

# Private Duty Nursing (PDN) Services

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[➔ Instructions for Use](#)

Table of Contents	Page
<a href="#">Coverage Rationale</a> .....	1
<a href="#">Definitions</a> .....	3
<a href="#">Applicable Codes</a> .....	4
<a href="#">References</a> .....	4
<a href="#">Guideline History/Revision Information</a> .....	5
<a href="#">Instructions for Use</a> .....	5

<b>Related Commercial Policies</b>
<ul style="list-style-type: none"> <li>• <a href="#">Home Health Care</a></li> <li>• <a href="#">Home Hemodialysis</a></li> <li>• <a href="#">Skilled Care and Custodial Care Services</a></li> </ul>
<b>Community Plan Policy</b>
<ul style="list-style-type: none"> <li>• <a href="#">Private Duty Nursing (PDN) Services</a></li> </ul>

## Coverage Rationale

### Indications for Coverage

Before using this guideline, refer to the member specific benefit plan document and any federal or state mandates to determine if the plan has an exclusion for Private Duty Nursing. If the plan has the exclusion for Private Duty Nursing, then the services are not eligible for coverage. When Private Duty Nursing is a covered benefit, refer to the member specific benefit plan document for additional information regarding benefit coverage.

### Requirements for Coverage

Private Duty Nursing (PDN) services are covered and considered Medically Necessary for members requiring individual and continuous [Skilled Care](#) when ordered by the member’s primary care and/or treating physician as part of a Treatment Plan and when a member meets all of the following criteria:

- Needs Skilled Care that exceeds the scope of [Intermittent Care](#); and
- Needs services that require the professional proficiency and skills of a licensed nurse (RN or LPN); and
- Is unable to have their care tasks provided through, Intermittent Care, or self-directed care; and
- Has a complex medical need and/or unstable medical condition that requires four (4) or more continuous hours of Skilled Care which can be safely provided outside an institution; and
- Requires Skilled Care that is Medically Necessary for the member’s disease, illness, or injury, as defined by the member’s physician; and
- Has family or other appropriate support that has the ability and availability to be trained to care for the member and assume a portion of the care. (Note: The intent of PDN services is to support not replace the caregiver); and
- Periodically reviewed Treatment Plan (no more frequently than every 90 days) updated by the treating physician; and
- The services are more cost-effective in the Home than in an alternate setting such as a hospital or a facility that provides Skilled Care (Note: Refer to the member specific benefit plan document for additional information regarding benefit coverage, as applicable)

### Coverage Limitations and Exclusions

- Requested services are defined as non-skilled or Custodial Care in the member specific benefit plan document (refer to the Coverage Determination Guideline titled [Skilled Care and Custodial Care Services](#), the member specific benefit plan document, and/or any federal or state mandate requirements) such as but not limited to:

- Members who are on continuous or bolus nasogastric (NG) or gastrostomy tube (GT) feedings and do not have other Skilled Care needs (Note: Transition from an inpatient setting to the Home may be considered Medically Necessary for these members when there is a need to train the member's family or caregiver to administer the NG or GT feedings);
- PDN services become maintenance or Custodial Care and not Medically Necessary when any one of the following situations occur:
  - Medical and nursing documentation shows that the member's condition is stable/predictable/controlled and that a licensed nurse is not required to monitor the condition;
  - The Plan of Care does not require a licensed nurse to be in continuous attendance;
  - The Plan of Care does not require hands-on nursing interventions (Note: Observation in case an intervention is required is not considered Skilled Care)
- The following are examples of services that do not require the skills of a licensed nurse and therefore do not meet the medical necessity requirements for PDN services:
  - Any duplication of care which is already provided by supply or infusion companies
  - Care of an established colostomy/ileostomy
  - Care of an established gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
  - Care of an established indwelling bladder catheter (including emptying/changing containers and clamping tubing)
  - Care of an established tracheostomy (including intermittent suctioning)
  - Help with daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
  - Institutional care, including room and board for rest cures, adult day care and convalescent care
  - Respite care, adult (or child) day care, or convalescent care
  - Routine administration of maintenance medications including insulin [this applies to oral (PO), subcutaneous (SQ) and intramuscular (IM) medications]
  - Routine patient care such as changing dressings, periodic turning and positioning in bed, administering oral medications; or
  - Watching or protecting a member
- Requested services are excluded in the benefit documents or state specific contracts.
- Respite care and convenience care unless mandated (Note: Respite care relieves the caregiver of the need to provide services to the member)
- Services beyond the plan benefits (hours or days) or member is no longer eligible for benefits under the plan or any federal or state mandate requirements
- Services that can be provided safely and effectively by a non-clinically trained person are not skilled when a non-skilled caregiver is not available such as but not limited to:
  - Member must have one caregiver willing and able to accept responsibility for the member's care when the nurse is not available. If parent/caregiver cannot or will not accept responsibility for the care, PDN will not be authorized as this is deemed an unsafe environment
  - Placement of the nurse in the Home is for the convenience of the family caregiver, including solely to allow the member's family or caregiver to go to work or school
  - Primary caregiver is identified as available and able, but is not willing to provide care to the member
  - There is no person available to assume the role of caregiver
- Services that involve payment of family members or non-professional caregivers for services performed for the member unless required by state contract

## Documentation Requirements

### *Initial Request for Authorization*

Initial service requests of PDN services (first time member is requesting services with UHC) must be submitted with all of the following clinical documentation:

- Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.); and
- A comprehensive assessment of the member's health status including documentation of the skilled need and medication administration record; and
- Consultation notes if the member is receiving services from subspecialist; and
- An assessment of the scope and duration of PDN services to be provided

Additional documentation clarifying clinical status (such as well child check and/or specialist visit notes) may be requested if clinical documentation provided does not support the hours required.

### ***Renewal of Services***

Requests for renewal of PDN services (any request subsequent to the initial request with UHC) will require submission of all of the following specific clinical documentation to support Medical Necessity:

- Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.); and
- Nurses' notes, logs and daily care flow sheets, as applicable

### ***Transition of Services***

If a member is transitioning from another health plan and is already receiving PDN services, then all of the following documentation must be submitted before the end of the required continuity of care period:

- Home Health Certification (CMS-485) which includes the Plan of Care signed by a physician (M.D. or D.O.); and
- Nurses' notes, logs and daily care flow sheets, as applicable

## **Definitions**

Check the member specific benefit plan document or any federal or state mandate language before using the definitions below; if definitions exist in the member specific benefit plan document, the specific plan document definitions must be applied.

**Custodial Care:** Services that are any of the following non-Skilled Care services:

- Non-health-related services, such as help with daily living activities. Examples include eating, dressing, bathing, transferring and ambulating.
- Health-related services that that can safely and effectively be performed by trained non-medical personnel and are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function, as opposed to improving that function to an extent that might allow for a more independent existence.

**Home:** Location, other than a hospital or other facility, where the patient receives care in a private residence.

**Intermittent Care:** Skilled nursing care that is provided either:

- Fewer than seven days each week
- Fewer than eight hours each day for periods of 21 days or less

Exceptions may be made in certain circumstances when the need for more care is finite and predictable.

**Medically Necessary:** Health care services that are all of the following as determined by us or our designee:

- In accordance with Generally Accepted Standards of Medical Practice
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms
- Not mainly for your convenience or that of your doctor or other health care provider
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We have the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons through [www.myuhc.com](http://www.myuhc.com) or the telephone number on your ID card. They are also available to Physicians and other health care professionals on [UHCprovider.com](http://UHCprovider.com).

**Plan of Care:** Written instructions detailing how the client is to be cared for. The plan is initiated by the private duty nurse or nursing agency with input from the prescribing physician.

**Private Duty Nursing:** Nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or Home setting when any of the following are true:

- Services exceed the scope of Intermittent Care in the home.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.
- Skilled nursing resources are available in the facility.
- The Skilled Care can be provided by a Home Health Agency on a per visit basis for a specific purpose.

**Skilled Care:** Skilled nursing, skilled teaching, skilled habilitation and skilled rehabilitation services when all of the following are true:

- Must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient,
- Ordered by a Physician,
- Not delivered for the purpose of helping with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair,
- Requires clinical training in order to be delivered safely and effectively, and
- Not Custodial Care, which can safely and effectively be performed by trained non-medical personnel

**Treatment Plan:** Treatment plan includes all of the following:

- Diagnosis
- Proposed treatment by type, frequency, and expected duration of treatment
- Expected treatment goals
- Frequency of treatment plan updates

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
T1000	Private duty/independent nursing service(s), licensed, up to 15 minutes

## References

- CMS Medicare Benefit Policy Manual, Chapter 7 Home Health Services @ <http://www.cms.hhs.gov/manuals/Downloads/bp102c07.pdf>. Accessed May 4, 2020.
- Colorado Medicaid. Long Term in Home Care: <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1205745755264>. Accessed May 4, 2020.
- MoHealth Net. Private duty nursing manual. 2017; [http://manuals.momed.com/collections/collection\\_pdn/print.pdf](http://manuals.momed.com/collections/collection_pdn/print.pdf).

North Carolina Division of Medical Assistance. Clinical coverage policy 3G-1: private duty nursing for beneficiaries age 21 and older. 2017; [https://files.nc.gov/ncdma/documents/files/3G-1\\_1.pdf](https://files.nc.gov/ncdma/documents/files/3G-1_1.pdf).

North Carolina Division of Medical Assistance. Clinical coverage policy 3G-2: private duty nursing for beneficiaries under 21 years of age. 2017; [https://files.nc.gov/ncdma/documents/files/3G-2\\_1.pdf](https://files.nc.gov/ncdma/documents/files/3G-2_1.pdf).

Oregon Administrative Rules. 410.132: private duty nursing services administrative rulebook. 2015; <http://www.oregon.gov/oha/HSD/OHP/Policies/132rb082515.pdf>.

Oversight Committee of North Carolina, Controlling the Cost of Medicaid Private Duty Nursing Services, December 10, 2008. Presenter Kieran McGorty, JD, PHD, Senior Program Evaluator.

## Guideline History/Revision Information

Date	Summary of Changes
08/01/2020	<b>Template Update</b> <ul style="list-style-type: none"><li>Reformatted policy; transferred content to new template</li></ul>
07/01/2020	<b>Template Update</b> <ul style="list-style-type: none"><li>Removed <i>Documentation Requirements</i> section; refer to the <i>Coverage Rationale</i> section of the policy for details on applicable documentation requirements</li></ul> <b>Definitions</b> <ul style="list-style-type: none"><li>Updated definition of “Private Duty Nursing”</li></ul> <b>Supporting Information</b> <ul style="list-style-type: none"><li>Updated <i>References</i> section to reflect the most current information</li><li>Archived previous policy version CDG.017.08</li></ul>

## Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.