

SECTION II - PRIVATE DUTY NURSING SERVICES

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200.000 PRIVATE DUTY NURSING SERVICES GENERAL INFORMATION

201.000 Arkansas Medicaid Participation Requirements for Providers of Private Duty Nursing Services 11-1-09

The following subsections, as well as the Provider Participation and enrollment requirements contained within Section 140.000 of this manual, present Arkansas Medicaid's participation requirements for providers of Private Duty Nursing Services (PDN). A school district or Education Service Cooperative enrolling as a PDN provider has a different set of criteria than other entities enrolling as a PDN provider.

201.100 Private Duty Nursing Services Providers 7-1-20

Private Duty Nursing Services (PDN) providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of this manual as well as the following criteria to be eligible to participate in the Arkansas Medicaid Program:

- A. The PDN provider must have either a Class A or Class B license issued by the Arkansas Department of Health. It must be designated on the license that the PDN agency is a provider of extended care services.
 1. A copy of the license must accompany the provider application and Medicaid contract.
 2. For purposes of review under the Arkansas Medicaid Program, agencies enrolled as Class B operators providing private duty nursing services must adhere to those standards governing quality of care, skill, and expertise applicable to Class A operators.

Providers who have agreements with Medicaid to provide other services to Medicaid beneficiaries must have a separate provider application and Medicaid contract to provide private duty nursing services. A separate provider number is assigned.

- B. All owners, principals, employees, and contract staff of a private duty nursing services provider must submit to an independent, national criminal background check, identity verification, and fingerprinting. Background checks must be repeated every three (3) years.

201.200 School District or Education Service Cooperative Private Duty Nursing Services Providers 11-1-09

Arkansas Medicaid will enroll Arkansas school districts and Education Service Cooperatives (ESC) as Private Duty Nursing Services (PDN) providers when the following criteria are met:

- A. The school district or Education Service Cooperative must complete a Provider Enrollment Application and Contract Package (Application Packet). See Section 140.000 for detailed provider enrollment information. [View or print Application Packet.](#)
- B. The school district or ESC must be certified by the Arkansas Department of Education (ADE) as a Local Educational Agency (LEA). The ADE will provide verification of LEA certification to the Provider Enrollment Unit of the Arkansas Division of Medical Services. Subsequent certifications must be provided when issued.
 - 1. Subsequent certifications must be forwarded to Provider Enrollment within 30 days of issue.
 - 2. Failure to ensure that current certification is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.

202.000 Private Duty Nursing Service Providers in Arkansas

9-1-14

Private Duty Nursing Services providers in Arkansas may be enrolled as **routine service providers** if they meet the applicable Arkansas Medicaid participation requirements as outlined in Sections 140.000 and 201.000.

- A. **Routine service providers** may furnish and claim reimbursement for private duty nursing services subject to the benefit limitations and coverage restrictions set forth in this manual.
- B. Claims must be filed according to specifications of this manual. This includes assignment of ICD and HCPCS codes for all services rendered.

203.000 Private Duty Nursing Service Providers in States Not Bordering Arkansas

3-1-11

- A. Providers in states not bordering Arkansas may enroll in the Arkansas Medicaid program as limited services providers only after they have provided services to an Arkansas Medicaid eligible beneficiary and have a claim or claims to file with Arkansas Medicaid. To enroll, a non-bordering state provider must download an Arkansas Medicaid application and contract from the Arkansas Medicaid website and submit the application, contract and claim to Arkansas Medicaid Provider Enrollment. A provider number will be assigned upon approval of the provider application and the Medicaid contract. [View or print the provider enrollment and contract package \(Application Packet\).](#) [View or print Medicaid Provider Enrollment Unit contact information.](#)
- B. Limited services providers remain enrolled for one year.
 - 1. If a limited services provider provides services to another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the most recent claim's last date of service, if the enrollment file is kept current.
 - 2. During the enrollment period, the provider may file any subsequent claims directly to the Medicaid fiscal agent.
 - 3. Limited services providers are strongly encouraged to file subsequent claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

204.000 Records Requirements

11-1-09

All provider participation, record keeping, and record retention requirements detailed within Section 140.000 must be met. The additional documentation requirements below are also required of Providers of Private Duty Nursing Services.

- A. Medicaid contract (form DMS-653) to participate in the Arkansas Medicaid Program.

- B. Copy of the license of the registered nurse (RN) and/or licensed practical nurse (LPN) providing private duty nursing services.
- C. Documentation verifying that RNs or LPNs are CPR certified.
- D. Documentation that the RN or LPN has received in-service training on the particular patient's equipment and care needs.
- E. Written contracts between contract personnel and the agency.
- F. Statistical, fiscal and other records necessary for reporting and accountability.
- G. Copies of the approved Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (Form DMS-2692). [View or print form DMS-2692 and instructions for completion.](#)
- H. Signed and dated notes on the condition and progress of each patient.
- I. The patient's PDN care plan (Home Health Certification and Plan of Care (form CMS-485), including written justifications of any modification in the PDN care plan or prescription of service by the physician. [View or print form CMS-485.](#)
- J. Any additional or special documentation deemed necessary by the provider or required by DMS.
- K. Documentation of PDN services provided to each eligible beneficiary, including the date, the actual time of day each service was delivered and the signature of the person who actually provided the service.

204.100 Additional Record Requirements for School District and Education Service Cooperative Providers 11-1-03

In addition to the record requirements in Section 204.000, the school district or Education Service Cooperatives (ESC) provider of Private Duty Nursing Services (PDN) is responsible for keeping on file the following information:

- A. Written contracts between the school district or ESC and the contract personnel.
- B. The PDN care plan (Home Health Certification and Plan of Care—Form CMS-485) with updates signed by the school district or ESC supervising RN. [View or print form CMS-485.](#) The Individualized Education Program (IEP) may not supersede or substitute for the PDN care plan.

205.000 Reserved 11-1-09

206.000 Electronic Signatures 10-8-10

Medicaid will accept electronic signatures provided the electronic signatures comply with Arkansas Code § 25-31-103 et seq.

210.000 PROGRAM COVERAGE

211.000 Introduction 7-1-06

The Arkansas Medicaid Program is designed to assist eligible Medicaid beneficiaries in obtaining medical care within the guidelines specified in this manual.

212.000 Scope 10-1-06

Private duty nursing services are those medically necessary services that are provided by a registered nurse or licensed practical nurse under the direction of the beneficiary's physician, to a beneficiary in his or her place of residence, a Division of Developmental Disabilities Services (DDS) community provider facility or a public school. Private duty nursing services means nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. 42 CFR 440.80. For purposes of the Medicaid program, private duty nursing services are those medically necessary services related to the coverage described in Sections 213.000 and 213.010 which must be delivered by a registered nurse or licensed practical nurse, as required by the State Nurse Practice Act. The registered nurse or licensed practical nurse providing services may not be a family member or taking on the role of a family member of the Medicaid beneficiary as described in Section 212.100.

212.100 Provider Exclusions**1-1-05**

The following family members or persons acting as family members cannot provide care to a client through the Arkansas Medicaid Private Duty Nursing (PDN) program:

- A. A spouse
- B. A minor's parent or anyone acting as a minor's parent
- C. A minor's guardian or anyone acting as a minor's guardian
- D. An adult's guardian or anyone acting as an adult's guardian
- E. Anyone, regardless of relationship, who actually resides with the client

212.200 Private Duty Nursing Service Locations**10-1-06**

- A. Medicaid-eligible beneficiaries age 21 and older may receive Private Duty Nursing Services (PDN). PDN services may be provided only in the beneficiary's own home and as necessary when the Medicaid beneficiary's normal life activities temporarily take the beneficiary away from the home. For purposes of this rule, normal life activity means routine work, school, church, office or clinic visits, shopping and social interactions with friends and family. The private duty nurse may accompany the beneficiary but may not drive. Normal life activities do not include non-routine or extended home absences.
- B. For Medicaid-eligible beneficiaries under the age of 21, PDN services are covered in the following locations:
 - 1. The beneficiary's home. PDN services may be provided only in the beneficiary's own home and as necessary when the Medicaid beneficiary's normal life activities temporarily take the beneficiary away from the home. For purposes of this rule, normal life activity means routine work, school, church, office or clinic visits, shopping and social interactions with friends and family. The nurse may accompany the beneficiary but may not drive. Normal life activities do not include non-routine or extended home absences.
 - 2. A public school. A school's location may be an area on or off-site based on accessibility for the student. When a student's education is the responsibility of the school district in which that student resides, "school" as a place of service for Medicaid-covered services is any location, on-site or away from the site of an actual school building or campus, at which the school district is discharging that responsibility.
 - a. When a child is attending school at a DDS community provider facility because the school district has contracted with the facility to provide educational services, the place of service is "school".
 - b. When the home is the educational setting for a child who is enrolled in the

- public school system, “school” is considered the place of service.
- c. The student’s home is not considered a “school” place of service when a parent elects to home school a child.
- 3. A DDS community provider facility.
- C. PDN services are not covered at/or in a hospital, boarding home, nursing facility, residential care facility, or an assisted living facility.

213.000 Coverage of Private Duty Nursing Services for Medicaid-Eligible Beneficiaries Under 21 10-1-06

Beneficiaries under age 21 to receive private duty nursing (PDN) services must require constant supervision, visual assessment and monitoring of both equipment and patient. PDN services may be covered for Medicaid beneficiaries under 21 who meet the following requirements:

- A. Medicaid-eligible ventilator-dependent (invasive) beneficiaries when determined medically necessary and prescribed by a physician or
- B. Medicaid-eligible beneficiaries under age 21 who are:
 - 1. In the Child Health Services (EPSDT) Program, and
 - 2. High technology non-ventilator dependent beneficiary requiring at least two (2) of the following services:
 - a. Intravenous Drugs (e.g. chemotherapy, pain relief, or prolonged IV antibiotics)
 - b. Respiratory – Tracheostomy or Oxygen Supplementation
 - c. Total Care Support for ADLs and close patient monitoring
 - d. Hyperalimentation – parenteral or enteral

Medicaid-eligible beneficiaries under age 21 who are in the Child Health Services (EPSDT) program require additional documentation to receive private duty nursing services. Refer to Section 225.000 of this manual.

PDN services may be provided by a registered nurse and/or licensed practical nurse as directed by the beneficiary’s physician.

All PDN services require prior authorization by the Medicaid Program. Refer to Section 220.000 of this manual for information on the prior authorization process.

213.010 Coverage of Private Duty Nursing Services for Medicaid-Eligible Beneficiaries Age 21 and Over 10-1-06

Beneficiaries 21 and over to receive PDN Nursing Services must require constant supervision, visual assessment and monitoring of both equipment and patient. In addition the beneficiary must be:

- A. Ventilator dependent (invasive) or
- B. Have a functioning trach
 - 1. requiring suctioning and
 - 2. oxygen supplementation and
 - 3. receiving Nebulizer treatments or require Cough Assist / inextufflator devices
- C. In addition at least one from each of the following conditions must be met:
 - 1. Medications:

- a. Receiving medication via gastrostomy tube (G-tube)
 - b. Have a Peripherally Inserted Central Catheter (PICC) line or central port
2. Feeding:
- a. Nutrition via a permanent access such as G-tube, Mickey Button, Gastrojejunostomy tube (G-J tube) feedings are either bolus or continuous
 - b. Parenteral nutrition (total parenteral nutrition)

PDN services may be provided by a registered nurse and/or licensed practical nurse as directed by the beneficiary's physician.

Additional documentation is required for PDN services for non-ventilator dependent beneficiaries age 21 and over. Please refer to Section 225.000 of this manual.

All PDN services require prior authorization by the Medicaid Program. Refer to Section 220.000 of this manual for information on the prior authorization process.

213.100 Coverage of Private Duty Nursing Services Provided by Public Schools 11-1-03

Effective for dates of service on or after November 1, 2003, the public schools will provide PDN services to Medicaid-eligible students who meet the following requirements:

- A. The requirements in Section 213.000.
- B. An Individualized Education Program (IEP) that includes and describes the PDN services for the Medicaid-eligible student.
- C. A PDN care plan (Home Health Certification and Plan of Care—Form CMS-485) has been developed. [View or print form CMS-485](#). The IEP does not substitute for the PDN care plan.

213.101 Public School Payment of Medicaid Matching Funds 11-1-03

Effective for dates of service on or after November 1, 2003, public schools are deemed to be the provider of service, and will pay the state match for Medicaid covered services that are included in a student's Individualized Education Program (IEP) and provided under this Medicaid Program manual.

This policy applies unless the student's parent or guardian has, in accordance with federal law, independently selected a certified Medicaid provider other than the school ("other provider"). This exception requires the existence of each of the following conditions:

- A. Neither the school nor anyone acting on behalf of the school referred the student, or the student's parent or guardian, to the other provider.
- B. There is no arrangement by the school or persons or entities in privity with the school for the other provider to furnish the services.
- C. The other provider does not, either directly or through another person or entity, have a contract with the school or persons or entities in privity with the school for referrals, consulting, or the provision of Medicaid-covered services.
- D. The other provider is not under control or supervision of the school or persons or entities in privity with the school.

For purposes of this rule, "privity" means a derivative interest growing out of a contract, mutuality of interest, or common ownership or control.

213.200 Coverage of Private Duty Nursing Medical Supplies 7-1-06

The Arkansas Medicaid Program covers Private Duty Nursing Services (PDN) medical supplies. Supplies are limited to \$80.00 per month, per beneficiary.

Refer to Section 242.130 of this manual for PDN nursing supplies.

213.210 Extension of Benefits for Private Duty Nursing Medical Supplies 11-1-03

With substantiated medical necessity, the maximum reimbursement for PDN medical supplies may be extended.

To request an extension of benefits for private duty nursing medical supplies, the PDN service provider must submit the following information to the Division of Medical Services Utilization Review Section:

- A. A completed Request for Extension of Benefits (Form DMS-699). [View or print form DMS-699.](#)
- B. Medical records and PDN service provider records that substantiate the medical necessity for extension of benefits.
- C. Physician prescription, which is dated within the past 12 months.

[View or print Utilization Review Section contact information.](#)

Within 30 working days, the PDN service provider will be notified in writing of the approval or denial of the request for extension of benefits or a request for additional information will be made. See Section 226.000 of this manual for the beneficiary's appeal process when adverse action is received.

214.000 Medical Criteria and Guidelines for Coverage of Private Duty Nursing Services for Ventilator-Dependent Beneficiaries 10-1-06

To receive private duty nursing services, beneficiaries must require constant supervision, visual assessment and monitoring of both equipment and patient. The following medical criteria and guidelines are utilized in evaluating coverage of private duty nursing services for a ventilator-dependent beneficiary:

- A. Selection of Patient
 1. Medical: The patient must have a related diagnosis requiring ventilator support. These diagnoses are:
 - a. Neuromuscular disease involving the respiratory muscles
 - b. Brainstem respiratory center dysfunction
 - c. Severe thoracic cage abnormalities
 - d. Intrinsic lung disease
 - e. Lung disease associated with cardiovascular disordersEach patient must have cardiovascular stability.
 2. Social: The patient must depend upon family members to provide support at home for medical and non-medical care on an ongoing basis.
 3. Cost Effectiveness: The cost of private duty nursing care should not exceed the cost for acute inpatient hospital care.
- B. Specific factors to be assessed
 1. Medical

- a. Mechanical ventilator support is necessary for at least six (6) hours per day and weaning has been tried but was unsuccessful.
 - b. Frequent ventilator adjustments are unnecessary.
 - c. Oxygen supplementation at or below an inspired fraction of 40% (F1O2@0.40).
 - d. There are no anticipated needs for frequent re-hospitalizations.
 - e. There is a record of reasonable expectation of normal or near-normal growth while receiving ventilator support. (This criterion applies to children only.)
2. Social/Emotional/Environmental: Major commitments on the part of family and community are mandatory to meet the beneficiary's extraordinary needs. Specific components include:
- a. Stable parent or parent figures.
 - b. Caregivers understanding of beneficiary's condition.
 - c. Primary care physician.
 - d. Family must ID at least one (1) additional family member and/or community person beyond the immediate family.
 - e. Demonstrated interest and ability in the care of the patient related to trach care, ventilator management, drug administration, feeding needs and developmental stimulation.
 - f. An adequate physical environment within the home.
 - g. Support system.
 - h. Family composition.
 - i. Sufficient resources within the community including emergency medical services, educational and vocational programs and other support programs.
 - j. Identified stressors.
 - k. Financial status.
 - l. Transportation requirements.

215.000

**Criteria For Coverage of High Technology, Non-Ventilator
Dependent Beneficiaries In the Child Health Services (EPSDT)
Program**

10-1-06

Beneficiaries under age 21 to receive private duty nursing services must require constant supervision, visual assessment and monitoring of both equipment and patient. In addition, the following specific factors must be assessed:

- A. Medical
1. Technology dependent children consist of those with medical technology including but not limited to the following. Each category requires a variety of services. The technology dependence is life threatening and requires attention around the clock with 2 or more of the below categories being present. The constancy of care exceeds the family's ability to care for the patient at home on a long-term basis without the assistance of home nursing care.
 - a. Intravenous Drugs (e.g., chemotherapy, pain relief or prolonged IV antibiotics)
 - b. Respiratory -- Tracheostomy or Oxygen Supplementation
 - c. Total Care Support for ADLs and close patient monitoring
 - d. Hyperalimentation – parenteral or enteral
 2. The technology dependence may be related to any of the following diagnoses.
 - a. Severe neuromuscular, respiratory or cardiovascular disease not requiring mechanical ventilatory support.

- b. Chronic liver or gastrointestinal disorders with associated nutritional compromise.
- c. Multiple congenital anomalies or malignancies with severe involvement of vital body functions.
- d. Serious infections that require prolonged treatment.

B. Social/Emotional/Environmental

Major commitments on the part of the child's family and community are mandatory to meet the child's extraordinary needs. Specific components include:

1. Stable parent or parent figures.
2. Caregivers understanding of beneficiary's condition.
3. Primary care physician.
4. Family must ID at least one (1) additional family member and/or community person beyond the immediate family.
5. Demonstrated interest and ability in the care of the patient related to trach care, drug administration, feeding needs and developmental stimulation.
6. An adequate physical environment within the home.
7. Support system.
8. Family composition.
9. Sufficient resources within the community including emergency medical services, educational and vocational programs and other support programs.
10. Identified stressors.
11. Financial status.
12. Transportation requirements.

215.100 Medical Criteria and Guidelines for Coverage of Private Duty Nursing Services for Medicaid-Eligible Non-Ventilator Dependent Beneficiaries Age 21 and Over

10-1-06

Beneficiaries age 21 and over to receive PDN services must require constant supervision, visual assessment and monitoring of both equipment and patient. The following medical criteria and guidelines are utilized in determining coverage of private duty nursing for non ventilator dependent beneficiaries age 21 and over:

A. Medical

1. Current medical records documenting the diagnoses and conditions necessary to support the medical necessity of a functioning tracheostomy, which requires suctioning and
2. Oxygen supplementation and
3. Nebulizer treatments or use of Cough Assist/inexsufflator devices
4. In addition, at least one from each of the following conditions must be met:
 - a. Medications:
 - (1) Requires administration of medications via gastrostomy tube (G –tube)
 - (2) Requires administration of medications in the home setting via Central Catheter (PICC) line or central port
 - b. Feeding:
 - (1) Requires the administration of enteral nutritional feedings via a

permanent access such as G tube, Mic-Key button, Gastrojejunostomy tube (G-J tube), which are either by bolus or continuous feeding

(2) Total Parenteral Nutrition (TPN)

B. Additional requirements:

Social/Emotional/Environmental: Major commitments on the part of family and community are mandatory to meet the beneficiary's home care needs. Specific components include:

1. Primary Care Physician (PCP)
2. Caregivers' understanding of beneficiary's condition
3. Named primary and secondary caregivers
4. Demonstrated interest and ability in all aspects of the patient's home care, including trach care, oxygen administration and respiratory procedures and treatments, administration of medications and feedings
5. Family must ID at least one (1) additional family member and/or community person beyond the immediate family.
6. An adequate physical home environment
7. Adequate support system
8. Sufficient resources within the community including emergency medical services, educational and vocational programs and other support programs
9. Transportation requirements

216.000

Exclusions

7-1-06

Private duty nursing services will not be authorized for a beneficiary in a boarding home, hospital, nursing facility, residential care facility or any other institutional setting or health care facility.

220.000

PRIOR AUTHORIZATION

221.000

Prior Authorization

11-1-03

Prior authorization (PA) is required for private duty nursing services.

222.000

Request for Prior Authorization

4-1-09

A request for prior authorization for private duty nursing services must originate with the provider. The provider is responsible for completion of the Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (form DMS-2692) and obtaining the required medical information. Form DMS-2692 must be signed by the beneficiary's physician with documentation that a physical examination was performed within 12 months of the beginning of the initial request or the recertification. [View or print form DMS-2692 and instructions for completion.](#)

For PDN services in the beneficiary's home a social/environmental evaluation indicating a commitment on the part of the beneficiary's family to provide a stable and supportive home environment must accompany the request for prior authorization. Refer to Section 224.000 of this manual for additional information required for the initial request.

All PA requests for Medicaid-eligible beneficiaries will be evaluated by the Division of Medical Services, Utilization Review (UR) Section, to determine the level of care and amount of nursing services to be authorized. [View or print Utilization Review Section contact information.](#)

The UR Section will notify the provider of the approval or denial of the PDN services PA request within 15 working days following the receipt of the PA request. If the PA request for PDN services is approved, page 5 of form DMS-2692 will be returned to the provider with the number of hours approved indicated on the form. The PA number will be assigned after the provider sends in documentation of the actual hours worked.

Prior authorization is required for private duty nursing supervisory visits. The Prior Authorization request must be submitted with the monthly service billing along with supporting documentation. The PA number will be assigned after the provider sends in documentation of the actual hours worked.

NOTE: The prior authorization number MUST be entered on the claim form filed for payment of these services. The initial PA approval will only be authorized for a maximum of 90 days. A new request must be made for services needed for a longer period of time. Recertification may be authorized for a maximum of six (6) months. Refer to Section 224.000 of this manual for information regarding recertification of PDN services. The effective date of the PA will be the date the patient begins receiving PDN services or the day following the last day of the previous PA approval.

Providers are cautioned that a prior authorization approval does not guarantee payment. Reimbursement is contingent upon eligibility of both the beneficiary and provider at the time service is provided and upon completeness and timeliness of the claim filed for the service. The provider is responsible for verifying the beneficiary's eligibility.

223.000 Additional Information Required For Private Duty Nursing Services 10-13-03
For Home Ventilator-Dependent Patients

The following additional information must be provided with the initial request for private duty nursing services for home ventilator-dependent patients:

- I. MEDICAL SUMMARY
- II. COMPREHENSIVE PSYCHOSOCIAL HISTORY
 1. Caregiver's understanding of the patient's condition
 2. Description of the household and existing relationships
 3. Primary and secondary caregivers
 4. Available family and community support
 5. Stressors identified within the family and complete financial picture
 6. Access to transportation
- III. PRE-HOME EVALUATIONS
 - A. Home Health Agencies
 1. Utility systems, i.e. water, heating, cooling, telephone, electricity
 2. Refrigerator present
 3. Cleanliness of home
 4. Environmental hazards and/or barriers
 - B. DME Agency
 1. Electrical capability/adequate outlets
 2. Space for equipment/supply storage
 - C. County Human Services Office (If applicable)
 1. Environmental concerns

2. Psychosocial concerns
- IV. VERIFICATION OF EMERGENCY PLAN
1. Capabilities of home members
 2. Emergency Plan
 - a. Identification of:
Hospital
Ambulance service
Primary Physician, Backup and call system
DME Company and call system
Home Health Agency and call system
 - b. Notification of:
Fire Department
Police
Gas
Utility Company
- V. VERIFICATION OF PATIENT/PARENT/SUPPORT CAREGIVERS EDUCATION
1. Trach
 2. Vent Equipment
 3. CPR
 4. Emergency Plan
 5. Diet/Feeding Technique
 6. Home OT/PT
 7. Disease Process
 8. Medications
- VI. DEVELOPMENTAL HOME PLAN
1. Developmental Assessment
 2. Speech Communication
 - a. Method/ability of beneficiary
 3. Community Services Available to Family/Beneficiary
 4. Other Services Available
- VII. NURSING CARE PLAN
1. Nursing Goals
 2. Procedures to be done
 3. Family/Patient Teaching to be done in the home
 4. Nursing Care Plan should reflect each level of care requested
 5. Supportive Services needed—e.g., Home Health Aide
 6. Medication - frequency and route
- VIII. OTHER DISCIPLINES PLAN OF TREATMENT
1. Services in the home

224.000

Recertification of Private Duty Nursing Services for Home Ventilator-Dependent and Non-Ventilator Patients

11-1-03

If there is a change in the prescription for care, the provider must submit a new Request for Private Duty Nursing Services Prior Authorization and Prescription Initial Request or Recertification (Form DMS-2692). [View or print form DMS-2692.](#) Include the following

information after the 90 days initial approval and every six (6) months thereafter for Medicaid recertification:

- A. Current physician/developmental assessment – Include changes since last certification.
- B. Psychosocial/Family assessment.
 - 1. How is patient responding to home environment?
 - 2. How is family responding to patient being home?
 - 3. If caregivers work, give their work schedule.
 - 4. Include changes since last certification.
- C. Results of teaching plan – List specific hours and days family cares for child and specific hours and days agency cares for the child.
- D. PDN care plan (Home Health Certification and Plan of Care – Form CMS-485) for continued care – Reflect any changes in child’s nutritional methods since last certification. [View or print form CMS-485.](#)
- E. Summary of other disciplines treatment and goals utilized.
- F. Emergency plan.

If there is no change in the prescription for care, provider must submit a copy of existing nursing care plan and note “no change.”

225.000 Filing for Prior Authorization

10-1-06

To request prior authorization, the Private Duty Nursing Services (PDN) provider must complete and forward the Form DMS-2692 to the Division of Medical Services Utilization Review Section. [View or print the DMS Utilization Review Section contact information.](#)

A copy of the form should be retained in the provider’s records.

Additional documentation is required for PDN services for eligible Medicaid beneficiaries under age 21. The following documentation must be provided:

- A. Current medical and surgical history
- B. Current psychosocial assessment
- C. Current PDN care plan (Home Health Certification and Plan of Care – form CMS-485) [View or print form CMS-485.](#)
- D. A copy of current EPSDT screening/referral from the current primary care physician (PCP) must be submitted. This referral must be the result of the Child Health Services (EPSDT) screen. This requirement may be waived *only* for the request of a hospitalized child.

This screening/referral must document all age appropriate Child Health Services (EPSDT) medical screening components. (Refer to the Child Health Services (EPSDT) provider manual Section 215.200)

Additional information is required for PDN services for non-ventilator dependent beneficiaries age 21 and over. The following documentation must be provided:

- A. Physician’s medical summary, current primary care physician (PCP) physical examination, current Pulmonologist examination and current ENT examination (current PCP exam may be waived only if the initial referral is secondary to current hospital admission)
- B. Comprehensive Psychosocial History

1. Caregivers' understanding of the patient's condition
 2. Description of the household and existing relationships
 3. Named primary and secondary caregivers
 4. Additional available family and community support
 5. Access to transportation
- C. Verification of Patient's or Caregiver's Education
1. Trach care and change
 2. Oxygen administration and use of other respiratory equipment
 3. Diet/feeding administration technique
 4. Disease process
 5. Emergency plan
 6. Administration of medications
- D. Documentation of all additional services in the home

New requests for PDN services should be sent to the Division of Medical Services, Utilization Review Section (UR) as early as possible after the medical need for private duty nursing is identified.

Providers must submit requests for prior authorization of PDN services within 30 days of the beginning date of service. Providers assume the risk of services ultimately being found not medically necessary. When PDN services are approved by UR at the level requested, the effective date of the prior authorization will be retroactive to the beginning date of service.

226.000 **Administrative Reconsideration and Appeals** 6-1-25

- A. Medicaid only allows one (1) reconsideration of an adverse decision. Reconsideration requests must be submitted in accordance with Section 160.000 of Section I of this Manual.
- B. When the state Medicaid agency or its designee denies a reconsideration request or issues any adverse decision, the beneficiary may appeal and request a fair hearing. A request for a fair hearing must be submitted in accordance with Sections 160.000, 190.000, and 191.000 of Section I of this Manual.

230.000 **REIMBURSEMENT**

231.000 **Method of Reimbursement** 10-13-03

Reimbursement for Private Duty Nursing Services is based on the lesser of the amount billed or the Title XIX maximum allowed.

Refer to Section 240.000 of this manual for billing instructions. One hour of service equals one unit.

231.010 **Fee Schedule** 12-1-12

Arkansas Medicaid provides fee schedules on the Arkansas Medicaid website. The fee schedule link is located at <https://medicaid.mmis.arkansas.gov/> under the provider manual section. The fees represent the fee-for-service reimbursement methodology.

Fee schedules do not address coverage limitations or special instructions applied by Arkansas Medicaid before final payment is determined.

Procedure codes and/or fee schedules do not guarantee payment, coverage or amount allowed. Information may be changed or updated at any time to correct a discrepancy and/or error. Arkansas Medicaid always reimburses the lesser of the amount billed or the Medicaid maximum.

232.000 Rate Appeal Process 5-1-08

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the provider to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Human Services (DHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

240.000 BILLING PROCEDURES

241.000 Introduction to Billing 7-1-20

Private Duty Nursing providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one (1) beneficiary.

Section III of this manual contains information about available options for electronic claim submission.

242.000 CMS-1500 Billing Procedures

242.100 Procedure Codes

242.110 Private Duty Nursing Services Procedure Codes 2-1-22

The following procedure codes are applicable when billing the Arkansas Medicaid Program for private duty nursing services.

[View or print the procedure codes for Private Duty Nursing \(PDN\) services.](#)

*Effective for dates of service on and after April 4, 2008 procedure code can be billed for a RN supervisory visit. The maximum time allowed for reimbursement per visit is 3 hours, with a maximum of 18 visits per state fiscal year. Supervisory visits (as defined by the Arkansas Department of Health Rules and Regulations for Home Health Agencies) must be face-to-face

and provided in a setting approved for private duty nursing services (see Section 242.200). Beneficiaries receiving extended care will require no less frequency than every two weeks of supervision. For beneficiaries classified as stable or chronic (beyond the first 3 months of extended care), RN supervisory visits will be no less than every 30 days.

242.120 Simultaneous Care of Two Patients 2-1-22

When a private duty nurse is caring for two patients simultaneously in the same location, the following procedure codes are to be used for the care provided to the second patient:

[View or print the procedure codes for Private Duty Nursing \(PDN\) services.](#)

242.130 Medical Supplies Procedure Codes 2-1-22

The following HCPCS procedure codes must be used when billing the Arkansas Medicaid Program for medical supplies. Providers will use the current Health Care Procedural Coding System (HCPCS) Book for procedure code descriptions.

*Refer to [Section 242.430](#).

Procedure codes shown below contain a modifier and an Arkansas Medicaid procedure code description.

[View or print the procedure codes for Private Duty Nursing \(PDN\) services.](#)

242.200 National Place of Service Codes 7-1-07

Electronic and paper claims now require the same national place of service codes.

Place of Service	POS Codes
Patient's home	12
DDS Facility (for beneficiaries under age 21, not school age)	52
Public School (for beneficiaries under age 21)	03

242.300 Billing Instructions—Paper Claims Only 11-1-17

Bill Medicaid for professional services with form CMS-1500. The numbered items in the following instructions correspond to the numbered fields on the claim form. [View a sample form CMS-1500.](#)

Carefully follow these instructions to help the Arkansas Medicaid fiscal agent efficiently process claims. Accuracy, completeness, and clarity are essential. Claims cannot be processed if necessary information is omitted.

Forward completed claim forms to the Claims Department. [View or print the Claims Department contact information.](#)

NOTE: A provider delivering services without verifying beneficiary eligibility for each date of service does so at the risk of not being reimbursed for the services.

NOTE: What was formerly type of service code "S" is now requiring the LEA number of the school district in Field 19 of the CMS-1500.

242.310 Completion of CMS-1500 Claim Form 9-1-14

Field Name and Number	Instructions for Completion
1. (type of coverage)	Not required.
1a. INSURED'S I.D. NUMBER (For Program in Item 1)	Beneficiary's or participant's 10-digit Medicaid or ARKids First-A or ARKids First-B identification number.
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	Beneficiary's or participant's last name and first name.
3. PATIENT'S BIRTH DATE	Beneficiary's or participant's date of birth as given on the individual's Medicaid or ARKids First-A or ARKids First-B identification card. Format: MM/DD/YY.
SEX	Not required.
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	Required if insurance affects this claim. Insured's last name, first name, and middle initial.
5. PATIENT'S ADDRESS (No., Street)	Optional. Beneficiary's or participant's complete mailing address (street address or post office box).
CITY	Name of the city in which the beneficiary or participant resides.
STATE	Two-letter postal code for the state in which the beneficiary or participant resides.
ZIP CODE	Five-digit zip code; nine digits for post office box.
TELEPHONE (Include Area Code)	The beneficiary's or participant's telephone number or the number of a reliable message/contact/emergency telephone.
6. PATIENT RELATIONSHIP TO INSURED	If insurance affects this claim, check the box indicating the patient's relationship to the insured.
7. INSURED'S ADDRESS (No., Street)	Required if insured's address is different from the patient's address.
CITY	
STATE	
ZIP CODE	
TELEPHONE (Include Area Code)	
8. RESERVED	Reserved for NUCC use.
9. OTHER INSURED'S NAME (Last name, First Name, Middle Initial)	If patient has other insurance coverage as indicated in Field 11d, the other insured's last name, first name, and middle initial.
a. OTHER INSURED'S POLICY OR GROUP NUMBER	Policy and/or group number of the insured individual.
b. RESERVED	Reserved for NUCC use.
SEX	Not required.
c. EMPLOYER'S NAME OR SCHOOL NAME	Required when items 9 a and d are required. Name of the insured individual's employer and/or school.

Field Name and Number	Instructions for Completion
d. INSURANCE PLAN NAME OR PROGRAM NAME	Name of the insurance company.
10. IS PATIENT'S CONDITION RELATED TO:	
a. EMPLOYMENT? (Current or Previous)	Check YES or NO.
b. AUTO ACCIDENT? PLACE (State)	Required when an auto accident is related to the services. Check YES or NO. If 10b is YES, the two-letter postal abbreviation for the state in which the automobile accident took place.
c. OTHER ACCIDENT?	Required when an accident other than automobile is related to the services. Check YES or NO.
d. CLAIM CODES	The "Claim Codes" identify additional information about the beneficiary's condition or the claim. When applicable, use the Claim Code to report appropriate claim codes as designated by the NUCC. When required to provide the subset of Condition Codes, enter the condition code in this field. The subset of approved Condition Codes is found at www.nucc.org under Code Sets.
11. INSURED'S POLICY GROUP OR FECA NUMBER	Not required when Medicaid is the only payer.
a. INSURED'S DATE OF BIRTH	Not required. This field is not required for Medicaid.
SEX	Not required.
b. OTHER CLAIM ID NUMBER	Not required.
c. INSURANCE PLAN NAME OR PROGRAM NAME	Not required.
d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	When private or other insurance may or will cover any of the services, check YES and complete items 9, 9a, 9c and 9d. Only one box can be marked.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	Enter "Signature on File," "SOF" or legal signature.
14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)	Required when services furnished are related to an accident, whether the accident is recent or in the past. Date of the accident. Enter the qualifier to the right of the vertical dotted line. Use Qualifier 431 Onset of Current Symptoms or Illness; 484 Last Menstrual Period.

Field Name and Number	Instructions for Completion
15. OTHER DATE	<p>Enter another date related to the beneficiary's condition or treatment. Enter the qualifier between the left-hand set of vertical, dotted lines.</p> <p>The "Other Date" identifies additional date information about the beneficiary's condition or treatment. Use qualifiers:</p> <p>454 Initial Treatment</p> <p>304 Latest Visit or Consultation</p> <p>453 Acute Manifestation of a Chronic Condition</p> <p>439 Accident</p> <p>455 Last X-Ray</p> <p>471 Prescription</p> <p>090 Report Start (Assumed Care Date)</p> <p>091 Report End (Relinquished Care Date)</p> <p>444 First Visit or Consultation</p>
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION	Not required.
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	Primary Care Physician (PCP) referral is required for Private Duty Nursing services. Enter the referring physician's name.
17a. (blank)	Not required.
17b. NPI	Enter NPI of the referring physician.
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	When the serving/billing provider's services charged on this claim are related to a beneficiary's or participant's inpatient hospitalization, enter the individual's admission and discharge dates. Format: MM/DD/YY.
19. LOCAL EDUCATIONAL AGENCY (LEA) NUMBER	Insert LEA number.
20. OUTSIDE LAB? \$ CHARGES	Not required. Not required.
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY	<p>Enter the applicable ICD indicator to identify which version of ICD codes is being reported.</p> <p>Use "9" for ICD-9-CM.</p> <p>Use "0" for ICD-10-CM.</p> <p>Enter the indicator between the vertical, dotted lines in the upper right-hand portion of the field.</p> <p>Diagnosis code for the primary medical condition for which services are being billed. Use the appropriate International Classification of Diseases (ICD). List no more than 12 diagnosis codes. Relate lines A-L to the lines of service in 24E by the letter of the line. Use the highest level of specificity.</p>

Field Name and Number	Instructions for Completion
22. RESUBMISSION CODE ORIGINAL REF. NO.	Reserved for future use. Any data or other information listed in this field does not/will not adjust, void or otherwise modify any previous payment or denial of a claim. Claim payment adjustments, voids, and refunds must follow previously established processes in policy.
23. PRIOR AUTHORIZATION NUMBER	The prior authorization or benefit extension control number if applicable.
24A. DATE(S) OF SERVICE	The "from" and "to" dates of service for each billed service. Format: MM/DD/YY. On a single claim detail (one charge on one line), bill only for services provided within a single calendar month.
B. PLACE OF SERVICE	Two-digit national standard place of service code. See Section 242.200 for codes.
C. EMG	Enter "Y" for "Yes" or leave blank if "No." EMG identifies if the service was an emergency.
D. PROCEDURES, SERVICES, OR SUPPLIES	One CPT or HCPCS procedure code for each detail. A modifier is required when billing for a second patient's PDN services.
CPT/HCPCS	
MODIFIER	
E. DIAGNOSIS POINTER	Enter the diagnosis code reference letter (pointer) as shown in Item Number 21 to relate to the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference letter for each service should be listed first; other applicable services should follow. The reference letter(s) should be A-L or multiple letters as applicable. The "Diagnosis Pointer" is the line letter from Item Number 21 that relates to the reason the service(s) was performed.
F. \$ CHARGES	The full charge for the service(s) totaled in the detail. This charge must be the usual charge to any client, patient, or other recipient of the provider's services.
G. DAYS OR UNITS	The units (in whole numbers) of service(s) provided during the period indicated in Field 24A of the detail.
H. EPSDT/Family Plan	Enter E if the services resulted from a Child Health Services (EPSDT) screening/referral.
I. ID QUAL	Not required.
J. RENDERING PROVIDER ID #	Enter the 9-digit Arkansas Medicaid provider ID number of the individual who furnished the services billed for in the detail or
NPI	Enter NPI of the individual who furnished the services billed for in the detail.

Field Name and Number	Instructions for Completion
25. FEDERAL TAX I.D. NUMBER	Not required. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. PATIENT'S ACCOUNT NO.	Optional entry that may be used for accounting purposes; use up to 16 numeric or alphabetic characters. This number appears on the Remittance Advice as "MRN."
27. ACCEPT ASSIGNMENT?	Not required. Assignment is automatically accepted by the provider when billing Medicaid.
28. TOTAL CHARGE	Total of Column 24F—the sum all charges on the claim.
29. AMOUNT PAID	Enter the total payments previously received on this claim. Do not include amounts previously paid by Medicaid. Do not include this total or the automatically deducted Medicaid co-payments.
30. RESERVED	Reserved for NUCC use.
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature, or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. SERVICE FACILITY LOCATION INFORMATION	If other than home or office, enter the name and street, city, state, and zip code of the facility where services were performed.
a. (blank)	Not required.
b. (blank)	Not required.
33. BILLING PROVIDER INFO & PH #	Billing provider's name and complete address. Telephone number is requested but not required.
a. (blank)	Enter NPI of the billing provider or
b. (blank)	Enter the 9-digit Arkansas Medicaid provider ID number of the billing provider.

242.400 Special Billing Procedures

242.410 Private Duty Nursing Billing Procedures

2-1-22

Private duty nursing services (PDN) are billed on a per unit basis. One unit equals one hour. Arkansas Medicaid will reimburse for the actual amount of cumulative PDN time on a monthly basis. Service time of less than one hour will not be rounded up to a full hour. Attach supervisory visit billing information with supporting documentation and assessment with the monthly private duty nursing billing. No supervisory visits will be covered without first providing prior authorized private duty nursing services within the same month. Billing units are cumulative up to one hour for the duration of one month. Supervisory visits of less than an hour can be

billed cumulatively on a monthly basis but any visit less than a unit (hour) cannot be rounded up. Providers must file separate claims indicating the number of hours for each patient.

Type of service code “1” must be used when filing paper claims. Public schools must use type of service code “S” when filing paper claims for beneficiaries under age 21.

Refer to Sections [242.110](#) and [242.120](#) for PDN procedure codes for single patient care and multiple patient care.

242.420 **Care of Multiple Patients**

242.421 **Simultaneous Care of Two Patients in the Beneficiaries’ Home or a DDS Facility** **2-1-22**

When a private duty nurse is caring for two patients simultaneously in a location other than a public school, Arkansas Medicaid reimburses 100% of the maximum allowable rate for the first patient and 50% of the maximum allowable rate for the second patient.

Providers must file separate claims indicating the number of hours of care for each patient.

Providers must request prior authorization for procedure codes.

[View or print the procedure codes for Private Duty Nursing \(PDN\) services.](#)

242.422 **PDN Care of Multiple Patients in a Public School** **11-1-03**

Arkansas Medicaid will reimburse the public schools based on the actual amount of cumulative time during the day used to provide PDN services to each Medicaid-eligible child. A separate claim must be filed indicating the total number of hours of PDN care for each child.

242.430 **Private Duty Nursing Medical Supplies** **2-1-22**

Procedure code, with types of service “S” and “1”, must be manually priced. Procedure code with a type of service of “1” requires a prior authorization (PA).

[View or print the procedure codes for Private Duty Nursing \(PDN\) services.](#)

Form DMS-679 may be used to request prior authorization. [View or print form DMS 679.](#)

242.440 **Electronic Claim-Filing for Benefit-Extended Medical Supplies** **11-1-03**

The Division of Medical Services (DMS) permits electronic filing of claims for benefit-extended medical supplies.

Upon notification of a benefit extension approval, the provider will file the claim electronically, entering the assigned Benefit Extension Control Number in the Prior Authorization (PA) number field. Subsequent benefit extension requests to UR will be necessary only when the benefit extension control number expires or when a patient’s need for services unexpectedly exceeds the amount or number of services granted under the benefit extension.