Clinical Policy: Private Duty Nursing for Beneficiaries Age 21 and Older

Reference Number: WNC.CP.105
Last Review Date: 09/21

Coding Implications
Revision Log

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

Note: 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.

Description[1]

Private Duty Nursing (PDN) is substantial, complex, and continuous skilled nursing services that are considered supplemental to the care provided to a beneficiary by the beneficiary's family, foster parents, and delegated caregivers, as applicable. PDN services are provided for beneficiaries who require more individual and continuous care than what is available from a home health service visit. PDN shall be medically necessary for the beneficiary to be covered by NC Medicaid.

Policy/Criteria[1]

I. It is the policy of WellCare of North Carolina® that Private Duty Nursing for Beneficiaries Age 21 and Older is **medically necessary** for the following indications:

A. PDN Level 1 Services
   1. Be dependent on a ventilator for at least eight (8) hours per day, **or**
   2. Meet at least four (4) of the following criteria:
      a. unable to wean from a tracheostomy;
      b. require nebulizer treatments at least two (2) scheduled times per day and one (1) as needed time per day;
      c. require pulse oximetry readings every nursing shift;
      d. require skilled nursing or respiratory assessments every shift due to a respiratory insufficiency;
      e. require oxygen as needed, also known as pro re nata (PRN) or has PRN rate adjustments at least two (2) times per week ;
      f. require tracheal care at least daily;
      g. require PRN tracheal suctioning. Suctioning is defined as tracheal suctioning requiring a suction machine and a flexible catheter;
      h. at risk for requiring ventilator support;
      i. require at least one non-respiratory skilled nursing intervention that requires more extensive and continual care than can be provided through a home health visit;
      j. evidence of 3 or more organ system deficiencies/failures that requires continual skilled nursing interventions (example: Skin (decubitus ulcers), GI (feeding tube), AND Neuro (TBI, seizures).

B. PDN Level 2 Services
   Medicaid beneficiaries who meet **ALL** the criteria for Level 1 nursing services plus at least one (1) of the criteria below may be eligible for additional PDN services **not to exceed** the program limit of 112 hours per week:

1. Use of respiratory pacer;
2. Dementia or other cognitive deficits in an otherwise alert or ambulatory recipient;
3. Infusions, such as through an intravenous, Peripherally Inserted Central Catheter (PICC) or central line;
4. Seizure activity requiring use of PRN use of Diastat, oxygen, or other interventions that require assessment and intervention by a licensed nurse.

C. A short-term increase in PDN services is limited to a **maximum of six (6) calendar weeks**. The amount and duration of the short-term increase is based on medical necessity.
Medicaid shall cover a short-term increase in PDN service when the beneficiary meets **ONE** of the following significant changes in condition:
1. New tracheostomy, ventilator, or other life-sustaining medical technology need, immediately post discharge, to accommodate the transition and the need for training of informal caregivers. Services generally start at a higher number of hours and are weaned down to previously approved hours over the course of the six (6) weeks.
2. An acute, temporary change in condition causing increased amount and frequency of nursing interventions.
3. A family emergency such as an acute change in the primary caregiver's ability to physically and/or cognitively provide care, or when the secondary caregiver is in place but requires additional support because of less availability or need for reinforcement of training.

D. Therapeutic Leave
1. Therapeutic leave and/or vacation requests (not for medical purposes such as an out-of-state hospitalization) shall be ordered by the beneficiary's attending physician. Approval of therapeutic leave is limited to **14 days** per calendar year and shall not exceed current approved hours. The attending physician shall indicate the beneficiary is able to travel safely and requires nursing care during leave time. The necessity for a nurse to travel with the beneficiary and caregiver(s) shall be documented in the attending physician-signed order.
2. The PDN service provider shall submit the attending physician-signed order for therapeutic leave to WellCare of NC for review at least **five (5)** business days prior to the therapeutic leave request.

II. It is the policy of WellCare of North Carolina® that Private Duty Nursing for Beneficiaries Age 21 and Older is **not medically necessary** for the following indications:

A. The beneficiary is receiving medical care in a hospital, nursing facility, outpatient facility, or residential-type medical setting where licensed personnel are employed;
B. The beneficiary is a resident of an adult care home, group home, family care home, or nursing facility;
C. The service is for custodial, companion, respite services (short-term relief for the caregiver) or medical or community transportation services;
D. The nursing care activities rendered can be delegated to unlicensed personnel (Nurse Aide I or Nurse Aide II);

E. The purpose of having a licensed nurse with the beneficiary is for observation or monitoring in case an intervention is required;
F. The service is for the beneficiary or caregiver to go on vacation or overnight trips away from the beneficiary's private primary residenc;
Note: Short-term absences from the primary private residence that allow the beneficiary to receive medical care in an alternate setting for a short period of time, and therapeutic leave requests may be allowed if the following are true: PDN is not provided for respite, PDN is not provided in an institutional setting, and when PDN is provided according to nurse and home care licensure regulations.
G. Services are provided exclusively in the school;
H. The beneficiary does not have informal caregiver support available;
I. The beneficiary is receiving home health nursing services or respiratory therapy treatment (except for Independent Practitioners Respiratory Therapy Services as allowed under NC Medicaid) during the same hours of the day as PDN;
J. The beneficiary is receiving infusion therapy services (from Home Infusion Therapy (HIT) program as allowed under NC Medicaid);
K. The beneficiary is receiving hospice services as allowed under NC Medicaid; **or**
L. The beneficiary is receiving services from other formal support programs (such as NC Innovations) during the same hours of the day as PDN.

III. It is the policy of WellCare of North Carolina® that Private Duty Nursing for Beneficiaries Age 21 and Older is **not covered** when:

A. PDN is provided by the beneficiary's near relative (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step- and in-law relationships). They may be employed by the PDN service provider to work with other beneficiaries;
B. The direct care nurse lives with the beneficiary in any capacity;
C. The PDN service provider is owned by the beneficiary's near relative (spouse, child, parent, grandparent, grandchild, or sibling, including corresponding step- and in-law relationships); **or**
D. PDN is provided by an individual who is legally responsible for the beneficiary.

Background[1]

PDN services are provided:

- primarily in the beneficiary's private primary residence;
- under the direction of a written individualized plan of care;
- as authorized by the beneficiary's attending physician; and
- By a registered nurse (RN) or licensed practical nurse (LPN) who is licensed by the North Carolina Board of Nursing (NCBON) and employed by a state licensed and accredited home care agency.

WellCare of North Carolina, consistent with NC Medicaid policy, shall determine the amount, duration, scope, and sufficiency of PDN services – **not to exceed 112 hours per week** - required by the beneficiary based on a comprehensive review of all the submitted documents, along with the following characteristics of the beneficiary:

- Active primary and secondary diagnosis
- Overall health status (i.e. mobility, nutrition, recent hospitalizations);

- Level and type of technology dependency
- Amount and frequency of specialized skilled nursing interventions required
- Amount of caregiver assistance available. WellCare of NC reserves the right to request verification of each caregiver's employment schedule annually, and as deemed appropriate by WellCare of NC. Allowances are not for second jobs, overtime, or combination of work and school, when the additional hours cause the policy limit to be exceeded. The NC Medicaid PDN policy available at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/ provides additional guidance on the PDN hour limitation based on caregiver type and availability.

Hours are approved on a per-week basis beginning 12:01 a.m. Sunday and ending at 12:00 a.m. Saturday. A beneficiary may use the hours as they choose within the week.. It is the responsibility of the beneficiary and caregiver to schedule time to ensure the health and safety of the beneficiary. Additional hours are not approved because the family planned poorly and 'ran out' before the end of the week. The hours approved are based on the needs of the beneficiary and caregiver availability, not the needs of other individuals residing in the home.
Note: Unused hours of services shall not be "banked" for future use or "rolled over" to another week.

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 2019, 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
No applicable codes listed	

HCPCS ®* Codes	Description
T1000	PDN Nursing Services

ICD-10-CM Diagnosis Codes that Support Coverage Criteria
+ Indicates a code(s) requiring an additional character

ICD-10-CM Code	Description
No applicable codes listed	

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	01/21	06/21

Reviews, Revisions, and Approvals	Date	Approval Date
Description revised. Clarified therapeutic leave definition to include vacation (section I.D.1.). Added Section III. Reviewed HCPCS code.	09/21	

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No: 3G-1 Private Duty Nursing for Beneficiaries Age 21 and Older. https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies. Published September 1, 2021. Accessed September 7, 2021.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise); or
   2. the NC Health Choice (NCHC is NC Health Choice program, unless context clearly indicates otherwise) Program on the date of service.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

EPSDT does not apply to NCHC beneficiaries.

Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information

Provider(s) shall comply with the, NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
   For NCHC refer to NCHC State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan
g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

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/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees 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/enrollees 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/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.