Driscoll Health Plan
Medical Necessity Guideline

Medical Necessity Guideline:	Creation Date:	Review Date:	Effective Date:
Private Duty Nursing, Skilled Nursing Visits, and Prescribed Pediatric Extended Care Center (PPECC)	08/23/2022	05/30/2025	07/17/2025

PURPOSE:

Authorization for private duty nursing (PDN), skilled nursing (SN), and the use of a Prescribed Pediatric Extended Care Center (PPECC) requires that the member must first meet medical necessity for nursing. The purpose of this guideline is to provide information on the Texas Medicaid benefits, policies, and applicable procedures for authorizing these services. While eligibility for skilled nursing is not age delimited, to be eligible for private duty nursing and/or placement in a prescribed pediatric extended care center, the member must be age birth through 20 years and be eligible for Medicaid and THSteps (Texas Health Steps – EPSDT Services in Texas).

LINE OF BUSINESS:
PDN and SNV: STAR, STAR Kids, and CHIP
PPECC: STAR Kids Only

DEFINITIONS:

Allowed Practitioner: a Texas Medicaid enrolled physician, a physician assistant, or an advanced practice registered nurse who is licensed as a certified nurse practitioner (CNP) or clinical nurse specialist (CNS) also enrolled in Texas Medicaid.

Medical necessity (MN): Medical necessity is the prerequisite for participation in the Medicaid (Title XIX) Long-term Care program. The general qualifications of a medical necessity determination are defined by the Texas Administrative Code (TAC) [1]. Per the TAC, medical necessity exists when an individual meets the following conditions:

1. The individual must demonstrate a medical condition that:
    a. is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and
    b. requires licensed nurses' supervision, assessment, planning, and intervention that are available only in an institution.
2. The individual must require medical or nursing services that:
    a. are ordered by an allowed practitioner;
    b. are dependent upon the individual's documented medical conditions;
    c. require the skills of a registered or licensed vocational nurse;

d. are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and
e. are required on a regular basis.

Skilled Nursing (SN): Nursing services ordered by an allowed practitioner that are short in duration (≤2.5 hours per episode and required to be performed ≤ 3 times per day), included in the Texas Medicaid home health services Plan of Care (POC), and provided by an RN or a licensed vocational nurse (LVN) currently licensed by the Board of Nurse Examiners of the State of Texas (BNE).

Private duty Nursing (PDN): Nursing services, as described by the Texas Nursing Practice Act and its implementing regulations, for clients who meet the medical necessity criteria, and who require individualized, continuous, skilled care beyond 7.5 continuous hours daily. PDN services may be provided by a registered nurse (RN) or a licensed vocational nurse (LVN).

Prescribed Pediatric Extended Care Center (PPECC): Nursing services provided in a facility outside the home where the member requires ongoing skilled nursing care beyond the level of Skilled Nursing (SN) that would normally be authorized under the Texas Home Health Skilled Nursing (HHSN) Service. This is an alternative to private duty nursing. The maximum length of stay is 12 continuous hours/day up to and including 7 days/week.

GUIDELINE:

A. Skilled Nursing

Authorization for SN visits may be considered when a client requires nursing services for an acute condition or an acute exacerbation of a chronic condition that can be met on an intermittent or part-time basis (no more than 2.5 hours per visit with a maximum number of visits ≤ 3 in a 24-hour period) and typically has an endpoint. SN visits may be provided on consecutive days. SN visits are intended to provide nursing care to promote independence and support the client living at home.

Criteria for Skilled Nursing Visits (SNV)

SN visits are considered medically necessary for a client who:

- Requires skillful observations and judgment to improve health status, skilled assessment, or skilled treatments or procedures.
- Requires individualized, intermittent, acute skilled care.

- Requires skilled interventions to improve health status, and if skilled intervention is delayed, it 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
- Examples of medically necessary skill nursing services:
  - Monitoring, observation and assessment of potential changing patient condition requiring change in treatment
  - Intravenous or intramuscular injections
  - Intravenous/parenteral feeding
  - Insertion, sterile irrigation, replacement, and management of catheters
  - Wound dressing and wound care
  - Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part of active treatment (e.g., the institution and supervision of bowel and bladder training programs)

Note: *When documentation does not support medical necessity for home health SN visits, providers may be directed to possible alternative services based on the client's age and needs* [2].

Documentation Requirement for SNV

Home Health SNVs require prior authorization. The following must be provided:

- Specific written and dated order signed by an allowed practitioner for SNVs or recertification with the reason for SNV, frequency and expected duration of SNV.
- Clinical documentation by an allowed practitioner of the client's medical condition and supporting medical necessity for skilled nursing tasks that will be required
- Home Health agency nursing Plan of Care (POC)
- An allowed practitioner's review and continued approval of the home health services POC at least every 60 days, or more frequently as the allowed practitioner determines necessary, including but not limited to when the client's condition changes [3].

B. PDN and PPECC

All PDN and PPECC services must be prior authorized having first met medical necessity (see definitions above). All members who are birth through 17 years of age must reside with a parent, LAR, or responsible adult who is either trained to provide nursing care or can initiate an identified contingency plan when the scheduled private duty nurse is unexpectedly unavailable. The amount and duration of PDN/PPECC must always be commensurate with the Member's

medical needs. Requests for any change in services must reflect changes in the Member's condition that affect the amount and duration of PDN/PPECC.

PDN and PPECC services provide nursing care and parent, guardian, or responsible adult training and education intended to:

- Optimize client health status and outcomes; and
- Promote family-centered, community-based care as a component of an array of service options by:
    - Preventing prolonged or frequent hospitalizations or institutionalization.
    - Providing cost-effective and quality care in the most appropriate, least restrictive environment.

The client must have a primary provider termed an allowed practitioner (see definitions above) who provides continuing care and medical supervision, including, but not limited to, examination or treatment within 30 calendar days prior to the start of PDN services. The allowed practitioner visit may be waived when a diagnosis has already been established by the allowed practitioner, and the client is under the continuing care and medical supervision of the designated allowed practitioner. A waiver is valid for no more than 365 days, and the client **must** be seen by his or her allowed practitioner at least once every 365 days. The waiver **must** be based on the allowed practitioner's written statement that an additional evaluation visit is not medically necessary. This documentation **must** be maintained by the allowed practitioner and the servicing provider in the client's medical record.

The following are all taken into account when determining medical necessity for PDN/PPECC:

- Member's History of present illness (HPI), past medical history (pertinent to the HPI), review of systems (pertinent to the HPI), and physical findings (pertinent to the HPI)
- Medications – indications, dosage, frequency of administration, route of administration as well as anticipated side effects that might complicate the member's current clinical status
- Devices – all devices that are being used to sustain life
- Acuity – the acuity of the member's current medical condition (e.g., ranging from acutely ill and/or unstable to having a chronic condition with prolonged stability)
- Social drivers (determinants) of health – family composition; extended family present to assist; other support systems that could impact member's healthcare status, insecurities of family finances, transportation, food, housing; legal matters that may impact the member's healthcare outcome; other family stressors
- Behaviors/barriers to care – member's ability to communicate, member's cognitive status, member-specific needs, member's sleep pattern, other children in the home that might negatively impact this member's ongoing healthcare.

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

Criteria for PDN and PPECC

Authorization for PDN is based on the need for skilled care in the Member's home or in the case for PPECC in a non-residential facility licensed by HHSC. To be eligible for PDN/PPECC services, a client must meet all the following criteria [4, 5]:

- Be birth through 20 years of age and eligible for Medicaid and THSteps (Texas Health Steps – EPSDT Services in Texas)
- Meet medical necessity criteria for PDN/PPECC
    - Member is stable for outpatient medical services
    - Member is medically or technologically dependent
    - Member requires ongoing and frequent skilled interventions to maintain or ameliorate 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.
- Member has an allowed practitioner provider who coordinates care, establishes a plan of care (POC) and is the prescriber of PDN/PPECC
- Admission to PPECC must be voluntary and based on the preference of PPECC versus PDN by the client or client's responsible adult in both managed care and non-managed care service delivery systems [6]
- 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.
- The delivery of PDN services may inherently result in the relief of the parent, guardian, or responsible adult, childcare, or some nonmedical, nonskilled activities in the course of providing nursing care.
- PDN services that are intended to provide mainly respite care; childcare; or do not directly relate to the client's medical needs or disability are not a benefit of Texas Medicaid.

Documentation Requirements:

a. Initial Documentation: [7, 8]
   - A prescription for PDN/PPECC services signed and dated by an allowed practitioner who has personally examined the client within 30 calendar days prior to admission and reviewed all appropriate medical records.
   - Signed and dated THSteps- *CC Prior Authorization form* completed by the member's primary allowed practitioner within 30 calendar days prior to the start of care (SOC) date.
   - A completed POC form submitted by the agency which defines nursing tasks that is signed and dated by the member's primary allowed practitioner within 30 calendar days prior to the SOC date.
   - A completed *Nursing Addendum to Plan of Care for Private Duty Nursing and/or Prescribed Pediatric Extended Care Centers form* that is signed and dated by:
     - The member's primary allowed practitioner
     - RN completing the assessment
     - The member, parent/Legally Authorized Representative (LAR), or responsible adult

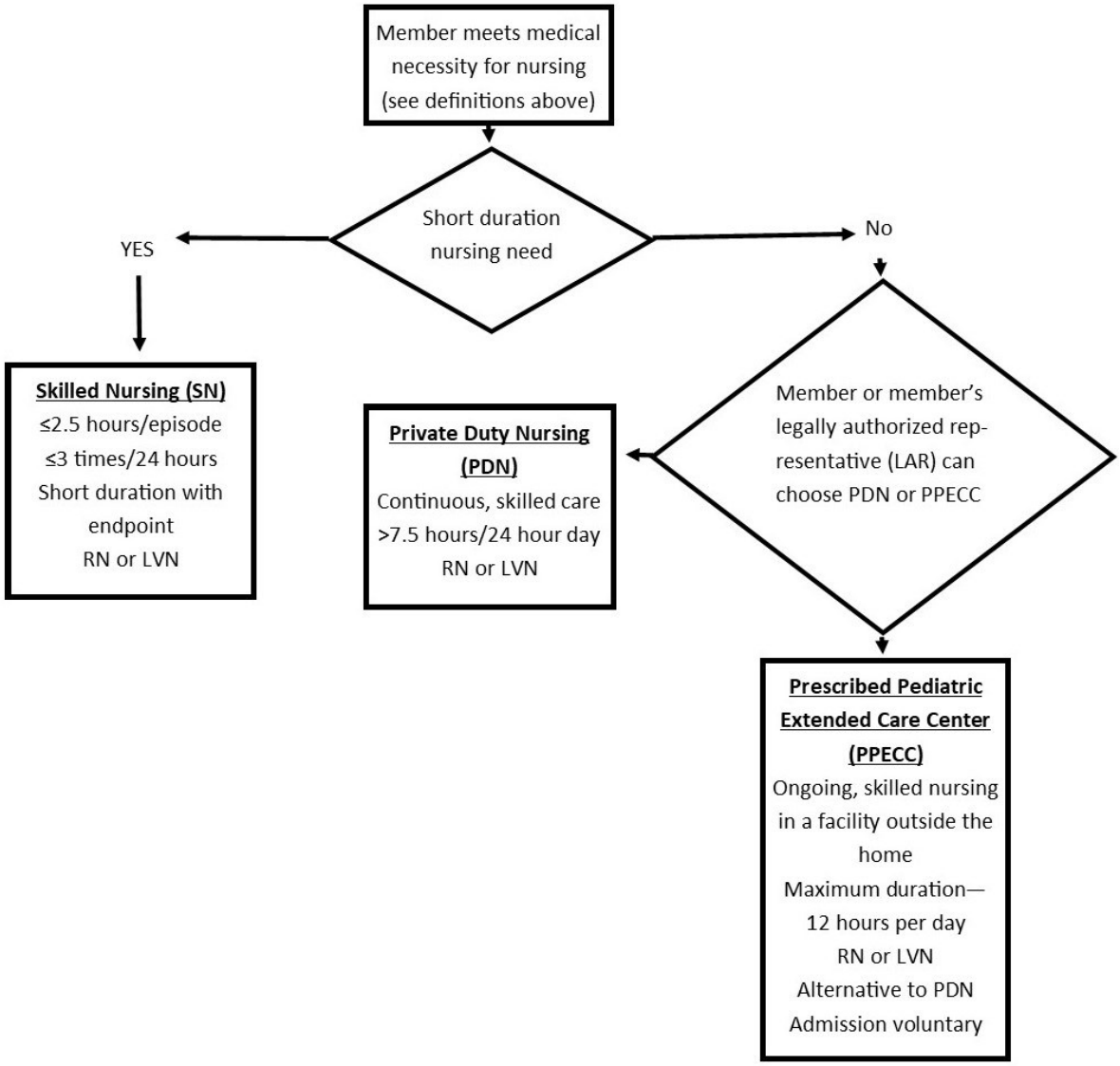
     within 30 calendar days prior to the SOC date. The completed Nursing Addendum form must include all the following:
       - An updated problem list
       - An updated rationale or summary page
       - A contingency plan
       - A 24-hour daily care flowsheet
       - A signed acknowledgement
   - Primary allowed practitioner and/or Subspecialist notes (within last six [6] months) describing the Members condition, treatment and continuous nurse need to support medical necessity for PDN/PPECC services
   - Other documentation such as ventilator and seizure logs
   - A signed consent for the client's admission to the PPECC signed and dated by the client or the client's responsible adult
   - Initial prior authorization may be authorized for up to a 90-day duration

b. Renewal Documentation:
   - All documentation required initially
   - At least two (2) weeks of nursing notes with description of interventions being provided
   - Renewal prior authorization may be authorized for up to a six (6) month duration

c. Documentation for Change in Requested PDN/PPECC:

- All of above documentation for changes in PDN/PPECC for initial and renewal PDN/PPECC.
- Current (within last three [3] months) primary allowed practitioner and/or Subspecialist clinical notes documenting the continued need or reason for change in PDN/PPECC services.

NURSING DECISION TREE FOR PRACTICING PHYSICIANS



BACKGROUND:

The peer-reviewed literature is lacking the details of medical decision-making for private duty nursing (PDN); how decisions are made when determining how many hours of PDN are required to keep a child or adolescent safe and free of avoidable hospitalization. In 1984, the American Academy of Pediatrics Ad Hoc Task Force on Home Care of Chronically Ill Infants and Children laid out a basic framework for the design and construction of a home healthcare system that would allow children and adolescents with chronic health conditions to live at home rather than in a hospital. The guiding principles were that the program should be comprehensive, cost-effective, support a nurturing home environment, and maximize the capabilities of the individual while minimizing the effects of their disabilities. The Task Force also set out that this program would require a case coordinator to oversee the implementation. Furthermore, when selecting patients for this type of program there were three factors that had to be taken into account. First, patient factors (i.e., the child or adolescent should be stable and there had to be a backup plan). Second, family factors (i.e., there should be parental involvement with mandatory training). Third, community factors (available resources including a primary care physician familiar with managing a child or adolescent with chronic healthcare issues in the home). Lastly, the task force stipulated that when planning to make this change from hospital to home, there had to be:

- a defined backup system of care
- family access to the healthcare system
- a plan for monitoring the child or adolescent making adjustments when necessary
- a primary care physician that would form the basis for a health home; and
- educational services for the child or adolescent [9].

Prior to 1981, children with chronic medical conditions requiring significant medical care in the home typically remained hospitalized. There was really no public option available to pay for the costs. If the parents desired to have their child at home, that cost was paid entirely by the family, with only a few notable exceptions [10, 11]. This began to change in 1981, the year that President Reagan signed the Omnibus reconciliation act. This law created the Medicaid Medical Home and Community Based Waiver. This waiver was called the 2176 Waiver because it was contained in Section 2176 of the Omnibus Reconciliation Act of 1981. The 2176 waiver was incorporated into the Social Security Act at Section 1915(c) giving it the title '1915(c) Waiver or Home and Community-Based Services Waiver' [11, 12], the title that persists even to this day. This was really the first step toward recognizing that children who had previously been hospitalized could be effectively cared for outside the hospital at a cost that was equal to or less than the cost of institutionalization. A caveat in this is if the family is unable or unwilling to provide some portion of the care, then home care costs could be equal to or greater than hospital costs. The corollary to this is that the cost to any third party is in direct proportion to how much care the family will provide [13].

There is one study that enumerated ranges of hours allocated to private duty nursing for technology-dependent children in Minnesota [14]. There was no specific rationale provided on how the allocation decisions were made. This study looked at 31 families in Minnesota who had technology-dependent children. Most families (96.8%) received some in-home nursing service and 16.1% received 24-hour care. The range of hours provided is in Table 1. Of note, more than half of the children were receiving between 1 and 16 hours per day with 32.3% getting between 1 and 8 hours per day. This has relevance when considering that many states have a "soft cap" on PDN at 16 hours per day [15].

Further details of these children included in this study are that most were <3 years of age, more than half were on home ventilators (61.3%), and there were 9 who had tracheostomies along with continuous tube feedings. This study's authors assessed all dependent as well as independent variables influencing how nursing hours were allocated in this very small sample. In doing this analysis they found the highest allotment of hours was associated with higher-income families and being on a ventilator. Furthermore, when adding in all variables even though the ventilated children were receiving more nursing hours, the child's condition or severity of the child's condition could not explain the variance in nursing hours. The other striking thing about this study was that those children receiving the lowest number of hours were found to be living in homes where the parents were married, had a lower income, and had another younger child [14].

TABLE 1 – Range of Hours Allocated for Private Duty Nursing (PDN)

Range of Hours Per Day Provided	Patients (Percentage of the entire sample)
0	1 (3.3%)
1 to 8	10 (32.3%)
9 to 16	7 (22.6%)
17 to 23	8 (25.8%)
24	5 (16.1%)

Agrawal reviewed state policies in 2015 regarding PDN and concluded that there was a striking lack of consistency in medical decision-making regarding how nursing hours should be allocated. Many states have begun to use standardized tools. There are, however, numerous problems when these tools are applied; they are arbitrary, they have not been validated or evaluated by pediatricians; there is no data in the peer-reviewed literature that correlates nursing needs with actual nursing hours received." [15].

Over one-quarter of states in a 50-state survey (14 states) provide Medicaid Managed Care Long Term Services and Supports (MLTSS) to children through 17 Medicaid managed care programs. In some cases, states have more than one Managed Medicaid (MMC) program to serve specific

groups of enrollees. The populations of children served in MLTSS programs vary across the country, but it generally begins with the child becoming eligible when it is determined that they are disabled and eligible for Social Security Supplemental Income (SSI). Other routes for enrollment are placement in foster care and/or enrollment in the 1915(c) Home and Community Based Services (HCBS) Waiver [16].

States include children in MLTSS programs in several different ways. A few states have taken a more targeted approach to providing MLTSS, particularly for children. Three states (Arizona, Texas and Virginia) have designed stand-alone MLTSS programs to specifically serve Medicaid populations with complex health care needs. Only one state, Texas, has two stand-alone MLTSS programs that exclusively serve children with complex needs. Texas STAR Health provides managed care services, including LTSS, to children in the foster care system, and Texas STAR Kids program provides managed care to children with disabilities [16].

Finally, as we become better able to sustain life in very fragile children, there is a growing population of children and adolescents who are now reliant on home-based health care, but there is a dearth of healthcare providers who are sufficiently trained to serve this growing population. The amount of skilled nursing required to keep these children and adolescents out of the hospital ranges from 20 to 30 hours a week up to round-the-clock nursing care (24/7). The lack of capacity in our healthcare system, according to these reviewers, is due to a number of factors, not the least of which are workforce gaps, inadequate payment models, and a lack of strong public policy that uniquely targets the home healthcare needs of children with medically complex conditions [17].

In a non-scientific Google search for methods to adjudicate requests for nursing services provided in Medicaid outside the hospital, we concluded that most (if not all) states use some form of checklist to determine the appropriate amount of nursing service needed by a beneficiary to support them in their home. While these checklists vary in their content and methodology, there are two common elements present in all – the amount of technology required to maintain the beneficiary in the home and the amount and duration of skilled nursing interventions required to do the same.

Due to a past court decision that prohibited the use of a checklist in determining private duty nursing hours allocated to Medicaid beneficiaries in the State of Texas [18], Driscoll Health Plan has developed a holistic methodology for determining the type of in-home nursing services (PDN versus SN) and the site of the service (Home versus PPECC) that begins with determining medical necessity for nursing using the Texas Medicaid Provider Procedures Manual as a basic starting point for each of these decisions. For SN, the request for prior authorization must meet all of the criteria listed above in the “Documentation Required” section. PDN and PPECC decisions take a slightly different path. For PDN and PPECC medical necessity determination,

Driscoll Health Plan has developed a method that comports with the processes outlined above in the "Documentation Required" section with a single caveat – the Case Review is created after an in-home, face-to-face visit conducted by a Complex Care Service Coordinator. The Complex Care Service Coordinator is a registered nurse with extensive experience in providing private duty nursing. Once the case review is completed, a Medical Director reviews the compiled information and makes a final decision on the amount of PDN or PPECC that is medically necessary and meets medical necessity. In a non-published Quality Improvement study conducted by a Medical Director at Driscoll Health Plan, this holistic and patient-focused case review method compares very favorably to checklists used in other states.

PROVIDER CLAIMS CODES:

For Skilled Nursing (SN) [19]

Procedure Codes		
G0156	G0299	G0300

For Private Duty Nursing (PDN) [20]

Procedure Code
T1000

Modifiers		
Prior to 12/1/2022	**Effective 12/1/2022**	**Description**
TD	TD or TD, U6 (MDCP)	Registered nurse (RN)
TD, UA	TD, UA or TD, UA, U6 (MDCP)	Specialized RN
TE	TE or TE, U6 (MDCP)	Licensed vocational nurse (LVN)
TE, UA	TE, UA or TE, UA, U6 (MDCP)	Specialized LVN
U3, TE	U3, TE or U3, TE, U6 (MDCP)	Independently enrolled LVN
U3, TE, UA	U3, TE, UA or U3, TE, UA, U6 (MDCP)	Ind. enrolled specialized LVN
U3, TD	U3, TD or U3, TD, U6 (MDCP)	Independently enrolled RN
U3, TD, UA	U3, TD, UA or U3, TD, UA, U6 (MDCP)	Ind. enrolled specialized RN

Diagnosis Codes for use with Modifier UA only							
J9500	J9501	J9502	J9503	J9504	J9509	J95850	Z430

Z930	Z990	Z9911	Z9912	Z9981	Z9989

Example: *Procedure code T1000 would be submitted with modifiers TD, U3, and UA for reimbursement purposes for PDN in increments of up to 15 minutes when provided by an independently enrolled RN to a client who has a tracheostomy or is ventilator dependent.*

For PPECC [21]

Procedure Codes		
Prior to 12/1/2022	**Effective 12/1/2022**	**Description**
T1025	T1025 or T1025, U6 (MDCP)	PPECC per diem code limited to once per day – greater than four hours
T1026	T1026 or T1026, U6 (MDCP)	Hourly procedure code – up to four hours
T2002	T2003 or T2003, U6 (MDCP)	Reimbursed once per day when the PPECC transports the client (NEMT)
S9123 & S9124	S9123 & S9124	Extended skilled nursing procedure code - may be billed on the same date of service but not at the same time as PPECC services

REFERENCES:

1. 26 Texas Administrative Code §554.2401 – General Qualifications for Medical Necessity Determination (effective January 15, 2021).
2. Texas Medicaid Provider Procedures Manual (TMPPM), May 2025 Edition – *Home Health Nursing and Private Duty Nursing Services Handbook*, Section 3.1.1: Medical Necessity (Home Health Skilled Nursing and Home Health Aide Services).
3. TMPPM, May 2025 Edition – *Home Health Nursing and Private Duty Nursing Services Handbook*, Section 3.4: Authorization Requirements.
4. TMPPM, May 2025 Edition – *Home Health Nursing and Private Duty Nursing Services Handbook*, Sections 4.1.1: Medical Necessity and 4.1.2: PDN Services.
5. TMPPM, May 2025 Edition – *Children's Services Handbook*, Section 2.15.1.1: Prior Authorization and Documentation Requirements.

6. TMPPM, May 2025 Edition – *Children's Services Handbook*, Section 2.15: Prescribed Pediatric Extended Care Centers (PPECC).
7. TMPPM, May 2025 Edition – *Home Health Nursing and Private Duty Nursing Services Handbook*, Section 4.1.4.2: Primary Physician Requirements.
8. TMPPM, May 2025 Edition – *Children's Services Handbook*, Section 2.15.1.1.1: Initial Authorization Requests.
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10. Koop, C. E. (1983). The Surgeon General's Workshop on Children with Handicaps and Their Families. Keynote Address. *Clinical Pediatrics*, 22(8), 567–571. https://doi.org/10.1177/000992288302200809
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15. Agrawal, S. (2015, September). Home Nursing Care: Who Should Get It, and How Much? An Analysis of State-by-State Diversity. *Complex Child.* https://complexchild.org/articles/2015-articles/october/home-nursing
16. Honsberger, K., Holladay, S., Kim, E., & VanLandeghem, K. (2018). *How States Use Medicaid Managed Care to Deliver Long-Term Services and Supports to Children with Special Health Care Needs: A 50-State Review*. National Academy for State Health Policy. https://nashp.org/wp-content/uploads/2018/12/MLTSS-and-CYSHCN-Issue-Brief-Final.pdf
17. Foster, C. C., Agrawal, R. K., & Davis, M. M. (2019). Home Health Care for Children with Medical Complexity: Workforce Gaps, Policy, and Future Directions. *Health Affairs*, 38(6), 987–993.
18. Alberto N. v. Taylor. (Case No. 6:99CV459, U.S. District Court for the Eastern District of Texas - Tyler Division). Settlement agreement accessed May 31, 2024. https://healthlaw.org/wp-content/uploads/2018/09/texas-epsdt-settlement-agreement.pdf
19. TMPPM, May 2025 Edition – *Home Health Nursing and Private Duty Nursing Services Handbook*, Section 3.1: Services, Benefits, Limitations, and Prior Authorization.

20. TMPPM, May 2025 Edition – *Home Health Nursing and Private Duty Nursing Services Handbook*, Section 4.1: PDN Services – CCP: Services, Benefits, Limitations, and Prior Authorization.
21. TMPPM, May 2025 Edition – *Children's Services Handbook*, Section 2.15.1.1.9: PPECC – Claims Filing and Reimbursement.

DOCUMENT HISTORY:

DHP Committee that Approved	*Review Approval Date (last 5 years)*				
Medical Director	09/14/2022	05/30/2023	05/31/2024	05/30/2025	
CMO	09/14/2022	06/06/2023	06/11/2024	06/10/2025	
Medical Policy Workgroup	09/14/2022	06/06/2023	06/11/2024	06/10/2025	
Utilization Management & Appeals Workgroup	09/27/2022	06/20/2023	06/18/2024	06/17/2025	
Provider Advisory Committee (PAC)	09/04/2022	06/09/2023	07/01/2024	06/24/2025	
Clinical Management Committee	10/25/2022	07/20/2023	07/24/2024	07/01/2025	
Executive Quality Committee	01/31/2023	07/25/2023	07/30/2024	07/17/2025	

Document Owner	*Organization*	*Department*
Dr. Fred McCurdy, Medical Director	Driscoll Health Plan	Utilization Management

Review/Revision Date	*Review/Revision Information, etc.*
09/01/2022	Created by Dr. Fred McCurdy and vetted through the PAC at DHP
05/30/2023	Reviewed by Dr. Fred McCurdy with no changes
05/31/2024	Reviewed and revised by Drs. Tessa Perez and Fred McCurdy

05/13/2025-5/30/2025	Annual Review and revision initiated on 05/13/2025 and completed on 05/30/2025 by Tessa Perez