

# Private Duty Nursing

Provider Manual  
Volume II

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Department of  
**HEALTH &  
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## Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change(s) including rule number if applicable.
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

<b>Change Log</b>					
<b>Date Change to Manual</b>	<b>Effective Date</b>	<b>Section/Sub-Section</b>	<b>Change Description</b>	<b>Reason</b>	<b>Related Communication</b>
4/7/2026	N/A	Throughout	Updated template language in various sections to align with updated General Billing Manual changes	To align with all other updated provider manuals	Provider Notice Dated October 25, 2022
4/7/2026	1/28/2023	4 and 6	Updated terminology and added detail related to the need for a DME and medication profile	Updated languages to align with changes made to administrative rules	He-W 540 effective 1/28/2023
4/7/2026	6/1/2024	6.3	Added information on Electronic Visit Verification	To provide detail on this federal requirement	Provider Notice Dated February 1, 2024

<b>Change Log</b>					
<b>Date Change to Manual</b>	<b>Effective Date</b>	<b>Section/Sub-Section</b>	<b>Change Description</b>	<b>Reason</b>	<b>Related Communication</b>
4/7/2026	6/1/2024	6.3.1	Added detail on use of TOD Modifiers	To clarify use of modifiers to prevent claims denials	Provider Notice Dated May 23, 2024
4/7/2026	6/1/2025	10	Added information on use of TT Modifier	To align with billing practices for home health and personal care	Provider Notice Dated May 12, 2025
4/7/2026	N/A	12	Added terminology section to the manual	To align with provider manuals template	N/A

## 1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes, which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with and comply with all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices Section encompasses a wide range of supplemental materials such as Contact Information, Common Acronyms, and general information.
- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

### 1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are **not** designed for use by NH Medicaid members (hereinafter referred to as members).

## 1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

## 1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

## 1.4 Notifications & Updates

Providers are notified of NH Medicaid program changes and any other changes applicable to participating providers through several types of media including provider bulletins, provider notices, memos, letters, website updates, newsletters and/or updated pages to the General Billing Manual –Volume I, and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely

manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

## 1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

## 1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

## 2. Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

Each participating provider of Private Duty Nursing (PDN) shall:

- a) Be a home health care provider licensed in accordance with RSA 151:2, I(b), and He-P 809;
- b) Require all staff providing PDN to be an R.N. or an L.P.N. licensed by the state in which s/he practices;
- c) Request and obtain service authorization from the department or its service authorization agent, before providing PDN; and
- d) Upon initiating PDN, provide to each member or the member's caregiver if the member is a minor, the home health care provider's written grievance policy that includes the phone number of the Department's ombudsman's office.

## 3. Covered Services

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization prior to service delivery to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and regarding the details regarding how to submit these requests can be found in this Provider Specific Billing Manual - Volume II.

PDN shall be a covered service when:

- a. It is part of the member's medical regimen and rendered under the order and general direction of the member's physician or other licensed practitioner;
- b. It is provided in one of the following locations:
  1. The member's home; or
  2. In locations other than the member's home when routine life activities take the member outside of the home if the services would have otherwise been provided in the member's home; and
- c. Prior authorization has been requested and obtained.

### 3.1 Service Limits

There are no service limits associated with the provision of PDN services.

## 4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid, and that should the member still choose to receive the service, then the member will be responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

PDN shall not be a covered service when the member resides in any one of the following:

1. A nursing facility licensed pursuant to RSA 151:2 and He-P 803;
2. A hospital licensed pursuant to RSA 151:2 and He-P 802;
3. An assisted living residence-supported residential health care (ALR-SRHC) facility licensed in accordance with RSA 151:2 and He-P 805;
4. A private non-medical institution as defined in 42 CFR 434.2, and licensed pursuant to RSA 151:2 and He-P 800;
5. An intermediate care facility for individuals with intellectual disabilities (ICFIID) as described in 42 CFR 440.150; and
6. An institution for mental diseases (IMD) as defined in 42 CFR 435.1010.

Services that consist only of assistance with activities of daily living or other non-skilled services needed to live at home that do not require a nurse, including but not limited to assistance with grooming, toileting, eating, dressing, getting into or out of a bed or chair, and walking shall not be covered as PDN.

## 5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The Contact Information in the Appendices of the General Billing Manual or on the SA form itself should be consulted for the name and method of contact.

Services Authorizations are required for all PDN services.

## 6. Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until resolution of any legal action(s) commenced in the six-year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I, for more detailed documentation requirements.

For each member, PDN service providers shall maintain complete and timely records as follows:

- a. A written, signed and dated physician's order for care provided, updated and signed every 60 days, which shall include:
  1. The member's diagnosis, with a description of the severity of the illness or condition; and
  2. A detailed explanation of the medical need for PDN, including:
    - a. The specific nursing services that are required; and
    - b. A description of the specific medical complications necessitating PDN;
- b. A nursing assessment with information that supports the need for PDN including, but not limited to, the following:
  1. Member identification information including:
    - a. Member name;
    - b. Medicaid identification number (MID); and
    - c. Date of birth;
  2. Contact information of the member's parent/guardian or primary caregiver including addresses and phone numbers;
  3. Private health insurance information including coverage dates;
  4. Information regarding the member's participation in any Medicaid program, including Medicaid to schools, waiver programs, and licensed nursing assistant (L.N.A.) services, or participation in the special medical services program;
  5. Name and contact information of the member's treating physician or other licensed practitioner, including the primary care physician and any specialists;
  6. A summary of the member's physical and behavioral health status including:
    - a. A list of the member's current conditions; and
    - b. A history of the conditions leading to the need for PDN;
  7. An assessment of the member's body systems including a medication profile;
  8. A functional assessment of the member's physical and cognitive status including a list of any durable medical equipment being utilized;

9. A description of the household make-up including the nature of the household member's relationship with the member and their ability and availability to provide care and support to the member;
  10. Information about the member's school participation including whether a nurse or aide is available to assist the member while at school and the number of hours per week the member attends school;
  11. The member's emergency plan in the event that the primary caregiver is unable to provide care; and
  12. Any additional medical or social information that the member wants to provide that supports the need for PDN, such as family stressors and their impact on the mental and emotional health of the member.
- c. A plan of care documenting the extent of the member's nursing needs, prepared by the PDN service provider, signed and dated by the member's physician or other licensed practitioner, and updated every 60 days in accordance with 42 CFR 484.60(c)(1);
  - d. Nurses' notes that fully document, for each date of service, the provision of services and the care and treatment provided to the member, including:
    1. The location of where the care was provided, and the time that the nursing shift began and ended;
    2. A description of each nursing service provided, including the type of nursing service, the time of the service delivery, and the member's response to the service so that an independent reviewer can replicate what happened during the shift;
    3. Details showing that the nursing services are consistent with the care plan and orders of the member's physician or other licensed practitioner;
    4. Any adverse findings and, if so, a plan of action to address those findings; and
    5. The member's progress towards established goals; and
  - e. Documentation of a face-to-face encounter between the member's physician or other licensed practitioner and the member within 90 days prior to, or within 30 days following the start of, the PDN service provision, as established in 42 USC 1395n and in accordance with 42 CFR 440.

## 6.1 Professional Principles of Documentation

Nursing documentation is any written or electronically generated information about a member that describes the member status or the care or service provided to that member. Nursing documentation must provide an accurate and honest account of what occurred and when during a nursing shift. It should be factual, accurate, complete, timely and organized. These principles apply in every practice setting.

Nurses should record relevant and member-focused information. Data collected through all aspects of the nursing process, e.g., assessment data, nursing interventions and evaluation of

outcomes should be recorded. This type of documentation allows for assessment of member progress and determination of which nursing interventions are effective and ineffective and identification of changes required to the plan of care. A good test to evaluate whether a member's record is a satisfactory clinical document is to answer the question: "if another nurse had to step in and provide care, does the record provide sufficient information for the seamless delivery of care: Both subjective and objective data may be included in the documentation. For subjective data, use quotation marks to delineate actual statements made by either the member or parent/guardian if relevant, rather than characterizing the statement or behavior. Write "patient smiling, asking staff about their day," rather than in "good spirits." The purpose of doing so gives the nurse following you a clearer picture of the situation than using a phrase in which you make a judgment. Objective data is the result of direct observation and measurement. It should contain descriptive, objective data about what the nurse sees. For objective data, avoid vague descriptions such as "status unchanged," "assessment done," "slept well," "vital signs stable." These are conclusions without supported facts. Be specific, "Slept quietly from 12 pm to 6 am."

## 6.2 Frequency of documentation:

The timeliness of documentation will be dependent on the member's medical condition. When member's acuity, complexity and variability are high, documentation will be more frequent than when members are less acute, less complex and their medical condition is less variable.

## 6.3 Electronic Visit Verification

Electronic Visit Verification (EVV) is an electronic scheduling, tracking, reporting, and billing system for in-home care and personal care service providers serving Medicaid recipients. Electronic Visit Verification is a requirement under the 21<sup>st</sup> Century Cares Act passed in 2016. New Hampshire Medicaid providers that provide in-home and personal care services must submit home care and personal care visits through an EVV solution. The state of New Hampshire offers an open model EVV solution that allows the provider to use at no cost or if a provider has their own EVV solution they can send the data to the Department's aggregator.

Additional information on Electronic Visit Verification can be found at the Department's [Electronic Visit Verification](#) website.

### 6.3.1 Time of Day Modifiers

Visits submitted electronically must be submitted using a TOD to prevent any denials for duplicate on claims submitted. Modifiers are required to differentiate same service, same day, same member situations. If a modifier is not included for the second and third visit in a day, claims may be a risk for denial. The state of New Hampshire has implemented the following modifiers & guidelines.

The state of New Hampshire has implemented the following time of day modifiers:

- UF – Services provided in the morning – 6:00am-11:59am
- UG – Services provided in the afternoon – 12:00pm-6:00pm
- UH – Services provided in the evening – 6:01pm-11:59pm
- UJ – Services provided overnight – 12:00am-5:59am

## 7. Surveillance and Utilization Review (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit, is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations CMS transmittals, provider fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

## 8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

## 9. Medicare/Third Party Coverage

Under federal law, the Medicaid program is the **payer of last resort**. All third-party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume I.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

## 10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third-party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

New Hampshire Medicaid utilizes a TT modifier in order to identify services provided by one provider to two or more patients. When billing for a single provider, seeing two or more patients in the same setting, the following codes should be used:

- T1019-TT Personal care services, per 15 minutes
- G0156-TT Services of Home Health/Hospice Aide in Home Health or Hospice Setting, per 15 minutes

The rate for the T1019-TT and G0156-TT codes will be consistent with the rates for those codes without the modifiers. The provider will be paid the same rate for both beneficiaries.

This modifier should be used by the following providers when working with two or more patients:

- Home Health Aide
- Hospice Aide
- Personal Care Services Aide

## 11. Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor state staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

### 11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One procedure or revenue code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

### 11.2 Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

### 11.3 Claim Completions Requirements for Private Duty Nursing Providers

Private Duty Nursing providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P.

Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted areas show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustments that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name or signature on file.

Please note that the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit  
PO Box 2003  
Concord, NH 03302-2003

## 12. Terminology

**Clinically appropriate** means care that is:

- (1) Provided in a timely manner and meets professionally recognized standards of acceptable medical care;
- (2) Delivered in the appropriate medical setting; and
- (3) The least costly of multiple, equally effective alternative treatments or diagnostic modalities.

**Department** means the New Hampshire Department of Health and Human Services (DHHS).

**Licensed practitioner** means:

- (1) Physician;
- (2) Physician's assistant;
- (3) Advanced practice registered nurse (APRN); or
- (4) Any practitioner with diagnostic and prescriptive powers licensed by the appropriate state licensing board.

**Medicaid** means the Title XIX and Title XXI programs administered by the department which makes medical assistance available to eligible individuals.

**Order** means a written authorization issued by a licensed practitioner for medications, treatments, recommendations, and referrals, and signed by the licensed practitioner using terms such as authorized by, authenticated by, approved by, reviewed by, or any other term that denotes approval by the licensed practitioner.

**Plan of care** means a plan of care prepared in accordance with 42 CFR 484.60.

**Prior authorization agent** means an individual or organization contracted by the department, responsible for reviewing prior authorization requests.

**Private duty nursing (PDN)** means the provision of skilled nursing services for recipients who require more individual and continual skilled nursing observation, judgment, assessment, or interventions than are available from a visiting nurse, in contrast to part-time or intermittent care, such as wound care.

**Reasonable attempt** means such action taken to accomplish the purpose as may be customary, appropriate, and suitable to the circumstances and that is in the best interests of the recipient.

**Recipient** means any individual who is eligible for and receiving medical assistance under the Medicaid program.

**Skilled nursing services** means services that are provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) because the nature of the service is inherently complex or the recipient's condition is such that the service can be safely and effectively provided only by a licensed nurse in accordance with the Nurse Practice Act, RSA 326-B.

**Title XIX program** means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.

**Title XXI** means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the Medicaid program.