

Clinical Policy: Private Duty Nursing Services

Reference Number: WA.CP.MP.503

Last Review Date: 04/24

Effective Date: 06/01/24

[Coding Implications](#)

[Revision Log](#)

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

Description

This policy describes the medical necessity guidelines for private duty nursing (PDN) services, which may be authorized under the Medically Intensive Children's Program (MICP).

Private duty nursing services consist of four or more hours of continuous skilled nursing services provided in the home to eligible clients with complex medical needs that cannot be managed within the scope of intermittent home health services.

Background

This policy is based on Washington State Health Care Authority Billing Guidelines, modified to reflect the use of InterQual LOC: Home Care Q&A Private Duty Nursing (PDN) Assessment. PDN assessment shall be completed at a minimum of every 90 to 180 days depending on clinical condition, for members/enrollees receiving in home PDN services, and every 180 days for members/enrollees residing in a medical group home. Additional assessments outside of the scheduled assessments may be indicated due to, but not limited to, prolonged hospitalization, change of condition, or change in placement. Coordinated Care will complete clinical reviews using documents submitted by the PDN agencies that demonstrate the continued skilled nursing needs of the member/enrollee.

Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., that to be eligible for private duty nursing services, a member/enrollee must meet ALL the following:
 - A. Under 18 years of age and
 - B. Require a minimum of four hours of continuous skilled nursing services and
 - C. Primary care and/or treating physician recommends PDN as part of a treatment plan and
 - D. Meet [medical necessity criteria](#) found in section II and
 - E. Have informal support by a person who has been trained to provide designated skilled nursing care and is able to perform the care as required.

- II. It is the policy of Coordinated Care that private duty nursing services are considered **medically necessary** when *all* of the following are present:
 - A. Member/Enrollee has unmet skilled nursing needs that cannot be met with less restrictive services (i.e., intermittent home health services) and
 - B. Member/Enrollee has a complex medical need that requires four or more *continuous* hours of skilled nursing care, which can be safely provided outside an institution and that cannot be delegated to a lower level of care provider (i.e., DDA Personal Care Giver) at the time of initial assessment and on-going assessments and

- C. Member/Enrollee requires substantial and ongoing daily skilled nursing care comparable to the level of care provided in a hospital setting to avert death or further disability and
- D. In the absence of home care, illness or disability would require admission to, or prolonged stay in a hospital.

III. It is the policy of Coordinated Care that InterQual criteria for PDN Assessment is used to determine the *number of hours* of PDN a member/enrollee may receive when such care is medically necessary.

- A. Per Washington Administration Code (WAC 182-551-3000) and the Health Care Authority Billing Guidelines, a member/enrollee may qualify for up to 16 hours of PDN services per day.
 - a. When provided in the patient's home, these services are billed using HCPCS code T1000 and the appropriate modifiers as defined in the HCA Private Duty Nursing Billing Guideline.
 - b. When provided in a medical group home setting, these services are to be billed using HCPCS code T1030.
- B. Members/Enrollees who are receiving PDN services when transitioning from another Managed Care Organization (MCO) will continue to receive services at levels authorized by the previous MCO for up to 90 days to ensure a safe transition.
- C. Requests by family, member/enrollee, caregiver or the PDN agency for additional support hours beyond the PDN Assessment allotted that are over the standard 16 hours/day allowable, will be reviewed under the Limitation Extension WAC 182-501-0169 and ESPDT WAC 182-534-0100 for up to 24 hours/day for what is medically necessary.
- D. Coordinated Care utilizes InterQual to determine appropriate nursing hours available to the member/enrollee. InterQual provides a range of clinically appropriate hours based on an assessment of the member/enrollee's care needs and clinical conditions. For members/enrollees meeting criteria within the suggested ranges of 8-16 hours, the Medical Director will review the request and determine the hours that are medically necessary per day.
- E. Coordinated Care recognizes the need for skilled nursing services may change as the pediatric member/enrollee develops. This could result in increased or reduced hours. Any reduction of hours due to a change in the member/enrollee's needs will be communicated to the family. A transition plan will be used that reduces two hours of PDN time every 30 days until the member/enrollee is at the identified hours. This will allow the PDN nurse to assess how the reduction is being tolerated and ensure the needs of the member/enrollee are being met effectively. Any concerns will be brought to the clinical team at Coordinated Care for reassessment.

IV. It is the policy of Coordinated Care that for members/enrollees in a medical group home, PDN nurse time may be medically necessary during medical transportation for medical appointments. Claims must be submitted by the 5th day of each month for the previous month using HCPCS code T1000 and the appropriate modifiers as defined the HCA Private Duty Nursing Billing Guideline.

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.

HCPCS Codes	Appropriate Modifier(s)			Description
T1000	TD			Private duty nursing, RN, per 15 minutes
T1000	TD	TU		Private duty nursing, RN, per 15 minutes, overtime
T1000	TD	TV		Private duty nursing, RN, per 15 minutes, holiday*
T1000	TD	TK		Private duty nursing, RN, second client same home, per 15 minutes
T1000	TD	TK	TV	Private duty nursing, RN, second client same home, per 15 minutes, holiday
T1000	TE			Private duty nursing, LPN, per 15 minutes
T1000	TE	TU		Private duty nursing, LPN, per 15 minutes, overtime
T1000	TE	TV		Private duty nursing, LPN, per 15 minutes, holiday*
T1000	TE	TK		Private duty nursing, LPN, second client same home, per 15 minutes
T1000	TE	TK	TV	Private duty nursing, LPN, second client same home, per 15 minutes, holiday
T1030				Nursing care, in the home, by registered nurse, per diem

***Paid Holidays are limited to:** New Year’s Day, Martin Luther King Day, Presidents’ Day, Memorial Day, Independence Day, Labor Day, Veteran’s Day, Thanksgiving Day and Christmas Day.

Reviews, Revisions, and Approvals	Date	Approval Date
Policy adopted. Split out from WA.UM.CM.29	07/19	07/19
Annual review. Reference updated. Removed statement about SNF placement with no SNF bed available.	05/20	08/20
Updated to reflect the decision to move to InterQual criteria vs. current policy. Removed all MATLOC criteria. Added Social Factors assessment for additional hours. Restructured document. Updated references. Replaced “member” with “member/enrollee” in all instances.	11/21	12/21
Annual review. Added HCA definition of Private Duty Nursing to the Description section. Added minimum hours to section I. Updated sections II.A and II.B to add clarity and examples. Reworded III.A. to add billing instructions for patient’s home in addition to the instructions for billing when in a group home. Clarified billing instructions in IV. Updated references.	2/23	3/23
Annual review. References reviewed and updated. Section III. A. updated to reference HCA Billing Guidelines. Section III. C. wording updated to include EPSDT WAC and clarified hours for limitation extension/EPSDT requests. EPSDT WAC added to references. Struck references to social/economic factors.	03/24	04/24

References

1. Washington State Health Care Authority. Private Duty Nursing for Children Billing Guide. <https://www.hca.wa.gov/assets/billers-and-providers/Private-duty-nursing-bg-20230511.pdf>
 Revisions effective May 11,, 2023.
2. Washington Administrative Code (WAC) 182-551-3000. Accessed 3/14/2024.
3. Washington Administrative Code (WAC) 182-501-0169. Accessed 3/14/2024.
4. Washington Administrative Code (WAC) 182-534-0100. Accessed 3/14/2024.

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.

Note: For Medicaid members/enrollees, 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.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene[®] and Centene Corporation[®] are registered trademarks exclusively owned by Centene Corporation.