Vermont Medicaid: High-Technology Nursing Services

Provider Manual Supplement

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Department of Vermont Health Access

Department of Disabilities, Aging, and Independent Living

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VERMONT DEPARTMENT OF HEALTH

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Introduction and Overview

This manual is designed as a supplement and does not replace the Vermont Medicaid General Provider Manual. This manual describes processes and guidelines to be followed by individuals and agencies providing High-Technology Nursing Services (HTN). All HTN providers must be actively enrolled with Vermont Medicaid. Instructions for the enrollment process can be found online at Provider Enrollment and Revalidation.

High-Technology Nursing Services are intended for individuals who require specialized nursing care in excess of what can be provided through part time or intermittent home health services (HCAR Rule 4.231 Home Health Services and the federal regulation for Home Health Services), personal care services, or other home health agency services. HTN is covered by Health Care Administrative Rule 4.232 Medically Complex Nursing Services. In other settings, HTN may be referred to as "private duty nursing."

There are two models for the delivery of HTN services: agency-directed and family-managed. Agency-directed means that a Medicaid enrolled home health agency is responsible for the delivery of HTN services, including the recruitment, hiring, and oversight of nurses who provide care. Family-managed means the member or their family are responsible for managing HTN services by coordinating with independent nurses in the community who are directly enrolled as providers with Vermont Medicaid.

HTN services may also be delivered in a blended model. This means that a portion of a member's weekly nursing allocation is provided by agency-directed nurses and the remaining hours are provided by independently-enrolled nurses.

The family-managed option also includes a provision that allows parents and legally-responsible guardians who are registered nurses to provide HTN services to their eligible family member. The family-managed HTN model is described in more detail in the Family Managed Program Manual.

The specific nursing activities and procedures performed by all HTN providers occur under the direction of a physician in a treating relationship with the member.

For pediatric members under 21 years old, HTN services are administered by Children with Special Health Needs (CSHN) at the Vermont Department of Health (VDH). For adult members 21 years and older, HTN services are administered by the Adult Services Division (ADS) of the Department of Disabilities, Aging, and Independent Living (DAIL).

Contact information for HTN programs at VDH and DAIL can be found on page 9 of this manual.

DEFINITIONS AND ABBREVIATIONS

This document uses the following definitions:

Provider: A licensed person or agency that provides a service specific to this program

Needs Assessment: A comprehensive assessment/screening for services conducted by a state authorized clinical provider to determine medical necessity, current resources, and additional services needed.

Prior Authorization: Process of clinical review for specific services by Medicaid prior to their being approved and implemented.

This document uses the following abbreviations:

HTN-High-Technology Nursing
VDH- Vermont Department of Health
DAIL-Vermont Department of Disabilities, Aging & Independent Living
HHA-Home Health Agency
DVHA-Department of Vermont Health Access

ELIGIBILITY

Eligibility for HTN is determined through a needs assessment conducted by a State-authorized clinical provider. This process involves administering an assessment tool and reviewing supporting clinical documentation. The State-authorized clinical provider may also consult directly with the member, their family members or representatives, and medical providers as part of the needs assessment process.

The assessment tool is used to document the individual's level of need for daily, continuous, or intermittent nursing supports, beyond what can be met through other home health services or similar benefits covered by Vermont Medicaid, in terms of frequency, duration, and complexity.

HTN services are considered "medically necessary" per the Vermont Medicaid definition.

Members must maintain Vermont Medicaid coverage and be a Vermont resident in order to access HTN services.

REFERRALS

Referrals for HTN must be completed by the member's physician. Referral forms for Pediatric HTN can be found online at Pediatric High-Tech Nursing Referral Form and for Adult High-Tech Nursing Referral Form. Both forms include instructions for submitting the referral. General inquiries about HTN can be made to the State HTN coordinators identified on page 9.

REDETERMINATIONS

The need for medically necessary HTN services is redetermined annually. Members and their representatives are notified in writing before a new needs assessment is required, usually 90-days prior to the end of the current authorization period. Once a needs assessment has been conducted, the State will issue a written Notice of Decision to the member and their representatives, the referring provider, and the local home health agency. Independently enrolled nurses providing HTN in a family-managed model are notified of changes in the member's award by the member or their representative.

Notices of Decision from the State will explain the reason(s) for the decision and include details about the member's right to appeal. Notices of Decision will comply with Health Care Administrative Rule 8.100, *Internal Appeals, Grievances, Notices, and State Fair Hearings on Medicaid Services*.

Needs assessments may be conducted outside of the annual redetermination cycle at the request of the member, their representatives, or the State, when indicated by a significant change in the medical needs of the member.

SERVICE AUTHORIZATIONS

HTN must be prior authorized by the State. Enrollment in HTN includes the prior authorization of both direct care nursing hours, as well as periodic nursing assessments. All services provided through the HTN benefit must be medically necessary.

HTN hours are allocated on an hours per week basis, following the outcome of the needs assessment process. However, prior authorizations are usually granted for an entire year. It is the responsibility of the providers to ensure the weekly delivery of nursing units does not exceed the total amount of HTN allocated over the entire authorization period. Minor variations in the weekly amount of HTN delivered are allowable to address small changes in the member's nursing needs, or to accommodate occasional scheduling challenges, but must not compromise the capacity of the prior authorization to cover an entire year.

Nursing assessments are prior authorized to cover monthly assessments, but the actual frequency at which assessments are conducted should be determined by what is medically necessary for the member's care. Providers are encouraged to communicate the need for additional nursing assessment units to the appropriate State HTN coordinator when indicated by changes in the member's medical condition or other relevant circumstances. Additional details about the provision and documentation of nursing assessments can be found in the next section.

SERVICE DELIVERY

High-Technology Nursing Services are intended to support clinically eligible Vermont Medicaid members in their homes and communities. HTN shall be provided by a Registered Nurse or a Licensed Practical Nurse who is employed by a Medicaid enrolled home health agency or is directly enrolled as a provider with Vermont Medicaid.

Nursing Services

The specific nursing services provided to an individual member must occur under the direction of a treating physician. A record of these procedures shall be documented in a Plan of Care (485) maintained by the HHA. In a family-managed model, it is the responsibility of the Primary Coordinator to collect, document, and distribute changes in the member's Plan of Care to independently enrolled nurses.

Nursing Assessments

Nursing assessments are intended for monitoring changes in the member's health status and to communicate these changes to other medical providers, including the treating physician. Nursing assessment duties also include care plan management. This means a nurse, acting within their scope of practice, will integrate physician-directed changes in the member's care procedures into the Plan of Care that guides the activities of individual nurses.

Nursing assessments units shall be used for the medically necessary monitoring, communication, and care plan oversite that cannot occur in the course of a typical nursing shift. For example: significant clinical consultation with the treating physician, or another medical provider, that is separate from a nursing shift; and communication with other nurses for the purpose of communicating changes in the Plan of Care.

Completed assessments must be maintained as part of the patient's chart and made available to the State upon request.

It is outside the scope of practice for an LPN to conduct a nursing assessment.

For billing purposes, nursing assessment units are limited to one (1) unit per day.

Nursing Assessments in Family-Managed HTN and blended HTN models

In a blended model, [wherein both agency-directed and independently enrolled nurses are providing care,] nursing assessment duties are shared between agency-directed nurses and independently enrolled nurses. Agency-directed nurses will perform nursing assessment duties as described above, within the limit of the prior authorization granted by the State. The Primary Coordinator is responsible for communicating changes to the independently enrolled nurses.

SERVICE DELIVERY (CONT'D)

Other Considerations

HTN can be delivered to pediatric beneficiaries who also receive Home and Community Based Developmental Waiver Services, Children's Personal Care Services, Pediatric Palliative Care Services, and hospice benefits. HTN can be delivered to adults who access Choices for Care. See the Hospice Services HCAR Rule 4.227 (found here) for information on concurrent care for beneficiaries 19 years and older.

Home health services nursing visits should not be provided concurrently with HTN services. HTN is a more comprehensive service and should be sufficient to address the types of medical conditions that would otherwise necessitate skilled nursing care. There cannot be two plans of care for the same service (nursing).

Billing

Agency directed:

Home Health Agency High-Tech Nursing Services base rate table.

Payment Model Summary:

- The HTN monthly payment is 33.3% of the equivalent FFS payment for providing the total authorized hours of service. Payments for recipients will vary according to approved (i.e., medically necessary) hours.
- Minimum service threshold: Home health agency retains monthly payment if recipient receives at least 50% of authorized hours during the month. If hours are below the threshold, provider would not retain monthly payment.
- Reconciliation of monthly payments will occur annually, based on home health agency services delivered during each month for each recipient.
- In addition to the monthly payment, providers will continue to be paid an hourly FFS payment for all services delivered.
- The intent of retaining a FFS Payment Component is to support more hours of medically necessary care.
- The FFS rate will be 66.7% of current FFS rates. The hourly FFS payment will be the same for all providers for all recipients.
- During annual reconciliation, FFS payments would be restored to 100% of the current rate for recipients with hours below the minimum service threshold of 50%. This would partially offset reconciliation of monthly payments for these recipients.

Independent Nurses:

For more information about Family-managed billing guide and rates.

SERVICE DELIVERY (CONT'D)

Medical Records and Reporting

Providers are responsible for establishing and maintaining a permanent medical record for each recipient, including the following:

- Physician's orders
- Home safety and accessibility assessment
- Record of ongoing HTN service provision, documenting dates and duration of visits, types of nursing activities conducted,
- High-Tech Nursing Assessment

On a regular basis, the State will request documentation from HHAs showing the amount of HTN service delivered to each recipient over a period of time defined in the request. This will occur at least quarterly but may occur more frequently when deemed necessary by the State.

As per the signed Provider Agreement, records must be maintained for 7 years.

CONTACT INFORMATION

Pediatric High-Technology Nursing Program:
Website: http://www.healthvermont.gov/children-youth-families/children-special-health-needs/high-tech-nursing
Email: ahs.vdhcshnhightechnursing@vermont.gov

Adult High-Technology Nursing Program:
Website: https://asd.vermont.gov/services/adult-high-technology-services
Phone: 802-241-0294

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