

## Clinical Policy: Private Duty Nursing - CHIP

Reference Number: TX.CP.MP.521

Last Review Date: 03/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

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### 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 parent or guardian'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 product: CHIP.

### 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. PDN Services may be authorized on a provider or member ratio other than 1:1;
  - B. Documentation by the primary provider includes all of the following:
    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, indicating the number of hours per day or week and the duration of the request;
      - a. Refer to *TX.UM.26 Electronic and Verbal Order Signature Policy* for other acceptable forms of orders.
    2. The plan of care must be up to date and include the member's current diagnosis, functional status, and medical conditions that are relevant to the intended skilled nursing services;
    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.*)
  - C. At least one of the following indications:
    1. Dependent on technology to sustain life; *or*
    2. Requires ongoing and frequent skilled interventions to maintain or improve health status; *or*

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3. Delaying skilled intervention is expected to result in:
  - a. Deterioration of a chronic condition; *or*
  - b. Loss of function; *or*
  - c. Imminent risk to health status due to medical fragility; *or*
  - d. Risk of death.
- D. Initial authorization of PDN services may be prior authorized  $\leq 90$  days and all of the following criteria must be met:
  1. The provider has examined or treated the member within the past 30 days.
  2. Requires prior authorization submission within three business days of the start of care (SOC) of services.
  3. During the authorization process, providers are required to deliver the requested services from the SOC date.
  4. The SOC date is the date agreed upon by the physician, the PDN provider, and the parent or guardian and is indicated on the submitted POC as the SOC date.
  5. The PDN provider requesting the authorization for PDN services must submit all of the following documentation:
    - a. A completed POC, signed and dated by the primary physician within 30 calendar days prior to the SOC date; *and*
    - b. Additional required documentation, which must be signed by the primary physician, registered nurse (RN) completing the assessment and parent or guardian within 30 calendar days prior to the SOC date, and include the following:
      - i. An updated problem list
      - ii. An updated rationale or summary page
      - iii. A contingency plan
      - iv. A 24-hour daily care flowsheet
- E. Revisions may be requested at any time during the authorization period if medically necessary.
  1. The provider must notify CCTX 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.
  2. Must be submitted within three business days of the revised SOC date.
  3. Revisions to a current certification must fall within the current authorization period.
    - a. If the revision is requested outside of an authorization period, the provider must request a new authorization with the initial authorization documentation noted in Section I.E.
  4. May be prior authorized for up to a maximum of six months.
  5. A request for a member that does not satisfy the criteria listed above for a six-month authorization may be authorized for a period up to three months.
- F. Recertifications may be prior authorized for up to a maximum of six months.
  1. The following criteria must be met before a member receives a six-month recertification:
    - a. The member must have received PDN services for at least three months, *and*
    - b. No significant changes in the member's condition for at least three months, *and*

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- c. No significant changes in the member's condition are anticipated, *and*
  - d. The member's parent or guardian, physician, and provider agree the recertification is appropriate.
- 2. The PDN provider requesting the reauthorization for PDN services must submit all of the following documentation:
  - a. A completed POC, signed and dated by the primary physician within 30 calendar days prior to the SOC date.
  - b. Additional required documentation, which must be signed by the primary physician, RN completing the assessment and parent or guardian within 30 calendar days prior to the SOC date, and include the following:
    - i. An updated problem list
    - ii. An updated rationale or summary page
    - iii. A contingency plan
    - iv. A 24-hour daily care flowsheet

*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.*

- 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, or activities of daily living (ADLs) for the member, 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.

*Note: An opportunity for a peer-to-peer discussion between the ordering provider and CCTX medical director will be offered prior to issuance an adverse determination.*

- III. PDN may be delivered in a member's residence, school, or daycare facility, or nurse provider's home.
- IV. To allow the member/legally authorized representative time to make arrangements to transition from denied or reduced PDN hours, the previously authorized PDN hours will remain in place for a period of time determined by Uniform Managed Care Contract from the date when the denial letter is sent out.

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#### Definitions:

- **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 administered as a Home Health skilled nursing visit.
- **Centene Company of Texas (CCTX), LP,** is a licensed Utilization Review Agent (URA) in Texas. This policy is applicable to complex care Medicaid program (CCMP) staff employed by CCTX, and performing utilization review.

#### 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
CHIP was removed from TX.CP.MP.520. New Policy created specifically for CHIP, TX.CP.MP.521, without impact to prior authorization critiera.	03/21	03/21
Annual Review. References updated. Updated Section IV per Uniform Managed Care Contract 8.2.6.6 Removed 1 B. regarding treatment within 3 months as not applicable to CHIP members	03/22	03/22

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#### References

1. HHSC Uniformed Managed Care Manual chapter 3.22 version.
2. Bailey KL. Establishing private duty in a Medicare world. *Caring*. 1998; 17(9):24-25, 27, 29-31.
3. Lulavage A. RN-LPN teams: Toward unit nursing case management. *Nurs Manage*. 1991; 22(3):58-61.
4. Creighton H. Private duty nursing: Part I - Reimbursement issues. *Nurs Manage*. 1988; 19(6):22, 26.
5. TX.UM.26 Electronic and Verbal Order Signature Policy
6. Uniform Managed Care Contract

#### **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

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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.

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