Clinical Policy: Private Duty Nursing - Medicaid

Reference Number: TX.CP.MP.520
Last Review Date: 03/24

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Private duty nursing (PDN) should prevent prolonged and frequent hospitalizations or institutionalization and provide cost effective and quality care in the most appropriate, least restrictive environment. Private duty nursing provides direct nursing care, caregiver training and education. The training and education is intended to optimize member's health status and outcomes, and to promote family-centered, community-based care as a component of an array of service options.

In order to render a member-centric decision, the nurse reviewer and medical director will consider requests for PDN based on the extent of the member's skilled needs, the complexity of those skilled needs, and the caregiver's or medical consenter's service delivery preferences. It is hoped that nursing care may be reduced over time if the member's medical condition improves or the nursing needs decrease. Prior to initiation of home services, the requesting provider should convey to the member or family what the expectations are regarding the weaning of nursing hours and the eventual termination of these services.

This policy applies to the following products: STAR, STAR Health (SH), and STAR Kids (SK).

Policy/Criteria

I. It is the policy of Superior HealthPlan that private duty nursing (PDN) services are **medically necessary** when all the following criteria are met:

A. Member is < 21 years of age;
B. PDN Services may be authorized on a provider or member ratio other than 1:1;
C. The primary practitioner's medical care must comply with the THSteps periodicity schedule.
D. Documentation by the primary provider includes all of the following:
   1. Signed and dated practitioner's order or signed plan of care (POC) for PDN that is less than 30 days old prior to the start of care, indicating the number of hours per day or week and the duration of the request.
      Note: PDN services must be ordered by a physician or a designated advanced practice registered nurse (APRN) or physician assistant (PA). The provider's signature and license number must appear on the forms where the physician signature and license number blocks are required.
      Note: If services begin as a result of a verbal order before the physician's dated signature, proof of the verbal order, received by a licensed staff authorized to accept verbal orders per TAC §550 must be submitted with the request.
   2. The POC must be up to date and include the member's current diagnosis, functional status, medical conditions that are relevant to the intended skilled nursing services.

Note: *PDN providers are responsible for maintaining a contingency plan in order that services are not interrupted.*

3. Member requires care that is beyond the level of services provided under a home health skilled nursing visit.
   Note: Provision of PDN is not for the convenience of the parent, guardian or caregiver.
4. At least one of the following indications:
   a. Dependent on technology to sustain life; *or*
   b. Requires ongoing and frequent skilled interventions to maintain or improve health status; *or*
   c. Delaying skilled intervention is expected to result in:
      i. Deterioration of a chronic condition; *or*
      ii. Loss of function; *or*
      iii. Imminent risk to health status due to medical fragility; *or*
      iv. Risk of death.

E. Specific criteria necessary for requested service type:
   1. Initial request of PDN services for ≤ 90 days when *all* the following criteria are met:
      a. The provider has examined or treated the member within the past 30 days.
      b. Requires prior authorization submission within three business days of the start of care (SOC) of services.
      c. During the authorization process, providers are required to deliver the requested services from the SOC date.
      d. The SOC date is the date agreed upon by the physician, the PDN provider, and the member, parent, or guardian and is indicated on the submitted POC as the SOC date.
      e. The PDN provider requesting the authorization for PDN services must submit *all* the following documentation:
         i. A completed THSteps-CCP Prior Authorization Request form signed and dated by the ordering practitioner within 30 calendar days prior to the SOC date; *and*
         ii. A completed POC form, signed and dated by the ordering practitioner within 30 calendar days prior to the SOC date; *and*
         iii. A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the ordering practitioner, the RN completing the assessment and parent or guardian within 30 calendar days prior to the SOC date.
   2. Revisions may be requested at any time during the authorization period if medically necessary.
      a. The provider must notify Superior Healthplan at any time during an authorization period if the member's condition changes and the authorized services are not commensurate with the member's medical needs.
      b. Must be submitted within three business days of the revised SOC date.

c. The PDN provider requesting the authorization for PDN services must submit *all* the following documentation:
   i. A completed POC, signed and dated by the ordering practitioner within 30 calendar days prior to the SOC date; *and*
   ii. Additional required documentation, which must be signed by the ordering practitioner, registered nurse (RN) completing the assessment and parent or guardian within 30 calendar days prior to the SOC date. Revisions to a current certification must fall within the current authorization period. *Note: If the revision is requested outside of an authorization period, the provider must request a new authorization with the recertification authorization documentation noted in Section I.E.3*.
d. May be prior authorized for up to a maximum of 180 days.
e. A request for a member that does not satisfy the criteria listed above for a 180 day authorization may be authorized for a period up to three months.

3. Recertifications may be prior authorized for up to a maximum of 180 days.
   a. The following criteria must be met before a member receives a 180 day recertification:
      i. The member must have received PDN services for at least three months, *and*
      ii. No significant changes in the member's condition for at least three months, *and*
      iii. No significant changes in the member's condition are anticipated, *and*
      iv. The member's parent or guardian, practitioner, and provider agree the recertification is appropriate.
   b. The PDN provider requesting the reauthorization for PDN services must submit *all* the following documentation:
      i. A completed THSteps-CCP Prior Authorization Request form signed and dated by the ordering practitioner within 30 calendar days prior to the SOC date.
      ii. A completed POC form, signed and dated by the ordering practitioner within 30 calendar days prior to the SOC date.
      iii. A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the ordering practitioner, the RN completing the assessment and parent or guardian within 30 calendar days prior to the SOC date.
      iv. A completed THS-Steps CCP Prior Authorization Private Duty Nursing 6-Month Authorization form when requesting prior authorization for six months.

Note: If a request for PDN is incomplete, inconsistent, or unclear Superior Healthplan *will contact the provider to request additional or clarifying documentation to enable Superior* Healthplan *to make a decision on the request.*

II. It is the policy of Superior HealthPlan that PDN services are considered **not medically necessary** for the following indications:

A. For the primary purpose of providing respite care, childcare, activities of daily living (ADLs) for the member, or housekeeping services.

B. For members whose only skilled nursing need is the provision of education for self-administration of prescribed subcutaneous (SQ), intramuscular (IM), or intravenous (IV) injections. Nursing hours for the sole purpose of providing education to the member and caregiver may be considered through intermittent home health skilled nursing visits.

C. Services that can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed nurse.

D. PDN provided for > 16 hours a day by a single, independently-enrolled nurse.

III. PDN may be delivered in a member's residence, school, or daycare facility, or nurse provider's home. Superior Healthplan must be prepared to authorize medically necessary PDN for their members at school.

A. **PDN is not a SHARS service.**
If a Medicaid-eligible student's Individualized Education Program (IEP) includes nursing services that can be met by PDN services provided at school, then the school district should note in the student's IEP that the student's nursing services are being met through PDN and may not bill SHARS for any reimbursement for nursing services.

B. Superior Healthplan **expectations related to PDN in schools:** It is not the responsibility of the school to assume PDN care if the member's PDN nurse is unable to provide services at school due to illness or some other reason. The school is only responsible for nursing services listed in the member's IEP if the member has one.
PDN policy requires that the PDN provider and the parent or responsible adult have a contingency plan in place in the event that the member's PDN nurse is unavailable. All parties should be aware of the contingency plan and understand when and how to activate it.
PDN service authorization requests must indicate who is responsible for the delivery of nursing services throughout a 24-hour day, including nursing services delivered by the member's school. Superior Healthplan should request this information from the member's PDN provider or the member's parent or legally responsible adult who must sign the 24-hour flowsheet that is required with all PDN service authorization requests.

C. **Coordination with the school:** Superior Healthplan service coordinators (SC's) may also attempt to coordinate with schools regarding PDN services provided in the school. However, plans should be aware that student privacy law governs that student information can be shared by schools and it can be obtained.
The Family Education Rights and Privacy Act (FERPA) governs the sharing of student records. Generally, schools must have written permission from the parents or eligible student to release information from a student's education record. If the parent or eligible student does not provide consent to share the contents of the IEP, for example, then the school cannot provide the records. Processes vary among school districts. Superior

Healthplan SC's should consult the member's school for more information regarding FERPA compliance when requesting information in the member's student record or IEP.

D. **Special Circumstances:** PDN services provided in a school or day care facility, at the request of the family, may be authorized provided the member requires the requested amount of PDN services if in the home.
PDN services may be provided in a hospital, SN facility or intermediate care facility for the individuals with intellectual disabilities, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the member, and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the member.

Background

Transition Period:

- To allow the member/legally authorized representative/medical consenter time to make arrangements to transition from denied or reduced PDN hours, the previously authorized PDN hours will remain in place for a period determined by the Uniform Managed Care Contract from the date when the denial letter is sent out.

Definitions

- **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):** The child and adolescent health component of the Medicaid program for recipients under 21 years of age, defined in the United States Code, Title 42, §1396d(r), and the Code of Federal Regulations, Title 42, §440.40(b). EPSDT means screening, vision, dental, hearing, laboratory, health care, treatment, diagnostic services, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions.
- **Skilled Nursing** means assessments, judgments, interventions, and evaluations of interventions requiring the education, training, and experience of a licensed nurse.
- **Private Duty Nursing (PDN) Services:** are nursing services as described by the Texas Nursing Practice Act and its implementing regulations, for members who meet the medically necessary criteria and who require individualized, continuous, skilled care beyond the level of skilled nursing visits normally authorized under Texas Medicaid Home Health Skilled Nursing and Home Health Aide Services.
- **School Health and Related Services (SHARS):** are Medicaid services provided by school districts in Texas to Medicaid-eligible students under the federal Individuals with Disabilities Education Act (IDEA). School districts who participate in the SHARS program may seek Medicaid reimbursement for nursing services.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for

informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
T1000	PRIVATE DUTY/INDEPENDEND NURSING LICENSED UP TO 15 MIN

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Date	Approval Date
Updated "Product Type" by adding MRSA and deleting Chip Perinate, Health Texas, Medicare Advantage and SSI. Added general criteria requirements. Deleted and updated specific criteria regarding hour limitations. Updated PA work process. Updated References. Updated signatories.	7/13	7/13
Update authorization work process and reference.	10/13	10/13
Deleted "requires continuous, skillful observations, judgments, and interventions to correct or ameliorate the member's health status" under initial authorization criteria. Added the verbal order work process under authorization process. Corrected some grammatical errors. Updated references, definitions and signatories.	06/14	06/14
Removed work process and imbedded in attachment section. Added policy to reference list.	02/15	02/15
Added PDN information under Policy section. Edits and additions made to Medical Necessity Criteria. Days associated with TAC reference, specified as calendar days. Removed work process attachment and placed in separate document. Updated Definition and Reference list.	06/15	06/15
Removed STAR+PLUS from Product types.	02/16	02/16
Grammatical edits. Removal of work process. Updated reference and signatories.	06/16	06/16
Updated scope. Removed MRSA and CHIP RSA from products, due to regional reference. Added STAR Kids. Clarified what constitutes a plan of care. Updated reference list.	03/17	03/17

Reviews, Revisions, and Approvals	Date	Approval Date
Added "For requests where the member is changing PDN provider or for new PDN requests, where the member has not had PDN services in the past, Centene staff may approve 2 weeks of PDN services with a completed request form and an MD order. The requesting provider will need to provide all the required documentation for an initial PDN request before the end of the 2 week approved period."	06/17	06/17
Changed approval duration from 90 days to 6 months. Updated products, review date, references and signatures.	07/18	07/18
Removed the section referring to the two week approval process for PDN services being requested upon discharge and for initials. The information to be outlined in individual product work processes. Updated signatories.	04/19	04/19
Updated to new template from TX.UM.10.20 (TX.CP.MP.520 nomenclature implementation 10/1/19). Reworded criteria for clarity and combined general criteria and medical necessity criteria. Removed work process criteria regarding line item authorizations. Updated references.	10/19	10/19
Added the following statement as a Note: For Medicaid members under age 21, the opportunity for a P2P discussion is offered prior to issuing an adverse determination for nursing services (PDN, HHSNV). Added HHSC Guidance for Medicaid MCO's Regarding PDN Provided at School updates completed, noted under section III. Added the following definitions: PDN services, Centene Company of TX, and School Health and Related Services. Updated references.	03/20	03/20
Added statement in accordance with TMPPM guidelines, 4.1.4.4 Prior Authorization of PDN Services, in section 1, D, 1.Signed and dated physician's order (physician-designated advanced practice registered nurse (APRN) or physician assistant (PA) is acceptable) or signed Plan of Care for PDN that is less than 30 days old prior to the start of care.	05/20	05/20
In Section I, added B. PDN Services may be authorized on a provider or member ratio other than 1:1. Added the following under Section I, C. Requested care, one of the following: 2. Initial requests must be submitted within three business days of the start of care (SOC) date. 5. Requests for revisions must be submitted within three business days of the revised SOC date; In Section I, added G. PDN services require prior authorization within three business of the SOC for initial request of services. Added the following under Section I, G: 1. During the authorization process, providers are required to deliver the requested services from the SOC date.	07/20	07/20

Reviews, Revisions, and Approvals	Date	Approval Date
2. The SOC dates is the date agreed upon by the physician, the PDN provider, and the member, parent, or guardian and is indicated on the submitted POC as the SOC date. 3. The PDN provider requesting the authorization for PDN services must submit all of the following documentation: a. A completed THSteps-CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date. b. A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date. c. A completed Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form signed and dated by the primary physician, RN completing the assessment, 4. Recertifications may be prior authorized for up to a maximum of six months. a. The following criteria must be met before a member receives a recertification: i. The member must have received PDN services for at least three months ii. No significant changes in the member's condition for at least three months iii. No significant changes in the member's condition are anticipated iv. The member's parent or guardian, physician, and provider agree the recertification is appropriate v. STAR Kids will require the CCP Prior Authorization Private Duty Nursing 6-Month Authorization form when requesting prior authorization for six months. In Section III, added D. Special Circumstances: PDN services provided in a school or day care facility, at the request of the family, may be authorized provided the member requires the requested amount of PDN services if in the home. PDN services may be provided in a hospital, SN facility or intermediate care facility for the individuals with intellectual disabilities, or special care facility with documentation from the facility showing it is unable to meet the SN needs of the member, and the services are medically necessary. These facilities are required by licensure to meet all the medical needs of the member.		
Added STAR Health under Section I, G. 4. a. v.: STAR Kids *and STAR Health* will require the CCP Prior Authorization Private Duty Nursing 6-	07/20	08/20

Reviews, Revisions, and Approvals	Date	Approval Date
Month Authorization form when requesting prior authorization for six months.		
Updated description of policy and added clarifying statement around "member centric decision". In Section I, added "Note: If a request for PDN is incomplete, inconsistent, or unclear CCTX will contact the provider to request additional or clarifying documentation to enable CCTX to make a decision on the request". In Section II, removed from criterion A, "or comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act". "For private duty nursing (PDN) services in the home, only the CCTX medical director may deny PDN services on the basis that the services do not correct or ameliorate the recipient's disability or physical or mental illness or condition. Before denying PDN services, the medical director will contact the member's treating physician to determine whether additional information or clarification can be provided that would allow for authorization of PDN services" added to 'Note'. In Section III added location of "nurse provider's home". Updated references.	11/20	
Restructured policy for clarification purposes- removed Section I. C and added the verbiage to sections of policy where it applied without impact to criteria. Added to Section I. D. 2, "diagnosis and functional status". Added the following indications to Section I. E. 3, "Deterioration of a chronic condition; or Loss of function; or Imminent risk to health status due to medical fragility; or Risk of death." Section I. G became section I. F, regarding initial authorizations. Clarified previous existing Section I. G by separating into two additional sections, G and H for revisions and recertifications. Added clarifying criteria for Section G. Revisions. Added HCPS code T1000. CHIP was removed from TX.CP.MP.520. New Policy created specifically for CHIP, *TX.CP.MP.521*.	03/21	03/21
Annual Review. Technical edits. Under Policy I. C: removed "three" replaced with "six" Updated Background section: Removed "Time (See TAC Rule357.11- 10 day Notification rule)", replaced with "Period". Removed "of 12 calendar days" replaced with "determined by the Uniform Managed Care Contract" Updated References. Removed: Texas Administrative Code; 10 Day Notification Rule--TAC RULE §357.11. Added: HHSC Uniform Managed Care Contract 2.34 version. Removed age range in Section II note per IPAR process in TX.UM.43	03/22	03/22
Annual Review. References updated. Reworded to clarify Section I C to "*The primary practitioner's medical care must comply with the THSteps periodicity schedule*". Added note to Section I " *Note*: *PDN providers are responsible for maintaining a contingency plan in order that services are not interrupted."* and removed *"Contingency plan"* from Section I.	03/23	03/23

Reviews, Revisions, and Approvals	Date	Approval Date
Changes made throughout document to align "physician" to allowed practitioners per amendments of 1 Texas Administrative Code rules 354.1031, 354.1035, 354.1037, 354.1039, 354.1040,and 354.1043 are in alignment with 42 Code of Federal Regulations §440.70.		
Annual Review. Updated references. Grammatical edits. Changes made throughout document to state "ordering practitioner" for consistency. Removed "allowed practitioner language from Section I. D. 1 *and placed note "PDN services must be ordered by a physician or a designated advanced practice registered nurse (APRN) or physician assistant (PA). The provider's signature and license number must appear on the forms where the physician signature and license number blocks are required."* Removed reference in section I.B.a to TX.UM.26 Electronic and Verbal Order Signature Policy and placed a note " *If services begin as a result of a verbal order before the physician's dated signature, proof of the verbal order must be submitted with the request".* Removed notes from Section II regarding peer-to-peer as it is operational. Removed definition for CCTX and changed reference throughout policy to "Superior HealthPlan". Added definition of EPSDT.	03/24	3/24

References

1. HHSC Uniform Managed Care Manual, Chapter 3.22 version 2.3.
2. HHSC Uniform Managed Care Contract 2.38 version.
3. Texas Medicaid Provider Procedures Manual: Vol. 2 Children's Handbook, February 2024.
4. Texas Medicaid Provider Procedures Manual: Vol. 2 Home Health Nursing and Private Duty Nursing Services Handbook, 4 Private Duty Nursing (PDN) Services – CCP, February 2024.
5. Texas Administrative Code Title 1, Part 15, § 363.311
6. Texas Administrative Code, Title 26, Part 1, § 550.702
7. Bailey KL. Establishing private duty in a Medicare world. Caring. 1998; 17(9):24-25, 27, 29-31.
8. Lulavage A. RN-LPN teams: Toward unit nursing case management. Nurs Manage. 1991; 22(3):58-61.
9. Creighton H. Private duty nursing: Part I - Reimbursement issues. Nurs Manage. 1988; 19(6):22, 26.
10. STAR Kids Handbook, Revision 22-3. December 1, 2022. https://hhs.texas.gov/laws-regulations/handbooks/skh/star-kids-handbook

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members

and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.