed

Prior Authorization: A process of clinical review in compliance with Medicaid Rule for specific services, items or procedures to verify:

² <http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>

- Medical necessity
- Consideration of less costly alternatives if appropriate
- Conformity to generally accepted best practice parameters

This document uses the following acronyms:

AHS – Agency of Human Services

CSHN – Children with Special Health Needs

CMS – Center for Medicare and Medicaid

DAIL – Department of Disabilities Aging and Independent Living

DME – Durable Medical Equipment

DVHA – Department of Vermont Health Access

HTN – High- Technology Nursing

IFS – Integrated Family Services

LPN – Licensed Practical Nurse

LNA – Licensed Nursing Assistant

NOD – Notice of Decision

RN – Registered Nurse

VDH – Vermont Department of Health

HIGH-TECH NURSING PROGRAM ELIGIBILITY CRITERIA

To meet eligibility criteria, the client must:

1. Have Vermont Medicaid,
2. Be a Vermont resident residing in-state,
3. Require more individual and continuous skilled nursing care than can be provided in a skilled nurse visit,
4. Require care outside the scope of services provided by a Home Health Aid/Personal Care Attendant; and
5. Have the necessary caretaker(s) commitment to comply with program standards:
 - a. Availability of at least one primary and one back-up caregiver, fully trained in all aspects of the client's care needs and reasonable availability to assume the role of active caregiver in the event that the primary caregiver is unavailable,
 - b. Successful completion of training by both the primary and back-up caregivers.
 - c. Caregiver commitment to the program goals and objectives,
 - d. Caregiver ability to undertake patient care responsibilities with anticipation of a decreasing level of supportive nursing, and
 - e. Reasonable plans for emergencies (such as power and equipment backup for those with life-support devices) and transportation must be established.

Examples of high technology may include but are not limited to:

- a. Daily continuous or intermittent mechanical ventilation (via trach, BiPAP, or CPAP)
- b. Tracheotomy and/or unstable airway requiring nursing assessment and intervention
- c. A documented illness or disability, which requires ongoing skilled observation, monitoring and judgment to maintain or improve health status of a medically fragile or complex condition

A client's eligibility for benefits and services can continue as long as s/he continues to meet the program and clinical eligibility criteria above.

POLICIES AND PROCEDURES

PROGRAM EXPECTATIONS

1. HTN services will be based on patient/family-centered planning and shall be designed to ensure quality and protect the health and welfare of the individual receiving services.
2. HTN services shall be provided in a cost-effective and efficient manner, preventing duplication, and unnecessary administrative tasks.
3. HTN services will be administered in accordance with all applicable State and Federal law.
4. Amount, type, and duration of high tech services must always be medically necessary.
5. Eligible individuals shall be informed of feasible service alternatives and their choices shall be respected.
6. Scheduled reduction or increase of nursing coverage will be based on specific treatment goals and objectives of the client's home care program, health status, and caregiver's skill level.
7. Services will be delivered in accordance to Medicaid Rule³ 7103, Home Health Services.

PROGRAM LIMITATIONS

Medicaid does not provide HTN under the following circumstances:

- Additional nursing services request as a result of illness or absence of caregivers
- Services requested to accommodate caregiver employment
- Services that can be safely and effectively provided by the caregiver(s)
- Services for children during school beginning the first full academic year the child is age 6
- Observational care for behavioral, eating disorders, or for medical conditions that do not require medically necessary intervention by skilled nursing personnel
- Custodial, sitter, and respite services
- Services after the recipient is admitted to a hospital or a nursing facility
- Services after the recipient is no longer eligible for Medicaid

COVERAGE

The maximum coverage of nursing care services that may be scheduled is 22 hours per day. This limitation is in keeping with the intent of the HTN program where the family is expected to be the primary caregivers with assistance from the program. Clients who need an average of 28 hours per week/4 hours per day will be referred for intermittent skilled nursing visits unless there are extenuating circumstances.

AGENCY PROVIDER RESPONSIBILITIES

Participating agencies are contracted Medicaid providers and are capable of providing the broad scope of services to support the HTN program including:

- Delivery of services to clients in their homes residing in Vermont
- Hiring and supervising HTN staff to meet the needs of enrolled beneficiaries
- Training and education of HTN staff in order to competently and safely care for HTN clients
- Scheduling services to best meet the need of the client

³ <http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>

- Interpreter services in person or telephonic for the participant and family, if needed
- Responsibility for employees and contracted service providers
- Supervision and training to staff with limited HTN experience
- Collaboration with other agencies in order to fill staffing needs to best meet the needs of the client
- Immediate communication with the appropriate HTN Case Manager if unable to deliver HTN services as requested

MEDICAL RECORD MAINTANENCE

The agency is responsible for establishing and maintaining a permanent medical record for each recipient including the following:

- The client's care plan per Agency standards and Medicaid Rule⁴
- HTN Agreement for Care form
- Home safety and accessibility assessment
- Any additional physician orders
- Signature log/electronic medical record with dates, duration of visits, types of service, and signature of the RN/LPN and the caregiver (a copy must be provided to the recipient or recipient's representative)
- Continuous progress reports
- Documentation of in-home RN visits to supervise the LPN
- Confidential information in compliance with Agency standard policies, state and federal laws and regulations, including HIPAA requirements

PLAN OF CARE

A plan of care must be developed and submitted with each request for service documenting the extent of nursing needs. Each nurse participating in the recipient's care must carefully review the recipient's status and needs. This plan must also include the following:

- Designation of a home care nurse case manager
- Involvement of a primary care physician with specific physician orders for medications, treatments, medical follow-up, and medical tests as appropriate
- Family access to a telephone
- A plan for monitoring and adjusting the home care plan
- A defined backup system for medical emergencies
- A plan to meet the educational needs of the recipient and caregivers
- A clearly shown planned reduction of HTN hours, when applicable
- Criteria and procedures for transition from HTN care, when appropriate

At each authorization period, the care plan will be approved, denied, or returned to request additional information. The recipient should transition to the most appropriate care when the recipient no longer meets the HTN criteria.

⁴ Medicaid Rule is available at <http://humanservices.vermont.gov/on-line-rules/dvha>

COLLABORATION WITH VDH/DAIL HTN NURSE CASE MANAGER

- Ensures timely initiation of services to newly enrolled clients
- Prevents laps in services between authorizations

CLIENT APPEALS PROCESS

- Full details related to appeals are available in the Department of Vermont Health Access Provider Manual⁵
- A client or client's guardian who wishes to appeal a decision regarding the clinical eligibility, termination or eligibility, and the type or amount of services authorized may request a formal review of that decision as reconsideration, and internal appeal, and/or a fair hearing before the Human Services Board
- The appeal process is outlined with every Notice of Decision

QUALITY ASSURANCE/QUALITY MANAGEMENT

- There will be a process for receiving and responding to complaints
- There will be a process for receiving feedback from beneficiaries, family members, and providers
- Each year, at minimum, every HTN client will be reviewed for continued eligibility by the HTN Case Manager in collaboration with the Medicaid Medical Director as needed

PERFORMANCE MEASURES

The following performance measures will be evaluated at least annually by DVHA in collaboration with DAIL and VDH:

1. % utilization of authorized High-Tech Nursing units
Baseline: 40% (2013)
Target: 90%
Data source: Medicaid claims data
2. % utilization of authorized High-Tech Case Management units
Baseline: 60% (2013)
Target: 100%
Data source: Medicaid claims data
3. % of patient that receive High-Tech services immediately upon discharge from the hospital
Target: 100%
Data source: Medicaid claims data

⁵ <http://vtmedicaid.com/Downloads/manuals.html>

HIGH-TECH COVERED SERVICES

HIGH –TECH NURSING CARE

Qualified Provider(s): Registered Nurse (RN) or Licensed Practical Nurse (LPN). *Clients receiving care by an LNA as of December 1, 2014 may continue to do so. Clients enrolled after December 1, 2014, may only have care provided by an RN or LPN.*

Service Expectations:

- a. Provided under a plan of care or service plan approved by the physician
- b. Provided by a nurse trained and qualified to deliver services outlined in the physician's orders
- c. Compliance with all state laws and guidelines
- d. Provide support, education, and supervision to caregivers
- e. Support caregivers in maintaining primary role in care provision of the client
- f. Based primarily in the client's place of residence, but may be used outside of the recipient's home during hours when normal life activities take them outside of their home

CASE MANAGEMENT

Qualified Provider(s): Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Service Expectations:

- a. Minimum of monthly provision of case management services
- b. Collaborative development of a family-centered care plan to best meet the needs of the client and their family in collaboration with the medical team
- c. Ongoing review of the care plan per Medicaid Rule⁶ 7401 or more often as indicated by a change in the participant's condition
- d. Ongoing communication with the HTN Case Manager to ensure appropriate and timely authorization of services
- e. Prevention of service redundancy and referral to services to meet unmet needs
- f. Assessment of the client's home and community environment on an ongoing basis to determine if it is safe and conducive to successful implementation of High-Tech Program services
- g. Initiation and/or participation in care conferences collaboratively with the client's medical team as needed to ensure goals of care and continuity are being maintained
- h. Communication with all medical team and the family unit to achieve integration of needs and medical treatment goals
- i. Coordinated care during transition periods, such as hospitalization, discharge, rehabilitation, out of state visits, etc.

⁶ Medicaid Rule is available at <http://humanservices.vermont.gov/on-line-rules/dvha>

- j. Assist the family unit in understanding recommended changes to the medical regimen as they occur and continuously review and update the goals of care as needed

BILLING CODES

PEDIATRIC			
Procedure Code	Description	Unit to Minutes	Provider Type
G0299HTHA	skilled nursing care	1 unit = 15 minutes	RN
G0300HTHA	Skilled nursing care	1 unit = 15 minutes	LPN
G0156HTHA	care by a licensed nursing assistant	1 unit = 15 minutes	LNA
T1001HTHA	Nursing assessment/evaluation	1 unit = 1 assessment	RN/LPN
ADULT			
Procedure Code	Description	Unit to Minutes	Provider Type
G0299HTHB	skilled nursing care	1 unit = 15 minutes	RN
G0300HTHB	Skilled nursing care	1 unit = 15 minutes	LPN
G0156HTHB	care by a licensed nursing assistant	1 unit = 15 minutes	LNA
T1001HTHB	Nursing assessment/evaluation	1 unit = 1 assessment	RN/LPN

PROGRAM OPERATIONS

OVERVIEW

Below is a stepwise explanation of each operational step from referral to disenrollment. In summary,

1. Program eligibility determination based on referral and supporting documentation
2. Service allocations determined by the VDH/DAIL HTN Case Manager based on evaluation of documentation from the health care team and needs assessment tool
3. Client selects Medicaid contracted Home Health Agency and DME provider from which to receive care (if multiple options available)
4. Prior authorization for approved services
5. Regular redetermination of program eligibility and service eligibility
6. Disenrollment when services are no longer medically necessary

REFERRAL

- A HTN Referral Form (see attachments) must be submitted to the appropriate (Pediatric or Adult) VDH/DAIL HTN Case Manager by the client's primary care MD/midlevel provider or subspecialist over-seeing their care
- Provider will be notified promptly by VDH/DAIL HTN Case Manager if additional information is needed to complete the program eligibility process

a) Required Referral Documentation

- High-Tech Referral Form
- Clinical documentation supporting medical necessity
- A primary ICD-10/diagnosis and code

ELIGIBILITY DETERMINATION

- Program eligibility is reviewed and approved by the VDH/DAIL HTN Case Manager in consultation with the DVHA Medicaid Medical Director, if applicable
- The VDH/DAIL HTN Case Manager will conduct a HTN Needs Assessment (see attachment) which informs the level of need

AGREEMENT FOR CARE

- An Agreement for Care Form (see attachment) must be completed prior to authorization of services
- Copies are provided to the VDH/DAIL HTN Case Manager, Home Health Agency, attending physician, and family

AUTHORIZATION OF SERVICES

- The VDH/DAIL HTN Case Manager will make a determination of services and frequency and approve them using the Prior Authorization process within 3 working days of receiving all necessary documentation to make a decision, but has up to 14 calendar days
- Services are authorized based on medical necessity and the needs assessment
- Services will be authorized for a 2-6 month period, depending on needs, with the understanding that the care plan may be modified at any time if the Agency or HTN Case Manager deems such a modification necessary based on the client's needs
- Appropriate documentation may be required to modify authorized services
- Per Medicaid rule, services are not authorized retroactively

COMMUNICATION OF SERVICES

- A Notice of Decision (NOD) will be sent to the client, referring physician, and delivering Home Health Agency or DME Provider, indicating dates, parameters, and units of services
- The NOD is automatically generated when services are authorized in the Medicaid Management Information System (MMIS)
- A letter stating eligibility determination will be mailed to the referring provider and client, including contact information for the appropriate VDH/DAIL HTN Case Manager and dates of service and/or appeals process as necessary

HOME HEALTH AGENCY IMPLEMENTATION OF SERVICES FOR NEW CLIENTS

- VDH/DAIL HTN Case Manager will facilitate a referral to the Home Health Agency selected by the client to deliver services, if it has not already been done
- The safety and accessibility of the client's home must be completed and documented *prior* to initiating services which includes assessment of:

- Accessibly
- Safety of home environment
- Housing stability
- Plumbing supports, water and sewage
- Adequate heating
- Smoke detector, fire extinguisher
- Reliable telephone service
- Adequate electricity and heating support in the event of an outage
- Communication with local emergency medical services
- HTN services should be made available to the client as soon as appropriate in accordance with the medical/care team
- If services cannot be delivered, regardless of reason, this should be immediately communicated to the VDH/DAIL HTN Case Manager and medical/care team

CONTINUATION OF SERVICES

- It is the responsibility of the Agency to manage services as authorized as outlined in the NOD
- If continuation of services are being requested at the end of a prior authorization, The Agency will send an up-to-date copy of the client's care plan to the appropriate VDH or DAIL HTN Case Manager **14 days** in advance of the current authorization ending to ensure timely re-authorization of services
 - Failure to do so may result in lack of payment for services if there is not active authorization in place. Medicaid does not authorize retroactively.
- The VDH/DAIL HTN Case Manager may contact the Agency or medical provider for additional clarifying information
- If an Agency has questions about or cannot locate the NOD, call HP Enterprises Provider Services at (800) 925-1706 or (802) 878-7871

ONGOING ELIGIBILITY DETERMINATION

- The VDH/DAIL HTN Case Manager will obtain referrals annually or as needed from the attending physician for each client enrolled
- The HTN Needs Assessment will be conducted annually or as needed, by the VDH/DAIL HTN Case Manager in collaboration with Agency case manager

DENIALS AND TERMINATION

Clients may be denied eligibility and active participants may be terminated from HTN services for the following reasons:

- A. Clinical Ineligibility: If the participant does not meet eligibility requirements
- B. Voluntary Withdraw: The participant/parent/guardian request it;
- C. Medicaid Ineligibility: If the participant is no longer eligible for Medicaid;
- D. Participant death;
- E. Permanent move out of state;
- F. Out of state greater than 30 days;

- G. There is a change in health status and no longer meets clinical eligibility; or
- H. Provider Termination.

A. Clinical Ineligibility

Services must be determined to be *Medically Necessary*: Per [Medicaid Rule](#)⁷, medically necessary is defined as health care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the client's diagnosis or condition. Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or similar general specialty as typically treat or manage the diagnosis or condition and

- Help restore or maintain the client's health
- Prevent deterioration or palliate the client's condition
- Prevent the reasonably likely onset of a health problem or detect an incipient problem

B. Voluntary Withdrawal

An applicant may voluntarily withdraw her/his application for High Tech Nursing Program (HTN) services or participation in HTN services at any time for any reason using the following procedures:

1. The individual shall inform the VDH/DAIL Nurse Case Manager and delivering Home Health provider.
2. The VDH/DAIL Nurse Case Manager will complete a letter of termination to be mailed to the referring provider, client, and delivering Agency stating the stop date for services.

C. Medicaid Ineligibility

The Department for Children and Families Economic Services Division (DCF-ESD) staff will determine eligibility for Medicaid. If the individual is found ineligible at any time, DCF will send a written notice of ineligibility to the individual and DVHA, including appeal rights.

D. Participant death

E. Permanent move out of state

If the individual permanently moves out of the state, the VDH/DAIL Nurse Case Manager will complete a letter of termination to be mailed to the referring provider, client, and delivering Agency stating the stop date for services.

F. Stay out of state-exceeding 30 continuous days:

If the individual leaves the state for more than 30 continuous days, the VDH/DAIL Nurse Case Manager will complete a letter of termination to be mailed to the referring provider, client, and delivering Agency stating the stop date for services.

G. The individual no longer requires HTN services to remain in setting of choice:

⁷ <http://humanservices.vermont.gov/on-line-rules/dvha/medicaid-covered-services-7100-7700/view>

If the nurse case manager or provider(s) has evidence which leads him or her to believe that the individual no longer requires HTN services to remain in the setting of their choice, the VDH/DAIL Nurse Case Manager will complete a letter of termination to be mailed to the referring provider, client, and delivering Agency stating the stop date for services.

H. Provider termination of services:

An Agency provider may terminate services for the following reasons:

- Dangerous environment placing staff at risk of physical harm.
- Don't cooperate with treatment you and your doctor have agreed to.

The VDH/DAIL Nurse Case Manager will complete a letter of termination to be mailed to the referring provider, client, and delivering Agency stating the stop date for services.

It is expected that the provider will make all reasonable attempts to remedy the situation prior to termination of services. Efforts may include, but are not limited to, negotiated risk contracts, involvement of Adult Protective Services, family care conferences, and multidisciplinary team meetings. Efforts must be clearly documented and the provider must contact the VDH/DAIL Nurse Case Manager prior to termination. Once a decision to terminate services has been made, the provider must send a written notice to the individual explaining the reasons for termination.

If the provider has terminated services, the situation is not remedied after 30 days, and other HTN services are not being successfully utilized, the individual may be terminated from HTN services. The provider must consult with DVHA prior to termination. The VDH/DAIL Nurse Case Manager will complete a letter of termination to be mailed to the referring provider, client, and delivering Agency stating the stop date for services.

IMPORTANT ADDRESSES AND TELEPHONE NUMBERS

*Pediatric High-Tech Nursing Program
Children with Special Health Needs (CSHN)
Vermont Department of Health (VDH)
108 Cherry Street
Burlington, VT 05402
Phone: (800) 660-4427
Fax: 802-863-6344
TTY/TDD: Dial 711 first*

*Adult High-Tech Nursing Program
Adult Services Division (ADS)
Department of Aging and Independent Living (DAIL)
Phone: (802) 871-3047
Fax: (802) 871-3052*

*Department of Vermont Health Access (DVHA)
312 Hurricane Lane, Suite 201
Williston, VT 05495
Phone: (802) 879-5900*

*HP Enterprise Systems Provider Services
Instate: 1-800-925-1706
Out of state: 1-802-878-7871*