



ECLEG SEP21 '12 PM 12:10

September 19, 2012

Honorable John Mills
Honorable Joseph Lorigo
Bryan Fiume, Chief of Staff
County of Erie Legislature
Republican Caucus
92 Franklin Street
Buffalo, NY 14202

Dear Mr. Mills, Mr. Lorigo and Mr. Fiume,

I wanted to take a moment to summarize our meeting and send the list of "Who's Who" in our many years of contact with County representatives regarding the private hiring of Medicaid enrolled nurses. I thank all of you for your time and look forward to working together to make Erie County a better place to live for those who live in our community, or want to come home to our community and have medically complexity.

The packet I left with you contained the basics of what we want bring to light. The State of New York has rules and regulations that govern the provision of home care services to any Medicaid recipient. Those rules and regulations are in place in every county in New York. They provide a solid framework for families and individuals who need home care services to understand how to get them. They also have rules and regulations that specify for those who choose to provide home care services, ie. Licensed Agencies, Licensed Practical Nurses, Registered Nurses what they must do to provide, bill and receive payment for service rendered. We are asking that the County of Erie abide by those rules and regulations when assisting individuals seeking home care. Furthermore, we would ask that the County of Erie refrain from enforcing additional mandates, rules or requirements beyond what the State has put in place.

Today you were able to hear first hand from Mrs. Mary Verdi, her son Gerald, Jr., their family nurse Danie and Melissa and Robert Pilon with their daughter Marin how the process that has been forced upon them by the Erie County Department of Social Services has caused delays in the provision of services, delays in discharge from the hospital, delays in payment to those who have rendered service. We also heard how this process costs monies that in the economic environment we are in can hardly be justified – longer hospital stays, additional medical care required due to medical complications brought about by the continued unnecessary hospitalization, burning out of the informal

Because there's no place like home

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caregivers who are the lifeline for these individuals, salaries of the additional County employees needed to administer the processes in place.

SKIP of New York has worked diligently for over 22 years to help families throughout this great State remain whole. To allow families to live in their communities and provide a loving nurturing environment for their children and loved ones who have medical needs that in the past could only be provided in institutional settings. These dedicated families should be thanked and assisted in the unbelievably difficult task of caring for their loved ones. We look forward to working with you and anyone else in the County of Erie to make that possible for many more years to come.

Sincerely,

Donna Andrzejewski
Regional Manager

Da
Enc. "Who's Who of Home Care in the County of Erie"



SKIP of New York's Who's Who in WNY Home Care

County of Erie

Brenda Chavers, Director of Nursing – 858-2358

Her staff provides the nursing component to each home care assessment conducted by CASA. She is employed by Jewish Family Services but works in the CASA offices located in Room 230 in the Rath Building

Kristen Maricle, Esq. , Counsel, Erie County Department of Social Services – 858-4883

She is the lead in the legal department that oversees the contract processes for all families requesting private hire and nurses wanting to provide private hire services.

Louis Menza, Administrative Director III, Medicaid Long Term Care, Department of Social Services –

He is in charge of CASA, Long Term Care Program and had previously been the Director of the CASA Program when the private hire of nurses issues were first brought to the County's attention.

Mary Reagan, Administrative Director CASA and Medicaid Long Term Care – 858-2301

She had requested I send a letter to her asking for the process to be looked at after we facilitated a meeting between the CASA staff and the Discharge Planners at Women and Children's Hospital. This meeting was held at the hospital's request because they wanted to discuss the failure of the current processes in place to help families get their kids home in a timely manner.

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To whom it my concern;

I am writing in regards to the difficult process of discharging medically fragile children home with their families. The very experienced nurses in our department work closely with all 8 counties in Western NY, as well as those in northern PA.

When our patient is from Erie County we have noticed through the years, there are more and more steps to get these children home. Families who are already in a crisis state due to a child with unexpected very special needs- are forced to deal with an even more difficult challenge- navigating the system in Erie County.

As nurse discharge planners, we speak with the family, the agencies such as SKIP, Nursing Agencies, County workers, state workers from various programs such as Care at Home, or CASA. We work from day one to move as quickly as possible to get the children home with their family- the best place for them to be cared for. However, the process starts with a minimum of 30 days before we can begin the process of SSI application, or Medicaid application. The family needs to pick a case management agency, which in turn needs to meet with them for assessment. Letters of Medical necessity that are very detailed are written, and provided to meet the required documentation.

On top of all this, parents need to learn to care for there medically frail child and identify a reliable back up care giver who also needs to be trained.

In Erie County a parent can not chose a private hire nurse without first checking all the agencies to see if there is availability- and also provide written documentation of the inability to staff. They are the **ONLY** county to do so. Time is lost, hospital days are spent unnecessarily searching for nurses that don't exist most times.

Once approval is attained- and nurses are found- which is **NOT** an easy task- a private hire nurse must have written documentation from the community physician saying it is OK to do so. On top of that-the private nurses must also then sign a contract with the county to take cases in Erie County. Again Erie County is the only county to require this additional step.

We are in crisis! Nurses working as shift nurses in the homes with these special children are very hard to find. The additional barriers the county of Erie has made make it even more difficult to staff cases. In addition it makes it hard to staff cases quickly! Children are ready to go, and the parent and child sit here waiting while the "process" for shift nursing continues.



We do have some issues with nurse finding in other counties. But the difficulties in Erie County as well as the number of clients top the scale! We have actually had people move to other counties after talking with other parents because it is so much less draining on families to work with the counties other than Erie y to get their nurses approved and staffed. It is the state that approves the nursing – so one would have to assume it is the additional processes in Erie County that prohibits timeliness.

The sooner we move patients into the home once medically ready- the less tax payer dollars spent for health care. Not to mention it is better for the patient who is already compromised and does not need to contract any of the many viral/ bacterial infections that are spread in hospitals despite all efforts to avoid this. This has indeed occurred resulting in further extending their hospitalization, and loss of home nurses who have had to move onto other cases. The domino effect of these unnecessarily prolonged hospitalizations results in undue stress on already challenged families, lack of quickly available beds for other sick children, burnout amongst staff who feel that the multiple layers in the system are inefficient, burdensome, and unnecessary. This list goes on and on.

Please look at county practice. Do all the steps need to be involved in securing a nurse to care for a patient in their home? Every nurse should be licensed by the state in which they work. Every physician that cares for the patient is not required to sign a contract. Does there need to be so many additional steps that are only required by Erie County?

Thus far we have stated our many complaints. However, we are very willing to help with solving the problems if asked to do so.

Patients and families should be the number one concern for all of us. Let's try to DO THE RIGHT THING!

Respectfully,

Roseann Kelly RN
Barbara Kourkounis RN
Lynette Panebianco RN
MaryAnn Nadolinski RN
Nancy Bujnicki RN
Jeanne Marmion RN

Patient Management Staff
Women and Children's Hospital Of Buffalo

**NEW YORK STATE
MEDICAID PROGRAM**

PRIVATE DUTY NURSING MANUAL

PRIOR APPROVAL GUIDELINES

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Section I - Purpose Statement

The purpose of this document is to assist the provider community to understand and comply with the New York State Medicaid (NYS-Medicaid) requirements and expectations for:

- Obtaining Prior Approval
- Field by Field Instructions for Prior Approval Form (eMedNY 361502)

This document is customized for Nursing Services providers and it should be used by the provider's billing staff as an instructional as well as a reference tool.

Section II - Instructions for Obtaining Prior Approval

Electronic prior approval requests and responses can be submitted on the HIPAA 278 transaction. The Companion Guide for the HIPAA 278 is available on the www.nyhipaadesk.com website. Click on eMedNY Companion Guides and Sample Files. Access to the final determinations will be available through eMedNY eXchange messages or by mail. To sign up for eXchange, visit www.emedny.org.

Prior approval requests can also be requested via ePACES. ePACES is an internet-based program available to enrolled Medicaid providers. For information about enrolling in ePACES, contact CSC at (800) 343-9000. A reference number will be returned to your ePACES screen, which can be later used to check the approval status on ePACES. Visit www.emedny.org for more information.

Paper prior approval request forms, with appropriate attachments, should be sent to Computer Sciences Corporation, PO Box 4600, Rensselaer, NY 12144-4600. A supply of the new Prior Approval forms is available by contacting CSC at the number above.

This section of the manual describes the preparation and submission of the New York State Medical Assistance (Title XIX) Program Order/Prior Approval Request Form (eMedNY 361502). It is imperative that these procedures are used when completing the forms. Request forms that do not conform to these requirements will not be processed by eMedNY.

Services that require prior approval are underlined in the Procedure Code Section of this Manual.

Receipt of prior approval does NOT guarantee payment. Payment is subject to client's eligibility and other guidelines.

Requests for prior approval should be submitted before the date of service or dispensing date. However, sometimes unforeseen circumstances arise that delay the submission of the prior approval request until after the service is provided. If this occurs, the prior approval request must be received by the Department within 90 days of the date of service, accompanied by an explanation of why the item was dispensed/service was provided before the prior approval request was approved.

Prior approvals must be obtained before services commence; except in cases of emergency. In that instance, no more than two (2) days [forty-eight (48) consecutive hours] will be approved retrospectively. In cases where services are provided on an emergency basis, the Medicaid Director or his/her designee must be notified on the next business day. In limited circumstances, prior approval may be granted retrospectively at the discretion of the Medicaid Director, or his/her designee, providing the prior approval request is received by the Medicaid Director or his/her designee within ninety

Nursing Services Prior Approval Guidelines

(90) days of the date of service was provided

The request must give a detailed explanation for the delay. Requests submitted without an explanation will be returned, without action, to the provider.

To reduce processing errors (and subsequent processing delays), please do not run-over writing or typing from one field (box) into another. The displayed Prior Approval Request Form is numbered in each field to correspond with the instructions for completing the request.

Prior Approval Form (eMedNY 361502)

NYS MEDICAL ASSISTANCE - TITLE XIX PROGRAM **ORDER/PRIOR APPROVAL REQUEST**

PROVIDER	PROVIDER POLICY NUMBER	PROVIDER TYPE	NY DRUG CODE	NY SUPPLIER	NY DRUG	EYE CARE	PHYSICIAN
			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
PROVIDER NAME	PROVIDER ADDRESS	CITY	STATE	ZIP	PHONE	FAX	EMAIL
ORDER NUMBER	ORDER DATE	ORDER TYPE	ORDER STATUS	ORDER CLASS	ORDER CATEGORY	ORDER SUBCLASS	ORDER SUBCATEGORY
ORDER DESCRIPTION	ORDER QUANTITY	ORDER UNIT	ORDER PRICE	ORDER TOTAL	ORDER TAX	ORDER NET	ORDER GROSS
ORDER COMMENTS	ORDER ATTACHMENTS	ORDER HISTORY	ORDER STATUS	ORDER DATE	ORDER TIME	ORDER USER	ORDER IP ADDRESS
1							
2							
3							
4							
5							
6							
7							

DO NOT WRITE IN SHADOW AREA

FA NUMBER SHOWN HERE

ALIGN TOP AND LEFT EDGES OF STICKER ATTACHMENT NUMBERS

eMEDNY-361502 (1/08)

Paperwork Requirements for 'New Cases'

A "New Case" refers to a client who has never received a Prior Approval number from Medicaid for Private Duty Nursing Services OR there has been a lapse in service. If you are unsure what constitutes a new case, call the Prior Approval office listed in the 'Prior Approval Business Location' section of this website page.

- 1. Letter of Medical Necessity from ordering physician to include all skilled needs, level of care (LPN or RN) and number of hours being recommended.**
- 2. Nursing Assessment – This is a head-to-toe, system-by-system physical assessment done by an RN. If the client is hospitalized, in a rehabilitation center or skilled nursing facility, an in-house RN can do the assessment. If the client is currently residing at home in the community, then a Certified Home Health Agency (CHHA) or Public Health Nurse (PHN) must do the assessment.**
- 3. Back-up/training statement signed and dated by the primary caregiver, i.e., "In the event a nursing shift is not covered, I will be responsible for taking care of (Beneficiary name), and have been fully trained in all skilled tasks."**
- 4. Documentation of training by facility staff (for hospitalized clients or those in a rehabilitation or Skilled Nursing Facility).**
- 5. Psychosocial Assessment to include:**
 - a. Who resides in the household with the client (include ages of any children);**
 - b. Caregiver(s) work schedules on their company letterhead;**
 - c. If applicable, client's school schedule and calendar;**
 - d. If primary caretaker is attending college, send course schedule on college stationary.**
- 6. Home assessment done by a Licensed Nursing Agency, PHN or CHHA. If the client is vent dependent a respiratory company must complete the assessment. This home assessment is to verify the safety of the client's home environment.**
- 7. If there is Primary Insurance, send an Explanation of Benefits (EOB) from the insurance company**
 - a. If the client has primary insurance and this is NOT disclosed on the Medicaid system, this may significantly delay the Prior Approval process.**

8. All skilled tasks must be "specified." For example, do not write suction "PRN," instead, document actual frequency such as suctioned Q 4hrs. For tube feedings – list the actual time of day administered (i.e.: 8a, 12N, 4p, etc.) as well as the name of the product, the amount per feeding and the method (bolus, gravity or pump). Medications must include name of drug, route, dose and frequency.
9. For cases to be staffed by independently enrolled LPN's: a "letter of oversight" signed by the ordering physician must be submitted. This letter should state, "I am aware that there are independently enrolled LPN's staffing this case and I am willing to provide oversight to them." This must accompany the initial prior approval request form (eMedNY361502) along with a list of all Independent providers servicing the case and their NPI numbers.
10. If PDN is for school, then submit a letter from the school district stating child cannot attend without 1:1 nursing and the district cannot provide it, or send a copy of the child's I.E.P.

Upon receipt of a complete package, a medical determination will be given in writing. The provider who has accepted the case can then begin providing services and must submit a Prior Approval Form (eMedNY361502) **within thirty (30) days of the initial date of service**, to Computer Sciences Corporation, in order to receive the initial Prior Approval Number.

Please fax the above information to the appropriate Business Review Location reviewing the request (call for fax number).

Section III - Field by Field (eMedNY 361502) Instructions

PROVIDER TYPE (Field 1)

Place an X in the box labeled Nursing.

ORDER DATE (Field 2)

Indicate the month, day, and year on which the order was initiated.

Example: September 9, 2005

ORDER DATE									
0	9	0	9	2	0	0	5		

Prescriber's Provider Number (Field 3)

Enter the 10 digit Prescriber's Provider Number as in the example below. .

Example:

Prescriber Prov. No.									
0	1	2	3	4	5	6	7	8	9

PROF CODE (Field 4)

Leave blank.

PRESCRIBED BY (NAME) (Field 5)

Enter the last name followed by the first name of the practitioner initiating the order.

PRESCRIBER (Field 6)

Enter the ordering practitioner's address.

PRESCRIBER TELEPHONE NUMBER (Field 7)

Enter the telephone number of the ordering practitioner.

PRESCRIBER SIGNATURE (Field 8)

The ordering practitioner must sign the form in this field. If the form is filled out by the nurse provider who has the written order on something other than the eMedNY 361502, the provider must maintain the signed order in his/her files for six (6) years following the date of payment. A copy of the written order must be submitted with the form.

PRIMARY DIAGNOSIS (Field 9)

Enter the ICD-9-CM diagnosis code that represents the condition or symptom of the Client that establishes the need for the service requested. ICD-9-CM is the *International Classification of Diseases - 9th Revision - Clinical Modification Coding System*.

Example:

PRIMARY DIAGNOSIS						
8	9	7	.	0		

SECONDARY DIAGNOSIS (Field 10)

Enter the appropriate ICD-9-CM diagnosis code that represents the secondary condition or symptom affecting treatment. Leave blank if there is no secondary diagnosis.

CLIENT ID (Field 11)

Enter the client's eight-character alphanumeric Welfare Management System (WMS) ID number.

Example:

CLIENT ID NUMBER							
A	A	1	2	3	4	5	X

NOTE: (WMS) ID numbers are composed of eight characters. The first two are alpha, the next five are numeric, and the last one is alpha.

CLIENT NAME (Field 12)

Enter the last name followed by the first name of the client as it appears on the Medicaid ID Card.

ADDRESS (Field 13)

Enter the client's address.

DATE OF BIRTH (Field 14)

Indicate the month, day, and year of the client's birth.

Example: April 5, 1940 = 04051940

DATE OF BIRTH									
0	4	0	5	1	9	4	0		

CLIENT TELEPHONE NUMBER (Field 15)

Enter the client's phone number.

SEX (Field 16)

Place an X on M for Male or F for Female to indicate the client's gender.

ORDER DESCRIPTION / MEDICAL JUSTIFICATION (Field 17)

The order description must include the objectives of treatment, the estimated duration of treatment, the length of time per day, and the number of days per week that nursing services are necessary. In addition, the specific procedures that the nurse will undertake to justify the need for either a registered professional or licensed practical nurse should be entered.

SERVICING PROVIDER NO (Field 18)

Enter the Servicing Nurse 10 digit provider number assigned to you.

Example

SERVICING PROVIDER NO									
0	1	2	3	4	5	6	7	8	9

SERVICING PROVIDER NAME (Field 19)

Enter the name of the independently enrolled private practicing nurse or the name of the LHHCSA agency that will provide care. If more than one provider within the same category of service will be sharing the prior approval, list all providers and their 10 digit provider numbers in Field 17.

ADDRESS (Field 20)

Enter the address of the provider listed in Field 19.

TELEPHONE NUMBER (Field 21)

Enter the telephone number of the provider listed in Field 19.

LOC CODE (Field 22)

Enter the three-digit location code to specify where you would like to receive PA related correspondence (Example 003).

DRUG CODE (NDC) (Field 23)

Leave blank.

PROCEDURE ITEM CODE (Field 24)

This code indicates the service to be rendered to the recipient. Refer to the New York State Procedure Code Section of this Manual. Enter the appropriate five-character code.

MOD (Field 25)

Enter the appropriate two-character modifier, if applicable. Refer to the New York State Procedure Code Section of this Manual.

RENTAL? (Field 26)

Leave this field blank.

DESCRIPTION (Field 27)

Enter the description of the service corresponding to the procedure code entered in Field 24.

QUANTITY REQUESTED (Field 28)

Enter the total number of hours of private nursing services for all the days for which prior approval is being requested.

Example: Quantity of 1,232

QUANTITY REQUESTED						
		1	2	3	2	.

TIMES REQUESTED (Field 29)

Enter the number of days on which private nursing services are requested.

TOTAL AMOUNT REQUESTED (Field 30)

Enter the dollar amount requested for the specific prior-approved service. Calculate this amount, based on the established fee for this client, to cover the total units requested.

PA REVIEW OFFICE CODE (Field 31)

This field is used to identify the state agency responsible for reviewing and issuing the prior approval. See Information for All Provider, Inquiry Section for the appropriate reviewing agency and enter the corresponding code as listed below.

CODE

- | | |
|-----------|---|
| A1 | Bureau of Medical Review and Payment, Office of Health Insurance Programs, NYS Department of Health (for clients from all other counties not listed below) |
| 55 | Westchester County Department of Social Services |

**NEW YORK STATE
MEDICAID PROGRAM**

**PRIVATE DUTY NURSING MANUAL
POLICY GUIDELINES**

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Section I - Requirements for Participation in Medicaid

Enrollment of providers of private duty nursing (PDN) services to Medicaid recipients shall be limited to home care service agencies licensed in accordance with the provisions of Part 765 Title 10, Rules and Regulations of the Department of Health (DOH) and to private practicing licensed practical nurses (LPN) and registered professional nurses (RN).

All nurses providing PDN services must possess a license to practice in the State of New York and be currently registered by the New York State Education Department (NYSED).

A nurse who practices in another state and provides PDN to a New York Medicaid recipient who is temporarily located outside New York State (NYS) must be currently licensed and registered with the appropriate agency of the state in which he/she practices.

Providers must be enrolled in the NYS Medicaid Program prior to the start of service.

Note: Independent enrollment in the Medicaid Program does not constitute an exception to, or expansion of, the LPN scope of practice, as defined by Section 6902(2) of the State Education Law.

The practice of nursing by LPNs must be under the direction of a RN, licensed physician or other licensed health care provider legally authorized to direct LPNs.

Receipt of provider ID # does not negate the need for a prior approval number for individual cases. Please review the prior approval information section of the Private Duty Nursing Manual before starting any cases. You will still be at financial risk if you begin a private duty nursing case before obtaining the appropriate prior approval number.

Written Order Required

PDN services may be rendered only under the direction of a physician as part of a comprehensive program of care. Each provider is required to obtain a physician's written recommendation or order prior to the provision of such services.

Orders may also be written by certified nurse practitioners who are currently registered by the NYSED and enrolled in the NYS Medicaid Program.

Record Keeping Requirements

Clinical Record

A record of the patient's care shall be maintained within the patient's home. The documentation in the record shall include:

- The physician's current written order and treatment plan, both of which shall be revised as the needs of the patient dictate;
- The dates and hours of private duty nursing care provided, the identity of the LPN or RN who provided the care;
- Patient status as observed, measured and evaluated by the nurse providing the care;
- A record of the administration of the patient's medications and other treatments, the response to said medications and/or treatments;
- A record of other therapies provided and the observed functioning and adequacy of the supporting medical therapies and equipment.
- The clinical record must be sufficiently documented to enable another professional to reconstruct what transpired during each hour of nursing service billed to Medicaid.
- A copy of the prior approval must remain in the beneficiary's clinical record.
- In addition, the clinical record must be submitted to the Department upon request, according to Medicaid policy and regulation.

Medical Review

Periodic documentation of the patient's progress, in accordance with the written order, should be made by the providing nurse to the attending physician.

Section II - Private Duty Nursing Services

Under the NYS Medicaid Program, medically necessary nursing services may be provided to eligible individuals in their homes.

Reimbursable services include skilled nursing care rendered directly to the individual and instructions to his/her family in the procedures necessary for the patient's treatment.

All nursing services must be in accordance with, and conform to, the ordering physician's treatment plan.

Nursing Services in the Home

PDN services may be provided upon a written physician's order and when a written assessment from a Certified Home Health Agency (CHHA), local department of social services (LDSS), or recognized agent of an LDSS indicates that the patient is in need of either:

- Continuous nursing services which are beyond the scope of care available from a CHHA; or,
- Intermittent nursing services which are normally provided by a CHHA but which are unavailable.

It is expected that those nursing services be provided by a Licensed Home Care Services Agency (LHCSA) and that full and primary use be made of the services provided by such agencies.

Services may be provided by RN or LPN on a private practitioner basis only when it has been determined that:

- There is no approved home health agency in the area to provide the needed skilled nursing services; or
- The patient requires individual and continuous nursing care beyond that which is available from a home health agency.

The written assessment shall include the reasons why the CHHA cannot service this particular case as well as the CHHA's independent recommendations as to the level and frequency of services medically necessary.

The nurse completing the written assessment shall not be a provider of the PDN care to the patient, nor shall he/she be affiliated with the patient's family or the patient's physician.

Section III - Basis of Payment for Services Provided

Reimbursement for nursing services will be at hourly fees not to exceed those negotiated by the LDSS Commissioners on behalf of their respective counties and approved by the DOH, Office of Health Systems Management and by the State Budget Director.

Claims for services provided in increments other than full hours should be rounded up or down to the nearest full hour where appropriate.

It is the responsibility of the family, private duty nursing agency, RN or LPN to assess, investigate, and exhaust all commercial insurance for the beneficiary prior to billing Medicaid.

Prior Approval

Prior approval of the Medicaid Medical Director (Medicaid Director) or his/her designee is required for all PDN services. All PDN services shall be in accordance with the attending physician's written order and treatment plan.

Approval for PDN services shall be at the LPN level unless:

- The physician's order specifically justifies in writing the reasons why RN nurse services are necessary. In this case the Medicaid Director or local designee must be in agreement.
- The required skills are outside the scope of practice for an LPN as determined by the NYSED.

Each prior approval request shall identify the name(s) of the PDN provider(s) who will be providing the nursing services requested along with their provider ID or NPI number.

Prior approval requests shall identify the name(s) of informal support caregiver(s) and a statement from the ordering practitioner (or educator) and the informal support caregiver(s) that the named individual(s) are trained and capable of meeting all of the skilled and unskilled needs of the patient.

Prior approval requests shall be accompanied by a written physician's order. Physician's orders shall reference all diagnoses, medications, treatments, prognoses and other pertinent information relevant to the nursing plan of care.

Additional clinical and/or social information may be required at the discretion of the Medicaid Director or his/her designee.

In the instance that PDN services are to be provided wholly or in part by an independently enrolled LPN, the ordering physician must certify the following in writing:

- He or she is willing to be responsible for oversight of the independent nurse to ensure adherence to the prescribed treatment plan; and
- The ordering physician (or his/her designee) will be available to consult with the independent nurse should the patient's medical condition change or treatment plan needs updating.
- The ordering physician will provide, or arrange, appropriate direction to any independently enrolled LPN working the case in accordance with State Education Law.

Initial approval of PDN services shall be for a period of no more than three (3) months but may be for a lesser or greater period if so determined in the medical judgment of the Medicaid Director or his/her designee.

Approval for continued PDN care beyond three months or the lesser period determined by the Medicaid Director or his/her designee shall be contingent upon:

- a reassessment by a CHHA, LDSS or recognized agent of a LDSS,
- updated medical orders from the prescribing physician and
- presentation of clinical evidence to the Medical Director or his/her designee which supports the appropriateness of the continuation of care.

When, at any time, the Medicaid Director, or his/her designee determines that PDN services are no longer clinically appropriate or safe, and the patient continues to request nursing care, the patient shall be advised of the determination and of their right to request a Fair Hearing.

When the determination to discontinue PDN services is made, the Medicaid Director or his/her designee may authorize continuation of the nursing services for a reasonable period of time sufficient to permit the patient's caregivers and his/her medical team time to implement an alternate treatment plan.

Prior approvals must be obtained before services commence; except in cases of emergency. In that instance, no more that two days [48 consecutive hours] will be approved retrospectively.

In cases where services are provided on an emergency basis, the Medicaid Director or his/her designee must be notified on the next business day.

In limited circumstances, prior approval may be granted retrospectively at the discretion of the Medicaid Director, or his/her designee, providing the prior approval request is

received by the Medicaid Director or his/her designee within ninety (90) days of the date service was provided.

Prior approval of PDN services is not a guarantee that there will be sufficient licensed agency or independently enrolled personnel to service a case.

Out-of-State Providers

NYS Medicaid recipients occasionally seek the services of an out-of-state provider. Private practicing nurses and nursing agencies must be enrolled in the NYS Medicaid Program and may accept an appropriately completed written recommendation from an out-of-state physician who is duly licensed in the state where that practitioner is located.

In the event that a NYS Medicaid recipient who is temporarily residing outside NYS requires the care of a PDN, services may be provided only by nurses who meet the certification requirements of the state in which they are practicing and who are enrolled in the NYS Medicaid Program.

Out-of-state nurses who wish to provide services within NYS must possess a license and current registration from the NYSED.

PDN services, whether rendered or ordered by an out-of-state provider, must conform to the prior approval requirements outlined in this Manual.

For more information regarding the provision of out-of-state medical care and services, please refer to the Information for All Providers, General Policy manual.

Participants of the Long Term Home Health Care Program Waiver

PDN services, as described in this manual, are not available to participants of the Long Term Home Health Care Program (LTHHCP) waiver.

All nursing services in the LTHHCP are provided or arranged for and billed by the LTHHCP provider.

Section IV - Unacceptable Practices

In addition to the guidelines that appear in the Information for All Providers, General Policy manual, PDN providers are specifically prohibited from engaging in practices considered *unacceptable*, including, but not limited to the following:

- Offering cash payments to a physician;
- Entering into agreements or arrangements of any kind with any practitioner or representative of a health facility whereby any benefit, financial or otherwise, shall accrue to the parties of such agreement;
- Billing for services available free of charge to the general public;
- Billing for services not properly ordered by a qualified or otherwise legally authorized physician or certified nurse practitioner;
- Nursing services provided by an individual nurse exceeding sixteen (16) hours in a 24-hour period;
- Billing for services provided by the patient's legally responsible relative.
- Billing for PDN services while the patient is receiving comparable or duplicative services in a physician's office, clinic, hospital or other medical facility;
- Billing for or providing PDN services for any component of dialysis or dialysis time.
- Operating a motor vehicle while the nurse is purported to be providing nursing services.

Section V - The Care at Home Waiver Program

The Medicaid Care at Home (CAH) waivers are 1915c home and community based services (HCBS) waivers for children under the age of 18 designed to care for a disabled child in the home. Enrollees in CAH have access to all medically necessary State Plan services as well as waiver services.

There are currently four CAH waivers in New York State. The Department of Health (DOH) oversees a waiver known as CAH I/II, which is operated on a daily basis by Local Departments of Social Services (LDSS). The remaining three waivers, CAH III, IV and VI, are operated by the Office for Mental Retardation and Developmental Disabilities (OMRDD) through its local Developmental Disabilities Service Offices (DDSO).

General eligibility for all CAH waivers requires that a child must be:

- Under 18 years of age and unmarried;
- Disabled according Supplemental Security Administration (SSA) program criteria;
- Able to be cared for safely in the community and at no greater cost to Medicaid than in an appropriate facility.

For CAH I/II, the child must also:

- Be certified physically disabled based on SSA criteria;
- Require a level of care provided in a hospital or skilled nursing facility;
- Be eligible for Medicaid when disregarding the parental income and if applicable resources, or Medicaid eligible based on parental income.

Waiver services are case management, respite, home modification/vehicle adaptation, and five palliative care services: family palliative care education, bereavement therapy, pain and symptom management, expressive therapy (music, art, and play) and massage therapy.

For CAH III, IV, and VI, the child must also:

- Have a developmental disability;
- Have a complex health care need;
- Be determined *ineligible* for Medicaid due to parents income and if applicable resources, and then be determined *eligible* for Medicaid when parents' income and if applicable, resources are not counted.

Private Duty Nursing Manual Policy Guidelines

The waiver services are respite, case management, and assistive technology. CAH III, IV, and VI each has a capacity for 200 children. The monthly expenditure cap is \$16,000.

The "CAH Parent Handbook" can be found online at:

http://www.health.ny.gov/facilities/long_term_care/docs/manual.pdf

Section VI - Definitions

For purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Certified Home Health Agency

A certified home health agency (CHHA) holds a certification issued by the State Commissioner of Health in addition to being an agency licensed to provide home health services.

The agency can be public or private, a non-profit organization, or a subdivision of such an agency or organization, which is primarily engaged in providing, directly or through arrangement, skilled nursing services and other therapeutic services to home-bound patients.

Such services are provided on a part-time or intermittent basis, in a place of residence that is used as the individual's home.

Licensed Home Care Services Agency

A Licensed Home Care Services Agency (LHCSA) refers to an organization primarily engaged in providing, directly or through contract arrangement, skilled nursing services and other therapeutic services to home-bound patients.

Such services are provided on a long-term, continuous basis, in a place of residence that is used as the individual's home.

A LHCSA is one that has been licensed by the State Commissioner of Health as evidenced by its possession of a current license.

Licensed Practical Nurse

A Licensed Practical Nurse (LPN) refers to an individual who is licensed and currently registered to practice the profession of nursing as an LPN pursuant to Article 139 of the NYS Education Law.

Registered Professional Nurse

A Registered Nurse (RN) refers to an individual who is licensed and currently registered to practice the profession of nursing as a registered professional nurse pursuant to Article 139 of the NYS Education Law.

New York State Medicaid Enrollment Form

Thank you for your interest in enrolling with the New York State Medicaid Program. As a Medicaid provider, you agree to comply with the rules, regulations and official directives of the Department including, but not limited to, Part 504 of 18 NYCRR (i.e., Title 18). Title 18 can be found by choosing the Laws and Regulations link of the Department of Health's website, www.health.ny.gov.

You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process. Payment will not be made for any claims submitted for services, care, or supplies furnished before the enrollment date authorized by the Department of Health. If you have any questions, contact the eMedNY Call Center at (800) 343-9000.

New York State's Personal Privacy Protection Law requires us to inform every person from whom we request personal information why we are requesting information and how we will use it. The information requested will permit proper payments to you as a Medicaid provider, according to the provisions of applicable State and Federal Law and Regulations. Collection of this information is authorized by Section 367-b of the Social Services Law. This information will be used as one element of various reviews before payment is made for the goods or services furnished and/or for any post payment audits required by the State or Federal authorities. This information will also be used to satisfy the reporting requirement imposed upon us by State and Federal Regulations (e.g., by IRS for payment information reporting purposes). Failure to provide us with the information will prevent establishing the records necessary to enroll you as a Medicaid provider. The information will be maintained by the New York State Department of Health, Office of Health Insurance Programs, Division of OHIP Operations, Bureau of Provider Enrollment, 150 Broadway, Albany, NY 12204

INSTRUCTIONS FOR COMPLETING THE NY MEDICAID ENROLLMENT FORM FOR LICENSED PRACTICAL NURSE / REGISTERED NURSE

1. General Instructions:

- Complete **ALL** items on the form **unless** otherwise instructed below. Failure to complete all required fields will result in your enrollment form being returned to you which may have an impact on the enrollment effective date.
- Required document (see #3 below) **MUST** cover the application date and be continuous through the current date.
- Completion of signature field is required and must be original. Initials or rubber stamped signatures will not be accepted.
- Type or legibly print in black or blue ink. Do not use red ink, nor white-out. All attachments will be scanned so they must be legible and on standard 8 1/2 x 11 paper in good condition.
- Keep a copy of all documents submitted.

2. Additional Instructions and Definitions for Form Completion:

Category(s) of Service: Enter the appropriate 4-digit code(s) on the Enrollment Form: **0521 – Licensed Practical Nurse**
0522 – Registered Nurse

Choose ONE and check the corresponding box on the Enrollment Form:

- ✓ Check **New Enrollment** if the NPI or Provider listed is not currently enrolled in NYS Medicaid
- ✓ Check **Revalidation** if the NPI or Provider is currently enrolled and you were notified that Revalidation is required per 42 CFR, Part 455.414. The Provider ID can be found on the Revalidation Letter you received
- ✓ Check **Reinstatement/Reactivation** if the provider was **previously** enrolled but is not **currently** active. Please note: You will be at financial risk if you render services to Medicaid beneficiaries before successfully completing the enrollment process.

DEA Number & Dates: Leave Blank

Service Address: Enter your home address

Type of Practice – Leave Blank

Place of Service – Leave Blank

Association Types: Enter the letter (B, F, H, M, P or U) which best corresponds to the individual's role:

B: Board of Directors Member

F: Facility Administrator

H: Compliance Officer

M: Managing Employee

P: Supervising Pharmacist

U: Laboratory Director

3. ADDITIONAL REQUIREMENTS

OMIG Provider Compliance Certification – Confirmation notice for the OMIG Provider Compliance Program may be required. Visit www.omig.ny.gov to determine if the Applicant / Provider must comply. If yes, a copy of the confirmation notice (printed from the website) must be included with this application.

To apply for the Medically Fragile Children PDN Enhancement, also complete form EMEDNY- 432301.

REQUIRED DOCUMENTS TO BE SUBMITTED WITH THIS FORM:

- > Copy of Your License

NY MEDICAID PROVIDER ENROLLMENT FORM
for
PRACTITIONERS
(not including Physicians)

Mail to:

Computer Sciences Corporation
PO Box 4603
Rensselaer, NY 12144-4603

Category(s) of Service: Enter the 4-digit code(s) given in the instructions: _____

<input type="checkbox"/> <u>New Enrollment</u> (not currently enrolled)	<input type="checkbox"/> <u>Revalidation</u> (enrolled; required to revalidate) NY Provider ID # _____ (from Letter)	<input type="checkbox"/> <u>Reinstatement/Reactivation</u> If Applicant was previously excluded/terminated from the Medicaid Program, complete the Prior Conduct Questionnaire found at www.eMedNY.org and include it with this Enrollment Form
---	--	---

Applicant Name (exactly as it appears on your license/registration) Last, First, MI

NPI (Individual) – If incorporated, completion of a Group application is also necessary.

SSN

License #	State of Licensure If not New York	Limited License? <input type="checkbox"/> Yes <input type="checkbox"/> No
Enrolling for e-Prescribing only? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applicant's e-Mail Address:	Are you enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No
DEA Number (if required)	DEA Effective Date (MM/DD/YYYY)	DEA Expiration Date (MM/DD/YYYY)
If affiliated with a Group, do you have a Private Practice as well? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	If member of a group or organization: Group/Org Name: _____	If member of a group or organization: Group/Org NPI: _____

CORRESPONDENCE: (Indicate where letters and claims forms, if any, should be sent) – PO Box not acceptable

Attention:	Street Address	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number

PAY TO ADDRESS: (Indicate where checks & remittance statements should be sent until EFT and e-Remits are in place):

Attention:	Street Address or PO Box	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number

CORPORATE ADDRESS: (Indicate where Annual Tax Documents (Form 1099) should be sent)

Attention:	Street Address or PO Box	Suite / Department/ Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	e-Mail Address

(This page may be copied for additional listings)

SERVICE ADDRESS: (where service is provided) – DO NOT LIST A PATIENT'S ADDRESS (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) <input type="checkbox"/> Individual (1) <input type="checkbox"/> Group (2)	Place of Service (Check One) <input type="checkbox"/> Private Office (1) <input type="checkbox"/> Freestanding Clinic (3) <input type="checkbox"/> Hospital/Nursing Home (2)	
SERVICE ADDRESS: (where service is provided) – DO NOT LIST A PATIENT'S ADDRESS (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) <input type="checkbox"/> Individual (1) <input type="checkbox"/> Group (2)	Place of Service (Check One) <input type="checkbox"/> Private Office (1) <input type="checkbox"/> Freestanding Clinic (3) <input type="checkbox"/> Hospital/Nursing Home (2)	
SERVICE ADDRESS: (where service is provided) – DO NOT LIST A PATIENT'S ADDRESS (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) <input type="checkbox"/> Individual (1) <input type="checkbox"/> Group (2)	Place of Service (Check One) <input type="checkbox"/> Private Office (1) <input type="checkbox"/> Freestanding Clinic (3) <input type="checkbox"/> Hospital/Nursing Home (2)	
SERVICE ADDRESS: (where service is provided) – DO NOT LIST A PATIENT'S ADDRESS (see instructions)		
Attention:	Street Address (PO Box is not acceptable)	Suite / Department / Floor
City	State	Zip Code (9 digit)
County (if in New York)	Telephone Number (w/ extension)	Fax Number
Type of Practice (Check One) <input type="checkbox"/> Individual (1) <input type="checkbox"/> Group (2)	Place of Service (Check One) <input type="checkbox"/> Private Office (1) <input type="checkbox"/> Freestanding Clinic (3) <input type="checkbox"/> Hospital/Nursing Home (2)	

DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned. Visit www.health.ny.gov to review definitions and policy found at 18NYCRR, Section 504.1 before completing this form.
(These pages may be copied for additional listings)

SECTION 1:

Disclosing Entity / Applicant (Individual named on page 2 of this application)

Name		NPI	
Home Address (Street)		City & State	Zip Code (9 digit)
SSN		Date of Birth (MM/DD/YYYY)	

Ownership in Applicant (If required by 18NYCRR, Section 504.1(d)(18)(iv)). Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104(b)(1)(i) for more information).

Name of Individual or Entity		% of Ownership	NPI
Address (Home Address if Individual)		City & State	Zip Code (9 digit)
SSN (if Individual)	FEIN (if entity)	Date of Birth (if Individual (MM/DD/YYYY))	Familial Relationship (if Individual if any)

SECTION 2:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR Part 455.104(b)(3)) - (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

SECTION 3:

Ownership in Subcontractors If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor Name	Tax Identification Number

SECTION 4:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a *familial relationship with a person with ownership or control interest in one of the subcontractors identified in Section 3).
*parent, child, sibling, spouse

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 5:

Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider). **Include** familial relationship to the Applicant (e.g., spouse, parent, child, sibling), if any. (This page may be copied for additional listings)

Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	
Name		Association Type (see instructions)	
Home Address		City & State	Zip Code (9 digit)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

SECTION 6:

Respond to these questions on behalf of:

1. the Applicant
2. all individuals and entities identified in Section 1
3. any entity in which the Applicant has a 5% or more ownership

1. Have any of the individuals/entities (1, 2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in New York or in any other State, Medicare, or any other governmental or private medical insurance program?
 Yes No
2. Have any of the individuals/entities (1, 2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?
 Yes No
3. Have any of the individuals/entities (1, 2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interest over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?
 Yes No
4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/entities (1, 2 and 3)?
 Yes No

NOTE: If you answered "Yes" to any of the questions above, you must complete and submit the "Prior Conduct Questionnaire" available at www.eMedNY.org.

5. Do you, including any entity in which you have ownership, have any unpaid balances owed to the NY Medicaid Program? Yes No If yes, indicate amount \$_____
- If yes, has payment been arranged? Yes No If yes, attach verification of arrangement.
 If no, this enrollment will be reviewed by the OMIG

SIGNATURE AND AFFIRMATION

By signing this enrollment form for participation in the New York State Medicaid Program, the Applicant/Provider understands and agrees to the following:

- ▶ As a Medicaid Provider you agree to comply with the rules, regulations and official directives of the Department including, but not limited to Part 504 of 18NYCRR which can be found at the Department of Health's website, www.health.ny.gov
- ▶ In addition, pursuant to 42 CFR, Part 455.105, by enrolling in the Medicaid Program you agree to disclose the following regarding business transactions within the next 35 days upon request of the Department or the Secretary of Health and Human Services.
 - (1) Information about the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request, and
 - (2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor during the 5-year period ending on the date of the request.
- ▶ As a Medicaid Provider you agree to abide by all applicable Federal and State laws as well as the rules and regulations of other New York State agencies particular to the type of program covered by this enrollment application.
- ▶ For those providers for whom the Mandatory Compliance Law applies (see www.OMIG.ny.gov), the Provider has certified via the Office of the Medicaid Inspector General's web site referenced above that the provider and its affiliates have adopted, implemented and maintains an effective compliance program that meets the requirements of Social Service Law Section 363-d & 18NYCRR, Part 521. A copy of the certification confirmation is included with this enrollment.
- ▶ Unannounced site visits by Medicaid, CMS or their agents/designated contractors may be a condition of initial and continued enrollment. In addition, the provider and/or owners (defined as at least a 5 % interest) may be required to consent to criminal background checks including fingerprinting.
- ▶ As a Medicaid Provider you agree to notify this Department immediately of any changes supplied in this enrollment agreement, including impending ownership changes.
- ▶ The Department may deny or terminate enrollment as a provider in the Medicaid program if it is determined that executive compensation, bonuses, incentives and costs of administration exceed reasonable levels.

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR SECRETARY, AS APPROPRIATE.

Applicant / Provider's Signature (original; no stamps)

Date (MM/DD/YYYY)

Name & Telephone Number of Person who Prepared Application

PRIOR CONDUCT QUESTIONNAIRE

Confidential Information

ADDITIONAL QUESTIONS REGARDING PRIOR CONDUCT

All responses must be thorough and complete. If there is not sufficient space available for a response, you may attach additional sheets to this form. Failure to fully respond or to provide accurate and detailed information can result in a delay in the processing of your application or can result in the denial of your request for enrollment or reinstatement request.

Please Note: For those entering information through Adobe Reader, character restrictions exist for lines requiring details, when a limit is met please Tab to the next line and continue your explanation.

Applicant Name: _____

New York State Provider ID #: _____ NPI #: _____

I. A. Prior Medicare History (Federal Program, Title XIX)

1. Have you ever been excluded, terminated and/or suspended by Medicare?

Yes No

If yes:

(a) Date of exclusion, termination or suspension. / /
MM / DD / YY

(b) Cause of exclusion, termination or suspension (you must be specific and provide full details).

(c) Were you reinstated? Yes No

If yes, provide a copy of your reinstatement letter.

(d) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your exclusion, termination or suspension will not be repeated. (See reinstatement instructions with application for examples)

2. Have you ever been restricted by agreement or sanctioned by Medicare which did not result in a exclusion, termination or suspension?

Yes No

(a) Identify date and type of action. _____

(b) Identify reason for restriction or sanction. _____

(c) Are you currently participating in Medicare without any restrictions or sanctions?

Yes No

(d) Date the restriction or sanction ended? / /
MM / DD / YY

B. Prior Medicaid History (State Program, Title XVIII)

1. Have you ever been excluded, terminated and/or suspended by Medicaid in any state?

Yes No

If yes:

(a) Date of exclusion, termination or suspension.

MM / DD / YY

(b) Cause of exclusion, termination or suspension (you must be specific and provide full details).

(c) Were you reinstated? Yes No

If yes, provide a copy of your reinstatement letter.

(d) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your exclusion, termination or suspension will not be repeated. (See reinstatement instructions with application for examples)

2. Have you ever been denied enrollment by Medicaid in any state?

Yes No

If yes:

(a) Identify state(s), date of denial and reason.

(b) Submit a copy of your denial letter.

3. Have you ever been restricted by agreement or sanctioned by Medicaid which did not result in an exclusion, termination or suspension?

Yes No

(a) Identify date and type of action.

(b) Identify reason for restriction or sanction.

(c) Are you currently participating in Medicare without any restrictions or sanctions?

Yes No

(d) Date the restriction or sanction ended?

MM / DD / YY

II. A. 1. Have you ever been convicted of stealing from any federally or state funded Medicaid/Medicare Program? (Medicaid/Medicare Fraud)

Yes No

If yes:

(a) What was the date and location of the conviction? _____

(b) What were the causes that resulted in the conviction? _____

(c) Provide a copy of your conviction papers.

(d) Are you currently on probation?

Yes No

If yes, provide a copy of your probation papers and a current status report.

(e) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to your conviction will not be repeated. (See reinstatement instructions with application for examples)

B. 1. Have you ever been convicted of public assistance or welfare fraud?

Yes No

If yes:

(a) Identify the state and date of the conviction. _____

(b) What penalty was imposed as a result of the conviction? _____

C. 1. Have you ever been convicted of any crime relating to the furnishing of or billing for medical care, services or supplies or which is considered an offense involving fraud, theft, against public administration, or against public health and morals, other than previously listed on this form?

Yes No

If yes:

(a) Identify the state(s) and date of conviction. _____

(b) What penalty was imposed as a result of the conviction? _____

III. A. 1. Has your medical license or registration ever been revoked and/or suspended in any state?

Yes No

If yes:

(a) Identify the state(s) and the date of revocation and/or suspension. _____

(b) Identify the causes for the revocation and/or suspension. _____

(c) Has your license been restored? Yes No

(d) Date your license was restored. _____
MM / DD / YY

(e) Are you currently on probation? Yes No

(f) Date you expect probation to end. _____
MM / DD / YY

(g) Provide information and documentation of any corrective steps you have taken to demonstrate the causes that led to the revocation, termination or suspension of your medical license will not be repeated. (See reinstatement instructions with application for example)

B. 1. Has your medical license or registration ever been surrendered in any state?

Yes No

If yes:

(a) Identify state(s) and date your license was surrendered. _____

(b) Identify the reason you surrendered your license. _____

(c) Date your license was re-issued. _____
MM / DD / YY

C. 1. Has your license and/or registration ever been placed on probation or have you entered into any type of agreement by any licensing authority in any state?

Yes No

If yes:

(a) Identify state(s) and date(s) of action. _____

(b) Identify reason for the action. _____

(c) List any restrictions placed on your license. _____

(d) If currently on probation, attach a letter which indicates you are currently in compliance with all terms of your probation.

IV. A. 1. Are there any pending proceedings that could result in any sanction in any state?
listed below: Yes No

If yes:

(a) Identify all sanctions that may result from the pending action:

Medicare:

- termination from Medicare
- denial of enrollment by Medicare
- suspension from Medicare
- restriction by agreement from Medicare
- conviction of Medicare fraud

Medicaid:

- termination from Medicaid
- denial of enrollment by Medicaid
- suspension from Medicaid
- restriction by agreement from Medicaid
- conviction of Medicaid fraud

Other:

- conviction for stealing
- conviction for welfare fraud or public assistance fraud
- license or registration revoked
- license or registration suspended
- license or registration surrendered
- license or registration restricted by probation
- license or registration restricted by agreement

B. 1. Expected date in which a decision should be rendered.

____ / ____ / ____
MM / DD / YY

I certify that the answers provided are correct.

Full name (please print): _____
First Middle Last

Provider Signature Date MM / DD / YY

PRIVATE HIRE PROCEDURE

Private hire responsibility of clients/directing party:

Manage the services of the nurse (s) employed including: recruiting, interviewing, selecting and monitoring the nurse (s) following written MD orders, scheduling, orienting, evaluation, and dismissing nurse (s). Assure that all nurses selected have clinical competency to care for the client

1. CASA Caseworker (CW) and Nurse complete an assessment to determine an appropriate care plan for the client per CASA's routine assessment process.
2. Supervisor and ACT Nurses approval per routine procedures.
3. SSTW contacts all providers for their ability to service the approved care plan. (For CAH cases – documentation from SKIP of all providers contacted and their responses is acceptable).
4. Meeting will be held with client/directing party, CASA, and interested providers etc., to determine if care plan can be filled.
5. If care plan can not be filled by the Traditional Licensed Providers, client/directing party can request private/direct hire nursing. The client/directing party will inform CASA CW of their interest in Private Hire Model of service.

CONTRACT INFORMATION REQUIRED:

(All private hire nurses must obtain a Medicaid Provider Enrollment number by calling the Bureau of Medical Review and Payment Office of Medicaid Management at (518) 474-8161).

6. Caseworker will complete a 1295 with the family's and client's name, address, phone number, approved care plan, potential discharge date (hospital), and a notation that all provider agencies have been contacted and are unable to service the case. Add to 1295 of the request is for straight private hire or a mixed model. If any private hire nurses names and/or MMIS # has been shared with the caseworker at this point, this information should also be added to the 1295. Forward the completed 1295 to CW Supervisor. (If CAH case – CW to write "CAH – No Prior Approval Required" on top of 1295.

CW Supervisor will fax completed 1295 to DSS Legal Office (Kristian Maricle). ECDSS Legal Department fax number is 858-6222.

7. Legal Department will fax a statement to the CW Supervisor indicating approval to start the Private Hire Process. Casework Supervisor will inform the caseworker of approval. Caseworker will then inform the family of all needed documents per Private Hire Nurse checklist (Appendix A).

After receipt and approval of the 1295 information, the Legal Department will send out the client/directing party's contract.

8. Client/directing party and private hire nurses must send all required information to the CW who will forward originals to ACT SSTW Liaison for holding until items 1-5 are received.

9. As the SSTW Liaison receives 1-5 of the contract information per nurse, she will forward originals to the Legal Department (ATT: Kristin Maricle). If item 6 "Malpractice Insurance is received, all documents will be forwarded.

Item 6 of contract information – the legal department will work with nurse (s) to handle all problems and questions that arise with the Malpractice Insurance.

10. Once the Legal Department has received numbers 1-6 of the contract and family information, they will mail each nurse their individual contract for signature. (The legal department will develop two types of contracts, CAH and IHHC as the Prior Approvals are not required with CAH and the contract language is different).

11. After receiving the signed contracts, the legal department will inform CW/CW Supervisor when all contracts are final. They will then mail a copy of final contracts to CASA, client/directing party, and each appropriate private hire nurse.

CASA INFORMATION NEEDED:

12. Once the client/directing party and private hire nurse (s) have contracted with Erie County, the following must be submitted to the CASA CW before private hire services can be approved and start

- Prior approval form, (Attachment B) listing names and MMIS numbers of all nurses who have contracted with the county and who will work the case. As each nurse obtains a MA number, the state will send them a provider manual and information on obtaining prior approvals. (No prior approval on Care At Home cases).
- MD orders. One nurse may take the lead in obtaining physician's orders for the group of nurses.
- Statement signed by MD per "Medicaid Management Information System Provider Manual – Nursing Services" – Section 2-42 (Attachment C).
- A first month schedule of how the nurses will fill the care plan.

13. After CASA have received all appropriate documents, the final review and approval have been made, the ACT SSTW Liaison will mail a copy of the completed Prior Approval form to the client/directing party.
(Service can now start)

Mixed Model and CAH specific private hire procedures will be developed at a later date.

6-21-06

Guidelines for Client/Caregiver Seeking To Obtain Independently Enrolled Nursing Services

These guidelines were developed to clarify the process of participating in the Independently Enrolled Nursing (IEN) model of Erie County CASA's home care service. These guidelines reflect the most commonly asked questions. It is strongly suggested that these guidelines be reviewed with all nurses interested in working your case.

NOTE: ALL NURSES WORKING YOUR CASE MUST HAVE A SIGNED CONTRACT WITH ERIE COUNTY BEFORE SERVICING THE CASE IN ORDER TO RECEIVE MEDICAID PAYMENT.

It is the responsibility of the client/caregiver to:

1. manage the services of the nurse(s) including:
 - recruiting, interviewing, hiring the nurse(s),
 - monitoring that the nurse follows written physician's orders,
 - scheduling, orienting, evaluating, and dismissing nurse(s).
2. assure that all nurses selected have clinical competency to care for the client.

Client/Caregivers Requirements:

A. Obtaining a Contract:

1. If active with the Private Duty Nursing Program (CASA), notify your Caseworker (CW) of your interest in IEN.

OR

If active with the Care at Home Program, notify your Case Management Agency of your interest in IEN.

Per the New York State Fair Hearing Office, Independently Enrolled Nursing is allowed only when Erie County Contracted Licensed Provider Agencies cannot service your case. Therefore, CASA must pursue your coverage from the Licensed Provider Agencies first.

Private Duty Nursing Program

If no provider can be found to service the case, your CASA CW will inform Erie County Department of Social Services (ECDSS) Legal Department that you are seeking IEN.

Care at Home Program

If no provider can be found to service the case, your CAH Case Manager will notify the CASA CW, who will then inform Erie County Department of Social Services (ECDSS) Legal Department that you are seeking IEN.

2. You, as the client/caregiver, must enter into contract with ECDSS. The ECDSS Legal Department will contact you with instructions on obtaining a contract.

3. Assisting the Nurse obtain his/her contract:

Each nurse is required to have a contract with ECDSS Legal Department for each CASA or Care at Home client he/she services.

The nurse will need to compile a packet of required information necessary for his/her contract and forward the completed packet to you. Once you have collected items a -e, you will need to send them to the CW. The nurse may choose to forward the information to the CW directly, in which case you need to be aware that this packet must consist of the following items:



- a. Copy of the nurse's current New York State Nursing License
- b. Copy of the nurse's current CPR certification
- c. Copy of the nurse's current National Provider Information (NPI) number
- d. Copy of the nurse's current Physical Report from his/her personal Physician
- e. Copy of the nurse's current PPD and MMR immunizations
- f. ***Malpractice Insurance Certificate with Eric County named as additional insured.***

NB: Do not send the information one item at a time as this will slow down the contract process.

*****If the nurse has not obtained item f, the ECDSS Legal Department can assist them in obtaining the Malpractice Certificate.*****

B. CASA Information Requirements:

Once you and the IEN have received signed contracts from Erie County, the following must be submitted to the CASA CW before the Independently Enrolled Nurse can start servicing your case.

1. Physician Orders & Plan of Treatment:

One nurse may take the lead in obtaining the physician's orders and plan of treatment for all the nurses servicing the client. CASA has developed a general "Physician's Ordering Form" (attached), which use may be beneficial to you.

2. Statement of Oversight signed by Physician:

This statement can be found in the "Medicaid Management Information System Provider Manual-Nursing Services". The Physician statement is specific to each client to be serviced; therefore each nurse's name does not need to be listed on the statement.

NOTE: It is strongly suggested that Nurses/Directing Party use CASA's form titled "Independently Enrolled Nurse(s) Physician's Order for Home Care Services" (attached), which has the physician's oversight statement incorporated.

3. For New IEN Cases, a first month schedule of how the nurses will fill the authorized service hours are required.

4. Items B: 1-3, once obtained, must be sent to your CASA CW.

***Sending items one at a time will slow down the process/start of service.**

5. Prior Approval Form:

The original Prior Approval Form must be completed and sent to Computer Science Corporation (CSC) by the Independently Enrolled Nurse or Client/ Directing Person. CSC will not accept a faxed copy of a Prior Approval form.

Prior Approvals forms must be completed listing the names and NPI numbers of all nurses who have contracted with Erie County and who will work the case. When each nurse obtains a Medicaid number, the state will send him/her a provider manual and information on obtaining prior approvals. (If a new nurse is hired to service your case, an e-medny "change request form" must be completed and sent to CSC listing the nurses' name and NPI number

If your case is authorized for LPN level of care and a RN work the case, when billing, the RN code must be listed on the prior approval form for the hours he/she worked. The RN will be paid at LPN rate.

NOTE:

- **Cases authorized for RN & LPN hours, or RN working at a LPN rate, the different levels are not interchangeable.**
- **The Prior Approval must list the number of hours to be allocated to RN level or RN working at LPN rate and the number of hours allocated to the LPN level. (E.g. Total authorized LPN hours for the 6 month period = 1400 hrs. The prior approval must list under the LPN code 800 hr. and under the RN code (working at LPN rate) 600 hours.**

Your CASA CW will notify you when IEN services can start.

Allowing the nurse to service your case before your CW has notified you could result in the nurse not being reimbursed for services.

ALL E-MEDNY FORMS CAN BE FOUND ON: e-medny.gov.

Guidelines for Nurses Seeking to Work On CASA CASES as an Independently Enrolled Nurse

These guidelines were developed to clarify the process of participating in the Independently Enrolled Nursing (IEN) model of Erie County CASA's home care service. These guidelines reflect the most commonly asked questions.

It is the responsibility of the client/caregiver to:

1. manage the services of the nurse(s) including:
 - recruiting, interviewing, hiring the nurse(s),
 - monitoring that the nurse follows written physician's orders,
 - scheduling, orienting, evaluating, and dismissing nurse(s).
2. assure that all nurses selected have clinical competency to care for the client.

Independently Enrolled Nurse Requirements:

A. As a Provider Agency for the Independently Enrolled Nursing model of care, you must have obtained a National Provider Information (NPI) number. The NPI number can be obtained by calling the Office of Health Insurance Program at (518) 474-8161.

B. You must enter into contract with Erie County:
To obtain a contract, the following six items must be sent to CASA before a contract will be issued to you by the ECDSS Legal Department.

1. Copy of your current New York State Nursing License
2. Copy of your current CPR certification
3. Copy of your current National Provider Information (NPI) number
4. Copy of your current Physical Report from your personal Physician
5. Copy of your current PPD and MMR immunizations
6. **Malpractice Insurance Certificate with Erie County named as additional insured.**

Once items 1-5 have been obtained, forward them to the client/caregiver or CASA CW.
If you have not obtained item 6, the ECDSS Legal Department can assist you in obtaining the Malpractice Certificate.

Special Notes:

1. Service cannot start until the CASA CW has notified the nurse and the client/caregiver. If you provide care before service is authorized, payment may not be approved. The CASA CW is the only person who can give permission for service to start.

2. All billing and prior approval questions must be directed to:
Computer Science Corporation (CSC) at (800) 343-9000.
As an Independently Enrolled Nurse, you are your own provider; therefore, please refer to your NYS Medicaid Program Nursing Service Prior Approval Guideline Manual issued to you from the Office of Health Insurance Program. Individual Provider Training is available by calling (800) 343-9000

3. Prior Approval Form:

The original Prior Approval Form must be completed and sent to Computer Science Corporation (CSC) by the Independently Enrolled Nurse or Client/Directing Person. CSC will not accept a faxed copy of a Prior Approval form.

Prior Approvals must be completed listing the names and NPI numbers of all nurses who have contracted with Erie County and who will work the case. When each nurse obtains a Medicaid number, the state will send him/her a provider manual and information on obtaining prior approvals. (If a new nurse is hired to service the case, an e-medny "change request form" must be completed and sent to CSC listing the nurses' name and NPI number.

If the case is authorized for LPN level of care and a RN is working the case, when billing, the RN code must be listed on the prior approval form for the hours he/she worked. The RN will be paid at LPN rate.

NOTE:

- Cases authorized for RN & LPN hours, or RN working at a LPN rate, the different levels are not interchangeable.
- The Prior Approval must list the number of hours to be allocated to RN level or RN working at LPN rate and the number of hours allocated to the LPN level. (E.g. Total authorized LPN hours for the 6 month period = 1400 hrs. The prior approval must list under the LPN code 800 hr. and under the RN code (working at LPN rate) 600 hours.

4. Each nurse is required to have a contract with ECDSS Legal Department for each CASA or Care at Home client he/she service.

5. Physician Orders & Plan of Treatment:

One nurse may take the lead in obtaining the physician's orders and plan of treatment for all the nurses servicing the client. CASA has developed a general "Physician's Ordering Form" (attached), which use may be beneficial to you.

6. Statement of Oversight signed by Physician:

This statement can be found in the "Medicaid Management Information System Provider Manual-Nursing Services". The Physician statement is specific to each client to be serviced; therefore each nurse's name does not need to be listed on the statement.

NOTE: It is strongly suggested that Nurses/Directing Party use CASA's form titled "Independently Enrolled Nurse(s) Physician's Order for Home Care Services" (attached), which has the physician's oversight statement incorporated.

7. For New IEN Cases, a first month schedule of how the nurses will fill the authorized service hours are required.

ALL E-MEDNY FORMS CAN BE FOUND ON: e-medny.gov.

**INDEPENDENT ENROLLED NURSE (S)
PHYSICIAN'S ORDER FOR HOME CARE SERVICES**

Client Name: _____ D.O.B _____ Sex: _____

Address: _____ CIN #: _____

Prior Approval Dates: From _____ To _____

Service Hours: _____

Orders Obtained By: _____ Phone #: _____

TO BE COMPLETED BY ORDERING PHYSICIAN: (Service can not be provided or continued without this information. Thank you).

Medical Diagnosis:

Seizure Precautions: _____ **Allergies:** _____

Functional Limitations: _____

Prognosis: _____

Medications:

Treatments:

Diet: _____

(continued on back)

Additional Comments: _____

New York State DOH requires, in the instance that private duty nursing services are to be provided wholly or in part by an **Independently Enrolled LPN or RN**, the ordering physician must certify to the following:

- He or she is willing to be responsible for oversight of the independent nurse to ensure adherence to the prescribed treatment plan; and
- The ordering physician (or his/her designee) will be available to consult with the independent nurse should the patient's medical condition change or treatment plan needs updating.
- The ordering physician will provide, or arrange, appropriate direction to any independently enrolled LPN working the case in accordance with State Education Law.

I CERTIFY TO THE ABOVE INDEPENDENT ENROLLED NURSE (S) OVERSITE STATEMENT AND THAT THE ABOVE MEDICAL INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

NOTE: If additional pages are attached, NYS DOH dictates that each page must be signed by the physician.

Physician: _____
Please Print

Address: _____

Phone #: _____

Fax #: _____

Physician's Signature

Date

New York State License #: _____

(Exhibit A)

ADM 0050 5/1/07-4/30/03

AGREEMENT**BETWEEN****Consumer and the Erie County Department of Social Services
to Direct Hire Private Duty Nurses**

Agreement made the _____ day of _____, 200__, by and between the County of Erie through the Erie County Department of Social Services, 95 Franklin Street, Buffalo, New York 14202, hereinafter referred to as the Department, and _____, hereinafter referred to as the Consumer, individually, and as parents and natural guardians of _____, a recipient of home care services under the Medicaid program, residing at _____.

WHEREAS, 18NYCRR 505.8 provides that under the specific circumstances set forth therein a recipient of home care services under the Medicaid program is authorized either individually or through a surrogate to directly obtain the services of Individual Licensed Practical Nurses and Licensed Registered Nurses, hereinafter referred to as Private Duty Nurses (PDN), so long as those PDN are registered providers enrolled in the Medicaid program and, as a consequence thereof, are in receipt of a Medicaid Management Information System (MMIS) Identification number necessary to facilitate the payment for home care services rendered, and

WHEREAS, the Department and the Consumer agree that under the specific circumstances of the home care services needed herein that the direct hire of PDN by the Consumer would allow for greater flexibility and freedom of choice consistent with the intent of 18NYCRR 505.8 to benefit chronically ill and/or physically disabled individuals while reducing administrative costs and

WHEREAS, although the PDN that are authorized to be hired privately are not a party to this Agreement, the PDN will be required to execute a separate Agreement with the Department confirming his or her responsibilities as enumerated under this Agreement, and that separate Agreement shall be deemed a condition precedent to any payment under the Medicaid program from the New York State Department of Health for the home care services rendered to the recipient.

NOW THEREFORE, the parties do mutually agree as follows:

- 1. The Consumer, individually and as parents and natural guardians of _____, a recipient of home care services under the Medicaid program, agrees to be solely responsible to undertake the following:**
 - a. Manage the services of the PDN employed, including: recruiting, interviewing and hiring PDN; monitoring the activities and care given by the PDN to insure that PDN adequately and properly abides by and follows the written directions of the treating primary physician; insuring that PDN has adequate and proper training sufficient to establish clinical competency for the care of recipient.**
 - b. Confirm that the PDN is currently licensed in the State of New York.**
 - c. Contact references provided by the PDN prior to the PDN rendering care to the recipient. It is recommended that a background check be conducted to determine if the PDN has a history of any previous substance abuse, and/or disciplinary problems.**
 - d. Confirm that PDN has malpractice insurance, with the Department being as an additional insured therein. A copy of that insurance must be forwarded to the Department.**
 - e. Act as an employer of the PDN or contracting party, acknowledging that the Department shall not be considered as the employer and that the PDN shall be deemed an independent contractor. The Consumer shall be responsible, to the extent required under local, state or federal law, rules, regulations or ordinances, for workers' compensation, unemployment insurance benefits, social security coverage, provision of tax forms and other applicable benefits. The Consumer agrees and acknowledges that the PDN are hired and supervised by them and that the Department assumes no liability for the above referenced requirements.**
 - f. Assure that the PDN is in good health and has proof of required immunizations.**
 - g. Confirms that the PDN has current CPR certification by asking to see the current certification issued by a person or agency authorized to train and issue such certification.**
 - h. Assure that the PDN follow the written directions of the treating primary physician and that PDN document in writing all medications**

administered, treatments provided, and all other hands on care rendered to the recipient. Such documentation shall be maintained for a period of a minimum of six (6) years.

- i. Assure that the PDN provide adequate and proper Universal Precaution Supplies and that PDN follow the Center for Disease Control (CDC) guidelines.
- j. Allow a home assessment by Erie County CASA six (6) months from the date of execution of this Agreement, and once every six (6) months thereafter if this Agreement is extended upon written mutual consent of the parties, to determine the level and amount of care required and provided for the benefit of the recipient.
- k. Shall not discriminate against PDN in interviewing, hiring and monitoring of home care services being performed on the basis of race, creed, color, national origin, gender, disability, marital status, sexual preference or veteran status.
- l. Abide by, and not act in violation of, any and all applicable local, state and federal laws, rules, regulations and ordinances, including, but not limited to, applicable civil rights and labor laws, rules and regulations, and ordinances in the interviewing, hiring, monitoring and establishment of work hours and conditions.
- m. Obtain from the treating primary physician a written certification that the model of home care service delivery established pursuant to this Agreement provides adequate and proper medical safety for this recipient.
- n. Provide to the Department proof that the PDN has executed the above referred to separate Agreement confirming his or her responsibilities as enumerated in this Agreement; provide a copy of the PDN's current professional licenses issued of the State of New York; provide a copy of the PDN's malpractice insurance naming Erie County as an additional insured, as required herein; provide a copy of verification that that PDN is enrolled in the Medicaid program and the MMIS identification number issued to PDN upon such enrollment; provide copies of the written directions issued by the treating primary physician for the adequate and proper home care services to be rendered to the recipient and the completed and properly executed prior approval form, DSS-3615. It being the mutual understanding of the parties that the commencement of this Agreement is conditioned upon the Department receiving these documents and proof and that no payment to the PDN will be authorized in the absence of such receipt.

all the PDN caring for the recipient during the approved period of service, will be returned to each nurse submitting the above referenced documents and information. Only nurses who have provided such documents and information can provide home care services for the recipient pursuant to the terms of this Agreement and claim reimbursement therefor.

3. The parties agree to the rates herein shown.
 - a. These rates are contingent upon the approval of the New York State Department of Health and are subject to change by it.
 - b. The parties agree to accept changes in these rates by the New York State Department of Social Services without the need to amend this Agreement subject to the parties' right to administrative or judicial review of these changes.

<u>Description</u>	<u>Rates Per Hour</u>
Licensed Practical Nurse	\$21.63
Licensed Registered Nurse	\$26.78

4. The Consumer agrees that no payment shall be made hereunder until such time as the Consumer has applied for, received and facilitated payment to the PDN hired under the terms of this Agreement by third party health insurance available to the Consumer for the payment of the home care services provided by those PDN. The funds available under that third party health insurance must be exhausted prior to any payment under the Medicaid program.
5. The parties agree to renegotiate this Agreement in the event that the Department of Health; NYDSS; and applicable federal agencies issue new or revised requirements on the Department as a condition for receiving continued or state reimbursement.
6. This Agreement contains all the terms and conditions agreed upon by the parties. Any items incorporated by reference are to be attached. No other understanding, oral or otherwise, regarding the subject matter of this Agreement, shall be deemed to exist or to bind the parties hereto.

- 7. This Agreement shall commence on XXXX, 2007 and terminate on XXXX, 2008, or shall commence upon the receipt by CASA of all the documentation and information required herein demonstrating that the Consumer has privately hired PDN enrolled in the Medicaid program sufficient to provide the home care services under the direction of the primary treating physician as prior approved by CASA, whichever shall occur first, and shall terminate twelve (12) months thereafter.
- 8. This Agreement may be terminated at any time by oral or written notice from the Department upon its determination that the Consumer has violated the terms of this Agreement. Termination shall otherwise be upon thirty (30) days written notice from one party to the other. In the event of termination, the parties agree to cooperate in the orderly transfer to the provision of requisite home care services to the recipient by qualified home care agencies.
- 9. This contract shall be deemed executory only to the extent of money available to the state for the performance of the terms hereof and no liability on account thereof shall be incurred by the State of New York beyond monies available for the purpose thereof.

IN WITNESS WHEREOF, the parties hereto have signed and executed this agreement on the date and year first written above.

APPROVED AS TO FORM

BY: _____
ECDSS Office of Counsel
DATE: _____

CONSUMER _____

STATE OF NEW YORK
COUNTY OF ERIE) SS.:

On this ___ day of _____, 200 , before me personally came _____, to me known, who, being duly sworn, did depose and say that (s)he resided in _____, that (s)he is an (the) Consumer, described in and which executed the foregoing instrument, and that (s)he signed (her)his name thereto.

NOTARY PUBLIC OR COMMISSIONER OF DEEDS

My Commission Expires _____

**FOR THE ERIE COUNTY DEPARTMENT
OF SOCIAL SERVICES:**

Commissioner

FOR THE COUNTY OF ERIE:

County Executive

AGREEMENT PDN # [REDACTED]

BETWEEN

**Private Duty Nurses
and the Erie County Department of Social Services
to Provide Home Care Services**

AGREEMENT, made the day of 200 , by and between the County of Erie through the Erie County Department of Social Services, 95 Franklin Street, Buffalo, New York 14202, hereinafter referred to as the Department and [REDACTED], a licensed registered nurse enrolled in the Medicaid program, hereinafter referred to as the private duty nurse (PDN), residing at [REDACTED].

WHEREAS, the Department has entered into a separate Agreement, with [REDACTED], hereinafter referred to as the Consumer, individually, and as parents and natural guardians of [REDACTED], a recipient of home care services under the Medicaid program, for the private hire by the Consumer of PDN to provide those services pursuant to 18NYCRR 505.8, and

WHEREAS, the above referenced PDN, a licensed registered nurse enrolled in the Medicaid program, desires to be privately hired by the Consumer subject to the prior approval by the Department, through CASA, to provide home care services to the recipient and receive payment for those services rendered from the New York State Department of Health.

NOW, THEREFORE, the parties do mutually agree as follows:

1. The PDN confirms that she has read the above referenced Agreement between the Department and the Consumer, agrees to meet the PDN responsibilities enumerated therein, and acknowledges that those responsibilities, as well as those set forth in this separate Agreement, are a condition precedent for any prior approval from the Department and payment from the New York State Department of Health for any home care services provided to the recipient. A copy of Agreement between the Department and the Consumer is marked Exhibit A, attached hereto and made a part of this Agreement.

2. The PDN must submit the following documents and information to the Department prior to providing home care services to the recipient.
 - a. Copy of his or her nursing license.
 - b. Copy of his or her Medicaid Provider Enrollment number documents issued by the New York State Department of Health setting forth enrollment and eligibility for payment under the Medicaid Management Information System (MMIS).
 - c. Certified copy of medical malpractice insurance naming the Department as an additional insured.
 - d. Completed prior approval form(DSS-3615), indicating in Section 1'Multiple providers will share prior'.
 - e. Copy of primary treating physician's orders, including, but not limited to, a statement that that physician deems the plan for the privately hired PDN to be a safe plan for the provision of requisite home care services to the recipient. (One PDN is authorized by the Department to obtain such physicians orders for the group of PDNs to be privately hired by the Consumer.
3. The Department, after reviewing and approving the documentation and information provided by the PDN and the Consumer pursuant to the Separate Agreement, if acceptable, will process the prior approval and enter the requisite information on MMIS which is necessary to allow the PDN to submit claims for payment to the extent that the PDN is entitled to such payment. A copy of the prior approval, documenting the total approved number of hours for all PDN providing home care services to the recipient during the approved period of service will be returned to each nurse.
4. The PDN agrees that he or she can claim reimbursement only for actual hours worked at authorized level and may not claim for training or overtime under the Medicaid program. The PDN further agrees and acknowledges that Medicaid payment is not approved for PDN to care to the Recipient in the hospital or other institutions, and the PDN will not be paid for any care delivered to the recipient in those settings.

5. The PDN agrees and acknowledges the total number of hours billed for home care services by the multiple PDN hired by the Consumer to provide home care services to the recipient shall not exceed the total number of hours approved for each designated service (licensed practical nurse or licensed registered nurse) prior approved by the recipient during the approved period of service. The PDN agrees and acknowledges that in the event that a licensed registered nurse works hours prior approved and authorized as licensed practical hours, that licensed registered nurses shall be paid at the licensed practical nurses rate. The PDN agrees and acknowledges that neither the Department nor the New York State Department of Social Services shall be responsible for payment for hours of home care services rendered in excess of the prior approved hours and services during the approved period of service.
6. The PDN agrees to provide the home care services ordered by, and under the direction of, the primary treating physician, documenting all shifts during which those services are performed and maintaining a medical record with nursing notes for all services rendered during those shifts. This documentation must be maintained by the PDN for a minimum of six (6) years in accordance with the laws of the State of New York.
7. The PDN agrees and acknowledges that he or she is an independent contractor hired by the Consumer, is solely employed by the Consumer and works under the supervision of the Consumer. The Department and the Consumer assumes no responsibility for worker's compensation, unemployment insurance benefits, social security coverage or other benefits required by local, state or federal law, rules regulations or ordinance, including, but not limited, to the deductions and/or payments for either local, state or federal taxes on behalf of the PDN.
8. The PDN agrees and acknowledges that he or she is responsible for billing and receiving payment from any third party health insurance available to the Consumer for the payment of home care services provided to recipient prior to making any claim for payment under the Medicaid program.
9. The PDN shall provide to the Department, forty-five(45) days before the prior approval expires, the documentation and information set forth above necessary for the Department to

issue any further prior approvals and authorization for payment.

10. The parties agree to the rates herein shown.
 - a. These rates are contingent upon the approval of the New York State Department of Health and are subject to change by it.
 - b. The parties agree to accept changes in these rates by the New York State Department of Social Services without the need to amend this Agreement subject to the parties' right to administrative or judicial review of these changes.

Description

Rates Per Hour

Licensed Registered Nurse

[REDACTED]

11. The parties agree to renegotiate this Agreement in the event that the Department of Health, NYDSS, and applicable federal agencies issue new or revised requirements on the Department as a condition for receiving continued or state reimbursement.
12. This Agreement contains all those terms and conditions agreed upon by the parties. Any items incorporated by reference are to be attached. No other understandings, and or otherwise, regarding the subject matter of this Agreement, shall be deemed to exist or to bind those parties hereto.
13. Except as otherwise stated herein the term of this Agreement shall commence on **[REDACTED]** and terminate on **[REDACTED]**.
 - a. The term of this Agreement shall coincide with the term of the separate, attached Agreement between the Department and the Consumer except as set forth below. If the term of that separate, attached Agreement is terminated this Agreement shall be deemed terminated. Additionally, the PDN agrees and acknowledges that as an employee of the Consumer it shall be within the authority of the Consumer to terminate that employment at any time as long as that termination is not in violation of applicable local, state or federal law, rules, regulations or ordinances.

Text of law should be given as amended. Do not include matter being eliminated and do not use italics or underlining to indicate new matter.

County City Town Village
(Select one)
of Erie

Local Law No. 6 of the year 2011

A local law rescinding a Local Law in relation to regulation of home healthcare services provided to
(Insert Title)
Erie County residents pursuant to contracts awarded by the County of Erie

Be it enacted by the Erie County Legislature of the
(Name of Legislative Body)

County City Town Village
(Select one)
of Erie

as follows:

SECTION 1. LEGISLATIVE INTENT. Local Law No. 14-2004 creates certain local requirements that govern home healthcare services in Erie County. These requirements are redundant to requirements of New York State Law. This redundancy increases costs to home healthcare providers as well as unnecessarily strains county resources. Repeal of the law will decrease costs to taxpayers and home healthcare providers with no effect on the provision of home healthcare services.

SECTION 2. Local Law No. 14-2004, which undertook and exercised its regulatory authority with regard to activities subject to regulation of home healthcare services, be and the same hereby is rescinded in its entirety.

SECTION 3. Hereafter the regulations set forth by the State of New York in regulation of home healthcare services shall provide the regulatory framework for and govern home healthcare services in the County of Erie.

SECTION 4. This Local Law shall take effect immediately upon filing in the office of the New York State Secretary of State, and in accordance with Section 27 of the Municipal Home Rule Law shall be filed within twenty (20) days after this Local Law shall have been adopted.

SPONSORED BY
LEGISLATOR RAYMOND WALTER

(If additional space is needed, attach pages the same size as this sheet, and number each.)

on 20____, in accordance with the applicable provisions of law.

2. (Passage by local legislative body with approval, no disapproval or repassage after disapproval by the Elective Chief Executive Officer.) I hereby certify that the local law annexed hereto, designated as local law No. 6 of 2011 of the (County)(City)(Town)(Village) of Erie Erie County Legislature was duly passed by the Erie County Legislature on October 6, 2011, and was (approved)(not approved) (repassed after disapproval) by the Erie County Executive (Elective Chief Executive Officer) and was deemed duly adopted on October 25, 2011. In accordance with the applicable provisions of law.

3. (Final adoption by referendum.) I hereby certify that the local law annexed hereto, designated as local law No. _____ of 20____ of the (County)(City)(Town)(Village) of _____ was duly passed by the _____ on _____ 20____, and was (approved)(not approved) (repassed after disapproval) by the _____ on _____ 20____. (Elective Chief Executive Officer)

Such local law was submitted to the people by reason of a (mandatory)(permissive) referendum, and received the affirmative vote of a majority of the qualified electors voting thereon at the (general)(special)(annual) election held on _____ 20____. In accordance with the applicable provisions of law.

4. (Subject to permissive referendum and final adoption because no valid petition was filed requesting referendum.) I hereby certify that the local law annexed hereto, designated as local law No. _____ of 20____ of the (County)(City)(Town)(Village) of _____ was duly passed by the _____ on _____ 20____, and was (approved)(not approved) (repassed after disapproval) by the _____ on _____ 20____. Such local law was subject to permissive referendum and no valid petition requesting such referendum was filed as of _____ 20____. In accordance with the applicable provisions of law.

* Elective Chief Executive Officer means or includes the chief executive officer of a county elected on a county-wide basis or, if there be none, the chairperson of the county legislative body, the mayor of a city or village, or the supervisor of a town where such officer is vested with the power to approve or veto local laws or ordinances.

6. (County local law concerning adoption of Charter.)

I hereby certify that the local law annexed hereto, designated as local law No. _____ of 20____ of the County of _____ State of New York, having been submitted to the electors at the General Election of November _____ 20____, pursuant to subdivisions 5 and 7 of section 33 of the Municipal Home Rule Law, and having received the affirmative vote of a majority of the qualified electors of the cities of said county as a unit and a majority of the qualified electors of the towns of said county considered as a unit voting at said general election, became operative.

(If any other authorized form of final adoption has been followed, please provide an appropriate certification.)

I further certify that I have compared the preceding local law with the original on file in this office and that the same is a correct transcript therefrom and of the whole of such original local law, and was finally adopted in the manner indicated in paragraph 2 above.

Clerk of the county legislative body, City, Town or Village Clerk or officer designated by local legislative body

Date: 10/27/11

(Seal)

(Certification to be executed by County Attorney, Corporation Counsel, Town Attorney, Village Attorney or other authorized attorney of locality.)

STATE OF NEW YORK
COUNTY OF ERIE

I, the undersigned, hereby certify that the foregoing local law contains the correct text and that all proper proceedings have been had or taken for the enactment of the local law annexed hereto.

Signature
Assistant County Attorney

Title

County _____
City of Erie
State _____
Village _____

Date: October 27, 2011

A LOCAL LAW rescinding a Local Law in relation to regulation of home healthcare services provided to Erie County residents pursuant to contracts awarded by the County of Erie.

BE IT ENACTED BY THE LEGISLATURE OF ERIE COUNTY AS FOLLOWS:

SECTION 1. LEGISLATIVE INTENT. Local Law No. 14-2004 creates certain local requirements that govern home healthcare services in the Erie County. These requirements are redundant to requirements of New York State Law. This redundancy increases costs to home healthcare providers as well as unnecessarily strains county resources. Repeal of the law will decrease costs to taxpayers and home healthcare providers with no effect on the provision of home healthcare services.

SECTION 2. Local Law No. 14-2004, which undertook and exercised its regulatory authority with regard to activities subject to regulation of home healthcare services, be and the same hereby is rescinded in its entirety.

SECTION 3. Hereafter the regulations set forth by the State of New York in regulation of home healthcare services shall provide the regulatory framework for and govern home healthcare

SECTION 4. This Local Law shall take effect immediately upon filing in the office of the New York State Secretary of State, and in accordance with Section 27 of the Municipal Home Rule Law shall be filed within twenty (20) days after this Local Law shall have been adopted.

SPONSORED BY

LEGISLATOR RAYMOND WALTER

BUFFALO, N. Y., OCTOBER 6, 2011

TO WHOM IT MAY CONCERN:

I HEREBY CERTIFY, *That at the 20th Session of the Legislature of Erie County, held in the Legislative Chambers, in the City of Buffalo, on the Sixth day of October, 2011 A.D., a Resolution was adopted, of which the following is a true copy:*

AYES: 15

NOES: 0

REFERENCE: Local Law Intro 6-1 (2011)

ATTEST

County of Erie designated for this purpose, and after due deliberation thereon, I, CHRIS COLLINS, County Executive of Erie County, do hereby APPROVE and SIGN said Local Law this 26th day of October, 2011.

Chris Collins

A Public Hearing was held on the foregoing Local Law Intro. No. 6-2011 on Tuesday, October 25, 2011, due notice thereof having been published in the official newspapers of the County of Erie designated for this purpose, and after due deliberation thereon, I, CHRIS COLLINS, County Executive of Erie County, do hereby DISAPPROVE and VETO said Local Law this ___ day of _____, 2011.
