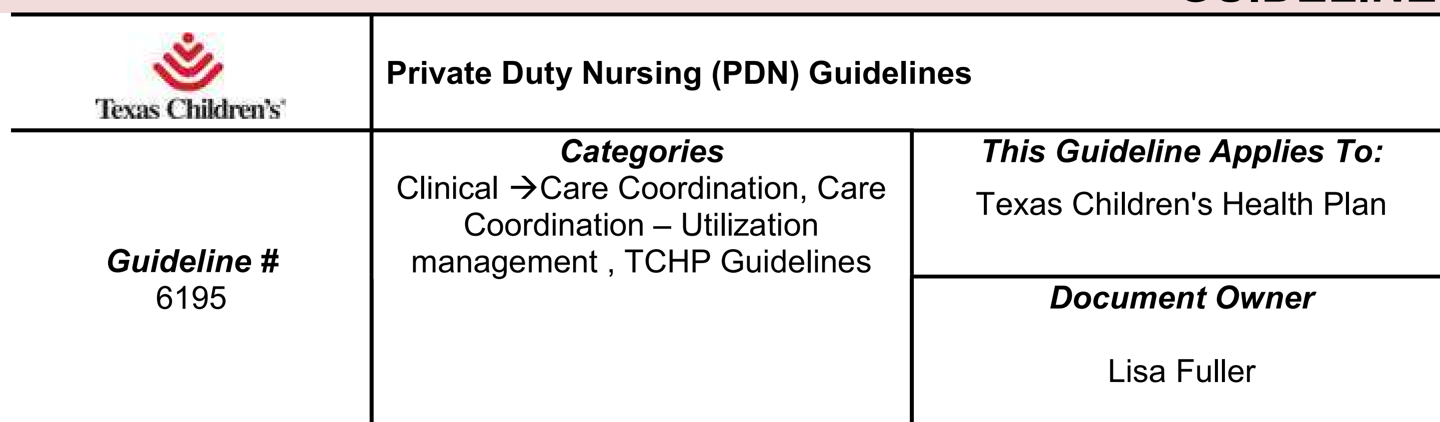
GUIDELINE



Texas Children's	Private Duty Nursing (PDN) Guidelines	
Guideline # 6195	***Categories*** Clinical →Care Coordination, Care Coordination – Utilization management , TCHP Guidelines	***This Guideline Applies To:*** Texas Children's Health Plan ***Document Owner*** Lisa Fuller

GUIDELINE STATEMENT:

Texas Children's Health Plan (TCHP) performs authorization of all private duty nursing services in the home

DEFINITIONS:

Private Duty Nursing in the Home (PDN) refers to nursing, when the member requires more individual and continuous care than is available from a visiting nurse or than is routinely provided by the nursing staff of a hospital or skilled nursing facility [1 Texas Administrative Code (TAC) § 363.303(15)].

- PDN services include observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a member who has a disability or chronic health condition or who is experiencing a change in normal health processes. [1 TAC § 363.303(15)].
- PDN services are nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for members who meet the medical necessity criteria, and who require individualized, continuous, skilled care beyond nursing needs that can be met on an intermittent or part-time basis through home health services or skilled nursing services. [Texas Medicaid Provider Procedures Manual: Volume 2, Home Health Nursing and Private Duty Nursing Services Handbook (TMPPM) § 4.1.].
- PDN services are provided by a registered nurse (RN) or a licensed practice nurse (LPN) or licensed vocational nurse (LVN) under the direction of the member's physician.

Responsible adult: An individual who is an adult, as defined by the Texas Family Code, and who has agreed to accept the responsibility for providing food, shelter, clothing, education, nurturing, and supervision for the member.

- Responsible adults include, but are not limited to: biological parents, adoptive parents, foster parents, guardians, court-appointed managing conservators, and other family members by birth or marriage. [1 TAC § 363.303(20)].

Respite Services: Direct care services needed because of an individual's disability that provides a primary caregiver temporary relief from caregiving activities when the primary caregiver would usually perform such activities [40 TAC §51.103(53)]

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PRIOR AUTHORIZATION GUIDELINES

1. All requests for PDN are submitted via fax, mail, or electronic submission. The requests are received by the Utilization Management Department and processed during normal business hours.
2. The Utilization Management professional receiving the request evaluates coverage and benefit limitations for the requested service.
3. Completed requests must be received and dated at least seven (7) calendar days before, but no more than thirty (30) calendar days before, the requested authorization start date or current authorization expiration date. The timeframe for receipt of a completed THSteps-CCP Prior Authorization Request form for private duty nursing signed and dated by the primary physician and a completed plan of care (POC) form is within 30 calendar days prior to the start of care (SOC) date.

   3.1 Initial certifications: the completed documents must be received no later than 3 business days after the SOC.

   3.2 Recertification: requests must be submitted at least 7 calendar days before, but no more than 30 days before, a current authorization period will expire.

4. The requested services are nursing services as defined by the Texas Nursing Practice Act and its implementing regulations.
5. Medical Necessity for requested services is clearly indicated including specifics of client's condition and caregiving needs.
6. The amount and duration of PDN must always be commensurate with the member's medical needs.
7. Requests for services must reflect changes in the member's condition that affect the amount and duration of PDN.
8. The explanation of the member's current medical needs is sufficient to support that the requested services correct or ameliorate the member's disability, physical or mental illness, or chronic condition.
9. The member's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) home health services skilled nursing services.

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Documentation requirements for Initial Requests:

10. Nursing assessment performed by an RN within the member's home environment that includes but is not limited to, the determination of:

10.1 Medical necessity for PDN services

- When an RN completes a member assessment and identifies a medical necessity for ADLs or health-related functions to be provided by a nurse, the scope of PDN services may include these ADLs or health-related functions.

10.2 Safety of providing care in the proposed setting

10.3 Appropriateness of care in the place of service

10.4 Receptivity to training and ability level of the parent, guardian, or responsible adult

11. The existing level of care and any additional health-care services to include, but not limited to, School Health and Related Services (SHARS), MDCP, PT, OT, ST, PCS, CFC, or case management services. Services provided under these programs will not prevent a member from obtaining medically necessary services.

12. The following forms signed within 30 calendar days prior to the start of care date of PDN services by the member's physician or by an advanced practice registered nurse (APRN) or Physician Assistant (PA) to whom the physician has delegated this authority.

12.1 A completed THSteps-CCP Prior Authorization request form signed and dated by the primary physician within 30 calendar days prior to the start of care date;

12.2 The physician signed Plan of Care (POC) signed and dated by the primary physician within 30 calendar days prior to the start of care date that includes:

- The member's Medicaid number; the physician's license number; and the provider's Medicaid number
- Date the member was last seen by the physician
- The start of care (SOC) date for PDN services
- All pertinent diagnoses
- The member's mental status
- The types of service requested, including the amount, duration, and frequency
- The equipment or supplies required
- Rehabilitation potential
- Prior and current functional limitations
- Activities permitted
- Nutritional requirements
- Medications, including the dose, route, and frequency
- Treatments, including amount and frequency
- Wound care orders and measurements
- Safety measures to protect against injury
- Responsible adult when the client is a minor child
- Contingency plan

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- List of all community or state agency services the member receives in the home (including, but not limited to, PCS, Community First Choice (CFC), MDCP
- Instructions for timely discharge or referral
- Member specific goals, including if receiving PPECC, the goal of ensuring coordination of ongoing skilled nursing services with the PPECC provider
- If the member also receives PPECC services, documentation that the client or client's responsible adult has been involved in the POC development, and description of how ongoing skilled nursing services will be coordinated between PDN and PPECC providers.

13. 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, and client, parent, guardian, or responsible adult within 30 calendar days prior to the SOC date.

    13.1 The completed Nursing Addendum form must include all the following:

    - Summary of the client's medical problems relating to the medical necessity for PDN including summary of recent health history.
    - Updated problem list focusing on the primary reasons that a licensed nurse is required to care for the client.
    - Updated rationale/summary page including:
        - The rationale for increasing, decreasing, or maintaining the level of PDN and must relate to the client's health problems and goals.
        - Contingency plan
        - 24-hour daily care flowsheet
        - A signed acknowledgement

Revision of Services During Current Authorization:

14. Requests for revisions may be submitted during the current authorization period if medically necessary and must include all required documentation for initial requests revised to reflect the updated medical needs.

    14.1 Requests for revisions must be submitted within three business days of the revised SOC date.

    14.2 Revisions to a current authorization are limited to that authorization period. If the requested revision will extend beyond the current authorization period, new authorization documentation must be submitted.

    14.3 If the revision is requested outside of an authorization period, the provider must request a new authorization and submit the following documentation:

    14.1.1 A completed THSteps-CCP Prior Authorization Request form signed and dated by the primary physician within 30 calendar days prior to the SOC date.

    14.1.2 A completed POC form, signed and dated by the primary physician within 30 calendar days prior to the SOC date.

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14.1.3 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, and parent, guardian, client, or responsible adult within 30 calendar days prior to the SOC date.

15. Revised services may be prior authorized for up to a maximum of six months.

15.1. A request for a client that does not satisfy the criteria listed above for a six-month authorization may be authorized for a period up to three months.

15.2. The provider is responsible for ensuring that the physician reviews and signs the POC within 30 calendar days of the start date of the revised authorization period, or more often if required by the client's condition or agency licensure.

15.2.1 The provider must maintain the physician-signed POC in the client's record.

15.2.2 PDN providers should not submit a revised POC unless they are requesting a revision.

Recertification of Authorization (Service Extension):

16. Recertifications may be prior authorized for up to a maximum of six months and require:

16.1 Member must have received PDN services for at least 3 months
16.2 No significant changes in the member's condition for at least 3 months
16.3 No significant changes in the member's condition are anticipated

17. The following documentation is required for recertification

17.1 The member's responsible adult, physician, and provider agree that a recertification authorization is appropriate.

17.2 Statement of the appropriateness of the length of the recertification.

17.3 A completed THSteps- CCP Private Duty Nursing six-month authorization signed and dated by the primary physician, nurse provider, and client, parent, or guardian

17.4 A completed THSteps CCP Prior Authorization request form signed and dated by the primary physician within 30 calendar days prior to the SOC date

17.5 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, and parent, guardian, client, or responsible adult within 30 calendar days prior to the SOC date

17.5 Medical necessity established by the ordering physician. Members must be seen by their treating practitioner no less than once every 365 days.

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18. TCHP will not require but recommends 7 to 10 days of nursing notes, ventilator logs (if applicable), suction logs (if applicable), and seizure logs (if applicable) be submitted with the prior authorization request to document the medical necessity for the requested skilled nursing services that are delivered and thus expedite prior authorization review.

    18.1 If not provided, these documents may be requested by TCHP if in the judgement of TCHP, these additional documents are required to adequately assess medical necessity for the requested private duty nursing services.

PDN and Total Parenteral Nutrition (TPN):

19. For member's who are receiving PDN services who also require TPN administration education, requests for prior authorization of intermittent skilled nursing (SN) visits may be separately authorized when:

    19.1 The PDN provider is not an RN appropriately trained in the administration of TPN and the PDN provider is not able to perform function; AND
    19.2 There is documentation that supports the medical need for an additional skilled nurse to perform TPN administration education.

Medical Necessity:

20. Medical necessity must be documented in the member's prior authorization request. PDN in the home is considered medically necessary when the following criteria are met:

    20.1 PDN services are considered medically necessary when a member has a disability, physical or mental illness, or chronic condition, and he or she requires continuous, skillful observations, judgments, and interventions to correct or ameliorate his or her health status including one or more of the following:

    - Dependent on technology to sustain life.
    - Requires ongoing and frequent skilled interventions to maintain or improve health status; and delayed skilled intervention is expected to result in:
        - Deterioration of a chronic condition;
        - Loss of function;
        - Imminent risk to health status due to medical fragility; or
        - Risk of death.

21. Professional and vocational nursing care consists of those services that must, under state law, be performed by an RN or LVN, and are further defined as nursing services in the Code of Federal Regulations (42 CFR §§ 409.32, 409.33, and 409.44).

    21.1 In determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and the accepted standards of medical and nursing practice.

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21.2 If the nature of a service is such that it can safely and effectively be performed by the average nonmedical person without direct supervision of a licensed nurse, the services cannot be regarded as nursing care.

21.3 If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a nursing service.

22. The member's nursing needs cannot be met on an intermittent or part-time basis through Texas Medicaid (Title XIX) home health services skilled nursing services.

23. Services must require the professional proficiency and skills of an RN or LPN/LVN.

    23.1 The decision to use an RN or LPN/LVN is dependent on the type of services required and must be consistent with the scope of nursing practice under applicable state licensure regulations.

    23.2 PDN performed by an LPN/LVN must be under the supervision of an RN following a plan of care developed by the physician in collaboration with the member, family/caregiver, and PDN.

    23.3 PDN services include nursing and caregiver training and education.

    23.4 If the client has no skilled nursing need other than provision of education for self-administration of prescribed injections (IM, SQ, or IV), then the client does not qualify for private duty nursing services. Nursing hours for the sole purpose of education to the client and caregiver may be considered through intermittent home health skilled nursing visits.

24. The ordering physician must provide examination or treatment within thirty (30) calendar days prior to the start of PDN services, or examination or treatment that complies with the THSteps periodicity schedule, or is within six (6) months of the PDN extension Start of Care (SOC) date, whichever is more frequent;

    24.1The physician visit may be waived when a diagnosis has already been established by the physician, and the member is under the continuing care and medical supervision of the physician.

    24.2 A waiver is valid for no more than 365 days, and the member must be seen by his/her physician at least once every 365 days.

    24.3 A waiver must be based on the physician's written statement that an additional evaluation visit is not medically necessary. This documentation must be maintained by the physician and the provider in the member's medical record; AND

    - Certify the medical necessity of PDN; **AND**
    - Approve a written treatment plan with short and long term goals specified.

25. Medically necessary PDN services will not be denied or reduced for members based on the parent or guardian's ability to provide the necessary PDN services.

26. The fact that the nursing care can be, or is, taught to the client or to the client's family or friends does not negate the skilled aspect of the service when the service is performed by a nurse.

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27. PDN services that are intended to provide mainly respite care; child care; or do not directly relate to the client's medical needs or disability are not a benefit of Texas Medicaid.
28. The delivery of PDN services may inherently result in the relief of the parent, guardian, or responsible adult, child care, or some nonmedical, nonskilled activities in the course of providing nursing care.

Coordination with Prescribed Pediatric Extended Care Centers (PPEC):

29. Both PDN and PPECC services are considered ongoing skilled nursing. A member has a choice of PDN, PPECC, or a combination of both PDN and PPECC for ongoing skilled nursing where PPECC services are available.
30. Skilled Nursing services are authorized for a set number of hours based on the client's medical necessity at the time of the prior authorization request.
31. PDN and PPECC providers must collaborate in developing their respective 24-hour flow charts found in the Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form each time a client's authorization for ongoing skilled nursing is initiated, renewed and revised.
32. A member receiving both PDN and PPECC services may choose to shift approved hours from one ongoing skilled nursing provider to another.
33. The receiving provider (PDN or PPECC provider who will gain hours in the shift) must submit all required documentation for a revision.
34. The sending provider (PDN or PPECC provider who will lose hours in the shift) will receive a notice from TCHP Prior Authorization Department with revised (decreased) hours and the effective date of the reduction.
35. The total combined hours between PDN and PPECC services are not expected to increase without member medical necessity for additional hours (e.g., change in client condition or authorized hours are not commensurate with the member's medical needs).

Residence:

36. Members who are 17 years of age or younger or have a managing conservator or legal guardian must reside with an identified responsible adult who is either trained to provide nursing care or capable of initiating an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable.

Length of Prior Authorization:

37. The length of the prior authorization is determined on an individual basis and is based on the goals and timelines identified by the physician, provider, and member or responsible adult.
    37.1 Initial requests may be prior authorized for a maximum of 90 days.

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37.2 Re-certifications may be prior authorized for up to a maximum of six months when:

- The member has received PDN services for at least three months
- The client's parent or guardian, physician, and provider agree the recertification is appropriate

Amount of PDN Services [TAC §363.309]:

38. The amount of medically necessary PDN services available to recipients will not be restricted.

    38.1 TCHP may deny or reduce PDN hours if the member's nursing needs decrease.

Duplicate Services – SHARS:

39. PDN that duplicates services that are the legal responsibility of the school districts are not reimbursed. The school district, through the SHARS program, is required to meet the member's skilled nursing needs while the member is at school; however, if those needs cannot be met by SHARS or the school district, documentation supporting medical necessity may be submitted with documentation that nursing services are not provided in the school and may be considered if medically necessary. [TAC § 354.1341]

Provider to Member Ratio:

40. PDN may be delivered in a provider to member ratio other than one-on-one.
41. An RN or LVN may provide PDN services to more than one member over the span of the day as long as each member's care is based on an individualized POC, and each member's needs and POC do not overlap with another member's needs and POC.
42. Only the time spent on direct PDN for each member is reimbursed. Total PDN billed for all members cannot exceed an individual provider's total number of hours at the POS.

    42.1 A single nurse may be reimbursed for services to more than one member in a single setting when the following conditions are met:

    - The hours for PDN for each member have been authorized through TCHP.
    - Only the actual "hands-on" time spent with each member is billed for that member.
    - The hours billed for each member do not exceed the total hours approved for that member and do not exceed the actual number of hours for which services were provided.

Services Not Covered:

43. PDN services are not covered when:

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43.1 The nurse providing care is the parent or guardian of a minor patient, the member's spouse, or the responsible adult.

43.2 The patient is in an acute inpatient hospital, inpatient rehabilitation, skilled nursing facility, intermediate care facility or a resident of a licensed residential care facility.

43.3 There is a Third Party Resource financially responsible for the services.

43.4 The services are for the primary purpose of providing respite care, childcare, ADLs for the member, housekeeping services, or comprehensive case management beyond the service coordination required by the Texas Nursing Practice Act. [1 TAC § 363.303(20); TMPPM § 4.1.3 & 4.1.4; 1 TAC § 363.309]

Cancelling a Prior Authorization:

44. The member has the right to choose their home health agency provider and to change providers. If the member changes providers, TCHP must receive a change of provider letter with a new Plan of Care.

    44.1The member must sign and date the letter, which must include the name of the previous provider, the current provider, and the effective date for the change. The member is responsible for notifying the original provider of the change and the effective date.

    44.2 Prior authorization for the new provider can only be issued up to three business days before the date TCHP receives the change of provider letter.

Termination of Authorization:

45. Authorization for PDN services will be terminated when:

    45.1 no longer eligible for Medicaid;

    45.2 no longer meets the medical necessity criteria for PDN services;

    45.3 place of service does not support member health and safety; OR

    45.4 member, parent, or guardian refuses to comply with the service plan and compliance is necessary to assure the health and safety of the member. [TAC § 363.311]

Denial or Reduction of Requested Services:

46. Requests that do not meet the criteria established by this guideline will be referred to a TCHP Medical Director/Physician Reviewer for review and the Denial Notice Policy and Procedure will be followed. [1 TAC § 363.311]

47. TCHP may not deny or reduce services based solely on the recipient's diagnosis, type of illness, or health condition.

48. TCHP may not deny or reduce services solely because the recipient's condition or health status is stable or has not changed.

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49. TCHP may deny or reduce PDN services when the:
    - Request is incomplete;
    - Information in the request is inconsistent;
    - Documentation does not explain to TCHP's satisfaction the medical need for a private duty nurse or no longer supports the medical need for a private duty nurse;
    - Documentation does not address how PDN services correct or ameliorate the recipient's disability or physical or mental illness or condition;
    - Requested PDN services are not nursing services as defined by the Texas Nursing Practice Act and its implementing regulations;
    - Medical director or physician reviewer, after conferring with the recipient's treating physician, determines the requested PDN services are not medically necessary to correct or ameliorate the recipient's disability or physical or mental illness or condition; or
    - Recipient's nursing needs could be met through a visiting nurse

Prior Authorization is Not a Guarantee:

50. Prior authorization is based on medical necessity and not a guarantee of benefits or eligibility. Even if prior authorization is approved for treatment or a particular service, that authorization applies only to the medical necessity of treatment or service. All services are subject to benefit limitations and exclusions. Providers are subject to federal, state, and local laws and regulations and failure to comply may result in retrospective audit and potential financial recoupment. [1 TAC § 363.311]

Continuity of Care:

51. TCHP ensures that members receiving services through a prior authorization from either another Managed Care Organization (MCO) or Fee for Service (FFS) provider receive continued authorization of these services for the same amount, duration, and scope for the shorter period of one of the following:
    - 90 calendar days after the transition to a new MCO
    - Until the end of the current authorization period
    - Until TCHP has evaluated and assessed the member and issued or denied a new authorization

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REFERENCES:

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